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| W 000 | INITIAL COMMENTS<br><br>The annual recertification survey was completed from 7/5/22 to 7/21/22.<br>As a result of the survey Standard level deficiencies were cited at W104, W124, W190, W210, W249, W250, W261, W263, W289, W290, W322, W350, W371, W454, W474 and Iowa Administrative Code (IAC) 481- Chapter 50.7(4).<br><br>The investigation of 103268-C was completed from 6/28/22 to 7/21/22 with the following results:<br>As a result of the investigation Standard Level deficiency was cited at W436.<br><br>The investigation of 103974-C was completed from 6/28/22 to 7/21/22 with the following results:<br>As a result of the investigation a Standard Level deficiency was cited at W436. | W 000 | See Attached<br><br>POC<br>9/27/22 | |
| W 104 | GOVERNING BODY<br>CFR(s): 483.410(a)(1)<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br>This STANDARD is not met as evidenced by:<br>Based on interview and record review the facility failed to develop policies and procedures to govern the use of restrictions to resident rights and incidents of unknown origin. This affected 4 of 4 sample clients (Client #1, Client #2, Client #3 and Client #4) and potentially all 41 clients who resided in the facility at the time of the survey (Client #1 to Client #41). Findings follow:<br><br>1. Record review of Client #1's file revealed a behavior program with restrictive measures such as psychotropic medication and limited access to | W 104 | | |

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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electronics. Additional record review revealed Client #1's bedroom window was screwed shut, withouot a replacement behavior program or informed gaurdian consent.

Record review of Client #2's file revealed behavior programs with the use of psychotropic medications.

Record review of Client #3's file revealed two behavior programs with the use of restrictive measures such as psychotropic medications, the use of blocking mat and a door alarm.

Record review of Client #4's file revealed two behavior programs with the use of several psychotropic medications.

When interviewed on 7/07/22 at 10:35 a.m. the Administrator confirmed the facility failed to develop policies and/or procedures to ensure all the necessary components were in place before the implementation of a rights restriction.

2. Record review on 7/7/22 revealed only one injury of unknown origin report/investigation from 1/1/22 to 7/7/22. The lone investigation/report involved bruising to Client #10's tailbone on 5/2/22. The document failed to indicate the Administrator or a designee was notified of the injury.

Further record review of several skin sheets revealed injuries to Client #31 on 4/7/22 where she was found with a "friction rub" on her right ribcage, on 4/23/22 with a bruise to the left eye lid and 5/5/22 with an abrasion to her mid back. Client #19 also had a report from 6/1/22 where an

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abrasion was found on his ear and eye. These were not documented as incident reports and/or investigated as injuries of unknown origin.

Record review on 7/7/22 revealed policy on incident reports last revised 11/29/11. The policy discussed employee incident/injuries as well as resident incidents/injuries. The policy that pertained to resident incidents/injuries indicated a factual, narrative description of the occurrence must be documented. The policy noted this must be completed as an incident report and it must also be copied into the resident's medical record. The policy noted all completed reports will be maintained for 5 years. The policy made no reference to injuries of unknown origin.

Record review of a policy for "Mandatory Reporting of Adult Abuse, Crimes or other Notifications" defined injuries of an unknown source as an injury not observed by a person and one in which the injured party can not explain. The policy further noted the injury needed to be suspicious based on extent or location or of the number of injuries over a certain period of time.

When interviewed on 7/12/22 at 1:45 p.m. the Director of Nursing (DON) and the Nurse Manager (NM) both confirmed the only injury of unknown origin investigation completed by the agency since 1/1/22 was the 5/3/22 incident with Client #10. They also confirmed the injuries to Client's #19 and #31 (listed above) were also injuries of unknown origin that were missed and not investigated. The DON and the NM stated they were not aware of any policies the agency had that specifically spelled out a process for how to handle injuries of unknown origin. They stated they knew they needed to investigate them if they

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| W 104 | Continued From page 3<br>had one, but admitted their system was not catching them properly which resulted in investigations not being completed.<br><br>When interviewed on 7/12/22 at 1:56 p.m. the Administrator confirmed the two policies she provided were the only documents she was aware of related to injuries of unknown origin. She confirmed neither policy outlined a process for identification and/or investigation of such injuries. | W 104 | | |
| W 124 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(2)<br><br>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.<br>This STANDARD is not met as evidenced by:<br>Based on interview and record review the facility failed to obtain guardian consent for the use of restrictive measures. This affected 2 of 4 sample clients (Client #1 and Client #4). Findings follow:<br><br>1. Record review on 6/27/22 revealed Client #1's behavior data sheet noted an incident on 3/22/22 at 4:00 p.m. The note referenced that the Qualified Intellectual Disabilities Professional (QIDP) questioned the client about leaving his room/the building without staff knowledge by use of his window. Client #1's behavior notes indicated he "became defensive, started yelling at staff and swearing/threatening staff, raised voice."<br><br>Record review on 7/07/22 revealed Client #1's progress notes from 4/17/22 which indicated staff | W 124 | | |

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called a missing person code when unable to locate Client #1 in his room. Client #1 later admitted he went out the comfort room window to the life skills building where he was found. Additional record review revealed no consent could be located in Client #1's chart for his bedroom window being screwed shut.

When interviewed on 6/30/22 at 9:08 a.m. QIDP A said the facility was suspicious Client #1 exited out his window when items were missing from the life skills building. QIDP A acknowledged Client #1 admitted he went out his room window.

When interviewed on 7/05/22 at 12:13 p.m. the Director of Nursing (DON) reported Client #1's window was modified by placing screws in the top of the frame. She also stated no incident reports could be located for the elopements from his window.

When interviewed on 7/13/22 at 11:10 a.m. QIDP A confirmed the facility failed to obtain consent for Client #1's window restriction nor had they notified the guardian of the situation or the risks associated with the restriction. The QIDP also confirmed she failed to implement a program for Client #1's elopement behavior.

2. Record review on 7/13/22 revealed a 90 day physician's order for Client #4 dated 6/6/22 which indicated an order for use of "bilat hand mitts and elbow restrains" to be released for 10 minutes every 2 hours as needed for skin picking.

Additional record review of Client #4's behavior programs for sleep and using coping skills failed to indicate the use of the restraints.

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| W 124 | Continued From page 5<br><br>When interviewed on 7/13/22 at 3:56 p.m. the Nurse Manager (NM) confirmed the order for the mitts and elbow restraints was current in the physician's orders. She says she has the order as she picks at her skin and can create significant holes which could be major health concerns. She stated it's just kind of used "as needed" or PRN. Additionally the NM provided a copy of the facility order dated 3/24/21, which indicated the mitts and elbow restrains to be used "as needed for skin picking". The NM stated she believed those would be in Client #4's behavior program and the facility would have consents since they are a restriction. She stated the order is for an "indefinite" period of time.<br><br>When interviewed on 7/13/22 at 2:40 p.m. QIDP B confirmed Client #4 used the restraints about one time per quarter to protect her chin. Initially she reported she believed they had consent for the restraints, but after looking admitted they did not have any consent or programming for the restraints. | W 124 | | |
| W 190 | STAFF TRAINING PROGRAM<br>CFR(s): 483.430(e)(2)<br><br>For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental,<br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews and record review facility staff failed to consistently utilize adaptive equipment for clients' as outlined in the individual program plan. This affected 1 of 2 sample clients who utilize a wheelchair (Client #3) and 5 clients who utilize a wheelchair added to the sample (Client #5, Client #6, Client #7, and | W 190 | | |

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Client #21). Findings follow:

1. Observations on 7/6/22 at 4:20 p.m. revealed Client #3 in bed without a mat on the floor. Additional observation with Qualified Intellectual Disabilities Professional (QIDP) C on 7/12/22 at 3:50 p.m. revealed the client again asleep in his bed with no mat on the floor beside his bed. At 4:33 p.m. the surveyor entered the client's bedroom with the Nurse Manager (NM). The client was again found asleep with no mat on the floor beside his bed. The NM located the mat propped up against the wall in the corner of the room and placed it by his bed. On 7/13/22 again Client #3 was observed at 2:30 p.m. asleep in his bed with no mat on the floor beside it.

Record review revealed medical nursing reports from Client #3's annual staff from 2/15/22. The report indicated the client has a low bed with two head of bed side rails on his bed and mats next to bed to help with positioning and safety.

When interviewed on 7/12/22 at 3:50 p.m. QIDP C stated if the mat wasn't by Client #3's bed then they must have taken it out of his programming. She stated she wasn't sure and asked the surveyor to ask the Nurse Manager.

When interviewed on 7/12/22 at 4:33 p.m. the NM stated if it's in his program then the mat is supposed to be used when he's in bed as it was a safety measure to prevent injury.

2. Observation on 6/27/22 from 11:50 a.m. to 12:28 p.m. revealed Client #5 sat in his wheelchair without his subbases bar latched in the common area. The Nurse Manager (NM)

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latched the bar and said the bar was supposed to be latched.

Record review on 7/12/22 revealed Client #5's Occupational Therapy Report dated 6/30/22, indicated Client #5 used a tilt space wheelchair with the use of a subbases bar. The report indicated the subbases bar needed to be used for safety to prevent Client #5 from sliding forward/falling out of his wheelchair.

When interviewed on 7/13/22 at 1:54 p.m. QIDP C confirmed staff should have latched Client #5's subbases bar to keep him safe.

3. Observations on 7/06/22 at 11:25 a.m. revealed Registered Nurse (RN) A pushed Client #6's wheelchair with his foot dangling and his shoe left on the foot pedal. At 11:27 a.m., Developmental Aide (DA) A pushed Client #6's wheelchair down the hallway to an activity area with his foot dangling and his shoe left on the foot pedal.

Record review on 7/12/22 revealed Client #6's Occupational Therapy Report dated 7/08/22, indicated he utilized a wheelchair with seatbelt and lap tray. He also utilized foot boxes with straps for safety and positioning of bilateral lower extremities due to his tone.

When interviewed on 7/13/22 at 2:03 p.m. QIDP C acknowledged Client #6's straps on his foot boxes should have been strapped.

4. Observation on 7/05/22 at 6:34 p.m. revealed Client #7 had no chest strap on in his wheelchair

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| W 190 | Continued From page 8<br>and QIDP B walked down the hallway next to him.<br><br>Record review on 7/12/22 revealed Client #7's Occupational Therapy Report dated 6/23/22 indicated he utilized a wheelchair with seat belt, chest strap, and pommel cushion.<br>When interviewed on 7/13/22 at 1:43 p.m. QIDP E acknowledged Client #7 should have had his chest strap on.<br><br>5. Intermittent observations on 7/05/22 in the afternoon revealed Client #21 sat in his wheelchair without a chest strap on. Additional observations on 7/06/22 in the morning revealed Client #21 sat in his wheelchair without a chest strap on.<br><br>Record review on 7/12/22 revealed Client #21's Routine Device Use dated 4/26/22, indicated he utilized a seat belt and chest strap when in his wheelchair and released every two hours for ten minutes.<br><br>When interviewed on 7/13/22 at 1:07 p.m. QIDP E acknowledged Client #21 should have had his chest strap on. | W 190 | | |
| W 210 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)<br><br>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.<br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to complete comprehensive assessments | W 210 | | |

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| W 210 | Continued From page 9<br>of client strengths and needs within 30 days of admission. This affected 1 of 1 sample clients admitted to the facility in the past year (Client #2). Finding follows:<br><br>Record review revealed Client #2 was admitted to the facility on 11/10/21 and had a 30 day staffing on 12/7/21. Further review revealed Client #2's Comprehensive Functional Assessment (CFA) was signed by the Qualified Intellectual Disabilities Professional (QIDP) on 12/14/21 after Client #2's 30 day staffing.<br><br>When interviewed on 7/13/22 at 12:39 p.m. QIDP D acknowledged the facility failed to complete Client #2's CFA prior to the 30 day staffing. | W 210 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews and record reviews the facility failed to ensure each client was consistently provided with opportunities to participate in an active treatment programming and programming that was in place was followed as written. This affected 2 of 4 sample clients (Client #3 and Client #4) and at 15 clients added | W 249 | | |

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to the sample (Client #5, Client #6, Client #8, Client #12, Client #13, Client #17, Client #18, Client #19, Client #26, Client #29, Client #32, Client #36, Client #37, Client #40 and Client #41). Findings follow:

1. Observation on 6/30/22 at 9:00 a.m. Client #8 hit Client #40 on the top of the head. Observations on 7/11/22 at 12:03 p.m. revealed Client #8 grabbed onto Client #28 wheelchair and pulled her backwards toward him. Client #8 hit Client #28 on the back and neck area, no staff intervened. At 3:54 p.m., Client #8 hit Client #22 multiple times on the back and neck area, no staff intervened.

Record review on 7/13/22 revealed Client #8's behavior program for aggression directed staff to maintain one and half arm's length between Client #8 and peers.

When interviewed on 7/13/22 at 12:28 p.m. QIDP E indicated staff supervision for Client #8 is to keep him one and half arm's length away from other clients. QIDP E acknowledged staff failed to follow his program which facilitated the opportunities to hit others.

2. Observations on 7/5/22 at 3:53 p.m. revealed Client #4 awake in her bed. Client #4 remained in her bedroom awake without being prompted to come out or offered any activities until 6:05 p.m. at dinner time. Continued observations of Client #4 on 7/6/22 at 8:15 a.m. revealed she was awakened by staff and brought directly to the dining room for breakfast. She finished breakfast at 8:53 a.m. and went right back to bed. At 9:13 a.m. staff placed a gait belt and weight vest on

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Client #4 and walked with her to the Oak Center. At 9:11 a.m. Client #4 was provided approximately 6 papers to shred which she completed in around 15 seconds. The client remained seated at a table where she often picked/rubbed her chin until 9:34 a.m. when she was given a few more papers to shred. She completed shredding the papers in under 30 seconds. At 9:39 a.m. Client #4 was asked to stack some magnets, which she did for approximately 15 seconds before she stopped. The client remained seated at the table without activity until 9:59 a.m. when Activities Aide (AA) A asked her to stand up as she placed the weighted vest on her and wiped the table down without asking the client to help. Staff then walked with Client #4 back to the main building. Further observations at 10:25 a.m. revealed Client #4 in her bed where she fell in and out of sleep until 12:05 p.m. when asked to come to the dining room for lunch. At 12:47 p.m. when Client #4 finished her lunch she immediately returned to bed and got under her covers. Continued observations on 7/6/22 at 4:20 p.m. revealed Client #4 in bed asleep where she remained until 5:20 p.m. when the observations ended. Additional observations of Client #4 on 7/12/22, 7/13/22 and 7/14/22 almost always revealed the client in bed under the covers usually awake and occasionally asleep.

Record review revealed a program for Client #4 for sleeping at night without disruption. The program indicated when the client was awake at night she would engage in self-injurious behaviors or disruptive behaviors. The program further noted the aggressive and self-abusive behaviors (SIB) displayed on the overnight shift when the client was awake posed a safety risk to

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herself and others. The program noted to help with this the client needed to be "actively engaged in her treatment schedule throughout the day". The Behavior Strategist Report dated 1/18/22, indicated sleep data was inconsistent and could not be found for over half the year. The report further confirmed the client was observed to sleep throughout most of the day "which could contribute" to her irregular sleep habits. Additional review revealed a program where Client #4 needed to be provided enough activity to keep her busy for at least 10 minutes while at the OAK Center (Opportunity Advancement Center) and record whether or not she stayed busy for at least 10 minutes. Another program indicated the client should be prompted to brush her hair anytime she is brought out of bed to the main living area, which staff failed to do on almost every observation.

When interviewed on 7/12/22 at 11:05 a.m. Qualified Intellectual Disabilities Professional (QIDP) B confirmed getting Client #4 out of her bedroom and engaged in active treatment was probably Client #4's biggest need. When asked what the current plan was to get the client out of bed and to participate the QIDP stated staff needed to ask her about every 30 minutes to engage in an activity. She admitted this was not documented anywhere, but just common sense. The QIDP was informed during survey observations that had not happened. The QIDP stated she would start a document for staff so they could record all the attempts to get her out of room on a given shift. When asked what this document would do she said it would demonstrate they are asking her to come out. She admitted the client would likely refuse, but at least they would have proof they asked. When

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asked how this would teach the client or increase the client's desire to come out of her bed she admitted it wouldn't. The QIDP admitted the treatment team needed to put their heads together and come up with a plan to get the client interested in coming out of her room. The QIDP further admitted the facility is short on staff and active treatment is not being done at the level they would like.

3. Observations on 7/12/22 at 3:50 p.m. revealed Client #3 asleep in bed. Further observation at 5:20 p.m. revealed the client was still asleep in bed. Observations on 7/13/22 at 10:20 a.m. and 2:30 p.m. revealed Client #3 in bed asleep with no mat on the floor by the bed.

Record review for Client #3 revealed a behavior program which indicted the client struggled to sleep at night. The program noted the client needed to be "actively engaged" in his treatment schedule throughout the day. The program also built in a period of rest to lay down from 3:00 p.m. daily to 4:00 p.m. daily. The program further noted when the client couldn't sleep at night it affected his active treatment during the day and caused his to struggle with making good choices which often led to SIB or aggression with higher intensity.

4. Additional observations on 7/5/22, 7/6/22/, 7/12/22 and 7/13/22 revealed numerous other clients who lived on E Hall spent large amounts of their day in their bedrooms in and out of sleep without being provided active treatment. The following is a list of just some clients (non-sample) who were observed and recorded

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for extended periods of time in their room without being offered any active treatment:

a. On 7/5/22 Client #37 stayed in her bed from 3:05 p.m. to 5:16 p.m. when brought out for dinner. The client returned to her bedroom right after dinner at 5:33 p.m. where she remained primarily laying down until the observation ended at 6:40 p.m. On 7/6/22 at 8:53 a.m. the client was observed in her bedroom. At 9:09 a.m. staff exited her bedroom and told her "night-night". Continued observations revealed the client was observed asleep in bed at 10:29 a.m. and remained in her bedroom until lunch at 11:26 a.m. At 11:51 a.m. the client screamed as she left the dining area for her bedroom while staff tried to wipe her mouth. At 12:47 p.m. the client was observed as she remained in bed under her blankets. Numerous other observations revealed the client primarily in her bed on every shift.

b. On 7/5/22 Client #18 remained in his bedroom without activity from 3:55 p.m. to 6:03 p.m. when he was wheeled out for dinner. On 7/6/22 at 4:20 p.m. the client was again seen in his bedroom leaning to the side in his wheelchair without activity. This was noted for many hours and on other occasions such as 7/12/22 at 11:05 a.m. and at 5:30 p.m. On 7/13/22 at 10:39 a.m. Client #18 was observed again in his bedroom with his roommate, door shut and slumped to the side half asleep in his wheel chair.

c. On 7/5/22 Client #29 remained in his bedroom with his roommate (Client #18) from 3:55 p.m. to 6:03 p.m. when wheeled out in his chair for dinner. On 7/6/22 at 4:20 p.m. the client was seen leaning to the side in his wheelchair without activity. This was noted for many hours and on

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other occasions such as 7/12/22 at 11:05 a.m. and at 5:30 p.m. On 7/13/22 at 10:39 a.m. Client #29 was observed again in his bedroom with his roommate. The door was closed and the client was slumped to the side, half asleep in his wheel chair. Both Client #29 and his roommate spent the majority of their days in the bedroom with the door closed reliant on staff to move their wheelchairs.

d. On 7/5/22 at 3:05 p.m. Client #36 was observed in his bedroom where he remained until 4:27 p.m. at which time he came out biting his hand/arm and was escorted right back to his bedroom where he remained until dinner. On 7/6/22 at 8:53 a.m. the client was observed seated on a chair just inside the door in and out of sleep and remained in the same position at 10:10 a.m. Also the client was observed in the bedroom at 4:20 p.m. and remained in the room at 4:48 p.m. when it was discovered the air conditioner had been shut off. Staff were alerted as it was very hot and the a/c was turned back on for Client #36 and Client #40 who remained in their room. The client remained in his bedroom for the majority of all observations, usually seated just inside the door and sometimes asleep.

e. On 7/6/22 at 8:53 a.m. revealed Client #40 in his bedroom in his wheelchair positioned in the middle of the room as he faced the door. Continued observation revealed the client was still in his bedroom at 10:10 a.m. in the same position. The client remained in the bedroom in his wheelchair until 11:37 a.m. when he came out to eat. The client finished lunch at 11:56 a.m. and was wheeled back down to his bedroom. The client was again observed in the bedroom at 4:20 p.m. and remained in the room at 4:48 p.m. when

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it was discovered the air conditioner had been shut off. Staff were alerted as it was very hot and the a/c was turned back on for Client #36 and Client #40 who remained in their room.

f. On 7/6/22 at 3:33 p.m. Developmental Aide (DA) escorted Client #19 back to his bedroom. The DA had his hands on the back of the client's shoulders and as the client leaned back the DA gave him nudges to from behind which seemed to force the client to move forward. On 7/6/22 at 9:04 a.m. Client #19 was seen as he slowly walked down the hall. Outside of the occasional walk outside in the hall Client #19 remained primarily in his bedroom during all observations from 7/5/22 to 7/13/22.

Record review revealed active treatment schedules with large quantities of days spent in leisure, rest, informal times or room times. For example Client #29's schedule revealed informal, personal time or rest almost the entire time from 10:00 a.m. to 2:30 p.m. Client #40's schedule listed primarily leisure, supper and toileting as the only activities for the client between 2:00 p.m. and 8:00 p.m. Client #37's active treatment schedule indicated it was last updated 9/2020 and listed some activities, but the client spent almost all of her time in her bedroom outside meals.

When interviewed on 7/12/22 at 11:07 a.m. QIDP B confirmed the agency was short staffed and struggled to provide active treatment. She stated they needed ideas and would need to be very creative if they were going to meet the condition of active treatment.

5. Additional observations on 7/5/22 and 7/6/22

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revealed numerous other clients who lived on D Hall spent large amounts of their day in their bedrooms without being provided active treatment. The following is a list of just some clients (non-sample) who were observed and recorded for extended periods of time in their room without being offered any active treatment:

a. Observations on 7/05/22 from 2:25 p.m. to 4:53 p.m. revealed Client #32 sat in her recliner in her room. She exited her room at the end of this time and used sign language to communicate to DA C.

Record review revealed Client #32's active treatment schedule consisted mostly of free time, room time, and lounge time throughout her day.

When interviewed on 7/13/22 at 12:54 p.m. QIDP E indicated with staffing patterns it was hard to provide active treatment. QIDP E acknowledged staff should have provided opportunities to participate.

b. Observations on 7/05/22 at 2:56 p.m. revealed Client #5 in his bed. At 5:29 p.m., Client #5 sat in his wheelchair in his room. At 6:36 p.m., Client #5 remained in his room and continued to sit in his wheelchair.

Observations on 7/06/22 from 7:39 a.m. to 10:03 a.m. revealed Client #5 lay in bed. At 10:13 a.m., Client #5 sat in his wheelchair parked in the hallway. At 10:51 a.m., Client #5 sat in his wheelchair in his room. At 11:27 a.m., DA H pushed Client #5's wheelchair to the activity room. At 12:33 p.m., Client #5 returned to his room in his wheelchair.

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Record review revealed Client #5's active treatment schedule included activities of daily living, activity, informal activity, group activity, feeding, check/changes, and rest time.

When interviewed on 7/13/22 at 1:54 p.m. QIDP C acknowledged staff should have provided opportunities to participate.

c. Observations on 7/05/22 at 2:53 p.m. revealed Client #12 lay in bed in her room. Continued observations from 4:45 p.m. to 5:28 p.m., Client #12 sat in her wheelchair in her room. Client #12 did not leave her room during this observation.

Observations on 7/06/22 at 7:24 a.m. revealed Client #12 lay in her bed. Continued observation from 9:48 a.m. to 12:36 p.m., Client #12 sat in her wheelchair in her room and made loud vocalizations. At 12:36 p.m., Client #12 exited her room then sat in her wheelchair in the hallway.

Record review revealed Client #12's active treatment schedule included activities of daily living, activity, informal activity, group activity, feeding, check/changes, and rest time.

When interviewed on 7/13/22 at 1:57 p.m. QIDP C acknowledged staff should have provided the client opportunities to participate.

d. Observations on 7/05/22 at 2:50 p.m. revealed Client #13 lay in bed. Continued observation at 5:26 p.m. Client #13 sat in his wheelchair in his room. At 6:36 p.m. the end of the observation Client #13 remained in his room.

Observation on 7/06/22 at 8:21 a.m. revealed Client #13 lay in bed. Continued observation from

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9:31 a.m. to 9:54 a.m., Client #13 sat in his wheelchair in his room. At 9:54 a.m., Client #13 went to another room in the facility to visit the podiatrist. From 10:30 a.m. to 11:24 a.m., Client #13 sat in his wheelchair in his room.

Record review revealed Client #13's active treatment schedule included activities of daily living, activity, lounge time, Opportunity Advancement Center, informal activity, group activity, feeding, check/changes, and rest time.

When interviewed on 7/13/22 at 2:00 p.m. QIDP C indicated Client #13 had many interests. She acknowledged staff should have provided him opportunities to participate.

e. Observations on 7/05/22 at 2:49 p.m. revealed Client #26 lay in bed. She remained in bed until she went to the activity area at 4:01 p.m. At 4:44 p.m., Client #26 sat in her wheelchair in her room until 5:47 p.m. when DA J pushed her would to the common area.

Record review revealed Client #26's active treatment schedule included mostly leisure time in the afternoon, reposition, snack, and supper.

When interviewed on 7/13/22 at 4:00 p.m. QIDP B acknowledged staff should have provided activities throughout the day.

f. Observations on 7/05/22 at 2:56 p.m. revealed Client #6 in his bed in his room. Client #6 remained in his room and sat in his wheelchair until 5:29 p.m.

Observations on 7/06/22 from 7:39 a.m. to 10:13a.m. Client #6 lay in bed. Continued

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observation from 10:13 a.m. to 11:27 a.m. Client #6 sat in his wheelchair in the hallway and yelled as he propelled around the hallway. At 11:27 a.m., DA H pushed Client #6 to the activity area. At 12:33 p.m., Client #6 returned to the hallway.

Record review revealed Client #6's active treatment schedule included activities of daily living, activity, lounge time, informal activity, group activity, feeding, check/changes, and rest time.

When interviewed on 7/13/22 at 2:06 p.m. QIDP C indicated Client #6 has a participation program. She acknowledged staff should have provided him with opportunities to participate.

g. Observations on 7/05/22 from 2:57 p.m. to 5:47 p.m. Client #17 sat in his wheelchair with his sensory items. At 5:47 p.m., DA D pushed his wheelchair out the dining area.

Observations on 7/06/22 from 6:25 a.m. to 8:27a.m. Client #17 sat in his wheelchair with his sensory items. At 8:27 a.m. Client #17 sat at the dining table. At 9:14 a.m., Client #17 returned to his room where he stayed till the end of the observation at 9:43 a.m.

Record review revealed Client #17's active treatment schedule included Opportunity Advancement Center, free time, informal time, toilet opportunity, life skills group, snack, room time, activity group, and supper.

When interviewed on 7/13/22 at 1:01 p.m. QIDP E acknowledged staff should have followed Client #17's active treatment schedule.

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h. Observations on 7/05/22 from 3:17 p.m. to 5:40 p.m. revealed Client #41 sat in his wheelchair in the common area without opportunity for participation in an activity. For a brief time at 4:05 p.m. staff took Client #41 to the bathroom. Then he returned back to the common area. Also at 5:13 p.m., DA J pushed Client #41's wheelchair to the table to eat.

Observations on 7/06/22 from 8:09 a.m. to 11:28 a.m. revealed Client #41 sat in his wheelchair in the common area without opportunity for participation in an activity. At 11:28 a.m., QIDP D pushed his wheelchair into the activity area.

Record review revealed Client #41's active treatment schedule included activities of daily living, activity, informal activity, group activity, supper, and check/changes.

When interviewed on 7/13/22 at 2:09 p.m. QIDP C indicated Client #41 would participate in activities if staff involved him. QIDP C acknowledged staff should have provided him opportunities.

Additional record review revealed a document for active treatment provided by the administrator. The document indicated its purpose was to ensure "residents are being provided continuous active treatment". The document indicated schedules should be followed and activities should not consume just 5 minutes of a 30 minute period. The document also indicated all the materials necessary should be provided and activities should be age and developmentally appropriate. The document indicated clients should not be just wandering around or that was sign that active treatment was not being provided.

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| W 249 | Continued From page 22<br>Activities needed to have purpose and a training outcome in mind. Staff needed to interact with residents during the majority of the observations and ensure clients with high behaviors or limited abilities received as much attention as other clients. The document indicated staff should be able to tell someone what activity is being worked on for any resident at any time.<br><br>When interviewed on 7/13/22 at 10:44 a.m. the Administrator confirmed active treatment should be continuous and the facility policy on active treatment could be identified in the definitions on the document she provided. She admitted clients are in the bedrooms way to often and for long periods of time. She indicated they were aware of the problem and trying to fix it. She expressed concern with the amount of staff they had and indicated it was very tricky and seemed unsure if it could be fixed with current staff to client ratios. She indicated they were struggling with taking on new admissions due to staff shortages and inability to provide the active treatment they wanted to provide. She indicated QIDP C who had worked at the facility for a long time and knew the residents well was in the process of dividing the clients into groups and producing a schedule that could provide for continuous active treatment in the future. | W 249 | | |
| W 250 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(2)<br><br>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.<br>This STANDARD is not met as evidenced by:<br>Based on interviews and record review, the | W 250 | | |

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| W 250 | Continued From page 23<br>facility failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) adequately developed and monitored client programs. This affected 2 of 4 sample clients (Client #1 and Client #2). Findings follow:<br><br>2. Record review of Client #1's file on 7/11/22 revealed an active treatment schedule which indicated from 8:00 a.m. to 3:00 p.m. the client was in school. After school Client #1 could check out his tablet during, supper, snack, and free times. Further review revealed an active treatment schedule without school (the client was currently on summer break) could not be located in Client #1's file.<br><br>When interviewed on 7/13/22 at 11:14 a.m. QIDP A confirmed the schedule needed to be updated since school was out.<br><br>3. Record review of Client #2's file on 7/11/22 revealed an active treatment schedule which indicated Client #2 was in school from 8:00 a.m. to 3:00 p.m. After school Client #2's schedule included homework/activity room, supper, shower time snack, and television. No updated active treatment schedule (for summer break) could be located in Client #2's file.<br><br>When interviewed on 7/13/22 at 11:14 a.m. QIDP D acknowledged she failed to update the schedule for Client #2 with school out for break. | W 250 | | |
| W 261 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)<br><br>The facility must designate and use a specially | W 261 | | |

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constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.
This STANDARD is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure by both policy and practice each client received the protection of a specially constituted committee made up of members who were trained to oversee programs which involve risks to client rights and protections. This affected 4 of 4 sample clients (Client #1, Client #2, Client #3 and Client #4). Findings follow:

Record review of Client #1's file revealed behavior programs which involved restrictive measures such as psychotropic medications and limited access to electronics.

Record review of Client #2's file revealed behavior programs which involved the use of psychotropic medications.

Record review of Client #3's file revealed two behavior programs which involved restrictive measures such an psychotropic medications, the use of blocking mat and a door alarm.

Record review of Client #4's file revealed two behavior program which involved the use of several psychotropic medications.

Additional record review revealed no signed consent from a human legal rights committee for any of the four clients' behavior programs.

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| W 261 | Continued From page 25<br>When interviewed on 7/14/22 at 8:02 a.m. the Human Legal Rights Committee Member (HLRCM) said the committee met over the phone and she was not able to see the signed consent from the guardian. She voiced concern with the phone she was not able to hear everything said in the meeting. The HLRCM said she was the only outside member at this time and noted it was hard to find people. She acknowledged she had not received any formal training as a HLRCM.<br><br>When interviewed on 7/12/22 at 5:30 p.m. the Administrator indicated the agency had no policy to define or govern their human legal rights committee (HLRC). She indicated their HLRC committee typically consisted of one person who sat in by phone once per quarter to go over each client and their restrictions. She also confirmed since Covid-19 the committee/member no longer came into the facility and therefore had not sign consents.<br><br>When interviewed again on 7/14/22 at 9:53 a.m. the Administrator acknowledged the facility had no formal documentation of annual training for the HLRCM. She indicated the committee consisted of two to three outside members. | W 261 | | |
| W 263 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)(ii)<br><br>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br>This STANDARD is not met as evidenced by:<br>Based on interviews and record reviews the facility failed to obtain documentation the human legal rights committee consistently verified written | W 263 | | |

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informed consent was received by the guardian before the implementation of restrictive programming. This affected 4 of 4 sample clients (Client #1, Client #2, Client #3 and Client #4). Findings follow:

Record review of Client #1's file revealed behavior programs which involved restrictive measures such as psychotropic medications and limited access to electronics.

Record review of Client #2's file revealed behavior programs which involved the use of psychotropic medications.

Record review of Client #3's file revealed two behavior programs which involved restrictive measures such an psychotropic medications, the use of blocking mat and a door alarm.

Record review of Client #4's file revealed two behavior program which involved the use of several psychotropic medications.

Additional record review revealed no documentation from a human legal rights committee member for any of the four client's behavior programs.

When interviewed on 7/14/22 at 8:02 a.m. the Human Legal Rights Committee Member (HLRCM) stated the committee met over the phone and she was not able to see the signed consent from the guardian, but had to take the facilities word they had received approval. She voiced concern with the phone as she was not always able to hear everything said in the meeting. The HLRCM mentioned she was the only outside member at this time and she had not

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| W 263 | Continued From page 27<br>received any formal training as a HLRCM.<br><br>When interviewed on 7/13/22 Qualified Intellectual Disabilities Professional (QIPD) A confirmed none of the clients in the facility had consents signed by HLRC for at least the last year that she knew of. She stated since she's worked there (about 1 year) they have been meeting quarterly by phone and had not secured any written consents/signatures from HLRC but only verbal approvals. | W 263 | | |
| W 289 | MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br>CFR(s): 483.450(b)(4)<br><br>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.<br>This STANDARD is not met as evidenced by:<br>Based on interviews, and record review the facility failed to incorporate the use of restrictions into the client's individual program plan. This affected 2 of 4 sample clients (Client #1 and Client #4). Finding follows:<br><br>1. Record review on 6/23/22 of Client #1's chart revealed a behavior sheet dated 6/10/22 that indicated Client #1 was placed on 15 minute checks due to inappropriate and unsafe electronic usage.<br><br>Record review of an informed consent dated 7/14/22 indicated the client had the following restrictions: behavior modifying drug: Focalin XR and limited access to electronics and game systems. | W 289 | | |

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Record review of a behavior plan for verbal aggression dated 3/15/22 identified one restrictioin which of Focalin XR (psychotropic medication). The behavior plan contained no other restrictions. The review revealed no behavior plan for restricted electronics/game systems in the chart.

When interviewed on 7/13/22 at 11:24 a.m. Qualified Intellectual Disabilities Professional (QIDP) A confirmed there was no program in place for Client #1's restricted electronics.

2. Record review on 6/23/22 revealed Client #1's behavior data for March 2022, which documented an incident on 3/22/22 at 4:00 p.m. The note referenced the antecedent the QIDP "asked about him leaving his room/the building without staff knowledge (out his window)". Client #1's behavior noted "became defensive, started yelling at staff and swearing/threatening staff, raised voice."

When interviewed on 6/30/22 at 9:08 a.m. QIDP A said the facility had suspicion Client #1 exited out his window when items were missing from the life skills building. QIDP A acknowledged that Client #1 admitted he went out his room window.

When interviewed on 7/05/22 at 12:13 p.m. the Director of Nursing said Client #1's modified window consisted of screws in the top so it could not be opened. She also indicated no incident reports could be located for the elopement from his window.

Record review on 7/07/22 revealed Client #1's progress note dated 4/17/22 indicated staff called

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a missing person code when unable to locate Client #1 in his room. Client #1 admitted he went out the comfort room window to the life skills building where he was found. Client #1's window was screwed shut, but there was no program to go along with the restriction.

When interviewed on 7/13/22 at 11:11 a.m. QIDP A confirmed the facility failed to implement a program for elopement to go along with the window restriction.

3. Record review on 7/13/22 revealed a 90 day physician's order for Client #4 dated 6/6/22 which indicated an order for use of "bilat hand mitts and elbow restrains" to be released for 10 minutes every 2 hours as needed for skin picking.

Additional record review of Client #4's behavior programs for sleep and using coping skills failed to include the use of any restraints/mitts.

When interviewed on 7/13/22 at 3:56 p.m. the Nurse Manager (NM) confirmed the order for the mitts and elbow restraints was current in the physician's orders. The NM stated she believed those would be in Client #4's behavior program and the facility would have consents since they are a restriction.

When interviewed on 7/13/22 at 2:40 p.m. QIDP B reported the client used the restraints about one time per quarter to protect her chin when she picked it open. Initially she reported she believed the restraints would be included in a behavior program and the facility would have consent. After looking in the behavior program the QIDP admitted there was no programming to go along with the restrictions.

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| W 290 | MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br>CFR(s): 483.450(b)(5)<br><br>Standing or as needed programs to control inappropriate behavior are not permitted.<br>This STANDARD is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to consistently ensure each client was not regularly subjected to or had standing orders for any behavioral interventions unless they were included in their individual program plan and monitored by the entire treatment team. This affected 1 of 1 sample clients with an order for mechanical restraints (Client #4). Findings follow:<br><br>Record review on 7/13/22 revealed a 90 day physician's order for Client #4 dated 6/6/22 which indicated an order for use of "bilat hand mitts and elbow restrains" to be released for 10 minutes every 2 hours as needed for skin picking.<br><br>Additional record review of Client #4's behavior programs for sleep and using coping skills failed to indicate the use of the restraints.<br><br>When interviewed on 7/13/22 at 3:56 p.m. the Nurse Manager (NM) confirmed the order for the mitts and elbow restraints was current in the physician's orders. She says she has the order as she picks at her skin and can create significant holes which could be major health concerns. She stated it's just kind of used "as needed" or PRN. Additionally the NM provided a copy of the facility order dated 3/24/21 which indicated the mitts and elbow restrains to be used "as needed for skin picking". The NM stated she believed those would be in Client #4's behavior program and the facility would have consents since they are a | W 290 | | |

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| W 290 | Continued From page 31<br>restriction. She stated the order is for an "indefinite" period of time. The NM was informed "as needed or standing orders" are not allowed in an ICF/ID.<br><br>When interviewed on 7/13/22 at 2:40 p.m. Qualified Intellectual Disabilities Professional (QIDP) B reported the client used the restraints about one time per quarter to protect her chin when she picked it open. Initially she reported she believed they had consent for the restraints, but after looking admitted they did not have any consent or programming for the restraints. | W 290 | | |
| W 322 | PHYSICIAN SERVICES<br>CFR(s): 483.460(a)(3)<br><br>The facility must provide or obtain preventive and general medical care.<br>This STANDARD is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure each client received preventative care consistent with recommended health standards or had a contraindication regarding such care. This affected 1 of 1 sample clients (Client #4) who qualified for preventative care based on age and gender. Findings follow:<br><br>Record review on 7/11/22 revealed Client #4 was 38 years old and lived at the facility almost 20 years. Further record review revealed she received a physical on 6/11/22, but no information could be found of a pap/pelvic exam.<br><br>Review of an email from the Nurse Manager (NM) on 7/14/22 at 9:39 a.m. indicated "there is nothing indicating she (Client #4) is needing a pap/pelvic exam". The NM further indicated this was not something the guardian indicated they | W 322 | | |

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| W 322 | Continued From page 32<br>wanted and the nurse felt it would be more harmful for the client than good.<br><br>When interviewed on 7/14/22 at 10:20 a.m. NM confirmed no pap/pelvic exam was completed for Client #4. | W 322 | | |
| W 350 | DENTAL SERVICES<br>CFR(s): 483.460(e)(3)<br><br>The facility must provide education and training in the maintenance of oral health.<br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to consistently ensure each client received training when necessary to promote dental health. This affected 1 of 1 sample clients who refused dental treatment (Client #4). Findings follow:<br><br>Observations on 7/6/22 at 9:19 a.m. revealed Client #4 seated at a table at the Oak Center as she picked her chin without an activity. It was also noted during the observation as the client opened her mouth her teeth appeared dirty and covered with a brown color/substance. Further observations over the next week revealed the same color/substance on her front teeth.<br><br>Record review on 7/11/21 revealed Client #4 saw the dentist on 5/27/21 and was determined to have moderate calculus, mild periodontal disease and a fractured tooth. Further review revealed the client saw the dentist again on 12/16/21 and refused the appointment so no evaluation could be done. Review of the annual staff report from the nursing documented the refusal for the 12/16/21 dental appointment, but noted no plan for follow-up. | W 350 | | |

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| W 350 | Continued From page 33<br><br>When interviewed on 7/12/22 at 1:05 p.m. the Director of Nursing (DON) and the Nurse Manager (NM) confirmed the 5/27/21 dental appointment revealed a fractured tooth for Client #4. Both nurses agreed this was the last successful appointment for the client as she refused the appointment 12/16/21. They noted her next scheduled appointment was 7/21/22. The DON stated if she refused again they would likely get her on the list to Iowa City dental where she would have to be sedated. She indicated it would likely take at least 3 months to get her an appointment once they got her on the list.<br><br>When interviewed on 7/12/22 at 11:07 a.m. Qualified Intellectual Disabilities Professional (QIDP) B confirmed the client's teeth have looked bad for a long time. She also confirmed she was aware the client refused her last appointment, but wasn't sure what the plan going forward would be. She estimated the client would eventually have to be taken to Iowa City where she would be sedated if she refused again, but she did not know when her next appointment was. She also indicated the client may already be scheduled for a sedated dental visit in Iowa City, but she wasn't sure. In a later interview on 7/13/22 at 10:23 a.m. she confirmed no programming had been put in place to ensure adequate tooth brushing was being completed for or by the client and no training to desensitize the client to dental appointments had been put in place. | W 350 | | |
| W 371 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(4)<br><br>The system for drug administration must assure that clients are taught to administer their own | W 371 | | |

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medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.
This STANDARD is not met as evidenced by:
Based on observations, interviews, and record review the facility failed to provide opportunities for client participation during medication administration. This affected 3 of 5 clients observed during medication administration (Client #3, Client #4 and Client #20).

Findings follow:

1. Observation on 7/07/22 at 8:08 a.m. revealed Registered Nurse (RN) A reviewed the Medication Administration Record (MAR) on the medication cart at the nurses station. The RN then popped each medication out of the cassette as well as the medications from bottles. RN A clicked each medication on the computer and then placed the medication in chocolate pudding. RN A walked to the common area where Client #20 sat in a chair. Client #20 was asked once to feed herself the medications and declined. RN A then fed the client the medications on the spoon mixed with pudding.

Record review 7/14/22 revealed Client #20's self-administration of medication dated 5/20/22 indicated the client could independently, requiring only one verbal prompt complete the following tasks: pick up medication cup, pour juice/water without spillage, hold cup appropriately, physically pick up as spoon, scoop pudding out of cup, able to take pill/pudding mixture and put in mouth safely, and throw med cup away. Client #20 required assistance from staff to pop medication from bubble pack and deposit medication from

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bubble pack. The assessment lacked information on what type of assistance Client #20 needed to complete the task.

When interviewed on 7/14/22 at 9:51 a.m. the Administrator acknowledged the RN should have allowed Client #20 to participate in the medication pass up to her level of ability.

2. Observations on 7/5/22 at 3:20 p.m. revealed Certified Medication Aide (CMA) A prepared three medications for Client #4 at the medication cart. The CMA then placed the medications in chocolate pudding and peanut butter and scooped them on a stick. He then walked over to the client and fed the medications to her from the wooden stick. The client drank a cup of water on her own.

Record review for Client #4 revealed a Comprehensive Functional Assessment (CFA) for the client dated 2022 and filled out by Qualified Intellectual Disabilities Professional (QIDP) B. The CFA revealed the client can pick up dining utensils and properly grasp them, take food to her mouth without spilling, can pour her own liquid, take dishes to the cart and put paper products in the garbage to name a few.

Record review for Client #4 revealed a medication self-administration assessment completed by the Nurse Manager (NM) on 5/20/22. The document indicated the client needed assistance to pick up a medication cup, hold a cup properly, physically pick up a spoon, throw her medication cup away and wipe her mouth. This infornmation was not consistant with the CFA.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 16G009 | A. BUILDING _____ B. WING _____ | 07/21/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HARMONY HOUSE HEALTH CENTER | 2950 WEST SHAULIS ROAD WATERLOO, IA 50701 |

| (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 |
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| W 371 | Continued From page 36 | W 371 | | |

3. Observations on 7/6/22 at 7:19 a.m. revealed the LPN prepared numerous medications for Client #3. She placed the medications in pudding and scooped them on a spoon. The LPN then walked over to the client and fed the medications to him from the spoon. The LPN then fed the client some thickened flavored water from a spoon. The client did not participate in any portion of the administration.

Record review revealed a CFA dated 2022 for Client #3 and completed by QIDP G. The CFA indicated the client was diagnosed with mild intellectual disability. The CFA further revealed the client could wash a table, could pick up and properly grasp dining utensils, scoop food off a plate, bring food to his mouth, drink from a glass without spilling and use a napkin when needed to name a few.

Record review revealed a medication self-administration assessment dated 5/20/22 and completed by the NM. The assessment indicated the only skill the client could do with one verbal prompt or less was safely swallow his pills. The assessment indicated he would need help to do very basic things such as physically pick up a spoon, throw his med cup away and wipe his mouth. This information was not consistant with the CFA.

When interviewed on 7/13/22 at 10:44 a.m. the Administrator confirmed active treatment should be continuous and clients should be allowed to do everything for themselves they can do. She confirmed this was true in all facets of their lives including meals and medication administration. The NM was also present confirmed Client #3

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| W 371 | Continued From page 37<br>could feed himself medications instead of having them fed to him and confirmed Client #4 might need hand-over-hand assistance with many thing, but medication passers could try to get the client to participate. The Administrator confirmed clients should have been prompted to try rather than just having the nurse do everything for them. | W 371 | | |
| W 454 | INFECTION CONTROL<br>CFR(s): 483.470(l)(1)<br><br>The facility must provide a sanitary environment to avoid sources and transmission of infections.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews, and record review the facility failed to provide a sanitary environment. This potentially affected 41 of 41 clients who lived in the home at the time of the survey (Client #1 to Client #41). Findings follow:<br><br>Observation on 6/27/22 at 6:51 p.m. revealed the Lead had her eye wear off next to Client #39.<br><br>Observation on 6/28/22 revealed the following:<br>a. At 8:38 a.m., Developmental Aide (DA) G wore her eye on the top of her head.<br>b. At 8:42 a.m., DA H wore her mask below her nose and played a game with clients.<br>c. At 8:54 a.m., DA H wore her mask below her nose.<br>d. At 9:01 a.m., DA H wore her mask below her nose next to Client #30 and Client #31.<br>e. From 8:55 a.m. to 9:16 a.m., the Environmental Services Laundry wore her mask below her nose and put away client's clothes.<br><br>Observation on 6/29/22 revealed the following: | W 454 | | |

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| | 16G009 | A. BUILDING _____ B. WING _____ | 07/21/2022 |

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| W 454 | Continued From page 38<br>a. At 8:14 a.m., DA H wore her mask below her nose and played a game with clients.<br>b. At 8:19 a.m., the Environmental Services Laundry wore her mask below her nose and put away client's clothes.<br>c. From 11:51 a.m. to 11:54 a.m., DA H wore her mask below her nose in the dining area.<br><br>Observation on 6/30/22 at 12:40 p.m. DA H wore her mask below her nose and assisted with meals.<br><br>Observations on 7/05/22 at 5:20 p.m. revealed DA A wore her mask below her nose next to Client #7.<br><br>Observations on 7/06/22 revealed the following:<br>a. At 6:29 a.m., DA B walked in the hallway without her mask on.<br>b. At 6:30 a.m., DA C wore her mask by her mouth next to Client #2.<br>c. From 7:41 a.m. to 7:45 a.m., DA D wore her mask below her nose next to Client #7.<br>d. From 8:31 a.m. to 8:36 a.m., DA D wore her mask below her nose next to Client #11<br>e. At 8:39 a.m., DA D wore her mask under her chin.<br>f. At 11:52 a.m., DA E wore her mask below her nose and assisted Client #41<br><br>Observation on 7/11/22 at 11:54 a.m. revealed DA F wore his eyewear on top of his head and transferred Client #18.<br><br>Record review on 7/14/22 revealed a facility policy for COVID-19 Exposure Control updated 8/11/21, which indicated individuals on the residential unit needed a "face covering or mask (covering mouth and nose)." | W 454 | | |

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| W 454 | Continued From page 39<br><br>When interviewed on 7/14/22 at 9:12 a.m. the Nurse Manager (NM) confirmed the staff should have had their mask over both their nose and mouth as well as eye wear over their eyes as they worked on the unit. | W 454 | | |
| W 474 | MEAL SERVICES<br>CFR(s): 483.480(b)(2)(iii)<br><br>Food must be served in a form consistent with the developmental level of the client.<br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews and record reviews facility staff failed to consistently ensure each client received their food in a form and amount consistent with special recommendations. This affected 1 of 1 sample clients (Client #3) with a specialized meal program. Findings follow:<br><br>Observations on 7/5/22 at 5:57 p.m. revealed Client #3 waited at the table in his wheelchair for dinner. At 6:20 p.m. the client ate dinner with a spoon from his plate which was filled with pureed food (cheeseburger and a side). The client continued to eat with a spoon under the supervision of staff and at 6:33 p.m. picked up a glass of thickened liquids and drank it himself as staff watched.<br><br>Record review revealed a speech therapy report dated 2/15/22, which indicated the client had a tendency to eat at a rapid pace and needed a pureed texture and small portion diet. The client needed a staff member with him at all times who would put 3 bites of his food on his plate at a time. The client was then capable of feeding himself the 3 bites, but then staff needed to feed | W 474 | | |

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| W 474 | Continued From page 40<br>the client a spoonful drink of his honey thickened liquids. This process was to be repeated throughout the meal.<br><br>Record review revealed Client #1 was diagnosed with dysphagia and it was recommended he received a g-tube placement, but his guardian did not want him to receive one at that time. Further review revealed the client was hospitalized from 11/1/21 to 11/8/21 with aspiration pneumonia.<br><br>When interviewed on 7/12/22 at 3:55 p.m. the Qualified Intellectual Disabilities Professional (QIDP) confirmed Client #3 should have had his full plate of food in front of him to eat or drank directly from his cup. The QIDP confirmed the client needed to follow the 3 bites at a time followed by 1 drink of thickened liquids. She confirmed the client was hospitalized in 2021 and swallowing was a challenge for the client. She indicated staff would need to be retrained right away for the client's safety. | W 474 | | |

**Harmony House Health Care Center**
**ICF/IID Plan of Correction**
**Survey Completed 7/21/2022**

Submitted on: _____

**Preparation and execution of this plan of Correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under Federal or State law.**

**W000 Correction Date: 09/27/2022**

***W104: GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility.***

Injury of Unknown Origin: Nursing department was educated in a Nurses Meeting on documenting origin of an injury i.e.: bruise, friction rub, etc. If the origin of injury is unknown, an investigation will be initiated immediately for all employees that have worked with client in the prior 24 hours. If there is known origin, documentation will include where injury came from. There will also be an incident report completed, skin sheet and notification to Provider, guardian (pending notification status), Program Coordinator and DON or Nurse Manager. All incident reports are discussed weekly at meetings, summaries are made based on Team decision. Nurse Manager will monitor weekly.

Rights restrictions will be reviewed with the interdisciplinary team prior to implementation. This will ensure that all necessary components are in place including consent. These will be reviewed and monitored weekly by the interdisciplinary team.

***W124: PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.***

All restrictions and modifications are included in the consent. Restrictions will be reviewed with the interdisciplinary team prior to implementation. This will ensure that all necessary components are in place including consent. Doctor's orders for temporary restraints will have guardian consent and be included in behavior program or a nursing concern.
Order for hand mitts and elbow splints has since been discontinued. All current programs have been reviewed and consents updated. Nurse Manager to review all restrictive measures in orders section, will review to ensure there are 0 "as needed" orders.

***W190: STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental,***

Use of floor mats and other safety devices will be reviewed quarterly. Interdisciplinary team will review for continued need and is included in audits by QIDP's. Nursing will monitor compliance.

***W210: INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission***.

Admission checklist will be reviewed for completion and ensure timelines are followed. This will be monitored by Social Worker and Program Coordinator.

***W249: PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.***

Additional groups have been developed. A schedule of informal activity opportunities has been designed and implemented for additional opportunities. Clubs will be run as scheduled. This will be monitored by the Program Coordinator.

Programs will be reviewed and updated as needed. This information will be reflected on a time study that staff will be educated to follow for the group they are assigned. Staff will attend a weekly meeting that will review any updates or changes to the resident's needs or programs. This information will also be communicated at shift change meeting daily. 1 week after programs are changed and/or updated, the Program Coordinator will complete an audit to ensure the program is being followed correctly. This will be monitored by the interdisciplinary team weekly.

***W250: PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.***

Schedules will be revised and communicated when major changes occur. As these revisions are made, they will be reviewed by the interdisciplinary team. Once approved by the team, they will be made into time studies for staff assigned to each group. This information will be available in their individual binder as well as the time study. Program Coordinator will monitor and educate staff weekly.

***W261: PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.***

The community representative(s) will attend the Human Rights Committee meetings in person. During this time, consents will be reviewed for necessity. The representative shall be called for any new consents as approved by the interdisciplinary team and review all consents at least quarterly. Guardians/family during yearly staffing's will be given a description of HRC and our policy, they will then be asked if they would like to become a representative of HRC. New representatives will be trained according to our procedures defined in the HRC policy document that was created. Program Coordinator will monitor compliance.

***W263: PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.***

The community representative(s) will attend the Human Rights Committee meetings in person. During this time, consents will be reviewed for necessity. The representative shall be called for any new consents as approved by the interdisciplinary team and review all consents at least quarterly. Guardians/family during yearly staffing's will be given a description of HRC and our policy, they will then be asked if they would like to become a representative of HRC. New representatives will be trained according to our procedures defined in the HRC policy document that was created. Program Coordinator will monitor compliance.

***W289: MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.***

All restrictive measures will be programmed, reviewed and have appropriate consent. This will be reviewed and monitored by the interdisciplinary team. All restrictions and modifications will be included in the consent. Restrictions will be reviewed with the interdisciplinary team prior to implementation. This will ensure that all necessary components are in place including consent. Doctor's orders for temporary restraints will have guardian consent and be included in the behavior program or a nursing concern.

***W290: MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(5) Standing or as needed programs to control inappropriate behavior are not permitted.***

All restrictive measures and modifications will be included in the consent and reviewed with interdisciplinary team prior to implementation. Doctor's orders for temporary restraints will have guardian consent and be included in behavior program or a nursing concern. Nurse Manager and Program Coordinator will monitor compliance.

***W322: PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care.***

Nurse Manager to review with provider appropriate “preventative screening” for each client. At annual staffing, these screenings will be discussed with client’s guardians. Will proceed with screenings based on provider recommendations and guardians approval/consent for said screenings. Nurse Manager and Q will monitor for on-going compliance.

***W350: DENTAL SERVICES CFR(s): 483.460(e)(3) The facility must provide education and training in the maintenance of oral health.***

In house dentist comes to facility as scheduled. Each client is to been seen by the dentist. If the dentist is unable to complete exam in facility or provide all necessary cares in the facility, that client may need to be seen in Iowa City or a local dental office. Nurse Manager and Transportation will coordinate who is needing to be seen outside of facility and ensure they are scheduled. This will ensure there is a successful dental screening as required. Nurse Manager and Q will monitor for on-going compliance.

***W371: DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.***

Nursing department was educated in a nurses meeting on importance of having clients participate in mediation administration. Each client will be given the opportunity to pour their beverage, scoop medications out, etc. during their medication times. If a client is unable to do so, the nurse/certified medication aide will do so for the client. The nurse or CMA will give the client the opportunity to perform as much of the medication administration, independently, as they are able to. Nurse Manager will continue to monitor for compliance.

***W454: INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections.***

Staff will be re-educated on the importance of the use of masks per our infection control policy. This will be monitored daily by nursing staff and at shift change meeting. The nurse will ensure the staff member has their mask on appropriately-covering the staff member’s nose and mouth.

***MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client***

Meal programs will be re-educated to staff. The interdisciplinary team will review changes. The Program Coordinator will monitor on-going.