ok 8/17/21

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G051	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILLAR OF CEDAR VALLEY	1410 WEST DUNKERTON ROAD WATERLOO, IA 50703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The investigation of #96107-C resulted in no deficiencies. The investigation of #97514-I resulted in a deficiency cited at W193. No deficiencies or concerns were noted related to the focused Infection Control Survey.	W 000	See Attached POC 8/16/21	
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff implemented client behavior support programs (BSP) to ensure client supervision and safety. This affected 2 of 2 clients identified in the investigation of #97514-I (Client #1 and Client #2). Finding follows: Record review on 5/24/21 revealed a facility investigation and incident reports regarding Client #1 and Client #2. According to facility documentation, Client #2 reported to staff Client #1 kissed her and touched her inappropriately on the evening of 5/17/21. Client #2 reported the incident on the same evening it occurred. She indicated Client #1 touched her breast and put his hand inside her pants/underwear and touched her vaginal/vulvar area. Client #2 had a history of making false statements and Client #1 denied the allegation. The facility and surveyor reviewed the video from	W 193		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla Matthes
TITLE: Executive Director
(X6) DATE: 7/29/21

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 193	Continued From page 1 three hallway cameras. The video revealed Client #1 approached Client #2 as she sat in her wheelchair in the hallway outside of her room on the evening of 5/17/21 at 6:21 p.m. Client #1 initially waved at Client #2 and gave her a brief hug and then pulled up a chair and sat next to Client #2. The video from the cameras did not show clearly show exactly what happened, but did reveal Client #1 leaned toward Client #2 twice with his hands reaching out toward Client #2's lap area for a few seconds. The video showed Client #1 stood up and faced Client #2, pulled down the front of his shorts and for a few seconds revealed what appeared to be his erect penis. Client #1 looked over his shoulder down the hallway several times as he interacted with Client #2, but staff were not in sight. Another client, identified as Client #3, walked down the hallway at one point and Client #1 turned in his chair so he was not facing Client #2. Client #1 then turned back toward Client #2 and reached out toward her torso, possibly touching her breast. The facility later interviewed Client #3 and he said he saw Client #1 touch Client #2's breast. Client #2 was in pajamas at the time and was not wearing a bra. Client #1 also stood and briefly kissed Client #2 on the lips. Client #1 and Client #2 were in the hallway near each other from approximately 6:21 p.m. to 6:33 p.m. Client #1 briefly left the area for about a minute during the time frame, but then returned to Client #2. Additional review of the video revealed Client #1 finished eating supper and went back to his room at approximately 5:08 p.m. on 5/17/21. Client #1 went back to his room without staff, so his bedroom door alarm was not set. Client #1 remained in his room until he came out into the hallway at approximately 6:21 p.m., which is	W 193		

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when he saw Client #2 sitting in the hallway. No staff person was observed on the video checking on Client #1 from at least 5:30 p.m. to at least 7:00 p.m. The video showed that Certified Nursing Assistant (CNA) A wheeled Client #2 to her room on 5/17/21 at 6:13 p.m. CNA A left the room, shut the door and turned on the alarm at 6:14 p.m., but then took a few steps and turned back to Client #2's room. CNA A opened the door and turned off the alarm. She appeared to speak to Client #2 briefly at the doorway and then CNA A left the room with the door open and the alarm not set. Client #2 propelled her wheelchair out of her bedroom and into the hallway near her doorway at 6:16 p.m. Client #2 sat in her wheelchair by her door for five minutes until Client #1 walked by and interacted with her. As Client #2 sat in the hallway, a staff person who appeared to be Developmental Assistant (DA) A, walked in and out of the hallway and saw Client #2, but did not appear to interact with her.

Client #1 was a 17 year old male with a diagnosis including mild intellectual disability, autistic disorder, attention deficit/hyperactivity disorder (AD/HD), conduct disorder, seizure disorder and a chromosomal disorder. Client #1 had been admitted to the facility on 10/16/19. He had a Behavior Support Program (BSP) with target behaviors of verbal and physical threats, physical aggression, property destruction, spitting at others, self-injurious behavior, suicidal gestures and elopement. According to the BSP, Client #1 should have his bedroom door alarm on when he was in his room. According to the annual Qualified Intellectual Disability Professional (QIDP) report dated 11/09/20, Client #1 had a history of inappropriate sexual behavior prior to his admission to the facility. The QIDP report

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When interviewed on 5/20/21 at 1:50 p.m. CNA B stated she was assigned to Client #1. She said staff had been retrained to increase Client #1's supervision to 15 minute checks when he was in his room and staff had also been retrained to make sure the bedroom door alarm was on when Client #1 was in his room. The surveyor observed CNA B accompany Client #1 to his room a short time later, at his request. CNA B shut the bedroom door and turned on the alarm.

When interviewed on 5/20/21 at 2:05 p.m. the Program Director (PD) said the facility had increased Client #1's supervision level to 15 minute checks when in his bedroom. When he was out of his room, he should be in his program area, supervised by staff. Staff had been instructed to keep Client #1 in sight if he left his program area. The facility was in the process of developing and implementing a new behavior support program for Client #1 to address inappropriate sexual behavior. According to the PD, Client #1 had lived at the facility almost two years and had no prior substantiated inappropriate sexual behavior at the facility. Another female resident with a history of making false statements had accused Client #1 of inappropriate touch in the past, but a review of the video did not support her claims. The PD said at the time of the incident, it would not have been acceptable for either Client #1 or Client #2 to be in the hallway unsupervised. They should have been in their bedrooms with the door alarms turned on, so staff would be alerted when they came out of their rooms.

When interviewed on 5/25/21 at 3:50 p.m. the PD and the Behavior Specialist (BS) confirmed at the

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time of the incident it was not acceptable for Client #1 or Client #2 to spend time in the hallway unsupervised. They should have been in their assigned program/activity room or in their bedrooms with the door alarms activated. The BS noted Developmental Aide (AD) A was in and out of the hallway as Client #2 sat in her wheelchair by her door for several minutes. She should have directed Client #2 to her room or to her program area, but DA A was a newer staff at the time. The PD and BS stated Client #1 and Client #2 had shown no prior romantic or sexual interest in each other. They confirmed that Client #3 said he saw Client #2 touch Client #1's breast. Client #2 did not appear to be upset by the incident, but she did report it to staff shortly after it occurred.

When interviewed on 5/26/21 at 2:30 p.m. CNA A acknowledged she wheeled Client #2 to her room after supper on 5/17/21. She said she took Client #2 to her room, shut the door and set both of the door alarms. CNA A said she went to check on Client #2 about 30 minutes later and saw that she was her room with the door open. CNA A said she didn't know how Client #2's door had been opened without the alarm sounding. Client #2 told CNA A of the incident with Client #1. When shown the video of leaving Client #2's bedroom door open on the evening of 5/17/21, CNA A said she recalled that Client #2 was angry and insisted her door be left open. CNA A said she thought she went to break around that time so she told another staff person that Client #2 had refused to have her door closed. CNA A didn't remember who she told. CNA A stated she knew on the evening of 5/17/21 that Client #2's bedroom door needed to be closed with her alarm turned on when she was in her bedroom. She indicated she asked another staff to address it when she went

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to break.

When interviewed on 5/26/21 at 2:45 p.m. Developmental Aid (DA) A reviewed the video of a staff person who had been identified as DA A by the QIDP, the BS, the PD and the surveyor. The staff person went in and out of the hallway as Client #2 sat in her wheelchair outside of her room between approximately 6:16 p.m. and 6:21 p.m. on 5/17/21. D A stated the staff person in the video was not her. She said she was a newer staff at that time and did not know that Client #2 should not be allowed to sit in the hallway unsupervised, but insisted the staff person in the video was not her.

When interviewed on 5/26/21 at 3:00 p.m. DA B confirmed she was assigned to Client #1 and four other clients on the second shift of 5/17/21. DA B said the clients typically ate supper around 5:00 p.m. She said she went to break from 5:30 p.m. to 6:00 p.m., leaving another staff person responsible for Client #1. She said she thought Client #1 was eating supper when she went on break at 5:30 p.m. When she returned from her break at 6:00 p.m., other staff told her that Client #1 was in his room, so she didn't check on him right away. She attended to her other clients. She said she probably checked on Client #1 around 6:30 p.m. and she thought he was in his room. She didn't recall if his door was shut with the alarm on. DA B said she knew Client #1 and Client #2 should have their doors shut and alarmed when they were in their rooms. It would not have been acceptable for either Client #1 or Client #2 to spend time in the hallway unsupervised.

When interviewed on 5/25/21 at 10:20 a.m. Client

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W 193	Continued From page 7 #2 recalled that Client #1 had touched her breast about one week before. She said she was sitting in the hallway and Client #2 came over to her. She said she didn't remember what else had happened. Client #2 did not appear to be upset by the incident. When asked how she felt about the incident, Client #2 said she told Client #1, "no". When interviewed on 5/25/21 at 10:30 a.m. Client #1 denied doing anything inappropriate toward Client #2. He said he went back to his room after supper without staff on 5/17/21. The door alarm was not turned on. He came out later and saw Client #2 in the hallway. When interviewed on 5/29/21 at 9:15 a.m. Client #3 recalled the incident when he saw Client #1 and Client #2 in the hallway together. He indicated he saw Client #1 touch Client #2's breast. When interviewed on 5/20/21 at 1:30 p.m. the QIDP stated the facility had taken the following actions since the incident on 5/17/21: retrained staff to set the bedroom door alarms according to client behavior support programs; checked door alarms to ensure they are functioning; keep Client #1 and Client #2 separated for all activities, dining and programming and the facility planned to move Client #2's bedroom to a different hallway (away from Client #1's bedroom). The facility moved Client #2 to a new bedroom on a different hallway on the afternoon of 5/20/21.	W 193		

ok 8/17/21

Plan of Correction

This plan of correction constitutes Pillar of the Cedar Valley's commitment to compliance. This allegation does not constitute an admission of guilt, but rather stipulates that Pillar of the Cedar Valley is in substantial compliance. Pillar of the Cedar Valley's continues to meet the applicable provisions of the State and Federal regulations.

W 193: The Pillar of Cedar Valley will ensure staff are able to demonstrate skills and techniques necessary to manage the inappropriate behavior of clients per their behavior support plans.

1. Client 1 and 2 behavior support plans have been reviewed and remain appropriate for Clients 1 and 2 by 5/24/2021.
2. Client 2 was moved to the alternate hallway on 5/20/2021.
3. A program has been initiated for Client 1 for Inappropriate Sexual Behavior on 5/24/2021.
4. At the time of incident, Client 1 was placed on 15-minute checks as of June 30, 2021. Client 1 will be on 30-minute checks.
5. Clients 1 and 2 remain in different areas for activities, dining, and programming.
6. All Staff will be provided further education on Client 1 and 2 behavior support plans by 8/16/2021. At the time of incident, the primary staff were provided immediate education on client 1 and 2 behavior support plan and alarms.

Routine monitoring of clients 1 and 2 Behavior Support Plans will be conducted through audits and observations by the QDDP/Program Supervisors. We will conduct DA meetings bi-weekly where the facility will review all clients Behavior Support Plans- 1 or 2 behavior support plans in bi-weekly meetings. The review will consist of target definition, triggers, de-escalation, interventions, problem solving and or debriefing. The Program Manager will monitor to ensure continued compliance with W193.