STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G055	A. BUILDING _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITH, HOPE, AND CHARITY	1815 WEST MILWAUKEE STREET STORM LAKE, IA 50588

(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 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff immediately reported allegations of abuse and/or mistreatment to administration. As a result, the facility also failed to ensure allegations of abuse and/or mistreatment were reported to the appropriate state agency in a timely manner. This affected 1 of 8 sample clients (Client #2). Finding follows: Record review on 8/30/16 revealed the facility's internal investigation into an incident occurring 6/28/16. According to the incident report included, dated 7/5/16, staff observed another staff throw a moccasin at Client #2's back. The moccasin hit Client #2 and he/she replied, "Ouch!" Further review of the internal investigation revealed the incident reported to the Department of Inspections and Appeals (DIA) on 7/5/16 and Child Protective Services (CPS) on 7/6/16. Record review on 8/30/16 revealed a Mandatory Reporter Requirements in the policy manual. The policy directed, "... In all FHC (Faith, Hope and Charity) programs the mandatory reporter should immediately call the appropriate on-call to review and consult on the potential incident or abuse... In addition to calling CPS (Child Protective Services), the ICF/ID (Intermediate Care Facility	W 153	See attached POC 10/31/16	

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

Catherine M | ED | 9-29-16

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 153	Continued From page 1 for the Intellectual Disabled) program will self-report by phone or online to DIA (Department of Inspection and Appeals) within 24 hours." When interviewed on 8/31/16 at 5:10 p.m. the Director of Social Services confirmed staff failed to follow facility policy for reporting. She further confirmed the facility failed to report the incident to the appropriate State Agency in a timely manner.	W 153		
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 review, the facility failed to ensure the Qualified Intellectual Disability Professional (QIDP) consistently coordinated, monitored, and integrated client services. This affected 2 of 8 sample clients (Client #6 and #9). Findings follow: 1. Record review on 8/31/16 revealed Client #9's Guardian Informed Consent, signed 6/7/16. The consent identified Client #9 wore a Life Saver bracelet due to a history of wandering away from his/her parental home. The consent indicated the bracelet was not used by the facility, but would not be removed while he/she was at the facility. Continued record review revealed Client #9's Behavior Strategy Plan (BSP), last revised 6/17/16. The BSP documented, "(Client #9) has a Life Saver bracelet as (he/she) has a history of wandering from (his/her) home in the middle of the night." The BSP failed to include any additional information regarding the bracelet.	W 159		

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W 159	Continued From page 2 When interviewed on 8/31/16 at approximately 10:40 a.m., the Residential Director (RD)/Qualified Intellectual Disabilities Professional (QIDP stated the bracelet was able to track Client #9 and was only utilized while with his/her mother/guardian. She stated the facility maintained the bracelet, but it was not used at the facility. The Residential Director (RD) confirmed the BSP failed to provide any information regarding the use, location of, reduction plan, or basic information about the bracelet. During follow-up interview on 8/31/16 at approximately 12:40 p.m. the RD stated the facility scanned the bracelet daily to check the battery and changed the battery when needed. She stated she did not know why the bracelet was not removed when Client #9 was in the facility since it was only used while Client #9 was with his/her mother. When interviewed on 8/31/16 at approximately 3:00 p.m. the Director of Social Services (DSS) stated Client #9 's mother/guardian wanted Client #9 to wear the bracelet and did not think his/her mother would allow the facility to remove it when Client #9 was at the facility. She stated Client #9 used to wander away from his/her mother's home, but Client #9 had never wandered away from the facility. She explained the bracelet was tracked by the Sioux City Police Department, but she was unsure of the distance the bracelet was able to track. When asked, the DSS stated the facility did not have a policy or additional information regarding the Life Saver bracelet. 2. The public school teacher for Client #6 was interviewed on 8/30/16 at 10:20 a.m. The teacher	W 159		

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W 159	Continued From page 3 reported Client #6's recent behaviors at school included attempting to open the emergency exit door located at the back of the school bus and hitting a teacher aid when redirected away from the door. The teacher also reported on 8/29/16, Client #6 entered the school's media room and would not leave when prompted to do so resulting in other high school students having to be removed from the area until the principal, the officer assigned to the school, and other school personnel physically escorted Client #6, using a two person escort technique, to his/her classroom. The teacher reported Client #6 recently bit her and showed a bruise on her upper right arm, which had teeth marks. The teacher confirmed Client #6 generally sat at the back of the room in a study carrel. Although attempts were being made to have Client #6 more integrated with the other students, he/she often required and/or preferred to remain in the area located in and behind the study carrel. The teacher said a daily note was sent home about Client #6's school day, but confirmed the information included in the note was mainly positive statements, and did not include information about the challenging behaviors he/she exhibited at school. When asked how the school documented the incidents such as the one on the bus, the one in the media room and the incident in which she was bitten, the teacher said there were generally no incident reports completed for those events and confirmed she did not complete incident reports for the incidents discussed. When interviewed on 8/30/16 at 1:15 p.m. the RD/QIDP reported she was not aware of the incidents involving Client #6 at school, including the incidents on the bus, in the media room, and	W 159		

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W 159	Continued From page 4 the incident during which Client #6 bit the teacher on the arm. The RD/QIDP stated often it took a week or longer to receive incident reports from the school, but reported an agreement between the facility and the school included notification of events via telephone calls and/or email. The RD/QIDP checked with Residential Coordinator (RC) C and confirmed RC C had no knowledge of any of the incidents described above. The RD/QIDP confirmed it was not the practice of the facility to incorporate behavior data from the public school on targeted behaviors such as biting, hitting, refusals, etc., into the overall data analysis conducted by the facility as part of the QIDP assessment. The RD/QIDP said it was not the practice of the facility to have QIDPs go to the public school regularly to make observations and to ensure service coordination. During further interview the RD/QIDP confirmed Client #6 began High School this year, and struggled with changes in his/her environment. He/she historically responded by escalating his/her behavior. The RD/QIDP had not visited the High School to observe Client #6 in his/her new classroom, although school had been in session for two weeks. When asked about reported escalation of Client #6's aggressive behaviors, the RD/QIDP explained until May 2016, the school had a PRN (as needed) order for the use of Clonidine. The school administered the PRN Clonidine on a frequent, almost daily, basis. According to the RD/QIDP, the frequent use of the PRN medication essentially served as a medication increase and once the PRN order for Clonidine was discontinued, the psychiatrist increased the dosage of the regularly scheduled Clonidine to help stabilize Client #6's behavior. When asked if she had requested documentation	W 159		

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W 159	Continued From page 5 of the administration of the PRN Clonidine from the school, the RD/QIDP said she had not, but had reported to the team. She further explained she also informed Client #6's psychiatrist Client #6 received the PRN dosage of the Clonidine at school almost daily. The RD/QIDP was asked to secure a copy of the school's documented use of the PRN Clonidine for review. Record review on 8/30/16 revealed the following: A. Client #6's Individualized Education Program (IEP), dated 4/21/16. The "Working Result" section of his IEP (school plan) documented, "(He/She) hasn't had any aggression in the last 4 weeks. (Client #6) hasn't had (his/her) emergency (PRN) Clonidine in over a month. (He/She) seldom needs this. (Client #6) also doesn't need a nap on the weighted blanket after lunch. (He/She) is able to work all afternoon most of the time now, but (he/she) still has the weighted blanket even if (he/she) doesn't sleep to help (him/her) calm down..." The "Other Information Essential For The Development Of This IEP" documented, "(Client #6) works alone and by (himself/herself) self in a study choral (sic) because (he/she) hasn't ' been appropriate or compliant when working with groups." b. Client #6's Individual Service Plan (ISP), dated 4/19/16, The "Procedure Plan" section of Client #6's ISP (residential plan) included a goal related to "self-soothing techniques." However, the ISP did not include the use of a weighted blanket to assist Client #6 with self-soothing. c. Client #6's record did not include copies of or reference to the incident reports from the public school associated with biting the teacher, attempting to exit the emergency exit at the rear	W 159		

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W 159	Continued From page 6 of the bus or refusing to leave the school's medial room causing other students to have to be evacuated from the area. When interviewed on 8/31/16 at 8:47 a.m. on 8/31/16, the RD/QIDP said she was not aware a weighted blanked was included as a self-soothing strategy for Client #6 at school and part of his/her IEP. The RD/QIDP confirmed Client #6 did not have or use a weighted blanket at home. The RD/QIDP confirmed she was unaware Client #6 sat at the back of the classroom in a study carrel, essentially separated from the other students, and said she was not aware the strategy was included in his/her IEP. The RD/QIDP confirmed she was unaware the IEP for Client #6 documented he/she seldom received the PRN dose of Clonidine and reiterated her belief the PRN Clonidine was given almost daily. The RD/QIDP confirmed she was unable to locate documentation from the school related to the incidents of physical aggression including biting the teacher, attempting to open the emergency exit on the bus and aggressing toward a teacher's aide, and disrupting the high school media room by refusing to leave the area. The RD/QIDP confirmed the data related to "physical aggression" (defined as, but not limited to: hitting, kicking, pinching, pushing, biting, pulling the hair and clothing of others and throwing things at others), which occurred at school or during home visits, was not incorporated into the overall data in order to assess whether the frequency and/or intensity of the behaviors were increasing and/or decreasing in response to programming and the use of the drugs for behavior management. At 3:56 p.m. on 8/31/16, the RD/QIDP provided a document from the public school attended by	W 159		

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W 159	Continued From page 7 Client #6 titled "Nurses' PRN Education Notes" (PRN Notes). The PRN Notes documented the use of all PRN medication given to Client #6, including PRN Clonidine, from 9/2/15 - 6/2/16. The PRN Notes documented the PRN Clonidine administered only twice from January 2016 until 5/7/16, when the PRN Clonidine was discontinued: January - None; February - 2/2/16 at 1:20 p.m. for non-compliance; March - 3/14/16 at 11:25 a.m. for non-compliance and aggression; April - None; and May - None. The RD/QIDP maintained the data from the school were inaccurate since she was under the impression Client #6 received the PRN Clonidine almost daily. The RD/QIDP confirmed she had not requested the written documentation from the school nurses, nor had she spoken with the school nurses about the use of the PRN Clonidine. The RD/QIDP confirmed she was unaware of the statement in the IEP, dated, 4/19/16, documented Client #6 had not received the PRN Clonidine in over a month.	W 159		
W 206	483.440(c)(1) INDIVIDUAL PROGRAM PLAN Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and (ii) Designing programs that meet the client's needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the interdisciplinary team (IDT)	W 206		

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W 206	Continued From page 8 included persons with expertise in functionally assessing skills, identifying needs, developing plans, training staff, and monitoring and making changes to the individual program plan for 1 of 1 sample client whose diagnoses included autism and whose targeted behaviors was identified as escalating (Client #6). Finding Follows: Record review on 8/31/16 at 1:15 p.m. confirmed the the team failed to include a person with expertise in functionally assessing skills, identifying needs, developing plans, training staff, and monitoring and making changes to the individual support plan. When interviewed on 8/30/16 at 1:15 p.m. and 8/31/16 at 8:47 a.m. Residential Director (RD)/ Qualified Intellectual Disabilities Professional (QIDP) confirmed Client #6's diagnoses included autism, more specifically Asperger Syndrome. The RD/QIDP could not identify anyone who served on Client #6's team with specialized training in functionally assessing skills, identifying needs, developing plans, training staff and monitoring and making changes to the individual support plan for a child with autism. When interviewed on 8/31/16 at 3:12 p.m. Director of Social Services (DSS) confirmed although the facility had a contract with an applied behavioral analyst, that person had not spent time with and/or worked with Client #6. She explained the Psychologist saw each client once annually and did not provide direct psychological services to assist with developing programs for clients with challenging and interfering behaviors. The DSS confirmed Client #6's behaviors continued to persist although he/she received services at the facility for more than three years. The DSS	W 206		

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W 206	Continued From page 9 confirmed the facility had not analyzed Client #6's behavior data, nor had a person with expertise in autism spent time observing Client #6 in various environments to functionally assess the targeted behaviors and to determine if environmental factors contributed to his/her aggressive and interfering behaviors. The DSS reviewed the names of the people who participated in the development of Client #6's Individual Support Plan, dated 4/19/16, and confirmed none of the team members had expertise in providing supports for children with autism.	W 206		
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to develop adequate interventions into client Behavior Strategy Plan (BSP) as evidenced by failure to include interventions to maintain safety of others during episodes of maladaptive behavior. This affected 1 of 2 clients added to the sample (Client #9). Finding follows: Observation on 8/30/16 at 7:12 a.m. revealed Client #9 walked past Client #1 and hit Client #1 on the top of the head. Staff redirected Client #9 into the other room and body positioned between Client #9 and other clients in the area. Client #9 intermittently attempted to hit staff and grab various items until approximately 8:05 a.m. During this time, staff continued to block, position between Client #9 and his/her peers, and redirect	W 240		

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W 240	Continued From page 10 Client #9. Record review on 8/30/16 revealed Client #9's BSP data. Review of the data between 3/1/16 and 8/29/16 revealed the following episodes of aggression toward peers and persons in the community: a. On 3/11/16, Client #9 threw a bottle of juice at a peer but no contact was made. b. On 3/17/16, Client #9 slapped peers face. c. On 3/20/16, Client #9 hit a peer on the top of the head. d. On 3/24/16, Client #9 swung his/her leg at a peer and then hit the peer on top of the head. e. On 4/2/16, Client #9 hit a peer two times. f. On 4/7/16, Client #9 hit a peer. g. On 4/23/16, Client #9 hit a peer in the back of the head. h. On 4/23/16, Client #9 hit a peer. i. On 4/30/16, Client #9 hit a peer. j. On 4/30/16, Client #9 kicked a peer. k. On 5/1/16, Client #9 hit a peer. l. On 5/14/16, Client #9 hit a peer in the face after tickling each other. m. On 5/16/16, Client #9 kissed a peer then smacked the peer on the forehead. n. On 5/19/16, Client #9 hit two peers. 0. On 5/20/16, Client #9 hit a peer on the top of the head. p. On 5/24/16, Client #9 pushed a chair and table when a peer was exhibiting inappropriate behavior. q. On 6/2/16, Client #9 grabbed the glasses off a child sitting next to him/her at the rodeo. r. On 6/3/16, Client #9 hit a peer on the top of the head. s. On 6/5/16, Client #9 hit a peer in the head/face area and scratched the peer when redirected.	W 240		

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W 240	Continued From page 11 t. On 6/9/16, Client #9 hit a person in the community and took the glasses off another person in the community. u. On 6/9/16, Client #9 reached over staff on the van and pulled a peers hair. v. On 6/10/16, Client #9 kicked a peer who was being loud and was close to him/her. w. On 6/14/16, Client #9 hit a peer on the head. x. On 6/15/16, Client #9 hit two peers on the head. y. On 6/20/16, Client #9 hit a peer on the head. z. On 6/20/16, Client #9 hit a peer on the leg. aa. On 6/21/16, Client #9 hit two peers on the head. bb. On 6/22/16, Client #9 hit a peer. cc. On 6/22/16, Client #9 hit two peers during a tornado drill. dd. On 6/15/16, Client #9 hit a peer on top of the head. ee. On 6/29/16, Client #9 hit a peer. ff. On 7/9/16, Client #9 hit a peer on the face. gg. On 7/26/16, Client #9 hit a peer on the head. hh. On 8/8/16, Client #9 hit a peer on the head. ii. On 8/9/16, Client #9 grabbed people in the community. jj. On 8/10/16, Client #9 hit a peer two times. kk. On 8/13/16, Client #9 hit one peer on the head, hit a second peer, and scratched a third peer by his/her eye. ll. On 8/26/16, Client #9 attempted to grab his/her surroundings including people and took the glasses off of three people while waiting for the bus. (The data did not indicate who was grabbed.) mm. On 8/26/16, Client #9 hit a peer on the top of the head with the closed butt of his/her fist. Continued record review revealed Client #9's BSP, last revised 6/17/16. The BSP instructed	W 240		

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(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 240	Continued From page 12 staff to keep Client #9 engaged in activities and find things to do. The program instructed staff to verbally redirect him/her to an activity and to physically redirect him/her to the activity if verbal redirection was unsuccessful. The program instructed staff to use body positioning and body blocking if he/she caused harm or engaged in property destruction. Staff were instructed to ask Client #9 to take a break in his/her bedroom if he/she continued to engage in aggression or property destruction. Additional review of Client #9's Level of Supervision, dated 8/29/16, stated Client #9 required staff present when in the back yard or the multipurpose room (MPR). When interviewed on 8/31/16 at approximately 10:40 a.m., the Residential Director (RD)/ Qualified Intellectual Disabilities Professional (QIDP) stated Client #9's level of supervision increased around June 2016 to have staff present when in the backyard or the MPR due to an increase in behavior. The RD stated Client #9 should have staff within close proximity at all times to block attempts at physical aggression towards others. She confirmed the facility failed to develop specific interventions into the BSP for staff to implement with Client #9. Additional interview on 8/31/16 at approximately 4:40 p.m. the Director of Social Services confirmed Client #9's BSP failed to include appropriate interventions to address his/her maladaptive behaviors.	W 240		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria	W 252		

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	16G055	A. BUILDING _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITH, HOPE, AND CHARITY	1815 WEST MILWAUKEE STREET STORM LAKE, IA 50588

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W 252	Continued From page 13 specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure data recorded in a manner to reflect the client's actual observed behavior. This pertained to 2 of 2 sample clients who demonstrated targeted behaviors identified as physical aggression (Clients #6 and #9). Findings follow: Record review on 8/30/16 revealed the facility's "Incident and Unknown Injury Reports" related to Client #6, for the time period from 1/1/16 - 8/7/16. The Incident and Unknown Injury Reports documented numerous incidents of physical aggression against staff including, but not limited to: fifteen incidents where Client #6 hit staff, eight incidents where Client #6 bit staff,and an additional four incidents where Client #6 attempted to bite staff, four incidents of kicking staff, four incidents of pulling the hair of staff, two incidents of scratching staff and one incident of pinching staff. When interviewed on 8/30/16 at 1:15 p.m. and 8/31/16 at 8:47 a.m. the Residential Director (RD)/Qualified Intellectual Disabilities Professional (QIDP) referenced Client #6's data records. The RD/QIDP confirmed the data maintained by the facility related to physical aggression was tied to the following programming objective: "(Client #6) will engage in 20 or less episodes of inappropriate behaviors per month." The RD/QIDP confirmed the data related to	W 252		

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W 252	Continued From page 14	W 252		

incidents of hitting, biting, kicking, hair pulling, scratching and pinching staff were maintained under the heading of "physical aggression" and were not sufficient in detail to determine the frequency of any discrete targeted behavior. The RD/QIDP explained if during a "behavior outburst,"Client #6 hit, bit and kicked staff multiple times, the data would be recorded as one "incident." The RD/QIDP confirmed the data were not sufficient to differentiate between an attempted bite or an actual bite which resulted in breaking of the skin. The RD/QIDP confirmed no one of the team for Client #6 reviewed the individual incident reports in order to identify the frequency and/or intensity of each discrete targeted behavior. The RD/QIDP confirmed no analysis of factors such as time of day, day of week, staff on duty, and/or other environmental influences which might affect Client #6's behavior. The RD/QIDP confirmed the data were not reflective of the actual behavior exhibited by Client #6.

2. Record review on 8/30/16 revealed Client #9's Behavior Strategy Program (BSP), last revised 7/22/16 with the following objective: "(Client #9) will engage in 40 or less inappropriate behaviors per month for 3 consecutive months, by 10/22/16." The BSP identified and defined inappropriate behavior as cursing, disrobing, inappropriate sexual behaviors (touching or grabbing others in their breasts or private areas, exposing oneself to others, humping objects or people, and rubbing and touching oneself in public areas), intentional incontinence, loud vocalizations, non-compliance, physical aggression (slapping, pulling hair, hitting, kicking, pulling on clothing and pushing other others, throwing things), property destruction, and

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	16G065	A. BUILDING _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITH, HOPE, AND CHARITY	1816 WEST MILWAUKEE STREET STORM LAKE, IA 50588

(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 252	Continued From page 15 self-injurious behavior (SIB) (biting, hitting, slapping, head banging, pulling hair). Continued record review revealed completed monthly data reviews for Client #9's BSP. The monthly review identified the total number of recorded incidents of inappropriate behavior and the number of incidents Client #9 exhibited by the identified category. For example, data for July 2016 identified Client #9 exhibited six incidents of physical aggression, but failed to identify what type of physical aggression he/she exhibited, the intensity of the incident, or who was aggressed upon. When interviewed on 8/31/16 at approximately 4:40 p.m., the Director of Social Services (DSS) confirmed the data collected on Client #9's BSP did not provide all necessary information to determine progress or regression. She confirmed the data was insufficient to obtain an actual understanding of the behavior incidents and if specific behaviors increased or decreased in frequency and/or intensity.	W 252		
W 291	483.450(c)(1) TIME OUT ROOMS A client may be placed in a room from which egress is prevented only if the following conditions are met: (i) The placement is a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus, emergency placement of a client into a time-out room is not allowed.) (ii) The client is under the direct constant visual supervision of designated staff. (iii) The door to the room is held shut by staff or by a mechanism requiring constant physical	W 291		

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W 291	Continued From page 16 pressure from a staff member to keep the mechanism engaged. This STANDARD is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure all time out rooms were free from hazardous conditions and the clients were under direct constant visual supervision of designated staff. This affected 1 of 1 homes with a time-out room. (Faith Home). Findings follow: Observation on 8/31/16 at approximately 2:50 p.m. revealed a time out room in Faith Home. Mats covered the floors and walls of the time-out room. Further observation revealed a covered light and electrical plug-in on the ceiling. Surveyor A looked through the window into the time out room and was unable to see the area in front of the door. Surveyor B entered the time out room and crouched in front of the door toward the left corner of the room; Surveyor A was unable to maintain visual observation of Surveyor B in the time out room. When interviewed on 8/31/16 at approximately 2:50 p.m. during the observation of the time-out room, the Residential Coordinator/Qualified Intellectual Disability Professional (RC/QIDP) stated she was able to maintain visual observation of Surveyor B when in the room, but confirmed the facility had at least one staff who was the same height or shorter than Surveyor A. While still crouched in front of the door toward the left corner of the time-out room, Surveyor B asked if the RC/QIDP was able to see what she was doing. RC/QIDP confirmed she was only able to see the Surveyor's elbow and not what the	W 291		

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W 291	Continued From page 17 Surveyor was doing. She stated the facility had one client who utilized the time-out room and staff prompted the client to sit at the back of the room, which he/she normally complied with, and staff were able to maintain visual supervision. The RC/QIDP confirmed she was not able to maintain constant visual supervision of the entire time-out room. When interviewed on 8/31/16 at 11:30 p.m. the Director of Social Services (DSS) stated the room used to have a mirror for observations, however it no longer existed.	W 291		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to incorporate the use of psychoactive medications into the individual plan. Furthermore, the facility failed to ensure medication was increased as the result of behavioral and medical data. This affected 1 of 8 sample clients (Client #6). Finding follows: When interviewed on 8/30/16 at 1:15 p.m. the Residential Director/ Qualified Intellectual Disabilities Professional (QIDP) was asked about the reported escalation of Client #6's aggressive behaviors. She explained until May 2016, the school had a PRN (as needed) order for the use	W 312		

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W 312	Continued From page 18 of Clonidine. According to the RD/QIDP, the school administered the PRN Clonidine on a frequent, almost daily basis. According to the RD/QIDP, the frequent use of the PRN medication essentially served as a medication increase and once the PRN order for Clonidine was discontinued, the psychiatrist increased the dosage of the regularly scheduled Clonidine to help stabilize Client #6's behavior. When asked if she had requested documentation of the administration of the PRN Clonidine from the school, the RD/QIDP said she had not, but reported to the team, and ultimately the psychiatrist was informed that Client #6 received, almost daily, a PRN dosage of the Clonidine at school. Record review on 8/30/16 revealed the following: a. Client #6's Individualized Education Program (IEP), dated 4/21/16. The "Working Result" section of his IEP (school plan) documented, "(He/She) hasn't had any aggression in the last 4 weeks. (Client #6) hasn't had (his/her) emergency (PRN) Clonidine in over a month. (He/She) seldom needs this. b. Client #6's Individual Service Plan (ISP), dated 4/19/16. The "Psychology" section of the ISP documented, "(Client #6) continues to present a behavior management challenge and has engaged in aggressive behavior that has caused or has the potential to cause injury. (His/Her) program encourages staff to keep (him/her) busy with tasks and activities. (His/Her) behavior management program appears to be adequate. ...(Client #6) continues to need close monitoring of behavior modifying medications. Review and adjustment of (his/her) medications should be	W 312		

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W 312	Continued From page 19 based on behavior response and done on a frequent basis ..." The ISP did not include additional information about how the drugs for behavior management were tied to Client #6's active treatment program. During additional interview with the RD/QIDP on 8/31/16 at 8:47 a.m. she confirmed she was unaware the IEP for Client #6 documented he/she seldom received the PRN dose of Clonidine and reiterated her belief the PRN Clonidine was given almost daily. The RD/QIDP confirmed the data related to physical aggression (defined as, but not limited to: hitting, kicking, pinching, pushing, biting, pulling the hair and clothing of others and throwing things at others), which occurred at school or during home visits, was not incorporated into the overall data in order to assess whether the frequency and/or intensity of the behaviors increased and/or decreased in response to Client #6's active treatment program and the use of the drugs for behavior management. At 3:56 p.m. on 8/31/16, the RD/QIDP provided a document from the public school attended by Client #6 titled, "Nurses' PRN Education Notes" (PRN Notes). The PRN Notes documented the use of all PRN medication given to Client #6, including PRN Clonidine, from 9/2/15 -6/2/16. The PRN Notes documented Client #6 received the PRN Clonidine only twice between 1/1/16 and 5/7/16, when the PRN Clonidine was discontinued. Although aware of the data recorded by the school nurse, the RD/QIDP maintained the data from the school were inaccurate and stated she continued to believe Client #6 received the PRN Clonidine almost daily. The RD/QIDP confirmed she had not	W 312		

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W 312	Continued From page 20	W 312		

requested the written documentation from the school nurses, nor had she spoken with the school nurses about the use of the PRN Clonidine. The RD/QIDP confirmed she was unaware of the statement in the IEP, dated, 4/19/16, which documented Client #6 had not received the PRN Clonidine in over a month.

When interviewed on 8/31/16 at 12:45 p.m. Residential Coordinator (RC) B the Health Service Director (HSD) both confirmed they provided verbal information to the psychiatrist about Client #6's behavior. The HSD and RC B confirmed neither spoke with the school nurses, nor asked for documentation related to the use of the PRN Clonidine. Rather, both confirmed they relied on the verbal information presented, in part by the RD/QIDP, which led them to believe, and to report to the Psychiatrist, that Client #6 received the PRN Clonidine almost daily when he/she attended school.

The HSD confirmed and provided documentation which verified Client #6's prescribing psychiatrist came to the facility on 2/6/16. Although Client #6 was on a home visit, verbal information about Client #6's "escalating behaviors" was presented to the psychiatrist and discussed with Client #6's mother/guardian via telephone. This consultation resulted in, "New order given for clonidine 0.05 mg orally every morning and at noon and 0.1 mg orally at 4:00 p.m. and at bedtime for 14 days and then increase to clonidine 0.1 mg orally every morning, 0.05 mg orally at noon and 0.1 mg orally at 4:00 p.m. and at bedtime."

The HSD confirmed and provided documentation which verified Client #6 was seen via telehealth on 3/5/16 by the psychiatrist with the outcome of

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W 312	Continued From page 21 no medication changes. The HSD confirmed and provided documentation which verified on 4/28/16, the facility received a verbal order to discontinue the use of the PRN Clonidine 0.1 mg, ¼ tab (0.025 mg) order. The HSD confirmed and provided documentation which verified on 5/23/16, she emailed the psychiatrist the following: "Emailed doctor to report that (Client #6's) behaviors (aggression to staff/peers and property destruction) have increased since (his/her) PRN Clonidine was discontinued. (He/She) was given the PRN frequently at school. (He/She) is coming home from school agitation almost daily. The staff try to keep (him/her) busy and have minimal down time... (He/She) does come home agitated most days since the PRN medication has stopped... Receive email from doctor with verbal order to increase clonidine to 0.1 mg orally four times a day. Increasing the noon dose would help with the time frame where (Client #6) is more agitated." The HSD confirmed and provided documentation which verified on 6/4/16, the psychiatrist came to the facility. The notes from that date document, "the psychiatrist feels (Client #6's) ADHD (Attention Deficit Hyperactive Disorder) is out of control due to the fact that (he/she) is obviously not getting a high enough level of the medication in (his/her) system to help (him/her) and recommends increasing (his/her) Clonidine to 0.15 mg orally four times per day." The HSD confirmed Client #6's diagnoses did not include ADHD. The HSD confirmed the information provided to the Psychiatrist was	W 312		

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W 312	Continued From page 22 verbal and not based on an analysis of the data maintained by the facility related to Client #6's targeted behaviors. RC B looked at the data maintained in Client #6's file and confirmed the data graphs did not indicate an increase in targeted behaviors and confirmed the data lacked the specificity to determine the actual frequency and intensity of the large number of targeted behaviors identified under the larger topic of "inappropriate behavior." RC B agreed the data did not include incidences of targeted behavior which occurred at school and/or when Client #6 was on home visits. RC B said the data was not sufficient to capture a valid representation of the behaviors exhibited by Client #6. RC B confirmed the ISP for Client #6 did not identify how the use of psychoactive medications were tied to his/her active treatment plan.	W 312		

VJH 10/31/16

W206 483.440(c)(1) Individual Program Plan

Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c) (3) of this section; and (ii) Designing programs that meet the client's needs.

POC:

1.) By October 31, 2016 the Residential Director and IDT members will review each resident's current Individual Service Plan summary for accuracy in the "services needed" section. Any changes will be recorded by the Residential Director in the October 2016 IDT notes. Any additional required services needs will be addressed by the dept. head of the associated discipline by October 31, 2016, and followed up on at the next month's IDT meeting. Residential Director will maintain the meeting minutes in their office.

2.) FHC's ICF/ID Program Coordinator will be responsible for accurately documenting individual services needed in each ISP summary on an annual basis. Coordination with appropriate profession, disciplines or service areas will be the responsibility of the dept. head of the associated discipline. ISP records will be maintained by the Program Coordinator.

3.) Services needed for new admission will be addressed at the resident's 30-day staffing, and on-going followup discussed at monthly IDT meetings. IDT meeting minutes will be maintained by the Residential Director.

W240 483.440 (c)(6)(i) Individual Program Plan

The individual program plan must describe relevant interventions to support the individual toward independence.

POC:

1.) By September 19, 2016, the QIPD role will be transitioned from FHC's Program Director position to FHC's Residential Coordinator position . The Executive Director will be responsible for revising job descriptions to reflect the new duties by September 19, 2016.

2.) FHC's Executive Director will contract with a qualified QIPD consultant to provide formal QIPD training to the Residential Coordinators. Consultants' qualifications and training curriculum will be maintained by the ED. Training will be completed by Nov. 30, 2016, with training records maintained in RC's personnel files by the Human Resources Director.

3.) By October 31, 2016, the QIPDs will review all current residents' behavior support plans for accuracy in currently identifiable interfering behaviors, their definitions and supportive strategies. Plans will also be reviewed for accurate tracking and trending of residents' interfering behaviors. The staff training of any potential changes will be addressed through the current program training system.

4.) By October 31, 2016, the Residential Director will create an electronic communication system between FHC and each resident's school program as a running document to communicate priority issues of each child. The Residential Director is responsible for monitoring the effectiveness of the system and managing any required changes.

Faith, Hope and Charity
POC
ANNUAL SURVEY
8/29/16 -9/1/2016

W153 483.420(d)(2) Staff Treatment of Clients

The facility must ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other official in accordance with State law through established procedures.

POC:

1.) FHC's Director of Social Services will create a training form stating the 24 hour notification requirement for any of the above mentioned issues. All currently working staff will complete the training by October 31, 2016. The Director of Social Services will be responsible for monitoring the trainings until completed. Verification of the training will be filed by the Director of Social Services in the Consumer Advocate Team documents. Any newly hired staff will be trained on the 24 hour requirement during their new staff orientation.

2.) Executive Director will be responsible to review and discuss the 24 hour abuse reporting requirement with all FHC staff at the Sept. 23, 2016, All-Staff meeting. Minutes of the meeting will be maintained by the ED.

3.) Residential Director will be responsible to review and discuss the 24-hour abuse reporting requirement with ICF Residential Staff at the Sept. 22, 2016, All-Homes meeting. Meeting minutes will be maintained by the RD.

W159 483.420(a) QIPD

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

POC:

1.) By September 19, 2016, the QIPD role will be transitioned from FHC's Program Director position to FHC's Residential Coordinator position . The Executive Director will be responsible for revising job descriptions to reflect the new duties by September 19, 2016.
2.) FHC's Executive Director will contract with a qualified QIPD consultant to provide formal QIPD training to the Residential Coordinators. Consultants' qualifications and training curriculum will be maintained by the ED. Training will be completed by Nov. 30, 2016, with training records maintained in RC's personnel files by the Human Resources Director.
3.) By October 31, 2016, the QIPDs will review all current residents' behavior support plans for accuracy in currently identifiable interfering behaviors, their definitions and supportive strategies. Plans will also be reviewed for accurate tracking and trending of residents' interfering behaviors. The staff training of any potential changes will be addressed through the current program training system.
4.) By October 31, 2016, the Residential Director will create an electronic communication system between FHC and each resident's school program as a running document to communicate priority issues of each child. The Residential Director is responsible for monitoring the effectiveness of the system and managing any required changes.

W252 483.440(e)(1) Program Documentation

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

POC:

1.) By September 19, 2016, the QIPD role will be transitioned from FHC's Program Director position to FHC's Residential Coordinator position . The Executive Director will be responsible for revising job descriptions to reflect the new duties by September 19, 2016.
2.) FHC's Executive Director will contract with a qualified QIPD consultant to provide formal QIPD training to the Residential Coordinators. Consultants' qualifications and training curriculum will be maintained by the ED. Training will be completed by Nov. 30, 2016, with training records maintained in RC's personnel files by the Human Resources Director.
3.) By October 31, 2016, the QIPDs will review all current residents' behavior support plans for accuracy in currently identifiable interfering behaviors, their definitions and supportive strategies. Plans will also be reviewed for accurate tracking and trending of residents' interfering behaviors. The staff training of any potential changes will be addressed through the current program training system.
4.) By October 31, 2016, the Residential Director will create an electronic communication system between FHC and each resident's school program as a running document to communicate priority issues of each child. The Residential Director is responsible for monitoring the effectiveness of the system and managing any required changes.
5.) By October 31, 2016, the Health Services Director will responsible for procuring Medication Administration Records from the Storm Lake Community School District for each FHC resident receiving medications during school hours, and maintaining these records in the Health Services Dept. HSD is responsible for monthly monitoring of the records, and addressing any medication-related issues with the appropriate professional.

W291 483.450 (c)(1) Time Out rooms

A client may be placed in a room from which egress in prevented only if the following conditions are met:....

POC:

1.) By September 26, 2016, the Executive Director will contact the FHC Maintenance department to investigate the installation a safety mirror in any time-out rooms in use. The installation will be coompleted by September 27, 2016.

W312 483.450 e (2) Drug Usage

Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically toward the reduction of the eventual elimination of the behaviors for which the drugs are employed.

POC:

1.) By October 31, 2016, the QIPDs will review all current residents' behavior support plans for accuracy in currently identifiable interfering behaviors, their definitions and supportive strategies. Plans will also be reviewed for accurate tracking and trending of residents' interfering behaviors. The staff training of any potential changes will be addressed through the current program training system.

2.) By October 31, 2016, the Residential Director will create an electronic communication system between FHC and each resident's school program as a running document to communicate priority issues of each child. The Residential Director is responsible for monitoring the effectiveness of the system and managing any required changes
3.) By October 31, 2016, the Health Services Director will responsible for procuring Medication Administration Records from the Storm Lake Community School District for each FHC resident receiving medications during school hours, and maintaining these records in the Health Services Dept. HSD is responsible for monthly monitoring of the records, and addressing any medication-related issues with the appropriate professional.