DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G020	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIORAL TECHNOLOGIES-DELTA	1200 WILLIAMS STREET DES MOINES, IA 50317

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W 000	INITIAL COMMENTS At the time of the investigation of #97863-I an Immediate Jeopardy (IJ) was determined on 6/16/21 at 1:38 p.m. The facility was notified of the IJ at 2:35 p.m. on 6/16/21. The IJ was removed on 6/18/21 at 10:11 a.m. A condition level deficiency was cited at W158. A standard level deficiency was cited at W189.	W 000	See Attached POC 7/23/21	
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to maintain substantial compliance with the Condition of Participation (COP): Facility Staffing. The facility failed to provide adequate training to ensure staff competently and consistently demonstrated skills and supervision supports to ensure client safety. Cross reference W189: Based on interviews and record review, the facility failed to provide each employee with training to enable them to perform their duties effectively, efficiently and competently. On 6/16/21/20 at 1:38 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure staff competency to keep clients safe. The facility was notified on 6/16/21 at 2:25 p.m.	W 158		

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

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

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W 158	Continued From page 1 The facility developed a plan to remove the IJ, which included re-training staff on conducting bed checks, checking alarms and communication between shifts. The IJ was removed on 6/18/21 at 10:11 a.m.	W 158		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide each employee with training to enable them to perform their duties effectively, efficiently and competently. This affected 1 of 1 client (Client #8) and potentially affected all clients in the home (Client #1, Client #2, Client #3, Client #4, Client #5, Client #6 and Client #7) at the time of the investigation of #97863-I. . Findings follow: 1. Record review on 6/15/21 revealed an Incident/Accident Report dated 6/13/21. The report documented notification of the Registered Nurse (RN) due to Client #8's elopement from the facility. The RN documented staff found Client #8 at 8:30 a.m. The RN examined her, found no injuries but sent her to a Family Medical Clinic for evaluation. The Family Medical Clinic report dated 6/13/21 noted staff checked on her at 7:20 a.m. and found she left the home unattended. She was	W 189		

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found at 8:30 a.m. at her father's home, several miles from the client's home. The report indicated Client #8 may have left the facility around 6:00 a.m. The Physician Assistant (PA) acknowledged Client #8's judgment and insight were impaired but noted no signs of trauma or dehydration.

Additional record review revealed the following:

a. Client #8's Consumer Information document on 6/15/21 revealed she was 21 years old at the time of incident and her diagnoses included: severe intellectual disability with behavioral disturbances, attention deficit hyperactivity disorder (ADHD), insomnia and anxiety disorder.
b. Client #8's Behavior Support Plan (BSP) dated 2/24/21. The Plan noted Client #8 should be monitored every two minutes during waking hours and every 15 minutes during sleeping hours. The BSP directed staff to "continuously" monitor Client #8 when she exhibited upset/agitation, physical aggression, leaving the building unattended and property destruction until she achieved 10 continuous minutes of calm/quiet. The BSP included restrictive measures to reduce unwanted behaviors. Specific restrictions related to elopement behavior included use of an alarm on Client #8's bedroom window and alarms on all exit doors.
c. A Person Centered Program Plan (PCPP) held on 5/4/21. The plan noted the BSP in place to reduce upset/agitation, property destruction, physical aggression and elopement behaviors. In addition, the PCPP noted that Client #8 should be "continuously monitored" when in the community.
d. Client #8's 3rd Shift bed check form revealed no documentation of checks throughout the third shift.

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e. A facility form with directives to staff to check the window and door alarms on each shift.

When interviewed on 6/15/21 at 9:05 a.m. the Program Coordinator Supervisor (PCS) confirmed he received a call from the Administrator on 6/13/21 after 7:00 a.m. He recalled she told him Client #8 eloped. The PCS indicated he went to the home and initiated an internal investigation. He interviewed Client #8 and confirmed she told him staff were sleeping when she left her home via the window in the dining room on 6/13/21. He acknowledged Client #8 required two (2) minute checks during waking hours and 15 minute checks when in her room sleeping. The PCS presented Client #8's 3rd Shift Bed check form. The form lacked staff initials for each 15 minute time period from 11 p.m. - 7:00 a.m. on 6/12/21 - 6/13/21.

The PCS then produced the resident sign in-sign out sheet. He explained the staff person responsible for Client #8 signed the form each shift to ensure supervision. Development Specialist (DS) A signed the document on 6/12/21 for the 11:00 p.m. - 7:00 a.m. shift.

The PCS said he drove the path he assumed Client #8 walked from the facility to Client #8's father's home. He estimated the distance at over two miles.

On 6/15/21 the surveyor completed a Google search of the same path. The search indicated the distance from the facility to the parental home was 2.3 miles.

A search on wunderground.com revealed the temperature in Des Moines on 6/13/21 at 6:54

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a.m. was 63 degrees Fahrenheit (F) with no precipitation and a light wind at three miles per hour (mph). At 7:54 a.m. the temperature was 69 degrees F., with no precipitation 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 statement by the Shift Supervisor. He documented he arrived at work at 7:00 a.m. and began medication administration with the male clients in the home. He noted he went to find Client #8 for her medications, did not find her and continued searching the home. He documented DA B said he last checked on Client #8 around 2:00 a.m. or 3:00 a.m.
b. The facility form to check door alarms. The form directed staff to record their initials in each box for the time the outside door alarms were checked and then to initial the box when window and bedroom window alarms were checked. The document identified all exit doors and all client bedroom windows as alarmed. The document lacked staff initials on the 3:00 p.m. and 11:00 p.m. checks.
c. Client #8's 3rd Shift Bed check form. The form lacked staff initials for each 15 minute time period from 11 p.m. - 7:00 a.m. on 6/12/21 - 6/13/21.
d. A statement by Client #8 taken by the Program Coordinator Supervisor (PCS) on 6/13/21. The document indicated Client #8 stated she left the home through the dining room window while staff were asleep.

When interviewed on 6/15/21 at 11:50 a.m. Client #8 walked with the surveyor and with the Program Coordinator (PC) to demonstrate the beginning of

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her walk to her father's home on 6/13/21. She walked out of her home, down some stairs to a sidewalk and walked ½ block north to a main city street. Client #8 said it was sunny, she was sweaty and she had pajama pants on when she walked to her parental home on 6/13/21. She maintained she stayed on the sidewalk while going to her father's. The street adjacent to the sidewalk ran four lanes in a business district with a posted speed limit of 40 mph. She confirmed the Program Coordinator (PC) found her at her father's home shortly after she arrived.

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.

The SS confirmed a history of elopement and attempted elopement by Client #8. He denied any other client in the home exhibited elopement behavior.

When interviewed on 6/15/21 at 1:10 p.m., the

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Qualified Intellectual Disability Professional (QIDP) confirmed Client #5 exhibited elopement behavior.

When interviewed on 6/15/21 at 3:00 p.m. the Program Coordinator (PC) confirmed Client #5 exhibited elopement behavior.

When interviewed on 6/16/21 at 11:45 a.m. the Director of ICF/ID Services confirmed Client #5 exhibited elopement behavior. She noted he liked to be outdoors.

When interviewed on 6/15/21 at 2:20 p.m., the Program Coordinator (PC) confirmed she received a call from the Shift Supervisor (SS) on 6/13/21 at approximately 7:10 a.m. to inform her Client #8 eloped. She recalled she went to the home and DS A shrugged his shoulders when she asked when Client #8 left the building. She recalled she felt concerned because she did not know how long Client #8 could have been gone. The PC recalled she drove to Client #8's father's home because she knew it was close to the facility office. She said she knocked on the door, Client #8's father answered the door and confirmed Client #8's presence in his home. He told the PC he instructed Client #8 to change her shirt because her sweatshirt was drenched with her sweat.

The PC stated she had a conversation with DS A when she returned to the home and he stated he completed the "long list" of cleaning tasks. He noted he last checked on Client #8 at 6:30 a.m. or 6:40 a.m. She recalled they reviewed the three ring binder containing the third shift bed check sheets and found no documentation that staff checked on Client #8 during the shift. She

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expressed concern for Client #8's safety and commented the path she took to her father's home included walking along a very busy street where she observed driver's speeding.

When interviewed on 6/16/21 at 8:35 a.m., Client #8's father confirmed she arrived at his home on 6/13/21 at approximately 7:30 a.m. He confirmed she looked hot and sweaty from walking and he directed her to change her shirt. He recalled she was dressed in a sweatshirt, pajama pants and tennis shoes. He confirmed she arrived alone but noted staff arrived shortly after he directed her to change her shirt. Client #8's father estimated staff arrived sometime after 8:00 a.m.

When interviewed on 6/15/21 at 3:55 p.m., DS F confirmed she worked the third shift at the facility. 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.

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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.

DS B maintained he last saw Client #8 at 4:40 or 4:50 a.m. He also maintained he did not sleep while at work and confirmed sleeping on third shift was not allowed.

When interviewed on 6/16/21 at 12:05 p.m., DS A confirmed he worked for the facility at another home but was moved to Client #8's home approximately a week prior to the incident. He said he did rounds and checked on Client #8, saw her in her bed and went outside to take a break at approximately 6:45 a.m. on 6/13/21.

He recalled DS B came out and told him he could not find Client #8. DS A said he and DS B went inside and found the dining room window cranked open. He noted the window did not have an alarm at the time. He acknowledged they assumed she went out the window and knew other staff later found her but he did not know where or when.

DS A stated DS B told him he had the "back group" but he denied accepting that responsibility and said he did not know who he had responsibility for on the night of 6/12/21 - 6/13/21. He denied being told when he signed into the sheet he accepted responsibility for Client #8.

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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 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

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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 lane 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

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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.

When interviewed on 6/15/21 at 12:43 p.m., the Shift Supervisor (SS) indicated a change in Client #8's level of supervision since the incident on 6/13/21. He said staff should keep her within eyesight.

When interviewed on 6/15/21 at 12:05 p.m., Developmental 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 E walked with Client #8 down the hall to her bedroom. DS E left the bedroom with Client #8 in the room and failed to keep her in constant eyesight. She returned approximately five seconds 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 documentation of the training from the Director of ICF/ID Services on 6/16/21 at 11:45 a.m. The facility failed to produce the training documentation.

3. Observations in the home at various times on

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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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G020	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIORAL TECHNOLOGIES-DELTA	1200 WILLIAMS STREET DES MOINES, IA 50317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 13	W 189		

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.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G020	A. BUILDING _____ B. WING _____	C 06/24/2021

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W 189	Continued From page 14 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. 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.	W 189		

DELTA INVESTIGATION 97863-I POC

W 189

1. Client #1's Behavior Support Plan will be revised to include that he/she will be on 24-hour continuous monitoring following an attempt or actual act of elopement.

   Director ICF/ID Services is responsible for revising the BSP and the house Program Coordinator is responsible for training the Developmental Specialists (DS). Both positions are responsible in assuring that the monitoring is carried out by speaking with staff on each shift and doing house checks.

2. All BT Developmental Specialists will be retrained on how to complete bed checks and documenting bed checks.

   Director ICF/ID Services will develop the training and the house Program Coordinators will be responsible for training Developmental Specialists. The house Program Coordinators will be responsible for checking the bed checks whenever working at house.

3. The New Employee checklist will be modified to include bed check and alarm checks.

   Director ICF/ID Services will be responsible for modifying the New Employee checklist and training and the house Program Coordinator will be trained on this checklist by the Program Coordinator Supervisor. The Delta house Program Coordinator will be responsible for training all new employees at the beginning of employment at the house with the modified training list and turning them into the office at the completion of the training.

4. All BT Developmental Specialists will be retrained on doing window and door alarm checks and documentation of these checks.

   Director ICF/ID Services will develop the training and the house Program Coordinator will conduct the training with the Developmental Specialists. The house Program Coordinator will monitor these checks by visual observation of checks being completed and documentation of alarm checks.

5. All BT Developmental Specialists will be trained on what their response to a door or window alarm sounding is to be.

   Director ICF/ID Services will develop the training and the house Program Coordinators will conduct the training with the Developmental Specialists. The Program Coordinators will monitor the Developmental Specialists response when on the floor. The Program Coordinator Supervisor, QIDP and Director ICF/ID Services will monitor for Developmental Specialists response during house visits.

6. All BT Developmental Specialists will be trained on between shift communication of significant events. A communication book will be implemented for Developmental Specialists to document these events in. Developmental Specialists are responsible for checking the communication book when they arrive at work.

   Director ICF/ID Services will develop the training and the house Program Coordinator will be responsible for conducting training with the Developmental Specialists and monitoring shift communication documentation when at the house.

7. Window alarms will be placed on all windows in the house that Client #1 can access to get out of.

   BT Director will contact maintenance to install these alarms. Maintenance will be responsible for the installation of the alarms. Alarms will be checked for being in working order or not on each shift (#3)

   Completion Date: 7/23/21