STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 At the time of the annual survey, Iowa Administrative Code (IAC) Chapter 50.7(3) was cited. See State Form. The survey also resulted in deficiencies cited at W125, W159, W287, W288, W331 and W339.	W 000	See attached POC 9/1/16	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, interviews, and records review the facility failed to ensure individual client rights as evidenced by denial of access to areas of their homes. This potentially affected 8 of 8 individuals in House E (Clients #5, #6, #12, #13, #15, #16, #17, and #18). Findings follow: Observation on 7/18/16 at 5:20 p.m. revealed Qualified Intellectual Disabilities Professional (QIDP) A unlocked Client #12's room. QIDP A explained Client #12 requested the room be locked because Client #6 goes into others rooms. Observation on 7/19/16 at 12:10 p.m. revealed QIDP A unlocked Client #13's room to obtain his/her wheelchair for the repairman. Client #13 laid in bed for time out of wheelchair. QIDP A stated staff asked Client #13 if he/she wanted the door locked when he/she laid down because of Client #6 going into other clients' rooms. At the same time Licensed Practical Nurse (LPN)	W 125		

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 125	Continued From page 1 A unlocked Client #12's door and looked inside for the client. When LPN A did not find the client in the room she re-locked the door and left the area. When interviewed at 12:15 p.m. QIDP A explained the staff in the home ask the clients when they lie down if they want the door locked because Client #6 goes into others' rooms. She confirmed Client #6 went into each of the other clients' rooms. Record review on 7/20/16 revealed the following: a. Client #5's Comprehensive Functional Assessment (CFA), completed 7/19/16, stated he/she could not indicate basic wants and needs. b. Client #12's CFA, completed 8/4/15, stated he/she could not indicate basic wants and needs. c. Client #13's CFA, completed 1/5/16, stated he/she could not indicate basic wants and needs. d. Client #15's CFA, completed 7/9/15, stated he/she could not indicate basic wants and needs. e. Client #17's CFA, completed 1/16/16, stated he/she could not indicate basic wants and needs. f. Client #18's CFA, completed 1/5/16, stated he/she could not indicate basic wants and needs. Additional record review on 7/20/16 revealed "Opportunity Living Client Rights Policy" included: "To live in the least restrictive environment." When interviewed on 7/19/16 at 2:30 p.m. QIDP A acknowledged clients living in House E did not have free access to their home.	W 125		

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W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the Qualified Intellectual Disabilities Professional (QIDP) failed to effectively monitor and coordinate services in order to meet client needs. This affected 3 of 4 sample clients (Client #5, Client #6, and Client #7) living in house E and F. Findings follow: 1. Record review on 7/20/16 revealed the following programs for Client #6: Eliminate episodes of PICA, Increase use of communication device, Eliminate episodes of elopement, Improve oral hygiene, Increase independence in grooming, Increase participation in medication administration. A current QIDP review of Client #6's programs could not be located. When interviewed on 7/20/16 at 1:30 p.m. QIDP A confirmed she failed to complete monthly program reviews. She stated she could not recall the date the last QIDP review was completed. 2. Record review on 7/19/16 revealed Client #5's Monthly Progress Notes, last noted on 11/5/15. The chart lacked seven months of monthly reviews. When interviewed at 3:00 p.m. QIDP A confirmed the lack of the monthly progress notes 3. Record review on 7/20/16 revealed Client #6's data sheets for a program to increase use of	W 159		

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W 159	Continued From page 3 communication device dated 4/16, 5/16, and 7/16. Data sheet from 6/16 could not be located. When interviewed on 7/20/16 at 1:30 p.m. QIDP A stated Client #6's data sheet for 6/16 was unavailable because she failed to provide a copy of the program to staff. 4. Record review on 7/19/16 revealed Client # 5's latest Staffing Conference Report on 4/30/15 (over a year ago). Goals at that time included toothbrushing, wipe mouth with hand over hand assistance, place clothing protector in hamper and staying in bed during sleeping hours. Interview with QIDP A at 3:00 p.m. confirmed the current Staffing Report was missing. She confirmed staff did not have access to the needed information. 5. Record review on 7/19/16 revealed Client #5's programs to hold a toothbrush, wipe mouth, drop clothing protector in basket and stay in bed during sleeping hours. The programs indicated a timeline from 5/1/15 to 5/1/16. A new program could not be located. When interviewed on 7/20/16 at 12:00 p.m. QIDP A confirmed she failed to update the program. 6. Record review on 7/20/16 revealed Client #7 moved to House F on 5/24/16. The record lacked a 30 day Staffing Conference. His/her 30 day review took place on 6/23/16 (27 days prior to record review). Observation of Client #7's communication book revealed the book included a behavior management pogrom, but lacked any other programs. Upon review of the un-typed review in a folder, Client #7's programs included	W 159		

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W 159	Continued From page 4 toothbrushing, participation in medications, and choice making. When interviewed on 7/20/16 at 9:00 a.m. QIDP A confirmed she failed to complete Client #7's review. She admitted her lack of completion meant the staff had not received the information or documented regarding the programs. The QIDP failed to train staff on the programs. The QIDP failed to provide information to staff to assist with the clients transition into the new home/environment. 7. Record review on 7/20/16 revealed Client #6's program to improve oral hygiene. The program indicated a timeline from 3/17/15 to 3/17/16. A new program could not be located. When interviewed on 7/20/16 at 12:00 p.m. QIDP A confirmed she failed to update the program. 8. Record review on 7/19/16 revealed Client #5's Comprehensive Functional Assessment (CFA) completed on 4/28/15. When interviewed at 3:00 p.m. QIDP A confirmed the record review lacked an updated CFA. 9. Record review on 7/20/16 revealed Client #6's written informed consent dated 3/20/16. The consent included a one-piece undergarment worn all waking hours. No program or procedure to reduce Client #6's restriction could be located. When interviewed on 7/20/16 at 12:00 p.m. QIDP A acknowledged the facility failed to have a procedure in place to reduce the restriction. 10. a. Observation on 7/20/16 at 8:20 a.m. revealed Client #6's communication device could not be located.	W 159		

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W 159	Continued From page 5 Record review on 7/20/16 revealed Client #6's program to eliminate episodes of elopement. The program instructed,"...I will be provided with a microswitch with a voice-output message stating that I want to go outside... the microswitch will be located near the door to go outside. It will be programmed with a message stating that I want to go outside. As I am leaving the house to attend to an activity outdoors, staff will ask me to activate the switch prior to leaving the house..." When interviewed on 7/20/16 at 8:20 a.m. facility staff in House B stated they had never seen a microswitch for Client #6. When interviewed on 7/20/16 at 12:00 p.m. QIDP A did not know the microswitch was missing. b. Additional record review revealed Client #6's program data sheets dated 4/16 through 7/16. The data sheets indicated on 4/2/16 and 7/8/16 Client #6 was discovered outdoors without supervision. Training for Client #6's elopement program could not be located. When interviewed on 7/20/16 at 12:00 p.m. QIDP A was unaware of incidents on 4/2/16 and 7/8/16. During further interview, QIDP A noted she believed staff documented wrong on 4/2/16 and 7/8/16. She confirmed she failed to ensure staff were trained on Client #6's elopement program. 11. Observation on 7/18/16 at 5:20 p.m. revealed QIDP A unlocked Client #12's room. QIDP A explained Client #12 requested the room be locked because Client #6 goes into others rooms.	W 159		

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W 159	Continued From page 6 Observation on 7/19/16 at 12:10 p.m. revealed QIDP A unlocked Client #13's room to obtain his/her wheelchair for the repairman. Client #13 laid in bed for time out of wheelchair. QIDP A stated staff ask Client #13 if he/she wanted the door locked when he/she laid down because of Client #6 going into other clients rooms. At the same time Licensed Practical Nurse (LPN) A unlocked Client #12's door and looked inside for the client. When LPN A did not find the client in the room she re-locked the door and left the area. Record review on 7/19/16 revealed Client #6's Living Unit Report dated 2/26/16. The report stated, "... continue to monitor going in to others rooms ..." Monitoring for Client #6 going in to others rooms could not be located. When interviewed on 7/20/16 at 12:00 p.m. QIDP A acknowledged the recommendation on the Living Unit Report was not followed.	W 159		
W 287	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR 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 interviews and record reviews the facility failed to consistently ensure formal and/or informal techniques to manage inappropriate client behavior were warranted and not used in lieu of adequate staff presence and/or competency. This affected 16 of 32 clients	W 287		

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W 287	Continued From page 7 residing at the facility (Client #5, #6, #7, #8,#12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23) (House E and House F). Findings follow: 1. Observation on 7/19/16 at 3:32 p.m. in House E revealed the door from the kitchen to the hallway locked. The Qualified Intellectual Disability Professional (QIDP) A explained the door was locked due to Client # 6 and it was programmed. Record review on 7/19/16 revealed Client #6's Behavior Management Program to eliminate episodes of PICA. The program stated, "...The west kitchen door (across from the office) will be locked at all times, unless I am not present in the house. If staff is unable to supervise the kitchen area, the south door may be locked for short periods of time until it can be supervised." 2. Observation on 7/18/16 at 4:40 p.m. in House F revealed the kitchen door to the hallway locked. The Senior Counselor (SC) A explained the door was locked because Client #14 stole food and clients may burn themselves. Record review on 7/19/16 revealed Client #14's Behavior Management Program to be free of cyclic behaviors. The program defined target behavior and included "I do not have good safety skills and may grab hot items on the stove or sharp objects." The interventions included "The south kitchen door (across from the office) will be locked at all times, unless I am not present in the house. If staff is unable to supervise the kitchen area, the east door may be locked for short periods of time until it can be supervised."	W 287		

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W 287	Continued From page 8 When interviewed on 7/20/16 at 12:00 p.m. Qualified Intellectual Disabilities Professional (QIDP) A acknowledged the facility failed to ensure Client #6's and Client #14's restriction to lock the south door of the kitchen was warranted and not used in place of adequate staff presence. She stated the restriction was only used when staff needed to assist other clients in their bedrooms.	W 287		
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to develop an active treatment program to teach and support appropriate behaviors in conjunction with the restrictive interventions used to rectify intrusive behavior of going into other clients rooms exhibited by 1 of 2 sample clients in house E (Client #6). Findings follow: Observation on 7/18/16 at 5:20 p.m. revealed Qualified Intellectual Disabilities Professional (QIDP) A unlocked Client #12's room. QIDP A explained Client #12 requested the room be locked because Client #6 goes into others rooms. Observation on 7/19/16 at 12:10 p.m. revealed QIDP A unlocked Client #13's room to obtain his/her wheelchair for the repairman. Client #13 laid in bed for time out of wheelchair. QIDP A stated staff ask Client #13 if he/she wanted the	W 288		

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W 288	Continued From page 9 door locked when he/she laid down because of Client #6 going into other clients rooms. At the same time Licensed Practical Nurse (LPN) A unlocked Client #12's door and looked inside for the client. When LPN A did not find the client in the room she re-locked the door and left the area. When interviewed at 12:15 p.m. QIDP A explained the staff in the home ask the clients when they go into lie down if they want the door locked because Client #6 goes into others rooms. She confirmed Client #6 went into each of the other clients' rooms. Record review on 7/19/16 revealed Client #6's Individual Programs Plans lacked inclusion of a program to teach Client #6 personal space and privacy of housemates. Interview on 7/19/16 at 1:30 p.m. with QIDP A confirmed staff asked clients' if they wanted their door locked because Client #6 entered and exited rooms freely. She admitted Client #6's active treatment plan lacked a program regarding him/her going into others rooms, even though it was common practice to lock/unlock doors for clients.	W 288		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to consistently ensure	W 331		

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W 331	Continued From page 10 clients received nursing services in accordance with their needs. This affected 1 of 1 client admitted in the last 2 months (Client #7) and 1 of 1 non sample client (Client #9) living in House A. Findings follow: 1. Observation on 7/19/16 at 1:00 p.m. revealed Client #9 laying in bed on his/her side. Circular red area to right buttock of 2 centimeters (cm) with 1 cm circular open area. No drainage noted. A white cream noted on area. Record review on 7/20/16 revealed Client #9's Incident Report, dated 7/16/16 at 9:00 a.m., documented Client #9 had an open area on his/her bottom. Nurse's assessment documented on 7/16/16 at 9:45 a.m. noted, "2 centimeters (cm) circular red area with a 1 cm circular open area (zero) drainage noted. Cleansed with soap and warm water, skin protectant applied. OTA (open to air). Nursing 24 hour follow-up on 7/17/16 documented the area as "Open area remains to right buttock. Zero drainage/bleeding 0.1 cm deep." Additional record review revealed the facility notified the physician, via fax on 7/18/16 of Client #9's open area. The comments noted: "... open area on R (right) buttock that is 0.9 x 0.8 cm. (He/She) has no history of this issue. We are keeping (him/her) open to air, repositioning (every 2 hours) and keeping (him/her) off of the area. May we have an order for Calmoseptine PRN (as needed) for skin irritation. The physician replied 7/19/16, as follows: " Please use Calmoseptine lotion to area prn open sore. please let me know if sore worsens or there are signs of infection." When interviewed on 7/19/16 at 3:40 p.m.	W 331		

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W 331	Continued From page 11 Registered Nurse (RN) B confirmed staff reported the wound on 7/16/16. She said the white cream currently on the area was a plain lotion. However, the medication Calmoseptine (a combination of menthol and zinc oxide for healing) had been ordered(7/19/16), but not yet initiated. The topical medication would be given that evening. She also admitted the client had not received any pain medication since the area was noted over 3 days prior. She agreed pain medication therapy would be started that evening. 2. Record review on 7/20/16 revealed Client #7 admitted on 5/24/16 with diagnosis to include Vagal Nerve Stimulator (VNS). Further review of the information in the communication book revealed the information to staff and in the program book lacked any mention of the VNS. The 30 day Nursing Evaluation completed on 6/23/16 (but not available to staff) included the statement: Client #7 "does not wear the VNS magnet at the time." When interviewed on 7/20/16 at 11:25 a.m. the Director of Nursing acknowledged Client #7 had petit mal seizures and she did not know when it should be used. She admitted lack of communication to the staff regarding the use or non-use of the VNS.	W 331		
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observation, interviews, and record	W 339		

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W 339	Continued From page 12 reviews, staff failed to consistently ensure all clients received nursing care and services as identified by their individual needs. This affected 1 of 1 non sample client (Client #9) living in House A. Finding follows: Observations on 7/19/16 at 12:25 p.m. revealed staff changed Client #9's brief and repositioned him/her. The staff was unaware of the last time Client #9 had been repositioned. Record review on 7/20/16 revealed Client #9's Incident Report dated 7/16/16 at 9:00 a.m. The incident stated Client #9 had an open area on his/her bottom. Nurse's assessment documented the area as 2 centimeter (cm) circular red area with a 1 cm circular open area zero drainage noted. Cleansed with soap and warm water, skin protectant applied. Nursing 24 hour follow-up on 7/17/16 documented the area as "Open area remains to right buttock. Zero drainage 1 bleeding 0.1 cm deep." Record review on 7/19/16 revealed Client #6's wound report/Temporary Health Care Plan, initated 7/16/16. The plan stated pericare after each incontinence open to air with repositioning every 2 hours. On 7/19/16 the facility obtained a physician's order to use Calmoseptine PRN (as needed) for the open area. When interviewed on 7/19/16 at 12:30 p.m. Staff A stated she completed the last position change for Client #9 at 10:00 a.m. She confirmed the next position change was completed at 12:25 p.m. When interviewed on 7/19/16 at 2:15 p.m. Qualified Intellectual Disabilities Professional	W 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 339	Continued From page 13 (QIDP) B mentioned the 2 hour time limit for position changes is part of the facility policy and staff should always follow the policy. QIDP B stated Staff A failed to follow the policy on repositioning Clients every 2 hours as the repositioning on 7/19/16 had been done at 10:00 a.m. and 12:25 p.m. Record review revealed a facility policy called Train the Trainer. The report stated every thirty minutes perform visual checks unless otherwise directed by the Interdisciplinary team. Every two hours bed checks will be performed where the person will be repositioned, checking bedding and clothing or briefs to determine whether they are wet. When interviewed on 7/20/16 at 1 p.m. Director of Programming and Services stated at the time of the incident Client #1 was to be repositioned every 2 hours. Staff failed to reposition Client #1 as needed and directed by the clinical record and intervention for skin integrity issues.	W 339		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAG0014	A. BUILDING: _____ B. WING _____	07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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) COMPLETE DATE
C 146	50.7(3) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(3) When there is an act that causes major injury to a resident or when a facility has knowledge of a pattern of acts committed by the same resident on another resident that results in any physical injury. For the purposes of this subrule, " pattern " means two or more times within a 30-day period. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report to the Iowa Department of Inspections and Appeals when a client has committed a pattern of acts on another resident that resulted in physical injury within a 30 day period. This pertained to 1 of 2 clients (Client #4) living in House B. Finding follows: Record review on 7/18/16 identified Client #3's Incident Report dated 5/11/16. The report indicated (Client #4) got up from the chair, ran over to the couch, and bit (Client #3) on the left shoulder. The 24 hour nurse follow-up identified the teeth marks remained present with light purple bruising in the center. Further record review indicated Client #11's Incident Report dated 5/26/16. The report indicated (Client #11) went and sat down beside (Client #4) and Client #4 bit Client #11. The report identified the bite did not break the skin but possibly bruised the area. The 24 hour nurse	C 146		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAG0014	A. BUILDING: _____ B. WING _____	07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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) COMPLETE DATE
C 146	Continued From page 1 follow-up report indicated the teeth marks located on the right forearm remained reddened but no broken skin or bruising noted. On 7/20/16 at 11:37 a.m. the Director of Nursing (DON) was interviewed and acknowledged the facility failed to report Client #4's aggressions to the Iowa Department of Inspections and Appeals (DIA).	C 146		

Opportunity Living

"Providing Special Persons Opportunities for Living"

David M. Staver
Executive Director
dstaver@opportunityliving.org
Connie Pagel
Director of Human Resources
cpagel@opportunityliving.org
Kelly Feldman
Director of Programming and Services
kfeldman@opportunityliving.org

1890 E. Main St.
Lake City, Iowa 51449-7706
Phone (712) 464-8961
Fax (712) 464-3320
www.opportunityliving.org
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CARF Accredited Services
Community Housing
Community Integration
Organizational Employment

CAC 8/18/16

Attention Sue Dudley
Inspections and appeals
Division of Health facilities
Lucas State office building
321 East 12 Street
Des Moines, Iowa 50319-0083

FC#6219
Opportunity Living
105 West View
Lake City, Iowa 51449

50.7(3)

The facility failed to report to the Iowa Department of Inspections and Appeals when a client has committed a pattern of acts committed by the same resident that result in any physical injury. For the purpose of this sub rule, "pattern means two or more times within a thirty day period.

We have developed a spread sheet that will assist us in making sure that an incident that causes injury by the same person more than 2 X's during a 30 day period is found and reported in a timely manner.

Plan of correction Implementation date: July 20th, 2016

Person Responsible: Director of Nursing
Monitored by: The Director of Programming and Services

CAC 8/18/16

OPPORTUNITY LIVING I
PLAN OF CORRECTION

Survey date: July 18th, 19th and 20th

W125 – Protection of Client Rights

The facility failed to ensure individual client rights as to evidence of denial of access to areas of their homes.

All areas of the home shall be accessible to the clients unless proper consent/notification has been received. This shall be monitored on a routine basis by both the QIDP and the Senior Counselor. Environmental surveys as well as random checks shall be done by the Director of Programming and Service.

Plan of correction implementation date: September 1st 2016

Person responsible: QIDP, Senior Counselor

Monitored by: The Director of Programming and Services

W159 – QIDP

The QIDP failed to effectively monitor and coordinate services in order to meet client needs.

The Client Record shall be up to date as of the 7th day of the current month
This will be monitored by monthly chart Audits the Director of Programming and Services

The client programs shall be in place on the first of the month and monitored on a monthly basis by the QIDP and progress or lack of will be noted on Data Summary Sheets as well as monthly progress notes.

Plan of correction implementation date: September 1st, 2016

Person responsible: QIDP
Monitored by: The Director of Programming and Services

W287 – MANAGEMENT OF INAPPROPRIATE CLIENT BEHAVIOR

The facility failed to consistently ensure formal and/or informal techniques to manage inappropriate client behavior were warranted and not used in lieu of adequate staff presence and or competency.

Staff training records should be made available for review as needed by both the Direct Support Professional and Nursing Staff. This shall be ensured by monthly review of Client Record as well as Staff Training Records. ✓

Plan of correction Implementation date: September 1st, 2016

Person responsible: QIDP, Senior Counselor
Monitored by: Director of Programming and Services

W288 – MANAGEMENT OF INAPPROPRIATE CLIENT BEHAVIOR

The facility failed to develop an active treatment program to teach and support appropriate behaviors in conjunction with the restrictive interventions used to rectify intrusive behavior.

QIDP shall have Programs in place that support appropriate teaching methods in conjunction with restrictive interventions used to rectify intrusive behavior. This will be insured by the QIDP in progress notes and audits conducted by the Director of Programming and Services on a regular basis. ✓

Plan of correction implementation date: Sept 1st, 2016

Person responsible: QIDP, Senior Counselor
Monitored by: Director of Programming and Services

W331 – NURSING SERVICES

The facility failed to consistently ensure clients received nursing services in accordance with their needs.

✓

Nurses at Opportunity Living will ensure all clients receive appropriate care according to their specified needs by:

1. Once a Temporary health care plan has be implemented for impaired skin integrity the nurse and QIDP will discuss the need to place a repositioning chart.

Person responsible: Nursing Staff and QIDP

Monitored by: The Director of Nursing or Designee
Plan of correction Implementation date: August 17th, 2016

W339- NURSING SERVICES

The facility failed to consistently ensure all clients received nursing care and services as identified by their individual needs.

1. The Director of Health Services or designee will complete a chart audit on new admits after the 30 day evaluation period and at least annually thereafter to ensure all key nursing components are present in the client record. ✓

Person Responsible: Nursing Staff and QIDP

Monitored by: The Director of Nursing
Plan of correction implementation date: September 1st, 2016