		_			
Citation Number: 1035				Date: July 22	2, 2021
Facility Name: Behavioral Ted	chnologies Delta			Survey Dates: June 14, 2021 – June 24, 2021	
Facility Address 1200 Williams Des Moines, lo					
		LK	#97863-I		
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date
64.60	481-64.60(135C) Federal regulations adopted conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319. Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility. This rule is intended to implement Iowa Code Section 135C.2(3).		-	\$5,500.00	Upon Receipt
W189					
	review, the facility fail employee with training their duties effectively competently. This af	g to enable them to perform			

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

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Citation Number: 1035				Date: July 2	2, 2021
Facility Name Behavioral Te	: chnologies Delta		Survey Dates: June 14, 2021 – June 24, 2021		
Facility Addre 1200 Williams Des Moines, le			#07062		
		LK	#97863-	ı	
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date
	#5, Client #6 and Clie investigation of #9786 1. Record review on 6 Incident/Accident Repreport documented no Nurse (RN) due to Clifacility. The RN docu at 8:30 a.m. The RN injuries but sent her to evaluation. The Family Medical Content of the client's home and 8:30 a.m. at her father the client's home. The may have left the faci Physician Assistant (Figure 18's judgment and instanced no signs of trausing Additional record reviews. Client #8's Consum 6/15/21 revealed she of incident and her distance in the client and he	cort dated 6/13/21. The otification of the Registered ient #8's elopement from the mented staff found Client #8 examined her, found no o a Family Medical Clinic for Clinic report dated 6/13/21 on her at 7:20 a.m. and found attended. She was found at tr's home, several miles from the report indicated Client #8 lity around 6:00 a.m. The PA) acknowledged Client sight were impaired but			Page 2 of 1

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		LK	#97863-I			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date	
	insomnia and anxiety b. Client #8's Behavio 2/24/21. The Plan no monitored every two rand every 15 minutes BSP directed staff to #8 when she exhibite aggression, leaving the property destruction of continuous minutes of included restrictive metabehaviors. Specific re elopement behavior in Client #8's bedroom verit doors. c. A Person Centered on 5/4/21. The plan re reduce upset/agitation physical aggression and addition, the PCPP no "continuously monitor d. Client #8's 3rd Shift no documentation of shift.	or Support Plan (BSP) dated ted Client #8 should be minutes during waking hours during sleeping hours. The "continuously" monitor Client dupset/agitation, physical he building unattended and until she achieved 10 f calm/quiet. The BSP easures to reduce unwanted estrictions related to included use of an alarm on window and alarms on all a Program Plan (PCPP) held noted the BSP in place to in, property destruction, and elopement behaviors. In oted that Client #8 should be red" when in the community, it bed check form revealed checks throughout the third directives to staff to check				

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Facility Address/ 1200 Williams Str Des Moines, Iowa	eet	T.V.	#0 7 000			
		LK	#97863-			
Rule or Code Section	Nature	e of Violation	Class	Fine Am	ount	Correction date
Pho 6. Cth Hhiviacicip Tii6. Toresi Sfort Fa	rogram Coordinator e received a call from /13/21 after 7:00 a.m. Elient #8 eloped. The ne home and initiated le interviewed Client im staff were sleeping in the window in the cknowledged Client hecks during waking hecks when in her rogresented Client #8's the form lacked staff me period from 11 p. /13/21. The PCS then product the product sheet. He explain the explaint esponsible for Client hift to ensure supervitation or the 11:00 p.m 7: the PCS said he drow the product was also be and he drow the product of the product of the 11:00 p.m 7: the PCS said he drow the product of th	#8 signed the form each ision. Development ned the document on 6/12/21				Page 4 of 1

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1035				July 22	2, 2021
Facility Name:	chnologies Delta		Survey I	Dates: , 2021 – June 24	2021
			June 14,	2021 04110 21	, 2021
Facility Addres	ss/City/State/Zip				
Des Moines, lo		116	"2		
		LK	#97863-I		
Rule or				Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					
	On 6/15/21 the surve	yor completed a Google			
	search of the same page	ath. The search indicated			
	the distance from the was 2.3 miles.	facility to the parental home			
	was 2.5 miles.				
		round.com revealed the			
		loines on 6/13/21 at 6:54			
		Fahrenheit (F) with no ht wind at three miles per			
	H · · · ·	a.m. the temperature was 69			
		recipitation and a three mph			
	wind.				
	Further record review	on 6/15/21 revealed the			
	following documents	as part of the PCS's			
	investigation:				
	a. A written statemen	t by the Shift Supervisor. He			
	documented he arrive	ed at work at 7:00 a.m. and			
	0	ministration with the male			
		He noted he went to find cations, did not find her and			
		he home. He documented			
		cked on Client #8 around			
	2:00 a.m. or 3:00 a.m	check door alarms. The			
	11	record their initials in each			
	box for the time the o	utside door alarms were			
	checked and then to i	nitial the box when window			

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·		LK	#97863-I		
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date
	document identified a bedroom windows as lacked staff initials on p.m. checks. c. Client #8's 3rd Shift lacked staff initials for from 11 p.m 7:00 a. d. A statement by Clie Coordinator Supervise document indicated Chome through the din were asleep. When interviewed on #8 walked with the su Coordinator (PC) to dher walk to her father walked out of her hon sidewalk and walked street. Client #8 said sweaty and she had pwalked to her parenta maintained she staye going to her father's. sidewalk ran four lane a posted speed limit of	alarms were checked. The II exit doors and all client alarmed. The document the 3:00 p.m. and 11:00 at Bed check form. The form reach 15 minute time period m. on 6/12/21 - 6/13/21. The street alignment with the Program for (PCS) on 6/13/21. The client #8 stated she left the fing room window while staff as home on 6/13/21. She he, down some stairs to a 1½ block north to a main city it was sunny, she was bajama pants on when she all home on 6/13/21. She don the sidewalk while The street adjacent to the less in a business district with of 40 mph. She confirmed ator (PC) found her at her after she arrived.			

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,		LK	#97863-			
Rule or Code Section	Natur	e of Violation	Class Fine Amount Co		Correction date	
	Upon returning to the house, Client #8 said she left the home via the dining room window and pointed to a crank out window in the dining room. She said staff did not see her leave and explained she saw DS A asleep in the living room. When interviewed on 6/15/21 at 12:43 p.m., the Shift Supervisor (SS) confirmed he discovered Client #8 missing on 6/13/21. He estimated the time of the discovery as 7:25 a.m 7:30 a.m. He acknowledged he arrived at 7:00 a.m. and began medication administration and completed the administration of the men's medications. He recalled he went back to Client #8's bedroom, did not find her and went to the shower room. He confirmed he did not see her and alerted third shift staff identified as DS A and DS B. The SS recalled DS B indicated Client #8 was in her bedroom.					
	attempted elopement	history of elopement and by Client #8. He denied home exhibited elopement				
		6/15/21 at 1:10 p.m., the Disability Professional				

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

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Facility Address 1200 Williams Des Moines, Id						
		LK	#97863-I			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date	
	behavior. When interviewed on Program Coordinator exhibited elopement by the work of the	6/16/21 at 11:45 a.m. the rvices confirmed Client #5 behavior. She noted he 6/15/21 at 2:20 p.m., the (PC) confirmed she he Shift Supervisor (SS) on tely 7:10 a.m. to inform her he recalled she went to the gged his shoulders when hat #8 left the building. She herned because she did not he was close to the did she knocked on the door,				

Facility Administrator Date

percent (35%) pursuant to Iowa Code section 135C.43A (2013).

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five

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,		LK	#97863-	I	
Rule or Code Section	Naturo	e of Violation	Class	Fine Amount	Correction date
	when she returned to completed the "long li noted he last checked 6:40 a.m. She recallering binder containing sheets and found not checked on Client #8 expressed concern for commented the path shome included walking where she observed on #8's father confirmed 6/13/21 at approximate confirmed she looked walking and he directed He recalled she was a pajama pants and tenshe arrived alone but after he directed her to #8's father estimated 8:00 a.m.	6/16/21 at 8:35 a.m., Client she arrived at his home on tely 7:30 a.m. He			Page 9 of 1

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Date

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·		LK	#97863-		
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date
	She stated she checked on Client #8 every hour on her shift. When interviewed on 6/15/21 at 5:30 p.m., DS B confirmed he worked the third shift on 6/12/21. He said he and DS A discussed duties for the night and DS A agreed to take responsibility for Client #1, Client #3, Client #6 and Client #8; known as "the back group". He recalled he assisted with ensuring clients used the restroom when he first arrived because DS A was mopping. He noted performance of duties throughout the shift like mopping and assisting clients in the bathroom. DS B recalled seeing Client #8 in bed at 4:50 a.m. He denied hearing any alarm or seeing her leave the building prior to being told the SS that she was missing. He estimated the SS told him she was missing at 6:00 a.m. DS B said he checked the alarms on the doors and windows when he arrived at work on 6/12/21. He acknowledged he failed to document the checks. DS B said he checked on the clients in the home "every hour or two" on the third shift. He did not recall being told to do bed checks every 15 minutes.				Page 10 of 1

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		LK	#97863-I		
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date
	4:50 a.m. He also may while at work and conwas not allowed. When interviewed on confirmed he worked home but was moved approximately a week said he did rounds an her in her bed and we approximately 6:45 a. He recalled DS B cannot find Client #8. DS inside and found the copen. He noted the valarm at the time. He assumed she went outler staff later found where or when. DS A stated DS B tole group" but he denied and said he did not know the consibility for on the denied being told.	c prior to the incident. He d checked on Client #8, saw ent outside to take a break at m. on 6/13/21. The out and told him he could a A said he and DS B went dining room window cranked window did not have an eacknowledged they at the window and knew her but he did not know the dim he had the "back accepting that responsibility"			

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Facility Name: Behavioral Tec	chnologies Delta		Survey Dates: June 14, 2021 – June 24, 2021		
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	DS A further denied receiving any training at the home. He said they moved him to Client #8's home "without one lick of training". He said he did bed checks every 15 - 20 minutes and did so by opening the door and looking inside the bedroom to see if the clients laid in bed. He denied sleeping while on duty at the home and said he was outside smoking prior to the discovery that Client #8 eloped. DS A recalled the SS arrived at 6:50 a.m. on 6/13/21 and then DS B came and told him Client #8 was missing. He recalled the PCS asked him why he did not check the alarms but contended he was unaware of the alarm checks. When interviewed on 6/16/21 at 11:45 a.m., the Director of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) Services stated staff are trained to check the alarms when they are hired. The Director could not produce documentation of staff training on checking alarms. When interviewed on 6/16/21 at 2:30 p.m., the Director of ICF/ID Services could not produce training documents for DS B. She produced a training packet for DS A; however, review of the				

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·		LK	#97863-			
Rule or Code Section	Natur	e of Violation	Class	Fine Amo	ount	Correction date
	training information revealed no information regarding when and how to conduct bed checks. The document lacked an explanation of checking alarms on each shift. When interviewed on 6/16/21 at 1:30 p.m., the Administrator confirmed she terminated DS A for failure to complete required documentation of bed checks and alarm checks. She noted Client #8 stated he slept while on duty and acknowledged her credibility. She confirmed DS B failed to document the required checks and acknowledged him as a longer term staff. She said he "should have known better". On 6/15/21 at 4:30 p.m., the surveyor drove the route facility staff suggested Client #8 walked on 6/13/21 to get from the facility to her father's home. The initial street is a four lane, with an initial speed limit of 40 miles per hour (mph). Client #8 had to walk west to get to her father's home and the street becomes more commercial and the speed limit lowers to 35 mph. The distance from Client #8's home to the facility office was approximately two miles on the surveyor's car odometer. Client #8 assumedly crossed the street and walked approximately three tenths of a mile, or six blocks along a two					

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	Iane residential street. No speed limit was posted in that area. On 6/16/21 at 6:15 a.m. the surveyor drove to the facility. The sun was rising and the traffic on the four lane street was light. 2. Observations on 6/15/21 at 11:25 a.m. revealed hand written pages posted on various doors in the facility. The message notified staff that Client #8 required continuous monitoring until further notice. Record review on 6/15/21 revealed Client #8's BSP dated 6/13/21. The BSP directed staff to maintain continuous monitoring of Client #8 for at least 24 hours after an attempt to elope or an actual elopement. When interviewed on 6/15/21 at 10:43 a.m. the Program Coordinator Supervisor (PCS) acknowledged the facility changed Client #8's supervision level from two minute checks to continually monitoring and explained staff needed to keep eyes on Client #8 at all times. He identified the Program Coordinator (PC) as the person responsible to train staff on the new level of supervision.					

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Rule or Code Section	Natur	e of Violation	Class	Fine Amou	int	Correction date
	Shift Supervisor (SS) #8's level of supervisi 6/13/21. He said state eyesight. When interviewed on Developmental Speci #8's continuous moniminutes. Observation on 6/16/2 E walked with Client # bedroom. DS E left the room and failed to eyesight. She returned seconds later. When interviewed on confirmed she trained continuous monitoring requested documentation of the ICF/ID Services on 6/2	When interviewed on 6/15/21 at 12:05 p.m., revelopmental Specialist (DS) C identified Client 8's continuous monitoring as checks every 5 - 10 minutes. Observation on 6/16/21 at 6:35 a.m. revealed DS walked with Client #8 down the hall to her redroom. DS E left the bedroom with Client #8 in the room and failed to keep her in constant yesight. She returned approximately five reconds later. When interviewed on 6/15/21 at 3:05 p.m. the PC confirmed she trained staff on Client #8's new continuous monitoring requirement. The surveyor requested documentation of the staff training. The surveyor made another request for the ocumentation of the training from the Director of CF/ID Services on 6/16/21 at 11:45 a.m. The accility failed to produce the training				

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Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date
	3. Observations in the home at various times on 6/15/21 and 6/16/21 revealed alarms on the exit doors. On 6/16/21 at 6:45 a.m., the surveyor opened the exit door adjacent to Client #8's bedroom. The alarm sounded but no staff responded. The exit door was located approximately 4-5 steps from Client #8's bedroom door. When interviewed at 6:46 a.m., the PC said she heard the alarm but could not respond due to providing cares to Client #4 at the time. When interviewed at 6:48 a.m. the PCS said he heard the alarm but did not respond. He supervised clients in the living room at the time. When interviewed on 6/16/21 at 6:55 a.m., DS E said she heard the alarm sound but could not check the door because she needed to provide constant monitoring of Client #8. When interviewed on 6/16/21 at 9:00 a.m., the Director of ICF/ID Services confirmed staff are expected to investigate the cause when an alarm sounded.				Page 16 of 1

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	4. When interviewed on 6/15/21 at 4:10 p.m. DS D confirmed Client #8 left the house on 6/12/21 after supper. He recalled the alarm sounded and staff followed her to the parking lot. He said she came back into the home with no further incidents prior to the end of his shift at 11:00 p.m. He said he failed to tell DS A about the incident. When interviewed on 6/16/21 at 6:55 a.m., DS E confirmed she worked second shift on 6/12/21 when Client #8 went outside and ran to the parking lot. She recalled DS D came out and Client #8 dropped to the ground and attempted to hit him. She said they were able to get Client #8 back in the house and she called the Director of ICF/ID Services. DS D recalled the Director advised her to keep an eye on Client #8, complete a Behavior Restraint Report (BRR) and tell DS D to complete an Incident Report. When interviewed on 6/15/21 at 2:20 p.m. the Program Coordinator (PC) noted when Client #8 becomes upset, staff should not take their eyes off her. She said had she known she attempted to leave earlier in the evening she would have advised staff to keep a closer eye on her. She stated DS D and DS E told DS A and DS B that she had a rough day but they failed to keep an eye on her.					

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	When interviewed on 6/15/21 at 5:30 p.m. DS B confirmed he saw DS E when he arrived at work but denied she told him about the attempt to elope earlier in the evening. When interviewed on 6/16/21 at 12:05 p.m. DS A denied being told Client #8 made an attempt to leave the facility earlier in the evening on 6/12/21. He noted no Incident Report or BRR existed to inform staff of the incident. He insisted staff wrote the BRR the following day. He stated the elopement incident could have been avoided if staff had told him Client #8 made a previous attempt to leave the home. When interviewed on 6/15/21 at 11:05 a.m., the Qualified Intellectual Disability Professional (QIDP) stated she had not received an IR or BRR from staff regarding Client #8's attempt to leave the facility during second shift on 6/12/21. When interviewed on 6/16/21 at 9:00 a.m., the Director of ICF/ID Services confirmed she received a call from DS E on the evening of 6/12/21. She said she directed staff to keep an eye on Client #8 but did not clarify the extent of time to enhance her supervision.					

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,		LK	#97863-I		
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date
	In summary, the facility failed to provide staff with adequate training to ensure competent implementation of systems in place for client safety. The failure lead to Client #8 walking a busy street in a metropolitan area with no supervision for over an hour. FACILITY RESPONSE				

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