VOK 12/15/16

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

PRINTED: 11/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G055	A. BUILDING _____ B. WING _____	C 11/02/2016

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 000	INITIAL COMMENTS During investigations 63137-I and 63980-I standard level deficiencies were cited at W159 and W234. Iowa Administrative Code (IAC)481-50.7(3) was cited. See State Form.	W 000		
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 interview and record review the facility failed to incorporate recommendations from professional staff into Individual Program Plans. This affected 1 of 1 client (Client #1) identified in investigations 63137-I and 63980-I. Finding follows: Client #1's record review on 11/1/16 revealed a report dated 2/17/16 from the consulting psychologist. The psychologist recommended to include awareness and provisions for directing Client #1 out of environments that were loud before the client became upset. Also, include in the Behavior Strategy Program (BSP) specific reinforcement procedures to be provided to the client for engagement in identified behaviors preferably incompatible with the challenging behaviors. The psychologist also recommended completing a functional analysis in order to obtain specific information to determine the reason for the inappropriate behaviors. Review of Client #1's Annual Individual Support Plan (ISP) dated 3/8/16 failed to include any discussion of recommendations by the	W 159	All attached POC 12/16/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christine Mod, ED | TITLE: ED | (X6) DATE: 11-23-16

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 159	Continued From page 1 psychologist. Record review of Client #1's BSP last updated on 9/27/16. The program addressed inappropriate behaviors of physical aggression, PICA, self-injurious behaviors (SIB), climbing, hyperactivity and running away. The program noted when Client #1 engaged in hyperactive behavior, he/she may become overstimulated which would lead to other behaviors such as SIB or physical aggression. The program directed staff to use verbal redirection or take away the inedible when the client engaged in PICA behavior. When exhibiting SIB or physical aggression, staff should verbally redirect or offer a break to the client, use picture symbol communication or body position/block. The program also addressed climbing behavior by directing staff to verbally redirect or physically assist the client down, when exhibiting hyperactive behavior provide verbal redirection or offer a break. When Client #1 exhibited running away behavior, staff should provide verbal redirection or physical redirection or body positioning. The program did not include the recommendations made by the psychologist. When interviewed on 11/1/16 at 5:00 p.m. the Residential Coordinator stated she had been working with a behavioral analyst regarding Client #1's behaviors and as a result had started a communication system with the client. She had not seen the report and recommendations by the psychologist therefore had not reviewed the information with the appropriate staff. When interviewed on 11/1/16 at 10:50 a.m. the Program Coordinator confirmed Client #1's programs failed to include any recommendations	W 159		

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W 159	Continued From page 2 made by the psychologist. She stated she was unaware of the psychologist's report.	W 159		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to ensure client behavior plans included clear direction on strategies to be implemented. This affected 1 of 1 sample client (Client #1) involved in investigations 63137-I and 63980-I. Finding follows: Record review on 10/31/16 revealed two facility self-reports of client-to-client aggressions resulting in injury which occurred within a thirty day period. Client #1's Incident Detail Reports documented on 8/19/16 Client #1 scratched Client #2 back without warning. On 8/28/16 Client #1 grabbed Client #2's by the right elbow resulting in several small scratches and small bruise. On 9/24/16 Client #1 scratched Client #3 without warning and on 10/21/16 scratched Client #2 on the neck as he/she walked through the living room. When interviewed on 10/31/16 at 2:10 p.m. Direct Support Staff (DSS) A stated Client #1 would get away from staff at times and aggressed toward other clients. She stated staff had been trained to stay close to the client, usually at arm's length. DSS A could not recall any other strategies noted in the client's program to prevent him/her aggressing toward others.	W 234		

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W 234	Continued From page 3 When interviewed on 10/31/16 at 3:00 p.m. DSS B stated the client would bolt away and staff should stay within arm's length when supervising him/her. She stated Client #1's program did not provide any direction on staff positioning during periods of aggression in order to prevent injury to others. When interviewed on 10/31/16 at 4:20 p.m. DSS C stated staff had been trained to move clients out of the area when Client #1 became aggressive. Staff should also position themselves between Client #1 and other clients. DSS C stated she could not recall any other information for staff positioning in order to prevent injuries. When interviewed on 11/1/16 at 8:40 a.m. DSS D stated staff could not always catch Client #1 during episodes of aggression and tried to block his/her behaviors with their bodies. She stated she had been trained on body blocking but not sure the techniques were practiced enough. DSS D stated she did not know how to prevent the client from getting to others. When interviewed on 11/1/16 at 8:55 a.m. DSS E stated staff should always stay close to Client #1 due to the unpredictability of the client's behavior. She stated staff communicate during aggressive situations but also felt it would be helpful for staff to have more direction on positioning to prevent injuries to others.	W 234		

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W 234	Continued From page 4 Record review of Client #1's Behavior Strategy Program (BSP) last updated on 9/27/16. The program addressed inappropriate behaviors of physical aggression, PICA, self-injurious behaviors (SIB), climbing, hyperactivity and running away. The program noted when Client #1 engaged in hyperactive behavior, he/she may become overstimulated which would lead to other behaviors such as SIB or physical aggression. The program directed staff to use verbal redirection or take away the inedible when the client engaged in PICA behavior. When exhibiting SIB or physical aggression, staff should verbally redirect or offer a break to the client, use picture symbol communication or body position/block. The program also addressed climbing behavior by directing staff to verbally redirect or physically assist the client down, when exhibiting hyperactive behavior provide verbal redirection or offer a break. When Client #1 exhibited running away behavior, staff should provide verbal redirection or physical redirection or body positioning. The program failed to adequately direct staff on the importance of body positioning and how to anticipate, block and intervene on aggressive behavior as well as other inappropriate behaviors. The program did not clearly outline teaching strategies and provide complete information regarding the use of a picture communication system. When interviewed on 11/1/16 at 9:25 a.m. the Program Coordinator confirmed more information in Client #1's BSP would be helpful for staff. She acknowledged staff may need more information on positioning during Client #1's behavioral situations in order to prevent injuries to others.	W 234		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA0012	A. BUILDING: _____ B. WING _____	C 11/02/2016

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C 135	50.7(10A, 135C) 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: This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to comply with Iowa Code 481 IAC 50.7 (3) by failure to report timely as required, to the Iowa Department of Inspections and Appeals (DIA) and facility policy with incidents of multiple peer to peer aggression which resulted in physical injury within a 30 day period. This affected 3 of 3 clients (Client #1, Client #2 and Client #3) involved in investigations 63137-I and 63980-I. Finding follows: Record review on 10/31/16 revealed two facility self-reports of client-to-client aggressions resulting in injury which occurred within a thirty day period. Client #1 scratched Client #2 on 8/19/16 and again on 8/28/16; the facility notified DIA on 8/30/16. Client #1 scratched Client #3 on 9/24/16 and Client #1 scratched Client #2 on 10/21/16. The facility notified DIA on 10/26/16. Record review on 10/31/16 revealed Client #1's Incident Detail Reports. The report dated 8/19/16 documented Client #1 scratched Client #2 back without warning. On 8/28/16 Client #1 grabbed Client #2's by the right elbow resulting in several small scratches and small bruise. On 9/24/16 Client #1 scratched Client #3 without warning and on 10/21/16 scratched Client #2 on the neck as he/she walked	C 135		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

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C 135	Continued From page 1 through the living room. Review on 11/1/16 of the facility policy/procedure titled Safety and Sanitation Policy identified the following: Any time a major incident which occurred at Faith, Hope and Charity's ICF/ID Services the administrative on-call staff should contact DIA and other appropriate entities within 24 hours or as soon as is safely possible. Incidents to be reported included when the facility had knowledge of a pattern of acts committed by the same resident on another resident that resulted in any physical injury. When interviewed on 11/1/6 at 9:25 a.m. the Program Coordinator confirmed she had been late in reporting the incidents on 8/19/16 and 8/28/16. She stated the facility generally reported incidents on the next business day and acknowledged she should have made the report on 8/29/16. When interviewed on 11/1/16 at 11:30 a.m. the Social Services Director stated the incidents which occurred 9/24/16 and 10/21/16 were reported as soon as she became aware of them. She stated generally the facility reported on the next business day but acknowledged the report should have been made before 10/26/16.	C 135		

12/15/16

FHC Plan of Correction
Investigation 63137-I & 63980-I
11/22/16

483.430(a) QIDP

- W159: Active treatment must be integrated, coordinated and monitored by a QIDP.
    - This standard was not met as evidenced by facility failed to incorporate recommendations from professional staff into individual program plans.

Plan of Correction:

1. By Nov. 14, 2016, the QIDP revised the current individual's Behavior Support Plan to include recommendations from the psychologist report dated Feb. 2016. The revised plan will be maintained by the Program Coordinator, with a copy of the plan maintained by the QIDP in Love home.
2. By Nov. 15, 2016, FHC's contracted BCBA consultant will review the resident's behavior documentation and make recommendations accordingly. The IDT will address these recommendations at the December, 2016, IDT meeting. Meeting minutes will be maintained by the Residential Director in the RD office.
3. By Dec. 9th, 2016, the QIPD will revise the individual's Behavior Support plan, incorporating the recommendations of the IDT. A copy of the revised plan will be maintained by the QIDP in Love Home.
4. By Dec. 16th, 2016, all appropriate staff will be trained on the revised plan, which will incorporate the IDT's recommendations for the Behavior Support Plan and/or Active Treatment Schedule. Training documentation will be maintained by the QIDP in Love home.

483.4(c)(5)(i) Individual Program Plan

- W234: Written training programs must specify the methods to be used.
    - This standard was not met as evidenced by the facility failed to ensure client behavior plans included clear direction on strategies to be implemented.

Plan of Correction:

1. By Nov. 14, 2016, the IDT will meet to discuss revisions to the Behavior Support Plan to include protective measures for others in the environment. Copy of the revised plan is maintained by the QIDP in Love home.
2. By Dec. 16th, 2016, all appropriate staff will be trained on the revised Behavior Support Plan using the current staff training system. Training documentation will be maintained by the QIDP in Love home.

481-50.7(10A,135C) Additional Notification

- C135: The director or designee shall be notified within 24 hours, or the next business day, by the most expeditious means available.
    - This standard was not met as evidenced by the facility failed to report timely multiple incidents of peer-to-peer aggression to the Iowa Dept. of Inspections and Appeals (DIA).

Plan of Correction:

3. By Nov. 14, 2016, FHC's Executive Director (ED) retrained the Social Services Director and Program Coordinator, who are responsible for timely reporting to DIA, with regard to FHC's Safety and Sanitation policy, as well as the Major Incident Reporting policy. Training documentation is maintained by the ED in the ED office.
4. By Dec. 16th, 2016, FHC's ED will revise the reporting procedure for peer-to-peer aggressions to include this additional step: Nursing staff will contact Administrative on-call within 24 hours for incidents of multiple peer-to-peer aggression which results in physical injury within a 30-day period.

5. By Dec. 23rd, 2016, all nursing and admin.-on-call staff will be trained on the revised Incident Reporting procedure by the Social Services Director, using the current staff training system. Training documentation will be maintained by the Social Services Director in the Administrative On-Call binder.