Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Number **FC 6447**			**Report Date** **February 9, 2017**
Facility Name **Opportunity Village**		**Survey Dates** **January 23-26, 2017**	
Facility Address **1200 North Ninth Street West**		**64797-I & Survey revisit**	
City **Clear Lake, IA. 50428**	**HL**		

Rule or Code Section	Nature of Violation	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, and 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 provision 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).** **DESCRIPTION:**	**I**	**$4000.00**	**Upon Receipt**
W 249	**483.440(d)(1) Program Implementation:** **As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.** Based on observation, interviews and record review the facility failed to ensure staff consistently followed client's level of supervision. This affected 1 client (Client #1) with an elopement identified during the survey revisit. Finding follows: Record review on 1/23/17 revealed Client #1's General Event Report (GER) dated 1/12/17. According to the			

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	report, transportation staff had called Moon Valley to inquire about a staff driving the van, removing the passenger side mirror upon exit of the garage and then drove the van to the sidewalk near Moon Valley. Within minutes of the call, Client #1 walked towards Moon Valley and made a statement the van would be ready to put his/her belongings in. After being questioned by the Qualified Developmental Disability Professional (QDDP), Client #1 returned the vehicle keys to staff. Follow-up with staff indicated Personal Support Professional (PSP) A laid the keys on the desk in the dining room at approximately 7:35 p.m. the previous evening for the next staff to use for another scheduled outing. Since no one chose to leave campus, no outing occurred, and staff did not put the keys away. All staff were notified about the importance of keeping the keys in a safe place away from person's served. Client #1's Behavior Intervention Plan (BIP) was revised to add information specifically related to keeping vehicle keys in the hands of staff and not allowing Client #1 to carry them. Follow-up documentation from the Regional Director (RD) on 1/12/17 on the GER stated she would be discussing with the transportation office to see if they needed to discuss doing anything differently and also had the QDDP review with Client #1 it was not safe to drive a vehicle without a license. The RD received an email from the transportation office on 1/13/17 to ensure staff kept the keys either locked up or given to the shift supervisor until they were needed. On 1/12/17 the QDDP documented she had talked to a witness (Transportation Driver) whom stated he did not see who was driving. He described the incident as a non-event with the exception of the mirror falling off stating the speed and driving of the van was no different than typical. On 1/16/17 the QDDP			

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	documented she had interviewed the four staff that had worked the morning of the incident. On 1/12/17 the QDDP documented in a communication memo to staff, Client #1 had left the house, prior to lunch, went to the transportation area, unlocked a van door, started the van, backed up taking the passenger side mirror off the van, then drove to the sidewalk area near Moon Valley, put the car in park and then came into the house. Client #1 was a 20 year old, with diagnoses including Moderate Intellectual Disability, Attention-deficit hyperactivity disorder, Impulse control, post traumatic seizures, hemiplegia and hemiparesis due to CVA in infancy affecting the right side and adjustment disorder. The client moved to the Moon Valley home on 6/1/16. Individual Support Plan (ISP) last updated on 11/7/16 documented the level of supervision as: staff would know Client #1's whereabouts in the home, on the campus and in the community. Staff would check on his/her well-being hourly and at natural occurring times to verify his/her location and safety. The document also noted the client did not have a history of elopement. Observation revealed the transportation center was located approximately 135 feet (straight route) across the parking lot from the street by the Moon Valley home of the Opportunity Village Campus. The center housed 2 offices and 5 stalls for facility vehicles. The Opportunity Village streets would only be open to staff and facility vehicles and not used for the general public. When interviewed on 1/24/17 at 8:35 a.m. Dispatcher A			

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	stated on 1/12/17 she looked out the window of the garage when she heard a noise which was the van mirror hitting the building. She had not seen who the driver was and shortly thereafter the Transit Driver (TD) radioed in the van mirror would need to be replaced. She called to Moon Valley to inquire about the person driving the van but they did not seem to know who had the van. She stated they had contacted Moon Valley earlier because the van keys had not been returned from an outing the previous evening. Dispatcher A stated the sign-out sheet had already been destroyed so would be unable to determine if the van had been checked out or not the previous evening. When interviewed on 1/24/17 at 9:40 a.m. the TD stated on 1/12/17 after returning from a trip to Mason City, he was parked in the facility parking lot. As he was cleaning his bus, the TD heard a noise and observed a facility van backing out of the garage, breaking off the mirror. He did not know who was driving the vehicle but radioed into the dispatcher the vehicle would need a new mirror. The person driving the vehicle did not stop to report the mirror was broken which the TD thought was strange. The van drove in front of his vehicle and he did not observe anything unusual about the driving of the vehicle. The TD did not visually follow the route of the van but he was contacted to do a pickup so left the parking lot shortly after he witnessed the incident with the van. The TD observed the van was parked on the street outside of Moon Valley when he left the parking lot. He could not recall anyone else being in the parking lot and there were a normal amount of staff cars in the parking area. He estimated the person possibly drove at least 200 feet to get to the			

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	location. When interviewed on 1/24/17 at 10:30 a.m. the Shift Supervisor (S'S) stated she worked in the morning on 1/12/17. She stated the previous day; Client #1 had packed up his/her belongings and moved them to the living room, claiming he/she would be moving to "Susan's house." The S'S did not know who Susan was. On 1/12/17, Client #1 refused to go to work stating he/she was waiting for Susan. Client #1 remained on the men's side lounge, sat in his/her recliner and listened to music on the Pad. She recalled seeing Client #1 between 9:30-10:00 a.m. when she left the area to complete other duties. The S'S could not recall the exact time, but heard information about Client #1 on the alkies talkie and left her office to find out what was going on. After talking with staff and Client #1 it was determined the client had driven the van to the street by Moon Valley. She recalled Client #1 had expressed interest in learning to drive but she did not know if he/she had ever driven. The S'S stated the client could walk to/from work independently and rode his/her bicycle on campus independently. She stated the client would call the worsted and Moon Valley notifying staff of his/her whereabouts when going/returning from the Day Center. The S'S stated Client #1 would know where the facility vehicles were stored but did not know if the client had ever gone to the buildings independently. When interviewed on 1/24/17 at 10:45 a.m. PSP AC stated she worked in the morning on 1/12/17. She recalled Client #1 had been focused on moving out of the facility the previous day, frequently stating he/she was moving to Susan's. The client had also called other cottages on 1/12/17 asking for keys and did not know if			

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	the client already had taken the set of keys. She had observed Client #1 around 9:30 a.m. in the men's side lounge playing on his/her Pad. PSP AC left the facility to complete an outing with another client and returned to the facility when she was notified about the incident. PSP AC stated Client #1 had limited movement with his/her right arm and leg but was ambulatory. She stated the client would have had to reach over with his/her left arm to shift the vehicle. She could not recall if the client had ever stated he/she wanted to drive a vehicle but usually requested for someone to take him/her places. When interviewed on 1/25/17 at 12:20 p.m. PSP D stated she worked the morning of 1/12/17 and gave Client #1 his/her medications. She left to go on an appointment at approximately 10:00 a.m. and Client #1 was in the dining room with his/her Pad. The client had been talking about moving to "Sue's house" and the day before talked about a black truck. PSP D stated Client #1 had expressed interest in the past in getting his/her driver's license. She stated the client could be on campus independently and generally would let staff know if he/she was leaving for work or would call Moon Valley and inform staff he/she would be coming home. PSP D stated she had never seen Client #1 over by the parking garages alone but had probably gone with staff to retrieve a vehicle for an outing or appointment. Client #1 generally just went to the main center to go to work or sometimes to get a pop. She stated if a vehicle was needed for an outing or appointment, she contacted transportation. They would assign a vehicle and while obtaining the keys would fill out a form to check it out. She stated she would complete a trip ticket after every outing.			

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	When interviewed on 1/25/17 at 12:30 p.m. PSP E stated Client #1 was home longer than usual on the morning of 1/12/17. For the past couple of weeks, the client had talked about moving and had moved his/her belongings to the living room. She last saw Client #1 in the kitchen area but could not recall what time she observed the client. PSP E was in the living room, when the phone rang and she had a conversation with the Dispatcher asking for the name of the person driving the van because they the van's mirror had been broken. PSP E stated she did not understand what was going on due to the locations of the other staff. As she talked on the phone, she looked out the window and observed Client #1 walking toward the house away from the van. PSP E walked outside, used her alkies talkie to notify the S'S and QDDP because she suspected Client #1 had driven the van. When she met Client #1 outside she could not get a clear answer to the questions she asked other than to say he/she would be getting his/her stuff. Client #1 did not have any keys in his/her hands and when she checked the van, it was turned off with no keys in the ignition. PSP E stated Client #1 had a coat, hat and boots on and recalled it had not recently snowed so the parking lot appeared clear. PSP E could not recall anyone else in the parking lot. She heard later the QDDP had retrieved the keys from Client #1. She stated Client #1 had limited mobility in his/her right arm and probably would have had to reach over with his/her left hand to shift the vehicle. PSP E stated when she drove facility vehicles she would immediately put the keys in her pocket upon return or the locked medication room. Since she had never been trained on a trip ticket she was unfamiliar with the process or when it was			

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	needed. When interviewed on 1/23/17 at 3:00 p.m. the Qualified Intellectual Disability Professional (QDDP) stated based on her interviews with staff, they were unaware Client #1 had left Moon Valley and went to the transportation center. She confirmed staff should know Client #1's whereabouts. **FACILITY RESPONSE:**			

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50.7 (4)	**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 (I,II,III): **50.7(4)** When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. **DESCRIPTION:** Based on observation, interviews and record review, the facility failed to report all incidents of client elopement, in accordance with state rule 50.7(4). This affected 1 of 1 sample client with an identified elopement. Finding follows: Record review on 1/23/17 revealed Client #1's General Event Report (GER) dated 1/12/17. According to the report, transportation staff had called Moon Valley to inquire about a staff driving the van, removing the passenger side mirror upon exit of the garage and then drove the van to the sidewalk near Moon Valley. Within minutes of the call, Client #1 walked toward Moon Valley and made a statement the van would be ready to put his/her belongings in. After being questioned by the Qualified Developmental Disability Professional (QDDP), Client #1 returned the vehicle keys to staff. Follow-up with staff indicated Personal Support Professional (PSP) A laid the keys on the desk in the dining room at approximately 7:35 p.m. the previous evening for the next staff to use for another scheduled outing. Since no one chose to leave campus, no outing occurred, and staff did not put the keys	II	$500.00	Upon Receipt

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	away. Client #1's Behavior Intervention Plan (BIP) was revised to add information specifically related to keeping vehicle keys in the hands of staff and not allowing Client #1 to carry them. Follow-up documentation from the Regional Director (RD) on 1/12/17 on the GER stated she would be discussing with the transportation office to see if they needed to discuss doing anything differently and also had the QDDP review with Client #1 it was not safe to drive a vehicle without a license. On 1/12/17 the QDDP documented she had talked to a witness (Transportation Driver) whom stated he did not see who was driving. On 1/12/17 the QDDP documented in a communication memo to staff, Client #1 had left the house, prior to lunch, went to the transportation area, unlocked a van door, started the van, backed up taking the passenger side mirror off the van, then drove to the sidewalk area near Moon Valley, put the car in park and then came into the house. Client #1 was a 20 year old, with diagnoses including Moderate Intellectual Disability, Attention-deficit hyperactivity disorder, Impulse control, post traumatic seizures, hemiplegia and hemiparesis due to CVA in infancy affecting the right side and adjustment disorder. The client moved to the Moon Valley home on 6/1/16. Individual Support Plan (ISP) last updated on 11/7/16 documented the level of supervision as: staff would know Client #1's whereabouts in the home, on the campus and in the community. Staff would check on his/her well-being hourly and at natural occurring times to verify his/her location and safety. The document also noted the client			

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	did not have a history of elopement. Observation revealed the transportation center was located approximately 135 feet (straight route) across the parking lot from the street by the Moon Valley home of the Opportunity Village Campus. The center housed 2 offices and 5 stalls for facility vehicles. The Opportunity Village streets would only be open to staff and facility vehicles and not used for the general public. Record review on 1/26/17 revealed Opportunity Village System for Reporting and Analyzing Incidents last revised on 10/15 documented "It is considered elopement when a resident who has impaired decision-making ability leaves the home without the knowledge or authorization of staff." When interviewed on 1/23/17 at 3:00 p.m. the Qualified Intellectual Disability Professional (QDDP) stated based on her interviews with staff, they were unaware Client #1 had left Moon Valley and went to the transportation center. She confirmed staff should know Client #1's whereabouts. At 3:10 p.m. the RD stated during a phone interview, she did not report the issue to Iowa Department of Inspections and Appeals because she understood the client could be anyplace on campus independently and did not feel the situation met the definition of elopement. **FACILITY RESPONSE :**			

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64.40	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and 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 provision 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).** **DESCRIPTION:**	II	$500.00	Upon Receipt
W368	**483.460(k)(1) DRUG ADMINISTRATION:** **The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.** Based on observation, interviews and record review the facility failed to ensure medications were administered according to physician orders. This affected 1 of 1 sample client (Client #1) involved in investigation 64796-I. Finding follows: Record review of Client #1's General Event Report (GER) dated 12/16/17 revealed the following information: on 12/15/16 the morning medication aide reported to Registered Nurse (RN) A she did not have 8:00 a.m. medications to administer to the client. Upon investigation, RN A determined the client had received			

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	extra medication on 12/10/16. RN A had found medication pouches for 8 a.m. and 8 p.m. on 12/10/16 and a.m. on 12/11/16 attached to each other indicating the client had received them all at the same time. The Health Services Supervisor (HSS) documented the client had been seen in the Emergency Room (ER) the afternoon of 12/10/16. The Medication Aide (MA) identified as the person possibly administering the medication was suspended from medication administration indefinitely pending investigation and re-training. Investigation summary completed by the Regional Director concluded although the facility could not 100% sure, it appeared medications were given incorrectly in the morning on December 10, 2016. A Plan of Correction documented spot checks on the medication aides would be completed, a Medication Aide meeting was completed on 12/12/16 to review administration procedures and retraining of the Medication Aide Curriculum would be completed. On 12/10/16 nursing documented staff reported Client #1 was unsteady on feet at approximately 10:30 a.m. so staff assisted the client back to bed. The nurse and staff assisted the client to the restroom due to continued unsteadiness but appeared alert and oriented. Due to the client remaining unsteady on his/her feet and requiring 1-2 staff assist, Client #1 went to the Emergency Room (ER). A CAT scan (computed tomography), lab work and urinalysis were all done with no abnormal values found. The Emergency Department documented from 12/10/16 diagnosed "Concussion, Fall." The client returned to the facility and staff reported the client was steadier on his/her feet but still required one staff for assistance. On 12/11/16 nursing assessment documented the client ambulated to			

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	the dining room for breakfast with stand by assistance from staff. Some unsteadiness was noted but much improved from previous day. Client #1 was a 52 year old, with diagnoses including Profound Mental Retardation, Chronic constipation, Hypoglycemia, Hyopia, Sleep Apnea, Speech impairment, Elevated Cholesterol, Congenital Anomaly Posterior segment, Stable Epilepsy and post-concussion syndrome (7/17/14). The client moved to the Moon Valley home on 12/6/94 and then to the Bedrock home in 2016. Observation on 1/26/17 revealed the client ambulated independently to the dining room. Client #1 made a choice of breakfast foods, was able to obtain appropriate place setting items and ate independently. Review of Client #1's Physician's Orders signed 9/29/16 revealed the client medication were to be administered as follows: Atorvastatin ordered for 10 milligrams (mg) daily Famotidine 20 mg daily Folic Acid 1 mg daily Lamotrigine 200 mg twice daily Metoprolol Tartrate 12.5 mg. twice daily Naproxen Sodium 220 mg twice daily On 1/26/17 at 11:45 a.m. RN verified Client #1 would have received the following doses of medications on 12/10/16 during the 8 a.m. medication administration: Atorvastatin 20 mg. Famotidine 40 mg. Folic Acid 2 mg. Lamotrigine 600 mg.			

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	Metoprolol Tartrate 37.5 mg. Naproxen Sodium 660 mg. When interviewed on 1/23/17 at 4:00 p.m. Personal Support Professional/Medication Aide (PSP/MA) A stated he was responsible to pass medications in Bedrock on 12/10/16 for the 8 a.m. medications. Client #1 did not want to get up that morning so he needed to take his medications to his/her bedroom around 9:00 a.m. After reviewing the Medication Administration Record (MAR) he took the storage box which contained the client's medications to his/her bedroom. PSP/MA A had not removed any medications from their packaging or the storage box prior to going to the bedroom. He recalled Client #1 did not want to sit up in bed to take his/her medications. PSP/MA A stated he did check the time on the packaging but failed to check the dates on the packets prior to administration which should have been done. He did not feel he gave the client medications from other days/time. Nursing staff had informed him they had found packets indicating more medications had been given on 12/10/16 but was never shown the packets. PSP/MA A stated the client generally had two to three packets of medications to be opened which contained approximately three pills each. He stated he generally ripped the packaging at the top and would try to involve Client #1 in the process according to his/her program. He stated he had been a medication aide for over two years and floated at times to other houses. PSP/MA A recalled it was a busy morning and he had to assist with other duties as well as medication administration.			

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	When interviewed on 1/26/17 at 8:30 a.m. PSP/MA B stated he had frequently passed medications at Bedrock. He stated staff should always check the date, and time on the packets. He acknowledged he did not check the date during some of the December medication passes involving Client #1. PSP/MA B stated he was used to giving Client #1 his/her medications so probably just saw they were the correct pills but did not check the dates. He stated if one of the Medication Aides got off track and administered the wrong date he probably administered the wrong date also. When interviewed on 1/26/17 at 9:40 a.m. the Pharmacist stated she had been made aware of the medication error involving Client #1. She stated due to the symptoms the client displayed on 12/10/16, in her opinion, could have been caused by the increased dosages of Lamotrigine. She stated this probably would not have shown up on a blood panel unless the hospital would have specifically been looking at this level. The Pharmacist stated the Lamotrigine would be absorbed rapidly with some immediate effect and another peak in 4-6 hours but generally would have been out of the client's system quickly. Due to the Lamotrigine being broken down in the liver, she did not feel there would be any lasting effect for Client #1. When interviewed on 1/26/17 at 10:45 a.m. PSP/MA C stated on 12/15/16 she noticed Client #1 did not have 8 a.m. medication packets. PSP/MA reported the situation to the nurse immediately. She stated if it was necessary to administer medications in a client's bedroom, the MA should complete their required checks in the medication room and only take the packets needed for the date/time. PSP/MA C stated she would underline the date and time			

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Administrator Date

Number FC 6447		Report Date February 9, 2017
Facility Name Opportunity Village		Survey Dates January 23-26, 2017
Facility Address 1200 North Ninth Street West		64797-I & Survey revisit
City Clear Lake, IA. 50428	HL	

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	and place a check by the client's name while checking the MAR as the procedure assisted her in ensuring she was giving the correct medication. When interviewed on 1/26/17 at 10:55 a.m. PSP D stated he worked with Client #1 on the morning of 12/10/16. The client enjoyed sleeping in on weekends but he continued to check on the him/her hourly. PSP D stated he took some clients on an outing after 9:00 a.m. PSP/MA A did not want him to leave until he had completed medication administration. While PSP D did not witness the staff give medications to Client #1 he was aware medications were given in the client's bedroom. When he returned from the outing, PSP D went to Client #1's room at approximately 10:15 a.m. to assist the client with his/her shower. When Client #1 started to sit up, he/she became very shaky so staff had him/her lay back on the bed. Client #1 tried to sit up again but remained shaky. PSP D notified the nursing staff who recommended he give the client some food. He brought cereal, toast and liquids to the bedroom and had to assist the client in holding the spoon and putting toast in his/her mouth. Client #1 appeared very thirsty but required assistance with the cup. When nursing came to assess the client, they assisted the client to the restroom. PSP D stated due to the client's condition, they decided to send Client #1 to the ER. PSP D stated he did not go with the client to the ER but did work with the client the next day. He stated Client #1 appeared normal and could not tell anything had been wrong the previous day. Record review of policy for Administration of Medications documented staff should verify the medication information on the container with the medication record for all the medications in that container (Person's name, drug name,			

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	dose and time to be give and any special instructions. When interviewed on 1/24/17 at 2:00 p.m. the HSS stated she was not directly involved in the investigation of the situation because she was not in her current position at the time. She stated she was present at a nurse's meeting when RN A brought the packets to the meeting. RN A showed the group there were five packets still attached. Each packet had a cut in it in order to remove the pills. One of the other nurses felt she knew who had completed the medication administration which matched who had been assigned on that day. The MAs in the following days should have seen they were not dispensing the correct dates of medications therefore did not following facility practice. Following the incident, nursing staff started completing spot checks with MAs and complete performance reviews every six months. She stated she also added checking for the correct date on the form as it was not a part of the past performance review. When interviewed on 1/24/17 RN A stated on December 15, 2016 PSP/MA C notified her she did not have any 8 a.m. medications for Client #1. She could not figure out why this would have happened so RN A pulled the box where medication packets were placed after administration. During the process, she identified December 10, 2016 had five packets still attached. These packets would have contained the 8 a.m. medications for December 10, 2016, 8 p.m. medications for December 10, 2016 and 8 a.m. medications for December 11, 2016. She was aware Client #1 had gone to the ER on December 10, 2016 but was not known the client possibly had too much medication. The ER had run blood levels but nothing showed up and they had thought the client had possibly hit his/her head. RN A stated staff would have administered the correct medications at the correct time for the			

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	remaining medication passes. She stated during medication administration the date, time and day of week were listed on the packets and staff should have recognized they had the wrong date on the packet. RN A showed the packets at the nurses' meeting following her discovery. Another nurse recognized how the packets had been opened (opened at the corner) because she had previously worked with PSP/MA A. She stated she could no longer find the packets to show how she came to her conclusion. RN A confirmed staff failed to follow the physician's orders on December 10, 2016. She also acknowledged staff failed to check the date on the packaging according to facility practice on that day and the following medication passes until December 15, 2016. **FACILITY RESPONSE:**			

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