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 _____	C 11/03/2022

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
W 000	INITIAL COMMENTS Investigations #105234-I and #105236-C, completed on 6/23/22 to 11/03/22, resulted in deficiencies cited at W154, W159, W214, and W287.	W 000	See Attached POC 12/03/22	
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to conduct a thorough investigation into an allegation of abuse. This affected 1 of 1 client identified during the investigation of #105234-I (Client #1). Finding follows: Record review on 6/23/22 revealed a facility investigation dated 6/22/22, documented on 6/17/22 Client #1 entered a room at the end of the hallway. The Registered Nurse searched for Client #1. At 5:35 p.m. staff called a code white (missing person). At 5:41 p.m. the RN walked into a room at the end of the hallway and reported Client #1 walked out of the bathroom. Client #2 sat in her recliner, with her pants and pull up on appropriately. The incident summary noted assessments completed for Client #1 and Client #2. The investigation noted the facility camera footage times and events that took place. The facility investigation contained the officer's information. The facility investigation failed to include a summary of findings, and documentation of 15-minute checks for Client #1. Observation on 6/28/22 at 9:46 a.m. of the facility camera footage revealed the camera's time stamp was an hour ahead of the actual incident	W 154		

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

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W 154	Continued From page 1	W 154		

time.

Record review on 6/28/22 revealed Client #1's 15-minute check documentation dated 6/17/22, indicated no documentation filled in for 6:30 p.m., 6:45 p.m., and 7:00 p.m. The time he went missing noted an A in the time slots of 5:30 p.m., 5:45 p.m., and 5:50 p.m. Further record review revealed the camera footage at 6:28 p.m. documented Client #1 out of the living room. At 6:29 p.m. Client #1 exited his room and his feet turned left, but the footage failed to reveal which room he entered. At 6:34 p.m. the RN looked down the hallway for Client #1. At 6:37 p.m. all staff looked for Client #1. At 6:41 p.m. Client #1 could be seen at the nurse's station.

Email received on 8/24/22 from the Detective revealed the detective received a letter from the facility Client #1 confessed to another client.

When interviewed on 8/24/22 at 10:19 a.m. the Administrator confirmed a statement from the Developmental Aide Lead (DAL) about Client#1's confession existed. She also indicated, once the facility received the court order, Client #1 would be moving out.

Record review on 8/30/22 revealed the DAL's written statement on 7/16/22, indicated Client #1 told Client #3 he "raped" Client #2 and wanted to go after Client #4, but needed Client #3's help. Further record review revealed Client #3's written statement documented Client #1 asked Client #3 to help him "do it" with Client #4. Client #3 reported Client #1 denied being blacked out and he did it on purpose. Client #1 told Client #3 he needed his help when he was off 24-hour checks.

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W 154	Continued From page 2 When interviewed on 8/30/22 at 3:14 p.m. the Administrator confirmed she failed to complete follow up with interviews with Client #3 or the DAL after their written statements. When interviewed on 11/03/22 at 1:12 p.m. the Administrator acknowledged the facility failed to note the discrepancies of the camera footage time and documentation.	W 154		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the Qualified Intellectual Disability Professional (QIDP) updated appropriate assessments and monitored individual program plan based on the Client's social history and behavioral needs for inappropriate sexual behavior. This affected 1 of 1 client with sexual behaviors for investigation #105234-I (Client #1). Finding follows: Record review on 6/28/22 revealed Client #1 to be a 17 year old male. His diagnoses included borderline intellectual functioning, major depressive disorder, attention-deficit hyperactivity disorder (ADHD), generalized anxiety disorder, conduct disorder, and autistic disorder. Continued record review of Client #1's Incident Report dated 3/14/21, indicated Client #1 was found with Client #4 in the bathroom. Client #4 had her pants down and her bra above her breasts. Staff found Client #1 pulling up his pants	W 159		

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W 159	Continued From page 3	W 159		

in the bathroom.

Additional record review of Client #1's 30-day Review dated 7/08/20 noted his placement history. The review failed to note his behavioral history at past placement which included inappropriate sexual behavior. The review indicated an assessment completed by QIDP B noted needs for profane language, aggresses toward others, and makes verbal threats and/or threatening gestures.

Further record review revealed Client #1's social history packet dated 12/03/19, from a previous placement contained information of four different incidents Client #1 displayed inappropriate sexual behavior. The incidents contained the following information:

a. On 3/28/19 Client #1 met with his therapist in the training room with the door open due to a recent inappropriate sexual behavior. The therapist sat closest to the door. Client #1 stared at her chest and she confronted him about his staring. Client #1 told her he wanted to see them. The therapist told him that was inappropriate and left the room.
b. On 3/26/19 Client #1 met with his worker. He went into the room, pulled down his pants,exposed his penis and said a comment for her to reciprocate the act. The worker said "I'm out of here," then left the room.
c. On 3/25/19 Client #1 met with his Department of Human Services (DHS) worker in an office. Client #1 asked for a hug and as he gave her a hug he put his hands down her shirt by her breasts. The DHS worker stated she tried to get Client #1 off of her and he grabbed onto her. The DHS worked reached for the door handle to exit

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W 159	Continued From page 4	W 159		

and Client #1 grabbed her and attempted to block her from leaving the room. The DHS worker got around him and exited.
d. On 8/19/18 Client #1 was outside with peers and staff. Client #1 talked to a female peer about his inappropriate songs on his MP3 player. Staff told Client #1 he needed to be appropriate. Shortly after Client #1 asked "want a dick trophy?" Staff moved between Client #1 and the female peer. Client #1 turned back to the female peer and stated "when we get red, we should run and hide out in the corn field so we can have sex."

Record review on 6/28/22 revealed Client #1's Comprehensive Functional Assessment (CFA) dated 6/20, identified he stole food and exaggerated/lied as the only maladaptive behavior displayed. The top of the same document contained a column dated 1/22, but failed to identify needs or strengths in the columns below. Record review of Client #1's Behavior Intervention Support Plan revised 3/15/22, indicated Client #1's behaviors consisted of: verbal aggression such as threatening to hurt others, cursing, name calling, intimidation, and teasing/instigating.

Additional record review of Client #1's Temporary Safety Plan dated 6/20/22, directed staff to keep Client #1 in direct supervision (staff eye sight) at all times. The plan directed staff to be monitoring for potential safety risks and precursor behaviors. The plan directed staff to go with Client #1 to his room to ensure the item he grabbed from his room could not be a potential safety risk to him or others. The plan directed staff to escort Client #1 to the bathroom and keep the door cracked open. The plan also directed staff to remain in the

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W 159	Continued From page 5	W 159		

shower room with the curtain pulled to monitor Client #1 for safety. The plan failed to contain information for possible sexual inappropriateness toward others. The implementation of the safety plan occurred after a potentional sexual incident between Client #1 and Client #2 on 6/17/22.

When interviewed on 6/29/22 at 8:24 a.m. QIDP A indicated discussion of 15-minute checks occurred in meetings due to Client #1 downloading inappropriate apps with sexual content on his tablet. The QIDP indicated there was not a program in place for the monitoring of the tablet. When interviewed at 10:13 a.m. QIDP A indicated during a team meeting on 6/10/22, it was decided Client #1 needed 15-minute checks due to Client #1 being inappropriate. QIDP A confirmed this occurred prior to the incident on 6/17/22.

Record review on 11/02/22 revealed a Supports Intensity Scale (SIS) dated 12/16/21, indicated Client #1 needed some support in prevention of nonaggressive but inappropriate sexual behavior such as inappropriate touching or gesturing. The other category of prevention of sexual aggression marked no support needed for Client #1.

When interviewed on 11/03/22 at 1:48 p.m. QIDP B acknowledged the safety plan should have noted inappropriate sexual behavior or boundaries as the reason for the plan. QIDP B indicated at the time of the 30 day review Client #1 had not displayed any inappropriate sexual behavior like he did at a prior placement. QIDP B indicated no programming was put into place with Client #1's tablet but he required increased supervision from staff.

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W 214	Continued From page 6	W 214		
W 214	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to identify the client's specific behavioral management needs with inappropriate sexual behaviors. This affected 1 of 1 clients with sexual behaviors for investigation #105234-I (Client #1). Finding follows: Record review on 6/28/22 revealed an Incident Report for Client #1 dated 3/14/21, documented he was found with Client #4 in the bathroom. Client #4 had her pants down and her bra above her breasts. Staff found Client #1 pulling up his pants in the bathroom. Continued record review revealed Client #1's Behavior Intervention Support Plan, revised 3/15/22, indicated Client #1 behaviors consisted of: verbal aggression such as threatening to hurt others, cursing, name calling, intimidation, and teasing/instigating. Additional record review of Client #1's Temporary Safety Plan dated 6/20/22, directed staff to keep Client #1 in direct supervision (staff eye sight) at all times. The plan directed staff to be monitoring for potential safety risks and precursor behaviors. The plan directed staff to go with Client #1 to his room to ensure the item he grabbed from his room could not be a potential safety risk to him or others. The plan directed staff to escort Client #1 to the bathroom and keep the door cracked open. The plan also directed staff to remain in the	W 214		

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W 214	Continued From page 7	W 214		

shower room with the curtain pulled to monitor Client #1 for safety. The plan failed to contain information for possible sexual inappropriateness toward others. The implementation of the safety plan occurred after a potentional sexual incident between Client #1 and Client #2 on 6/17/22.

Record review on 11/02/22 revealed a Supports Intensity Scale (SIS) dated 12/16/21, indicated Client #1 needed some support in prevention of nonaggressive but inappropriate sexual behavior such as inappropriate touching or gesturing. The other category of prevention of sexual aggression marked no support needed for Client #1.

When interviewed on 6/29/22 at 8:24 a.m. Qualified Intellectual Disability Professional (QIDP) A indicated 15-minute checks were discussed in meetings due to Client #1 downloading inappropriate apps on his tablet with sexual content. The QIDP indicated there was not a program in place for the monitoring of the tablet.

Record review on 6/28/22 revealed Client #1's Comprehensive Functional Assessment (CFA) dated 6/20, identified he stole food and exaggerated/lied as the only maladaptive behavior displayed. The top of the same document contained a column dated 1/22, but failed to identify needs or strengths in the columns below. Additionally, no updates to Client #1's CFA could be located following the implementation of the safety plan on 6/20/22.

When interviewed on 11/03/22 at 1:42 p.m. QIDP B confirmed the CFA should have been completed or reviewed yearly. QIDP B acknowledged the CFA should have contained

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W 214	Continued From page 8 the the verified inappropriate behavior.	W 214		
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure restrictive measures were not implemented for the convenience of staff. This affected 1 of 1 sample clients (Client #1). Finding follows: Record review on 6/23/22 revealed Client #1's Temporary Safety Plan dated 6/20/22, directed Client #1 must be in staff sight at all times for potential safety risks and precursor behaviors. The plan further directed, "when all other residents are asleep for the night, (Client #1's) mattress is to be moved into the main lounge area, directly in front of the television. (Client #1) is not to be in any other area during this time, especially behind the wall or near any windows. (Client #1) may have two blankets and two pillows, as well as a fitted sheet on his mattress. Third shift is also to monitor (Client #1) under direct supervision at all times, verbally passing him off and receiving verbal confirmation. Each morning: (Client #1) is to wake before other residents enter the lounge, move his mattress back to his room, and return to his normal morning routine (breakfast, ect) under direct supervision." Additional record review revealed Client #1's Incident Report on 6/17/22 notified the guardian	W 287		

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W 287	Continued From page 9 of Client #1's direct supervision. When interviewed on 6/23/22 at 2:35 p.m. the Administrator acknowledged the facility had Client #1 sleep in the common area by the nurse's station for staff to monitor him. She admitted Client #1 did not pose a threat sleeping in his room. The Administrator confirmed the facility did not have consent for Client #1 to sleep in the common area.	W 287		

Harmony House

2950 West Shaulis Road • Waterloo, IA 50701 • Ph: (319) 234-4495

Harmony House Health Care Center
ICF/ID Plan of Correction

Survey Completed 11/03/2022
Investigations: 105234-I and 105236-C
Correction Date: 12/03/2022

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.

W154: STAFF TREATMENT OF CLIENTS
CFR(s): 483.420(d)(3)

The facility must have evidence that all alleged violations are thoroughly investigated.

1. In the case of future investigations, any documentation related to the investigation will be collected by the Program Coordinator, Administrator, or designee, including a summary of findings, written statements, and documentation of any emergency or safety protocols as needed.

2. Any discrepancies will be resolved and/or documented by the Program Coordinator, Administrator, or designee as incidents occur.

3. The Program Coordinator or Administrator will complete follow up interviews with staff reviewing their statements as incidents occur.

W159: QIDP
CFR(s): 483.430(a)

Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.

1. When completing assessments, QIDP's will document according to the clients present and past history found from their admission packets and/or program data. The skill deficits and needed supports of the individuals will be identified by the QIDP in the functional assessment completed by the QIDP by the time of the 30-day staffing and reviewed annually. The reason for discharge and placement history will be recorded by the Social Worker in the history. The Social Worker and Program Coordinator will monitor for completion.

2. A Level of Supervision protocol was created to identify the specifics of what supervision for each individual resident will entail. This is to be used when creating/ revising programs. The Behavior Strategist has revised programs to ensure the program is using the least restrictive level of supervision.

3. When creating temporary safety plans or restrictive measures, the client's history will be taken into consideration. These are to be implemented at the time of admission after appropriate consent is received and communicated. The client's active treatment program will be reviewed annually, or as a change of condition or significant event occurs. Temporary safety plans and restrictive measures are implemented and reviewed by the interdisciplinary team.

W214: INDIVIDUAL PROGRAM PLAN
CFR(s): 483.440(c)(3)(iii)

The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.

1. The Behavior Strategist will implement a behavior programming baseline before the 30 day staffing to assess areas of needed supports and previous behavioral concerns. Behavior programs are reviewed and approved by the interdisciplinary team.

2. The Comprehensive Functional Assessment will identify skill deficits and needed supports. All programs and assessments will be completed by the 30-day staffing which will include the client's history. CFA's are monitored by the Program Coordinator at the 30-day staffing and are reviewed for completion. They are to be reviewed annually or as a change in condition or significant event occur.

W287: MGMT OF INAPPROPRIATE CLIENT BEHAVIOR
CFR(s): 483.450(b)(3)

Techniques to manage inappropriate client behavior must never be used for the convenience of staff.

1. The DE Unit of Hierarchy of Behavioral Intervention will be reviewed when putting restrictive measures into place.

2. The Behavior Strategist, Program Coordinator, or designee will receive proper consents when restrictive measures are implemented. Any restrictive measure will also be communicated, discussed, and approved by the interdisciplinary team prior to implementation. Consents are reviewed by the interdisciplinary team at each Human Rights Committee meeting.