Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#6357	Fine amount reduced by 35% to $2,600.00 on December 16, 2016 pursuant to Iowa Code Section 135C.43A	Date: 11/23/16
Christian Opportunity Center		Survey Dates: 10/24/16 – 11/3/16
1554 Broadway		
Pella, IA 50219	JKM	

		Class	Fine Amount	Correction date
64.60	**481—64.60(135C) Federal regulations adopted—conditions of participation.** Regulations in 42 CFR Part 483, Subpart D, Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319. Classification of violations is I, II, and III, determined by the division using the provisions in 481—Chapter 56, "Fining and Citations," to enforce a fine to cite a facility. This rule is intended to implement Iowa Code section 135C.2(3).	I	$4,000	Upon Receipt
W 104	The governing body must exercise general policy, budget, and operating direction over the facility. **DESCRIPTION:** Based on observations, interviews and record review, the facility failed to consistently implement policies and procedures and provide adequate operating direction to address and ensure provision of a safe environment. This failure affected 1 of 1 client during the investigation of incident #63147-I (Client #1) and potentially affected all clients residing in the facility. Findings follow: 1. Record review on 10/24/16 revealed a General Event Record (GER) which documented Client #1's elopement from the "plant" (facility vocational program) on 9/19/16 at 11:00 a.m. The report documented by Work Skills Supervisor (WSS) A described her transfer of supervision of Client #1 to WSS B. She noted she asked WSS B to assume supervision of Client #1 and take his/her "band"			

Facility Administrator Date

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	so she could gather more work materials. WSS B asked WSS A to leave Client #1's band on the table and chose not to wear it because WSS A was sick. WSS A placed the band on the table and left the area, referred to as "the green room.' She returned to the area, with the WSS/Speech Aide, walked through and entered the "middle room," work area adjacent to the green room. She talked with the WSS/Speech Aide in the middle room about work materials and two other staff entered to ask about a client's medication. The Motor Skills Coordinator entered the middle room to address staff's request for a client's medication and the WSS/Speech Aide told WSS A she would bring some work materials back to the green room. WSS A returned to the green room and discovered Client #1 absent from his/her designated work seat. She questioned Client #1's whereabouts and WSS B replied, "Oh gosh" and started to look for him/her. WSS B looked outside and WSS A quickly looked in the restroom in the green room. They failed to locate Client #1, so WSS A went to the middle room and asked staff if they had seen him/her; they had not. WSS C left the middle room and went to the outer hall of the plant to look for Client #1. WSS A left the green room and went to the Vocational Program Manager's office to inform her of the elopement. While still looking in the plant for Client #1, WSS C approached WSS A and told her the Human Resources Associate found Client #1 and he/she returned to the green room. The GER noted staff reasoned Client #1 exited the green room via an exit door that hadn't completely shut and latched resulting in a chime not sounding. WSS A noted a Program Coordinator saw Client #1 walk on the sidewalk outside her office. WSS A estimated Client #1 lacked staff supervision for approximately 2 minutes. The Center is located on a residential street.			

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	Further record review revealed Client #1's Individual Data sheet. Documented diagnoses included: Severe Intellectual Disability, Catatonic type Schizophrenia, Major Depressive Disorder, Generalized Epilepsy and Gastroesophageal reflux disease (GERD). According to the Individual Data sheet, Client #1 was 63 years old, "partially" verbal and walked on his/her own. The document noted he/she could not safely cross a street and paced up and down the hallway when home. Supervision comments included, "(Client #1) needs assistance for all ADLs (Activities of Daily Living) and needs 24 (hour) awake staff. Staff should know (his/her) whereabouts within the house/vocational setting." Continued record review revealed an Individual Support Plan (ISP) effective date 2/25/16, with a review date of 9/15/16. The ISP documented Client #1's needs, supports and services. Page 4 noted, "My team agrees that I am an elopement risk. I may not walk to/from the plant independently". In addition information regarding the work site included a need to let staff know when he/she wanted to leave the work area and a lack of tolerance for others coming through the work area. An identified Goal or Service included the statement, "(Client #1) will stay in the building and (his/her) work room unless supervised by staff during the day or night 100% of the days per month for six consecutive months". Record review revealed an ISP Program which noted staff should inform Client #1 if he/she wanted to go outside, he/she needed to inform staff. The ISP program noted Client #1 used a roam alert system at home for his/her safety due to not looking when crossing the street and not dressing appropriately for the weather. The program stated at work if Client #1 attempted to leave the work room and attempts by staff to redirect him/her failed, staff should offer him/her to go for a walk or ride or call for support staff assistance. The program explained			

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	he/she wore a Roam Alert band on his/her wrist that activated the Roam Alert system at his/her home. When he/she got within close proximity of the entryway door a "mag lock" activated and prevented him/her from opening the door. The program stated at the plant Client #1's WSS would have him/her "in visual sight". It explained if the WSS needed to leave the area for any reason, staff would verbally inform other staff and hand them the wrist band (expanded as a band worn to indicate the staff responsible for supervision of Client #1). The program stated staff responsible for supervising Client #1 must have him/her "within their sight, and/or the exits to the large plant area and the outside of his/her work area." Additional record review revealed a copy of Client #1's ISP program to stay in the building signed by WSS B on 10/11/16. A copy of the facility People Supported (PS) Supervision Responsibility Statement also noted WSS B's signature with a date of 10/11/16. The statement acknowledged WSS B received training and understanding of the supervision responsibilities for each PS. Record review on 11/2/16 revealed the Maladaptive Behavior portion of Client #1's Comprehensive Functional Assessment (CFA) completed by the Behavior Analyst on 2/23/16. The assessment noted "notifies staff when leaving" as a need. Further review of the CFA on 11/3/16 revealed the Travel, Dressing and Safety portions of the CFA. Travel needs included use of traffic lights, use of sidewalks, use of crosswalks and looking both ways when crossing streets. The dressing assessment noted Client #1 needed assistance to dress appropriately for the weather. The safety assessment indicated he/she could not independently walk to/from the plant safely.			

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	Further record review on 11/2/16 revealed an e-mail from the Program Coordinator (PC) sent to the Vocational Program Manager on 9/19/16 at 12:07 p.m. The PC wrote she saw Client #1 walking unaccompanied on the sidewalk outside her office and watched him/her walk towards the end of the building. She noted she then heard Client #1's voice inside the building talking with staff. Additional record review revealed the facility Missing Person procedure. The procedure gave staff direction in the event a client eloped. The final directive noted, "An 'Emergency Drill/Actual Event Report' and other appropriate reports must be completed." Observation on 10/24/16 at 4:15 p.m., in the green room at the plant revealed a piece of paper on the exit door. The paper included the following typed message, "Make sure the door is latched when closing". The Regional Director explained she posted the sign after Client #1's incident of elopement on 9/19/16. She said when she looked at the door following the incident, it wasn't latched and she presumed Client #1 was able to exit without a chime sounding. She added the chime was only used as a safety measure to notify staff if/when anyone entered the building. Observation on 11/2/16 at 10:00 a.m., revealed a concrete sidewalk outside the exit door of the green room at the plant. The surveyor followed the path of the sidewalk around the building and noted several windows with office equipment inside, as well as a double door and an entrance to the building at the end of the sidewalk. The sidewalk just outside the exit sloped slightly but remained level and in good condition on the remainder of the path. Maintenance personnel at the facility indicated the distance Client #1 presumably			

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	traveled to walk from the exit door by the green room to the door he/she entered to get back into the plant measured 144 feet. Observation in the green room on 11/2/16 at 10:10 a.m. revealed Client #1 sat at a table with work materials on the table. He/she sat on the opposite side of the room from the exit door. WSS D handed WSS A a purple elastic band that she placed on her arm. WSS A left the green room and entered the middle room to gather work materials. She failed to keep Client #1 within eyesight or pass supervision of Client #1 to another staff. 3. When interviewed on 10/24/16 at 4:05 p.m., the Regional Director stated staff wore a wrist band to denote supervision of Client #1. She stated staff failed to keep "eyes on" (Client #1) on 9/19/16 because the room was "busy". When interviewed on 11/2/16 at 9:35 a.m., the Vocational Program Manager confirmed WSS A laid the wrist band on the table on 9/19/16 because WSS B didn't want "germs" from WSS A. She confirmed the Human Resource Associate called her and told her the PC saw Client #1 outside the plant, unaccompanied by staff. When interviewed on 11/2/16 at 10:20 a.m., WSS A confirmed she transferred supervision of Client #1 to WSS B by placing the band on the table on 9/19/16. She confirmed WSS B didn't want to take the band because WSS A had a bad cold. She noted WSS B accepted supervisory responsibility for Client #1 before she left the green room. She confirmed multiple staff enter and exit the area because of appointments, activities, etc., and that she passed through the green room with the WSS/Speech Aide. She didn't recall whether Client #1 sat at his/her work table when she passed through, as			

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	she was looking for bags to complete a work task. She noted Client #1 consistently sat at the same table observed by the surveyor. She acknowledged she and WSS B realized Client #1's absence and began to search for him/her. She noted the Janitor found Client #1 walking in the hallway and WSS C brought him/her back to the green room. WSS A stated Client #1's level of supervision at work was 3 - 5 minute checks. She looked at Client #1's ISP program and confirmed the level of supervision written in the program stated within eyesight. She admitted she did not keep Client #1 within eyesight in the green room when she entered the middle room to get work materials on 11//2/16. When interviewed on 11/2/16 at 11:00 a.m., WSS B confirmed she accepted supervision for Client #1 on 9/19/16. She noted she had supervisory responsibility for several clients in the room that day and confirmed Client #1 sat in his/her normal seat in the green room. She recalled both staff and clients passed through the room that morning. She also recalled Client #1 stood up several times and she prompted him/her to sit down. She estimated Client #1 was out of the room for approximately one minute before staff found him/her because WSS A was not gone long. She stated Client #'1's level of supervision included checks every 10 minutes, but she tried to keep on "top of things". She said Client #1 was "high level of supervision" and acknowledged staff should keep him/her in eyesight when shown the ISP program. She admitted she didn't see Client #1 leave the green room on 9/19/16. WSS B stated she was re-trained on Client #1's level of supervision following the incident on 9/19/16 and confirmed her signature on the ISP program and Supervision statement dated 10/11/16. When interviewed on 11/2/16 at 11:30 a.m., the			

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	Vocational Program Manager confirmed staff shouldn't leave the green room and go to the middle room when they have supervisory responsibility for Client #1 per his/her ISP program. When interviewed on 11/2/16 at 11:38 a.m., WSS C stated she didn't see Client #1 leave the green room on 9/19/16, but when she heard he/she left without supervision, she went to look for him/her. She recalled she left through the main door of the middle room and walked down the hall out to the main hallway. She noted the Janitor and Client #1 were walking down the main hallway and she assumed responsibility for Client #1. She estimated Client #1 went unsupervised for approximately 2 - 3 minutes. She didn't recall what Client #1 wore or what the weather conditions were on 9/19/16. She recalled Client #1 had no injuries and noted she "looked (him/her) over" but didn't document any findings. WSS C stated Client #1 required 3 -5 minute checks when at home and at the plant required eyes on him/her at all times. She confirmed staff can hear the door chime from the middle room and stated she didn't hear any chime on 9/19/16. She explained the purpose of the wrist band was to ensure staff held responsibility for Client #1. She said whoever has the band has responsibility for his/her safety. When interviewed on 11/2/16 at 11:50 a.m., the State Climatologist stated it was 82 degrees at the airport in Pella on 9/19/16 at 10:55 a.m. He noted clear skies, a 7 mile per hour (mph) wind from the southwest and a heat index of 84. When interviewed on 11/2/16 at 1:15 p.m., the Vocational Program Manager stated no policy regarding client supervision existed. She said the ISP defined the level of supervision and staff should follow the supervision			

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	guidance in the ISP and/or ISP program. She noted she asked all staff in the plant if they saw Client #1 leave, and all responded no. She said from that information, she reasoned Client #1 left via the exit door in the green room. She confirmed the chime existed for safety reasons and typically staff only used the door for fire drills. When interviewed on 11/2/16 at 1:35 a.m., the Human Resources Associate confirmed she walked down the main hall of the plant with the Janitor on the morning of 9/19/16 and saw Client #1 walking down the hall unaccompanied by staff. She questioned the Janitor about Client #1 being unsupervised and the Janitor stated he/she shouldn't be alone. The Human Resources Associate recalled the Janitor took Client #1 by the crook of the arm and prompted him/her to go back to work. She said a staff from Client #1's program met them in the hallway. She stated Client #1 didn't appear to be in any distress and cooperatively walked with the Janitor. She stated she didn't see Client #1 enter the building. When interviewed on 11/2/15 at 1:43 p.m., the Janitor confirmed she knew Client #1 from seeing him/her in the Physical Therapy area of the building. She recalled she and the Human Resources Associate finished their break and walked down the hall. She estimated the time to be 10:20 a.m. She said the Human Resources Associate saw Client #1 first and asked her if he/she should be walking alone. The Janitor said she knew he/she shouldn't be alone so she approached him/her and took hold of a gait belt around his/her waist and walked down the hall with him/her. She didn't recall the name of the staff, but noted a staff from Client #1's program met them in the hall. She described Client #1 as "congenial" and said he/she walked cooperatively with her. She said she			

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	didn't see him/her come in the door at the end of the hall. When interviewed on 11/2/16 at 2:00 p.m., the WSS/Speech Aide stated she didn't remember much about the day of the incident. She did recall WSS A came and asked about work materials and she directed her back to the middle room because often staff fail to find materials in their areas. She recalled staff came and asked for a medication for another client and she left the area. She confirmed knowledge of Client #1's elopement behavior but stated she was unaware of the incident until later in the day. The WSS/Speech Aide stated she knew staff working with Client #1 should wear a colored band and pass it to another staff before they leave the area. She said this process ensured staff knew Client #1's whereabouts at all times. She said Client #1 walks independently and only encounters difficulty walking if she lacks sleep. She confirmed she participated in fire drills at the plant and used the exit door of the green room. She said the chime lets staff know if someone comes in the building. She again noted staff are to know Client #1's whereabouts at all times at the plant and check on him/her every 5-7 minutes when he/she is at home. When interviewed on 11/2/16 at 2:10 p.m., the Motor Skills Coordinator described Client #1's mobility as "good". She said though his/her mobility fluctuated due to fatigue he/she didn't fall when walking. She said the Human Resource Associate told her about the elopement incident. She recalled being in the middle room and receiving a medication cassette from staff on 9/19/16 but did not recall seeing Client #1. She confirmed she goes in and out of the area multiple times to escort clients to her area for Physical Therapy. She noted she remains focused on that individual and doesn't pay attention to others in the area. She confirmed she participated in fire			

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	drills in the building and used the green room exit door. She confirmed the chime on the door alerts staff to persons entering the building. She identified Client #1's level of supervision as "visual contact". She further noted staff use a purple wrist band to let everyone know who has supervision of him/her. She confirmed she accepted the band whenever she went to the green room to get Client #1 for physical therapy. She added she gave the band back to staff when she returned Client #1 to the green room. At 2:25 p.m., the Vocational Program Manager stated the distance from Client #1's seat/table to the exit door in the green room measured 37 feet. When interviewed on 11/2/16 at 3:30 p.m., the Regional Director stated each staff signs the Supervision statement upon hire to assure they know the responsibility involved in supervision of each client. When interviewed on 11/2/16 at 3:35 p.m., the Behavior Analyst confirmed she wrote Client #1's ISP program to stay in the building. She couldn't remember the last time Client #1 eloped but noted elopements seemed to occur more at the plant. She noted a time earlier in the year when Client #1 went out the exit door in the green room but staff followed her. She confirmed it was the same door as the facility assumed she left from on 9/19/16. She said staff need to know Client #1's whereabouts when at work, but she didn't want staff to stare at Client #1 so they could leave the area as long as they could see the exit door. She acknowledged the wording in the ISP program "within sight," implied staff should be able to see Client #1 at all times. She confirmed 3 -5 minute or 10 minute checks at the plant would not provide sufficient supervision. She added she would heighten her awareness of Client #1's whereabouts if he/she needed			

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<tr><td></td><td colspan="2">multiple prompting to sit down. She confirmed the program lacked that directive to staff.
After review of the CFA and a programmatic data report, the Behavior Analyst stated the data report failed to indicate Client #1 actually left the building on 9/19/16. She said he/she "can't go anywhere at the plant without staff."

When interviewed on 11/3/16 at 10:30 a.m., the Qualified Intellectual Disability Professional (QIDP) confirmed Client #1 couldn't safely cross a street and didn't dress appropriately for the weather. She noted he/she shouldn't be outside alone.

When interviewed on 11/3/16 at approximately 10:37 a.m., the QIDP, the Behavior Analyst and the Residential Program Manager confirmed staff should follow the level of supervision designated in the ISP program. The QIDP stated staff failed to provide close supervision of Client #1 on 9/19/16 resulting in an elopement. The Behavior Analyst noted staff failed to wear the band to heighten awareness of the responsibility of supervision for Client #1.

When re-interviewed on 11/3/16 at approximately 10:50 a.m., WSS A stated her understanding of the level of supervision in Client #1's ISP program meant staff needed to keep eyes on him/her at all times.

When re-interviewed on 11/3/16 at 11:05 a.m., WSS B again stated Client #1 should be checked on every 10 minutes. She said she would not constantly look at Client #1 but staff should be able to see him/her in the room at work.

In summary, the facility failed to provide clear direction to staff regarding supervision needed to ensure safety. In</td><td></td><td></td><td></td></tr>
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	addition, staff failed to correctly identify the level of supervision indicated in the ISP program even after an incident of elopement and re-training.			
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W 193	Staff must be able to demonstrate the skills and techniques necessary to administer interventions to administer the inappropriate behavior of clients. **DESCRIPTION:** Based on observation, interviews and record review, the facility failed to ensure staff consistently implemented the level of supervision identified in client Individual Support Plans and programs (ISPs). This affected 1 of 1 client (Client #1) during the investigation of incident #63147-I. Findings follow: Record review on 10/24/16 revealed Client #1's General Event Report (GER) written by Work Skills Supervisor (WSS) A on 9/19/16 . The report described the actions of			

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	WSS A and WSS B prior to an elopement by Client #1. WSS A documented she laid a wrist band which was used to designate supervision of Client #1 on a table in the green room (Client #1's work area). She noted WSS B accepted supervision of Client #1 and she left the area to find more work materials. Within a few minutes, WSS B returned to the green room and discovered Client #1 missing. A search ensued and in approximately 2 -3 minutes WSS C returned to the green room with Client #1. Continued record review on 10/24/16 revealed Client #1's Individual Support Plan (ISP) meeting held on 2/5/16. The document noted the team identified Client #1 as an elopement risk and at work he/she needed to let staff know when he/she wanted to leave the area. Further record review revealed Client #1's ISP program to stay in the building and work room unless supervised. The program stated at the plant (facility vocational program) staff will have Client #1 in "visual sight". The program explained the transfer of responsibility of supervision of Client #1 included use of a wrist band. The wrist band would be worn by whoever supervised Client #1. Additional record review revealed a copy of Client #1's ISP program to stay in the building signed by WSS B on 10/11/16. A copy of the facility People Supported (PS) Supervision Responsibility Statement also noted WSS B's signature with a date of 10/11/16. The statement acknowledged WSS B received training and understood the supervision responsibilities for each PS. Observation on 11/2/16 at 10:10 a.m., revealed Client #1 sat at a table in the green room with work materials on the table. WSS D handed WSS A a purple cloth/elastic band which she placed on her arm. WSS walked out the green room and entered the room adjacent, known as the			

Facility Administrator Date

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#6357		Date: 11/23/16
Christian Opportunity Center	**Fine amount reduced by 35% to $2,600.00 on December 16, 2016 pursuant to Iowa Code Section 135C.43A**	Survey Dates: 10/24/16 – 11/3/16
1554 Broadway		
Pella, IA 50219	JKM	

		Class	Fine Amount	Correction date
	middle room. She failed to keep Client #1 in eyesight or pass supervision of Client #1 prior to leaving the area. When interviewed on 11/2/16 at 11:20 a.m., WSS A stated she laid Client #1's wrist band on the table on 9/19/16 because WSS B didn't want to wear it because WSS A was ill. She noted WSS B accepted supervision of Client #1 so she left the area. When she returned a few minutes later, staff realized Client #1 left the area without supervision. WSS A defined Client #1's level of supervision as 3 - 5 minute checks. When shown the ISP program, WSS A said the program stated Client #1 should be in staff eyesight. She acknowledged she failed to keep Client #1 in eyesight on 11/2/16 at 10:10 a.m. When interviewed on 11/2/16 at 11:00 a.m., WSS B confirmed she accepted responsibility for supervision of Client #1 on 9/19/16. She recalled the room was busy with staff and clients going in and out. She said WSS C brought Client #1 back to the green room within a minute of realization that he/she eloped. She confirmed she received training following the incident and further confirmed her signature on a copy of Client #1's ISP program to remain in the building. She acknowledged she signed a copy of the facility Supervision Responsibility statement on 10/11/16. She stated staff should check on Client #1 every 10 minutes. When interviewed on 11/2/16 at 11:30 a.m., the Vocational Program Manager confirmed staff shouldn't leave the green room and go to the middle room when they have supervisory responsibility for Client #1 per his/her ISP program. When interviewed on 11/3/16 at approximately 10:37 a.m., the Qualified Intellectual Disability Professional (QIDP), the Behavior Analyst and the Residential			

Facility Administrator   Date

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	Program Manager confirmed staff should follow the level of supervision indicated in the ISP program. In summary, the facility failed to ensure staff consistently knew and followed the level of supervision in client ISP program. In addition, staff failed to correctly identify the needed level of supervision even after an incident of elopement and re-training. **FACILITY RESPONSE:**			

Facility Administrator ______________ Date ______________

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