STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G032	A. BUILDING _____ B. WING _____	R 01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY VILLAGE	1200 NORTH NINTH STREET WEST CLEAR LAKE, IA 50428

(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 The annual health survey revisit was completed 1/23/17 - 1/26/17. During the course of the revisit, a determination of an Immediate Jeopardy (IJ) was made due to concerns of client safety; specifically, a client left the home without staff knowledge, took a facility van from the transportation garage, and drove it to the home, all without staff knowledge. The facility was notified of the IJ at 3:10 p.m. on 1/23/17. A plan was provided, which included development of a facility policy to ensure the securing of vehicle keys and training of staff. The IJ was removed on 1/25/17 at 12:20 p.m. As a result of the IJ the Condition of Participation for Governing Body and Management (W102) would remain out of compliance. Standard-level deficiencies were recited at W104 and W249 due to the IJ. W460 was also recited due to lack of compliance. State Standard 50. 7 was also cited due to not reporting an elopement. The condition-level deficiency cited at W459 during the health survey was determined to be met. Additionally, standard-level deficiencies previously cited during the annual health survey at W247, W436, W460, W462, W475, and W488 were met.	{W 000}		
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by:	{W 102}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 102}	Continued From page 1 Based on observation, interviews and record review, the facility failed to maintain minimal compliance with the Condition of Participation (CoP) - Governing Body and Management. The governing body failed to consistently evaluate significant incidents and adequately provide operating direction to effectively ensure individuals were safe. These findings led to a determination of Immediate Jeopardy. Findings follow: Cross reference W104: Based on observations, interviews and record review, the facility failed to obtain sufficient information during the investigation and provide adequate direction to ensure measures were in place addressing van safety which led to the determination of Immediate Jeopardy. This potentially affected 28 of 28 clients (Client #1 - Client #28) residing at the facility.		W102 The ICF leadership team (QDDP's, RD, QL and others as appropriate) will meet weekly for six weeks to review GER's and any significant events. They will ensure appropriate follow up was completed. Additional Quality Leaders will review all ICF GER's for six weeks and notify the QDDP of any concerns they note. After the six weeks, the ICF Leadership team will evaluate the need to review all GERs and the frequency that they need to meet. Person Responsible: QDDP/RD Start Date: Immediately	
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to obtain sufficient information during the investigation and provide adequate direction to ensure measures were in place addressing van safety which led to the determination of Immediate Jeopardy (IJ). This potentially affected 28 of 28 clients (Client #1 - Client #28) residing at the facility. Finding follows:		W104 The ICF Leadership will obtain sufficient information during the investigation and provide adequate direction to ensure measures are in place to address safety	

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{W 104}	Continued From page 2 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 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	{W 104}	of individuals served. Root Cause Analysis will be used when appropriate to identify the underlying issues. Two management people will review all major incidents to ensure a thorough investigation has been completed. Person responsible: QDDP/RD Start Date: Immediately	

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{W 104}	Continued From page 3 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 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	{W 104}		

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{W 104}	Continued From page 4 vehicles and not used for the general public. When interviewed on 1/23/17 at 5:00 p.m. Personal Support Professional (PSP) A stated he had taken clients out on an outing on 1/11/17. When he returned and prior to leaving at approximately 8:00 p.m. he laid the keys to a facility vehicle on the desk by the phone because staff were going to be using the vehicle after he left. He stated they normally locked the keys in the medication room/locked office or returned the vehicle to the garage and put the keys in the office of the garage. He stated he was trying to help out a co-worker because they were going to be leaving on another outing but apparently the outing never happened. When interviewed on 1/23/17 at 6:20 p.m. PSP B stated he drove the transit van on 1/11/17 and returned to the facility around 6:30 p.m. Upon his return, he handed the keys to the van to PSP A. PSP B stated he should have returned the van to the garage and locked the keys up. He did not complete a trip ticket because he thought trip tickets were used for long distance trips. When interviewed on 1/24/17 at 8:35 a.m. Dispatcher A 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	{W 104}		

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{W 104}	Continued From page 5 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 location. When interviewed on 1/24/17 at 10:30 a.m. the Shift Supervisor (SS) 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 SS 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 IPad. She recalled seeing Client #1	{W 104}		

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{W 104}	Continued From page 6 between 9:30-10:00 a.m. when she left the area to complete other duties. The SS could not recall the exact time, but heard information about Client #1 on the walkie 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 SS stated the client could walk to/from work independently and rode his/her bicycle on campus independently. She stated the client would call the worksite and Moon Valley notifying staff of his/her whereabouts when going/returning from the Day Center. The SS 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 C 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 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 IPad. PSP C left the facility to complete an outing with another client and returned to the facility when she was notified about the incident. PSP C 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.	{W 104}		

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{W 104}	Continued From page 7 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 IPad. 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. 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	{W 104}		

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{W 104}	Continued From page 8 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 walkie talkie to notify the SS 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 needed. Record review on 1/24/17 revealed a revision to Client #1's teaching methods in his/her Behavior Intervention Plan. The plan identified the client's desire to be "In Charge," documenting the client wanted to hold a position of authority and at times would ask to do tasks that could be perceived as staff tasks. Staff should not allow Client #1 to carry the vehicle keys or walkie talkie at any time. Staff should redirect the client to a preferred activity when he/she sounded "bossy" towards other housemates. When interviewed on 1/23/17 at 3:00 p.m. QDDP A stated there was no investigation completed	{W 104}		

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{W 104}	Continued From page 9 regarding the incident of Client #1 driving the van due to no injuries. She talked to the TD whom witnessed the vehicle leave the garage and indicated there was nothing unusual about the person driving the vehicle. She clarified the van was not parked on the sidewalk but on the street next to Moon Valley. QDDP A stated she did retrain staff about not leaving keys out but no written policy/procedure existed. She stated Client #1 could walk around campus independently but staff should know his/her whereabouts. Additional interview on 1/25/17 at 12:00 p.m. QDDP A stated staff did not consistently follow facility practice regarding securing keys and completing trip tickets. She confirmed the facility lacked a written policy regarding checking out facility vehicles and securing keys when not in use and policies were developed as a result of the Immediate Jeopardy. 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. While the facility completed an investigation and provided some follow-up, no review of facility policies had been completed as evidenced by a lack of written procedures for securing facility vehicle keys. Facility staff did not consistently implement the completion of documentation when responsible for a facility vehicle. The investigation failed to review the process and provide follow-up to inconsistent implementation. Also, while Client #1's BIP was revised as a result of the incident, the supervision level had not been	{W 104}		

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{W 104}	Continued From page 10 reviewed and revised in the ISP until the IJ had been determined demonstrating a lack of review during the investigative process. These findings led to a determination of IJ due to concerns of client safety; specifically, the client leaving the home without staff knowledge, taking a facility van from the transportation garage, and drove it to the home, all without staff knowledge. The facility was notified of the IJ at 3:10 p.m. on 1/23/17. A plan was provided, which included development of a facility policy to ensure the securing of vehicle keys and training of staff. The IJ was removed on 1/25/17 at 12:20 p.m.	{W 104}		
{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. This STANDARD is not met as evidenced by: 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 report, transportation staff had called Moon Valley to inquire about a staff driving		W249 All staff will be reminded of each client's level of supervision and will be shown where they can quickly find this information on Therap. All staff will sign off stating that they have been retrained and that they know where to find this information. This information will be reviewed quarterly at house meetings. The QDDP's will include this in meeting notes which will be shared with staff via scomms. This information will continue to be covered with new staff orientation. Person responsible: QDDP Start date: Immediately.	

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{W 249}	Continued From page 11 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 documented she had interviewed the four	{W 249}		

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OPPORTUNITY VILLAGE	1200 NORTH NINTH STREET WEST CLEAR LAKE, IA 50428

(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 249}	Continued From page 12 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 stated on 1/12/17 she looked out the window of the garage when she heard a noise	{W 249}		

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{W 249}	Continued From page 13 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 location. When interviewed on 1/24/17 at 10:30 a.m. the	{W 249}		

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{W 249}	Continued From page 14 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 the client already had taken the set of keys. She had observed Client #1 around 9:30 a.m. in the men's	{W 249}		

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{W 249}	Continued From page 15 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. When interviewed on 1/25/17 at 12:30 p.m. PSP E stated Client #1 was home longer than usual on	{W 249}		

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{W 249}	Continued From page 16 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 needed. When interviewed on 1/23/17 at 3:00 p.m. the	{W 249}		

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{W 249}	Continued From page 17 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.	{W 249}		
{W 350}	483.460(e)(3) DENTAL SERVICES The facility must provide education and training in the maintenance of oral health. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to provide education/training programs addressing oral hygiene needs for 2 sample clients (Clients #6, and #7) identified at the annual survey. At the time of the survey revisit, the programs had not been implemented. Findings follow: 1. Record review on 1/26/17 revealed Client #6's dental examination report completed on 10/26/16. The report indicated oral hygiene for the client was poor. The report also added the client diagnosis of chronic adult periodontitis. Client #6's record failed to contain any training program or procedure addressing oral hygiene needs. 2. Client #7's dental examination report completed on 10/26/16 documented the client's oral hygiene as poor with severe gingivitis. The record failed to contain a program/procedure addressing Client #7's oral hygiene concerns. When interviewed on 1/23/17 at 2:20 p.m. QDDP B confirmed programming had not been developed as a result of the exams for Client #6	{W 350}		

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C 147	50.7(4) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(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. This REQUIREMENT is not met as evidenced by: 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 away.	C 147	C147 The Regional Director will train the QDDP's and other members of management on 50.7(4). The QDDP's will then ensure all of their staff are retrained on the definition of elopement and reminded of the requirement monthly. If an individual does leave their home without the knowledge or authorization of staff, it will be reported to DIA within 24 hours or the next business day. Person responsible: QDDP/RD Start date: Immediately Jane Wilson, RD 2/16/17	

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

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{W 350}	Continued From page 18 or #7. She stated the interdisciplinary team had discussed the issue at Client #6's recent annual review and would develop a program. QDDP B further stated the team had discussed Client #7's issues that day and would be developing a program.	W350	Opportunity Village will provide education and training in the maintenance of oral health to individuals who need this support. The QDDP's will submit a report to the Regional Director which will include: each individual, when there last dental was, what the recommendations were and what the team is doing to address these concerns. The RD and Q will review this report to ensure each individual has a procedure or program if it is recommended or needed based on last dental. The nurse will communicate directly via scomm or email to the QDDP after each dental appointment, and the team will address any concerns as needed. The nurse will ensure the dental form has sufficient information for the team to address any concerns. The QDDP will communicate with the nurses on what information is needed so they can determine what kind of program/procedure may be needed.	

Person Responsible: QDDP/Nurse Start date: Immediately

DEPARTMENT OF INSPECTIONS AND APPEALS

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C 147	Continued From page 1 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 Mooh 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	C 147		

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C 147	Continued From page 2 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.	C 147		