STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G139	A. BUILDING _____ B. WING _____	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANAGER PLACE	2309 C STREET SW CEDAR RAPIDS, IA 52404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS An on-site Infection Control Survey was completed on 8/20/20 with no deficiencies cited. However, concerns are noted as follows: - Staff at both ICF/IID homes removed their face masks and ate meals with clients. The staff sat immediately next to the clients as they ate and chatted during the meal times. Administrative staff confirmed it was acceptable practice for staff to remove their masks and eat meals with clients. Tables were visibly not clean when the tables were set and clients set down to eat. - A sign on an administrative building from 8/17/20 to 8/19/20 directed staff to wear masks in common areas of the building. Intermittent observations revealed the majority of the staff did not wear masks when in common areas. Clients were not present. The revisits for #84963-I (August 2019) and the annual health facility survey and investigations #86444-I, #87056-I, #87271-I, #87325-I, and #87406-I (December 2019) were completed on 8/20/20 with deficiencies corrected, other than W104, which was re-cited under investigations #92686-I and # 92745-I and W193, which was re-cited under investigation #90681-I. The investigations of #88831-I, #90174-I, #90205-I, #90427-I and #92693-I resulted in no deficiencies cited. The investigation of #90681-I resulted in a deficiency cited at W193. The investigation of #92686-I resulted in deviancies cited at W104 and W189.	W 000	See attached POC 9/17/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 The investigation of #92745-I resulted in a deficiency cited at W104.	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to develop and implement policies and procedures related to exit door alarms/chimes. This affected 1 of 1 client identified during the investigation of #92686-I (Client #3). The facility also failed to develop policies and procedures related to staff use of walkie-talkies. This affected 2 of 2 clients identified during the investigation of #92745-I (Client #1 and Client #4). Findings follow: Cross Reference W189 1. Record review on 8/17/20 revealed a facility investigation and Critical Incident Report (CIR) for Client #3 regarding an elopement on the evening of 7/21/20. Client #3 left Sinclair Cottage without staff knowledge. A facility Licensed Practical Nurese (LPN) drove by the facility and saw Client #3 standing near the driveway entrance to the apartment complex next door to the facility. Client #3 returned to the facility with the LPN. He was not injured. The facility investigation estimated Client #3 was absent from the facility	W 104		

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W 104	Continued From page 2 for 3-8 minutes before being spotted by the LPN. According to the facility investigation, the facility initiated the following interventions after the elopement incident: door alarm fixed on 7/22/20 and door alarm battery checks were added to weekly maintenance checklists; written coaching and counseling to staff working at the time of the incident and additional elopement education provided to staff through team meetings and emails. According to the state climatologist, the temperature in Cedar Rapids around 8:00 p.m. on 7/21/20 was 68 degrees Fahrenheit with no precipitation. Additional record review on 8/17/20 revealed Client #3 was almost 14 years old at the time of the incident, with a birth date of 7/27/06. His diagnosis included moderate intellectual disability, attention deficit hyperactivity disorder, unspecified trauma and stress related disorder and disruptive behavior disorder by history. Client #3 had basic functional communication skills and no apparent physical disabilities. Client #3 had several behavior programs to address maladaptive behavior, including a behavior program to use coping skills instead of leaving the facility cottage, school or group without permission. According to the program, Client #3 was supposed to ask permission before leaving the cottage and/or group. The elopement program did not include the use of a door alarm/door chime. Client #3's written informed consent, which included his restrictions, noted an environmental restriction for door chimes. Client #3's level of supervision was not noted in his Individual Habilitation Plan or any of his behavior programs.	W 104		

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W 104	Continued From page 3 Observations on 8/17/20 at 12:40 p.m. at Sinclair Cottage revealed when either of the two bedroom wing exit doors opened a door chime sounded one time. The chime could be heard throughout the cottage. The front door and the kitchen exit door did not have door chimes/alarms. Eight clients (all minors) resided at the Sinclair Cottage on 7/21/20. The distance from Sinclair Cottage to the entrance driveway of the apartment complex next door where staff found Client #3 was approximately one block. When interviewed on 8/17/20 at 12:40 p.m. the Supervisor stated the door chimes on the bedroom wing exit doors were for "extra security". She said the doors would sound if a client left the facility without staff permission/knowledge. The Supervisor said staff usually monitored the bedroom wing hallways if more than one client was in that area. On the evening of 7/21/20, Youth Service Worker (YSW) C and YSW D were present at the cottage. A third staff person had been pulled to another cottage to help manage a client behavior. The Supervisor said the door chime wasn't working at the time of the incident. A piece of the door chime was missing. Maintenance repaired the door chime the day after the incident. According to the supervisor, staff didn't routinely check to ensure the door chimes were working. She said since the incident on 7/21/20 she was not aware any routine checks of the door chimes had been implemented. When interviewed on 8/17/20 at 2:30 p.m. YSW C confirmed she worked at Sinclair Cottage around 8:00 p.m. on 7/21/20. The other staff person present was YSW D. A third staff had gone to another cottage to assist with a client behavioral incident. YSW C said she last saw	W 104		

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W 104	Continued From page 4 Client #3 around 8:00 p.m. She saw him down the girls' hallway in the sensory room, along with YSW D. Client #3 didn't appear to be upset. A client began escalating in the television (TV) room and YSW C went to attend to that client. The TV room was near the front door, so YSW C would have seen Client #3 if he had gone out the front door. She didn't see Client #3 go down the boys' hallway because she was busy attending to the upset client in the TV room. YSW D also came to the TV room area to assist with the escalated client. They calmed the client after a few minutes and then YSW C went to check on the other clients. She saw the exit door was open on the boys' wing. She noticed the door chime didn't work. Within a minute or so she heard on her walkie-talkie the LPN was with Client #3 outside. About a minute later, the LPN returned Client #3 to the cottage. YSW C said she didn't know the boys' wing exit door chime was not working. No one told her it wasn't working or that staff needed to increase their level of supervision since the door chime didn't work. YSW C said she put in a work order after Client #3 returned to the cottage on 7/21/20.. YSW C estimated a maximum of 10 minutes passed from when she last saw Client #3 until she heard on the walkie-talkie that he was with the LPN. YSW C said staff typically checked on the clients every 5-10 minutes, but it was not a set rule. When interviewed on 8/17/20 at 2:50 p.m. YSW D acknowledged he was working at Sinclair Cottage around 8:00 p.m. on 7/21/20, along with YSW C. A third staff person went to another cottage to assist with a client behavioral incident. YSW D said he last saw Client #3 in the girls' hallway. Client #3 had been standing near the sensory room door. YSW D said it was a couple	W 104		

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W 104	Continued From page 5 of minutes after 8:00 p.m. and he was telling the two clients in the sensory room to leave the room and get ready for bed. Client #3 left the doorway of the sensory room and walked back toward the central area of the cottage. The other clients left the sensory room and YSW D heard yelling coming from the TV room. He went to the the TV room to assist YSW C in managing the escalated client. As they dealt with that situation, the upset client moved into the larger common area near the staff desk. No staff was monitoring the boys' hallway during this time. YSW D said he knew the door chime on the boys' wing exit door was broken. He noticed it the evening before (7/20/20). There was a piece missing from the door chime box. He recalled that he and other staff talked about putting in a work order. YSW D said he didn't know if supervisory/management staff knew the door chime was broken. Staff hadn't been told to increase supervision or awareness due to the broken door chime. YSW D said he thought the LPN called around 8:20 p.m. and said she found Client #3 outside and was bringing him back. YSW D estimated about 20 minutes passed from when he last saw Client #1 until he learned the LPN was with Client #1. YSW D said staff were supposed to monitor the hallways if more than one client was down the hallway, but he and YSW C were busy dealing with the escalated client. He didn't know if there was more than one client down the boys' hallway at the time of the incident. YSW D said he didn't know of any facility rule regarding how often clients should be checked during waking hours. When interviewed on 8/17/20 at 3:15 p.m. the LPN stated she was driving past the facility on the evening of 7/21/20. She planned to drop off her dog at a relative's house and then go to to the	W 104		

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W 104	Continued From page 6 facility to work. The LPN saw Client #3 standing about five feet from the driveway entrance to the apartment complex next door to the facility. Client #3 wore shorts, T-shirt and socks, but no shoes. The LPN checked her cell phone and it was 8:08 p.m. She stopped and talked with Client #3. Client #3 walked back to the facility property, with the LPN following him. Client #3 said he left the cottage because it was too loud. The LPN walked Client #3 back to Sinclair Cottage. She assessed him for injuries, but there were none. When interviewed on 8/17/20 at 1:15 p.m. Qualified Intellectual Disability Professional (QIDP) B stated Client #3 had a history of elopement attempts, but in the past staff were able to follow him and he typically stayed on facility property. QIDP B acknowledged Client #3's level of supervision was not specified in this programs. She said staff should typically check on the clients every 5-10 minutes during waking hours. QIDP B said staff were not typically assigned to specific clients, but were expected to communicate with each other regarding supervision. QIDP B stated staff were not required to monitor the boys' and girls' bedroom wings as long as no more than one client was in a room at a time. When asked the purpose of the door chimes, QIDP B said the door chime alerted staff if a bedroom wing exit door opened. The doors were not routinely used, so the door chimes alerted staff that someone probably went outside. The doors were locked from the outside. QIDP B said she didn't know whether the door chimes had been routinely checked to see if they worked. She said she didn't know whether they were routinely checked since the incident of Client #3's elopement on 7/21/20.	W 104		

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W 104	Continued From page 7 During a follow up interview on 8/17/20 at 1:40 p.m. QIDP B said she talked with a maintenance staff who told her staff put in a work order for the door chime on the weekend of July 18th or 19th. After Client #3 eloped on the evening of 7/21/20, staff put in a second work order. Maintenance staff fixed or replaced the door chime on 7/22/20. QIDP B said she didn't know whether that staff working at the time of the incident were aware the door chime was not working. She said staff had not been provided with additional training/information regarding increased supervision or awareness of client whereabouts when the door chime didn't work. When interviewed on 8/18/20 at 10:55 a.m. the Maintenance Staff (MS) said he recalled that a work order first came in for the Sinclair Cottage boys' wing door chime on the weekend of July 18th or 19th. He said he wasn't able to get to it right away. The MS said he thought he fixed the door chime on 7/22/20, the day after Client #3's elopement, but he was not sure of the date. Due to a power outage, he was unable to access the maintenance requests to verify dates. The MS said at the time of the incident on 7/20/20, the facility maintenance staff did not routinely check the door chimes They fixed them when they got work orders for them. The MS said to his knowledge the maintenance staff was still not routinely checking the exit door chimes. When interviewed on 8/17/2 at 3:05 p.m. the Director of Inpatient Services (DIS) and the Associate Director of Inpatient Services (ADIS) said the facility had no policies or procedures related to the use of exit door alarms/chimes, or checking to ensure they worked or alerting staff when the door chimes did not work.	W 104		

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W 104	Continued From page 8 During a follow up interview on 8/18/20 at 3:00 p.m. the ADIS provided the work orders for the door alarm/chime on the boys' wing exit door at Sinclair Cottage. She was able to access them from the computer system. A work order on 7/06/20 indicated the alarm on the exit door of the boys' hallway was missing the main piece of the alarm. According to the work order, the request was assigned to MS on 7/13/20 and was resolved on 7/23/20. A second work order by YSW C dated 7/21/20 at 10:20 p.m. indicated the alarm on the boys' hallway exit door didn't work and needed to be replaced. The work order was resolved on 7/22/20. The ADIS said to the best of her knowledge the dates on the work order forms were correct. 2. Record review of the facility investigation and Critical Incident Report (CIR) revealed Client #1 and Client #4 left the facility without staff permission on the afternoon of 7/15/20. YSW E followed Client #1 and Client #4 as they walked/ran approximately seven blocks to a Hy-Vee gas station/convenience store at a busy intersection. YSW E used the gas station phone to call the facility and request additional staff assistance. Client #1 and Client #4 left the gas station after a short time and crossed the street to the Hy-Vee parking lot and grocery store. They threw rocks and YSW E, hitting her at times. The two clients entered the grocery store and YSW E called the police, using a by-stander's phone. The dispatcher told YSW E to monitor the exit doors but not to go into the grocery store. YSW E estimated the two clients were in the store about 15 minutes when they started to come out, but then apparently saw YSW E and went back inside. Approximately 10 more minutes passed	W 104		

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W 104	Continued From page 9 before three additional facility staff and the police arrived. Two of the staff entered the store and came out with Client #1 and Client #4, who were yelling at the staff. Client #1 became physically aggressive, resulting in intervention by police and facility staff. The police searched Client #1's pockets and found razor blades and Ibuprofen tablets. Client #1 also became self-injurious after the additional staff and police became involved, by biting himself and banging his head on the cement sidewalk, resulting in physical holds. According to the state climatologist, the temperature in Cedar Rapids on 7/15/20 at 1:00 p.m. was 74 degrees Fahrenheit with no precipitation. The temperature at 2:00 p.m.. was 71 degrees Fahrenheit with no precipitation. Record review revealed Client #1 was a 15 year old self-identified male with a diagnosis including Mild Intellectual Disability, Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder and Conduct Disorder. Client #1 resided at the facility for approximately one year. Client #1 had multiple programs for behavioral issues, including leaving the facility without staff permission. His elopement program noted he should request staff permission before leaving the cottage. Client #1 had a history of multiple elopement attempts Record review revealed Client #4 was a 13 year old male with a diagnosis including Mild Intellectual Disability, ADHD, Disruptive Mood Disregulation Disorder, Unspecified Anxiety Disorder and Disruptive Behavior Disorder. Client #4 was admitted to the facility on 5/04/20. Client #4's behavior program included an objective to comply with authority figures and	W 104		

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W 104	Continued From page 10	W 104		

follow rules. An objective related to using coping skills instead of eloping was added to his behavior program after the elopement incident on 7/15/20.

Observation on 8/18/20 revealed the Hy-Vee grocery store was approximately seven blocks from the facility. Wilson Ave was the primary street connecting the facility and Hy-Vee. The posted speed limit was 30 miles per hour. Traffic on Wilson Ave was steady. The Hy-Vee gas station was on the southwest corner of the intersection of Wilson Ave and Bowling Street, a busy intersection with a 4-way stop. The Hy-Vee parking lot and grocery store was on the northwest corner of the intersection.

When interviewed on 8/18/20 at 11:00 a.m. YSW E confirmed her prior statements regarding the incident. At approximately 1:30 p.m. on 7/15/20, Client #1 and Client #4 ran out the kitchen door of Sinclair Cottage. Client #1 didn't have shoes on. YSW E followed the two clients. They said they were going to the facility playground, but they didn't go that way. Client #1 and Client #4 walked across the facility grounds, along C Street and then crossed to Wilson Ave, within about 2 ½ minutes. YSW E followed, but disengaged verbally, as she had been trained. About 1/3 of the way to Hy-Vee, Client #4 crossed Wilson Ave, to the south side of the street and walked along the sidewalk. He was still in staff sight. Client #1 stayed on the north side of Wilson Ave with YSW E following. They walked along Wilson Ave about 15 minutes before coming to the Hy-Vee gas station. Client #4 ran across Bowling Street to the gas station. He was then out of staff eyesight when he went into the convenience store. Client #4 crossed Wilson Ave and Bowling Street and

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W 104	Continued From page 11 also went into the gas station convenience store. Client #4 went into the men's restroom and Client #1 waited for him outside the door. YSW E used the gas station phone to call the facility and spoke with the Shift Leader. She told the Shift Leader she needed additional staff to come to the Hy-Vee gas station with a vehicle to assist with the situation. Immediately after YSW E got off the phone, Client #1 and Client #4 went out the front door of the gas station. They crossed Wilson Ave to the Hy-Vee grocery store parking lot. They picked up rocks and threw them at YSW E, with some of the rocks hitting her. The two clients put rocks in their pockets and went into the grocery store. YSW E used a citizen's phone to call the non-emergency police number. The operator/dispatcher told YSW E to stay outside, so she stayed outside and monitored the doors. About 15 minutes later, Client #1 and Client #4 came out the front door, but apparently saw YSW E and went back inside. Another 10 minutes passed and three Tanager Place staff arrived. YSW E told the other staff the two clients were in the store and two of the staff went into the store. Immediately after that, YSW E flagged down a police car in the parking lot. There were two police cars that showed up, around the same time the facility staff got there. The two facility staff came out of the store with the two clients before the police had the chance to go inside. Client #1 and Client #4 were yelling at the staff. Client #1 said Client #4 had a knife, so the police patted Client #4 down and put him in the police car. YSW E didn't recall that Client #4 actually had a knife or any type of weapon. Client #1 became physically aggressive toward the staff, trying to bite them. The police became involved. Someone told police that Client #1 had something in his pockets. Client #1 refused to comply with	W 104		

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police requests to empty his pockets, so they physically intervened, but were having a difficult time, so staff assisted with a Mandt hold. The police recovered five razor blades and approximately twenty 200 mg tablets of Ibuprofen from Client #1's pockets. Client #1 continued to try to aggress toward staff and police and also tried to bang his head on the cement side walk. The three staff put him in a Mandt hold for about 15 minutes. Client #1 began to calm and eventually got into the van and returned to the facility. Client #4 returned to the facility in the police car. When asked whether she had a walkie-talkie, YSW E said she got a walkie-talkie as she went out the cottage door, following the two clients, but the walkie-talkie didn't work when she tried to contact the facility. She said staff were supposed to have walkie-talkies on them, but she hadn't checked to make sure the walkie-talkie was working. She was helping cover at the Sinclair Cottage while the regular staff were at a staff meeting. YSW E said she didn't have a cell phone on her and the walkie-talkie didn't work. She said Client #1 and Client #4 generally crossed the streets safely and looked for traffic, so they did not appear to be in danger when crossing the streets. YSW E estimated it took facility staff 25-30 minutes to show up at Hy-Vee after she called the Shift Leader from the gas station and asked for help. This seemed like an excessive amount of time to her. The Shift Leader had seen her run out the door after the two clients, but had not sent anyone to check on her. YSW E estimated it took the police about 25 minutes to arrive after she called them. She said the two clients were not injured during the actual elopement, but Client #1 caused some injuries to himself from biting himself and banging his head on the cement sidewalk after the other staff and

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W 104	Continued From page 13 police arrived and became involved. When interviewed on 8/18/20 at 1:35 p.m. the Shift Leader said he was helping cover at Sinclair Cottage at the time of the incident on 7/15/20, while the regular Sinclair Cottage staff were at a staff meeting. He was aware that YSW E ran out the door after Client #1 and Client #4. The Shift Leader knew YSW E had a walkie-talkie with her, so he assumed she would radio for help if it was needed. There were not enough staff at the cottage to immediately send another staff with YSW E. Staff kept walkie-talkies on them. There was a checklist that staff used each shift to ensure the walkie-talkies were present. The Shift Leader said staff usually checked the walkie-talkies to make sure they were working. The Shift Leader said less than 30 minutes passed from when the two clients and YSW E ran out the door until YSW E called him and said she needed more staff to assist her at the Hy-Vee gas station. The Shift Leader said he then contacted the conference room where the Sinclair Cottage staff were having a staff meeting. There was a mix-up, because initially a staff person came to the cottage to provide additional assistance. The Shift Leader then clarified they needed a van, a driver and additional staff to go to the Hy-Vee gas station. He said it was possible that it took 25-30 minutes for the staff to arrive at the Hy-Vee grocery store from the time YSW E had called him for help. When interviewed on 8/18/20 at 1:15 p.m. the Supervisor for Sinclair Cottage said she and other Sinclair staff were at a staff meeting in another building when the elopement occurred. The Supervisor said staff were supposed to have walkie-talkies on them at all times when working.	W 104		

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W 104	Continued From page 14 She said staff used a checklist each shift to verify the walkie-talkies were present, but did not necessarily check to see if they were working correctly. The Supervisor recalled that someone got her and two other staff out of the staff meeting to go assist YSW E with Client #1 and Client #4, who eloped. They got a facility van and went to the Hy-Vee gas station. They didn't see YSW E or the clients, so they circled around the area and then saw YSW E outside of the Hy-Vee grocery store. The Supervisor estimated about 7-8 minutes passed from when she was told of the incident until she and the other staff arrived at the Hy-Vee grocery store. When asked if a staff person should have checked on YSW E and the two clients after they ran out the door, the Supervisor said probably so, but it would be better to ask with the Shift Leader, who was there at the time of the incident. The Supervisor obtained the staff checklist for 7/15/20, which revealed a staff person initialed on first shift that three walkie talkies were there. The staff person who initialed the form no longer worked at the facility. When interviewed on 8/18/20 at 2:30 p.m. the DIS and the ADIS said the staff used a checklist on each shift and it included counting the walkie-talkies to ensure they were there, but not that they were actually working. The DIS said the facility did not have policies or procedures to address the use of the walkie-talkies. When asked about the delay in the amount of time it took for the facility to provide additional assistance for the incident, the DIS noted that YSW E estimated the amount of time and it might not have actually taken as long as she estimated. The DIS said it probably did take a certain amount of time to gather the additional staff,	W 104		

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W 104	Continued From page 15 locate a qualified driver for agency vehicles and get the agency van out of the garage.	W 104		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to provide adequate staff training related to exit door alarms/chimes. This affected 1 of 1 client identified during the investigation of #92686-I (Client #3).(Cross Reference W104.) Finding follows: Record review on 8/17/20 revealed a facility investigation and Critical Incident Report (CIR) for Client #3 regarding an elopement on the evening of 7/21/20. Client #3 left Sinclair Cottage without staff knowledge. A facility LPN was driving by the facility and saw Client #3 standing near the driveway entrance to the apartment complex next door to the facility. Client #3 returned to the facility with the LPN. He was not injured. The facility investigation estimated Client #3 was absent from the facility for 3-8 minutes before being spotted by the LPN. According to the facility investigation, the facility initiated the following interventions after the elopement incident: door alarm fixed on 7/22/20 and door alarm battery checks were added to weekly maintenance checklists; written coaching and counseling to staff working at the time of the incident and additional elopement education provided to staff	W 189		

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W 189	Continued From page 16 through team meetings and emails. Additional record review on 8/17/20 revealed Client #3 was almost 14 years old at the time of the incident, with a birth date of 7/27/06. His diagnosis included Moderate Intellectual Disability, Attention Deficit Hyperactivity Disorder, Unspecified Trauma and Stress Related Disorder and Disruptive Behavior Disorder by History. Client #3 had basic functional communication skills and no apparent physical disabilities. Client #3 had several behavior programs to address maladaptive behavior, including a behavior program to use coping skills instead of leaving the facility cottage, school or group without permission. According to the program, Client #3 was supposed to ask permission before leaving the cottage and/or group. The elopement program did not include the use of a door alarm/door chime. Client #3's written informed consent, which included his restrictions, noted an environmental restriction for door chimes. Client #3's level of supervision was not noted in his Individual Habilitation Plan or any of his behavior programs. According to the state climatologist, the temperature in Cedar Rapids around 8:00 p.m. on 7/21/20 was 68 degrees Fahrenheit with no precipitation. Observations on 8/17/20 at 12:40 p.m. at Sinclair Cottage revealed when the two bedroom wing exit doors opened a door chime sounded one time. The chime could be heard throughout the cottage. The front door and the kitchen exit door did not have door chimes/alarms. Eight clients (all minors) resided at the Sinclair Cottage on 7/21/20. The distance from Sinclair Cottage to the	W 189		

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W 189	Continued From page 17 entrance driveway of the apartment complex next door where staff found Client #3 was approximately one block. When interviewed on 8/17/20 at 12:40 p.m. the Supervisor stated the door chimes on the bedroom wing exit doors were for "extra security". She said the doors would sound if a client left the facility without staff permission/knowledge. The Supervisor said staff usually monitored the bedroom wing hallways if more than one client was in that area. On the evening of 7/21/20, Youth Service Worker (YSW) C and YSW D were present at the cottage, which has A third staff person had been pulled to another cottage to help manage a client behavior. The Supervisor said the door chime wasn't working at the time of the incident. A piece of the door chime was missing. Maintenance repaired the door chime the day after the incident. According to the supervisor, staff didn't routinely check to ensure the door chimes were working. She said since the incident on 7/21/20 she was not aware that any routine checks of the door chimes had been implemented. When interviewed on 8/17/20 at 2:30 p.m. YSW C confirmed she was working at Sinclair Cottage around 8:00 p.m. on 7/21/20. The other staff person present was YSW D. A third staff had gone to another cottage to assist with a client behavioral incident. YSW C said she last saw Client #3 around 8:00 p.m. She saw him down the girls' hallway in the sensory room, along with YSW D. Client #3 didn't appear to be upset. A client began escalating in the television (TV) room, so YSW C went to attend to that client. The TV room was near the front door, so YSW C would have seen Client #3 if he had gone out the	W 189		

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front door. She didn't see Client #3 go down the boys' hallway because she was busy attending to the upset client in the TV room. YSW D also came to the TV room area to assist with the escalated client. They calmed the client after a few minutes and then YSW C went to check on the other clients. She saw the exit door was open on the boys' wing. She noticed the door chime didn't work. Within a minute or so she heard on her walkie-talkie the LPN was with Client #3 outside. About a minute later, the LPN returned Client #3 to the cottage. YSW C said she didn't know the boys' wing exit door chime was not working. No one had told her it wasn't working or that staff needed to increase their level of supervision since the door chime didn't work. YSW C said she put in a work order after Client #3 returned to the cottage. YSW C estimated a maximum of 10 minutes had passed from when she last saw Client #3 until she heard on the walkie-talkie that he was with the LPN. YSW C said staff typically checked on the clients every 5-10 minutes, but it was not a set rule.

When interviewed on 8/17/20 at 2:50 p.m. YSW D acknowledged he was working at Sinclair Cottage around 8:00 p.m. on 7/21/20, along with YSW C. A third staff person had gone to another cottage to assist with a client behavioral incident. YSW D said he last saw Client #3 in the girls' hallway. Client #3 had standing near the sensory room door. YSW D said it was a couple of minutes after 8:00 p.m. and he was telling the two clients in the sensory room to leave the room and get ready for bed. Client #3 left the doorway of the sensory room and walked back toward the central area of the cottage. The other clients left the sensory room and YSW D heard yelling coming from the TV room. He went to the the TV

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room to assist YSW C in managing the escalated client. As they dealt with that situation, the upset client moved into the larger common area near the staff desk. No staff was monitoring the boys' hallway during this time. YSW D said he knew the door chime on the boys' wing exit door was broken. He had noticed it the evening before (7/20/20). There was a piece missing from the door chime box. He recalled that he and other staff had talked about putting in a work order. YSW D said he didn't know if supervisory/management staff knew the door chime was broken. Staff hadn't been told to increase supervision or awareness due to the broken door chime. YSW D said he thought the LPN called around 8:20 p.m. and said she had found Client #3 outside and was bringing him back. YSW D estimated about 20 minutes passed from when he last saw Client #1 until he learned the LPN was with Client #1. YSW D said staff were supposed to monitor the hallways if more than one client was down the hallway, but he and YSW C were busy dealing with the escalated client. He didn't know if there was more than one client down the boys' hallway at the time of the incident. YSW D said he didn't know of any facility rule regarding how often clients should be checked during waking hours.

When interviewed on 8/17/20 at 3:15 p.m. the LPN stated she was driving past the facility on the evening of 7/21/20. She planned to drop off her dog at a relative's house and then to to the facility to work. The LPN saw Client #3 standing about five feet from the driveway entrance to the apartment complex next door to the facility. Client #3 had on shorts, T-shirt and socks, but no shoes. The LPN checked her cell phone and it was 8:08 p.m. She stopped and talked with Client

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W 189	Continued From page 20 #3. Client #3 walked back to the facility property, with the LPN following him. Client #3 said he left the cottage because it was too loud. The LPN walked Client #3 back to Sinclair Cottage. She assessed him for injuries, but there were none. When interviewed on 8/17/20 at 1:15 p.m. Qualified Intellectual Disability Professional (QIDP) B stated Client #3 had a history of elopement attempts, but in the past staff were able to follow him and he typically stayed on facility property. QIDP B acknowledged Client #3's level of supervision was not specified in this programs. She said staff should typically check on the clients every 5-10 minutes during waking hours. QIDP B said staff were not typically assigned to specific clients, but were expected to communicate with each other regarding supervision. QIDP B stated staff were not required to monitor the boys' and girls' bedroom wings as long as no more than one client was in a room at a time. When asked the purpose of the door chimes, QIDP B said the door chime alerted staff if a bedroom wing exit door had been opened. The doors were not routinely used, so the door chimes alerted staff that someone had probably gone outside. The doors were locked from the outside. QIDP B said she didn't know whether the door chimes had been routinely checked to see if they worked. She said she didn't know whether they were routinely checked since the incident of Client #3's elopement on 7/21/20. During a follow up interview on 8/17/20 at 1:40 p.m. QIDP B said she had talked with a maintenance staff who told her staff had put in a work order for the door chime on the weekend of July 18th or 19th. After Client #3 eloped on the	W 189		

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W 189	Continued From page 21 evening of 7/21/20, staff put in a second work order. Maintenance staff fixed or replaced the door chime on 7/22/20. QIDP B said she didn't know whether that staff working at the time of the incident were aware the door chime was not working. She said staff had not been provided with additional training/information regarding increased supervision or awareness of client whereabouts when the door chime didn't work. When interviewed on 8/17/2 at 3:05 p.m. the Director of Inpatient Services and the Associate Director of Inpatient Services said the facility had no policies or procedures related to the use of exit door chimes, or checking to ensure they worked or alerting staff when the door chimes did not work.	W 189		
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff provided the required level of supervision in order to provide a safe environment. This affected 2 of 2 sample clients identified in the investigation of #90681-I (Client #1 and Client #2). Findings follow: Record review on 8/04/20 revealed a facility investigation and Critical Incident Report (CIR) regarding an incident that occurred on 3/25/20. According to the facility investigation and CIR, Client #1 reported to staff on the afternoon of	W 193		

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3/25/20 that Client #2 had pulled down his pants and shown Client #1 his penis. Youth Service Worker (YSW) A was responsible for supervising Client #1 and Client #2 at the time of the incident, but left them alone in the recreation room together. The facility investigation concluded YSW A had left Client #1, Client #2 and Client #3 alone in a room together without staff supervision. According to the facility investigation, the facility conducted additional staff training regarding client supervision and provided "coaching and counseling" to YSW A as a result of the incident.

Record review revealed Client #1 was a 15 year old female with a diagnosis including Mild Intellectual Disability, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Conduct Disorder. Client #1 had resided at the facility for approximately one year. Client #1 had multiple programs for behavioral issues, but inappropriate sexual behavior was not an identified target behavior. Her level of supervision when in the cottage common areas with peers was not identified in her programs. At the time of the incident, Client #1, who was born a female, identified as a female. At the time of the DIA investigation, Client #1 identified as male. Client #1 is referred to as "she" in this deficiency since she identified as female at the time of the incident.

Additional record review revealed Client #2 was a 15 year old male with a diagnosis including Mild Intellectual Disability, Autism Spectrum Disorder, Anxiety, Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. Client #2 had resided at the facility for approximately two years. Client #2 had multiple programs for behavioral issues, including a program to have appropriate

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W 193	Continued From page 23 boundaries with peers. According to the program, when Client #2 was spending time with peers, "staff will monitor for appropriate (not touching) boundaries" and remind Client #2 of "personal bubble". The program also noted, "Due to age and history of sexualized behavior, (Client #2) will be in staff eyesight when with his peers in cottage common areas." In a facility statement dated 3/25/20, YSW A said Client #1, Client #2 and Client #3 were playing with Barbies in the recreation room around 3:00 p.m.. According to YSW A, she had been supervising the clients, but Client #1, Client #2 and Client #3 wanted to play alone together, so YSW A went around the corner to paint at a table as the children played. YSW B told YSW A the clients were acting strangely and asked YSW A to go back to the recreation room. YSW A said she didn't witness any inappropriate contact between the clients. She did not estimate how long the clients were unsupervised. YSW A no longer worked at the facility at the time of the DIA investigation, so was unavailable for interview. In a facility statement dated 3/25/20, YSW B said she was doing training on the computer in the staff office when she went to the bathroom between 3:00 and 3:30 p.m. YSW B noticed Client #1, Client #2 and Client #3 were in the recreation room unsupervised. YSW B saw a staff person sitting at a table in the other room and asked her to go to the recreation to supervise the clients, which the staff person did. YSW B prompted the clients to gather for group time a short time later. Client #1 approached YSW B and asked to speak with her privately. Client #1 told YSW B that she had seen Client #2's private area in the recreation room due to feeling peer	W 193		

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pressured. YSW B immediately called a supervisor to report the incident. YSW B no longer worked at the facility at the time of the DIA investigation, so was unavailable for interview.

When interviewed on 8/13/20 at 11:25 a.m. Client #1 appeared to be calm when recalling the incident. Client #1 said Client #2 quickly showed her his penis. Client #1 said she didn't know the location of the assigned staff person when the incident occurred. When asked how she felt about the incident, Client #1 said it felt weird.

When interviewed by facility management staff on 3/25/20 regarding the incident, Client #2 denied exposing his penis to Client #1. He said Client #1 showed him the top of her underwear.

When interviewed by facility management staff on 3/25/20 regarding the incident, Client #3 stated Client #2 was talking inappropriately, but he said that no one pulled down their pants.

When interviewed on 8/13/20 at 10:40 a.m. the Associate Director of Inpatient Services (ADIS) stated it was not clear what actually happened when Client #1, Client #2 and Client #3 were left unsupervised for a period of time on the afternoon of 3/25/20, since the three clients gave different accounts of what occurred. The ADIS said YSW A should have been supervising the clients while they were in the room together. She said staff were trained to supervise an area and keep the clients in eyesight if more than one client was present.

When interviewed on 8/17/20 at 10:45 a.m. Qualified Intellectual Disability Professional (QIDP) A confirmed Client #2 had a history of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G139	A. BUILDING _____ B. WING _____	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANAGER PLACE	2309 C STREET SW CEDAR RAPIDS, IA 52404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 193	Continued From page 25 inappropriate sexual behavior and needed to be in staff eyesight when around peers, per his behavior program.	W 193		

TANAGER PLACE PLAN OF CORRECTION

OK 10/7/20

TANAGER PLACE
YOUR CHILD : OUR FOCUS

W104 – The governing body must exercise general policy, budget, and operating direction over the facility.

Failed to develop and implement policies and procedures related to exit door alarms/chimes. Failed to develop policies and procedures related to walkie-talkies.

Immediate actions taken:

- Discussed in team meeting 08/26/2020 and provided clarity around expectations pertaining to exit door alarms/chimes as well as walkie-talkies.
- Policies for use of door chimes created. This includes timeframes for maintenance to resolve work orders related to alarms/door chimes, training of staff around alarms/door chimes, as well as redundancy plans should alarms/door chimes be non-operational.
- Policies for walkie-talkies created. This includes timeframes for maintenance to resolve work orders related to walkie-talkies, training of staff around walkie-talkies, as well as redundancy plans should a walkie-talkie be out of range or non-operational.
- Daily checks created to ensure that alarms/door chimes are operational.
- Daily checks created to ensure that walkie-talkies are operational.
- Procedures put in place to remove non-operational items from milieu until such time that they can be restored to an operational state, thus preventing staff from inadvertently picking up a device that is not functioning properly.
- Monthly maintenance checks were reinstated.

Methods to monitor compliance: IP Governing body [Program Managers will monitor policy adherence, at a minimum quarterly. Supervisors will review daily checks to ensure that staff are indicating that the device was checked. Monthly door checks will occur by a member of the maintenance team.

Person[s] responsible: ICFID Program Manager, Cottage Supervisors

Date of correction: Immediate, upon receipt 09/17/2020

[redacted]

TANAGER PLACE
YOUR CHILD · OUR FOCUS

W193: Training Program: Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the appropriate behavior of clients.

Facility failed to ensure staff provided the required level of supervision in order to provide a safe environment.

- Immediately following internal review of the incident, staff had undergone additional training as well as further coaching and counseling regarding heightened supervision protocols and duration of time in which clients are to remain in eyesight.
- Onboarding template had been revised and includes a competency checklist for heightened supervision protocols.
- Staff members are to demonstrate development of competency before being placed into ratio.
- BMPs include identification of any supervision needs.
- Monthly case reviews include discussion on supervision needs. This clearly identifies whether the identified level of supervision requires clients to be within staff eyesight at all times and/or if able to divert their attention for a few seconds.
- Daily change-overs include identification of clients placed on heightened supervision.
- Weekly fidelity checks have been implemented by Supervisors and Program Managers to ensure that staff are providing the required level of supervision.

Methods to monitor compliance: Supervisor monitors competency development for all new hires. Supervisors and Program Managers conduct weekly fidelity checks to ensure staff are providing the required level of supervision.

Person[s] responsible: ICFID Program Manager and Cottage Supervisors

Date of correction: Fully corrected immediately, upon receipt 09/17/2020