Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6580	Fine amount reduced by 35% to $1,625.00 on October 2, 2017 pursuant to Iowa Code Section 135C.43A	Date: July 17, 2017
Facility Name: Oak Ridge		Survey Dates: June 22-26, 2017
Facility Address/City/State/Zip 2007 Ravens Court Sioux City, Iowa 51104		
	DS	

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, 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 facility. This rule is intended to implement Iowa Code section 135C.2 (3).	I	$2500	Upon Receipt
W158	**483.430 Facility Staffing** The facility must ensure that specific facility staff requirements are met.			
W159	**483.430(a) QIDP** Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.			
W193	**483.430 Staff Training Program.** Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. **DESCRIPTION:**			

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	Based on interviews and record review, the facility QIDP failed to coordinate and monitor the treatment plan for Client #1 and failed to ensure staff were adequately trained to correctly and consistently implement behavior strategy plans/programs to manage inappropriate client behavior. Client #1 eloped from the facility and walked 3.2 miles, mostly on a 4 lane highway with speeds from 25-50 miles per hour and near a train track which placed this client in an unsafe situation. The police returned the client to the facility and Client #1 left again, however, the staff followed the resident. Findings follow: Review of the facility investigation revealed Client #1 left the home to use the safe route on 6/17/17. Staff A called the surrounding homes to have staff from other homes assist to "watch" for the client on the walk. At 8:30 p.m. Staff A went out to check on Client #1 and saw the client walking back down the street toward home. Staff A went back inside to assist another person served. When staff noticed the client had not returned after 20 minutes he went looking for the client. He received a call from the Administrator on call who knew the client was on Floyd Boulevard walking. He left to follow the client. Client #1 refused to get in a vehicle with staff. The police were informed			

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	after 2 hours and he/she returned home with police. Review of Client #1's Admission Record revealed a 28 year-old with the following diagnose: other specified intracranial injury without loss of consciousness, attention deficit hyperactivity disorder, unspecified mood (affective) disorder borderline personality disorder and mild intellectual disabilities. Client #1 was admitted to Opportunities Unlimited on 2/4/16. Review of Sioux City Police Department records revealed a report dated 6/17/17 at 8:55 p.m. The report narrative indicated police took the client home after staff followed (him/her). The report indicated the client stated (he/she) would just leave as soon as the officer left. The elopement documentation noted the client left again, however, staff followed him/her the entire time. Upon return at 2:15 a.m. on 6/18/17. the head to toe assessment documented only superficial scratches on the client's wrist which the client admitted were self-inflicted. Observation of the area on 6/26/17 at 10:30 a.m.: On 6/17/17 Client #1 walked in 25, 30, 40 and 50 mile per hour (mph) zones. The streets were mostly four lane streets. On Floyd Boulevard train			

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	tracks were adjacent to the street, approximately 20 feet from the street. The distance from the client's home to the area staff reported police picked him/her up was 3.2 miles. The terrain was flat with the walk passing a salvage yard and an over pass above a small part of a river. Review of Client #1's Program Procedural Format (updated on 6/12/17) revealed the client utilized walking as a coping skill. The program incorporated the use of walking a safe route- including Glen Oaks Boulevard, Outer Belt Drive or North High School track. The program also directed staff "Due to (his/her) escalated state staff will follow (him/her) on (his/her) safe route. If (he/she) detours from (his/her) safe route, staff will continue to follow, notify Residential On-Call who will then provide further instruction and support. If (Client #1) places (himself/herself) in immediate danger, due to the route (he/she) has taken, staff will contact 911." An interview with Staff A on 6/22/17 at 11:00 a.m. revealed he worked in the Oak Ridge home on the p.m. shift 6/17/17. Client #1 became upset when nursing showed up a little early for medications. Staff A talked with him/her and Client #1 wanted to walk the safe route. Staff A called the other Opportunity Unlimited homes on the boulevard for them to watch the client walk. At			

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	about 8:30 p.m. he noted the client approaching the house and he went to assist another person. Approximately 20 minutes later he noted the client did not return. He searched the area and returned to house to make calls and continue searching when he received a call from the on call Administrator. He stated he worked Oak Ridge AM and PM shifts several times in the last several months. He stated he was not aware of any recent change with Client #1's programming. He stated if changes occur there was an email telling the staff of the change. The last he knew staff were to call the other homes to assist with watching him/her. When interviewed on the phone on 6/22/17 at 1:50 p.m. Staff B confirmed she worked Oak Ridge on the evening shift of 6/17/17. She stated she was a Tri State contracted employee. She denied any training regarding Client #1's programming. Interview with the Administrator on call on 6/22/17 at 11:50 a.m. revealed she received a call from her husband at 8:15 p.m. on 6/17/17. He noticed Client #1 walking on Floyd Boulevard. The Administrator on call then called the house and talked to Staff A. Staff A followed him/her and later the Administrator on call assisted with following Client #1. She stated she received the			

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	call at 8:15 p.m. and from where the client was she probably was without staff supervision for 25 minutes. She confirmed Client #1 left a second time and third time however staff followed the client. The client walked north of Leeds close to D 12. The police returned the client and the Administrator on call at approximately 2:15 a.m. on 6/18/17. She completed the head to toe assessment at that time with only 3 superficial scratches noted. The client admitted these were self- inflicted. She stated the weather was mild and the client wore longer shorts and a hooded sweatshirt while walking with heavy shoes. She stated staff are supposed to have eyes on Client #1 whenever he/she walked the safe route. She did not think it "specified" when the staff were to follow him/her. She added, "I don't remember it saying to follow (him/her)." When interviewed on 6/22/17 at 1:10 p.m. Staff C (who currently worked with Client #1 in the home) stated her understanding was the client could walk to the other Opportunity Unlimited homes alone and return. The staff were to call the other homes to have the other staff watch the client. She denied being trained on the program/procedure. When interviewed on 6/22/17 at 1:15 p.m. Staff D (who currently worked with Client #1 in the home)			

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	stated she was a Tri state contract employee. She usually worked the home three to four days a week. She denied receiving training regarding Client #1's program. She stated the other staff working shows her or tells her of changes and what to do. Interview with Staff E on 6/22/17 at 2:45 p.m. revealed Staff E worked the home only several times in the last several months. Staff E stated the staff call other homes to watch Client #1 walk on the boulevard. She added "no staff" need to be with (him/her). When interviewed on the phone on 6/22/17 at 1:50 p.m. Staff B confirmed she worked Oak Ridge on the evening shift of 6/17/17. She stated she was a Tri State contracted employee. She denied any training regarding Client #1's programming. When interviewed on 6/22/17 at 10:50 a.m. Qualified Intellectual Disability Professional (QIDP) A explained according to the Program Procedural Format staff were to follow Client #1 while on a walk-even if he/she was in a good mood. She explained this was a coping skill and the purpose of it was for her to cope when he/she was upset. The QIDP stated the previous QIDP changed the program on 6/12/17 and failed to			

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	train any of the staff. She reiterated staff are supposed to follow Client #1 because the client put him/herself in "harms way." When interviewed on 6/22/17 at 2:30 p.m. the Chief Executive Officer acknowledged the same client eloped on 4/3/17. She confirmed the program changes from the previous elopement were not completed timely. She stated they realized this on 6/19/17. She explained the QIDP's changed roles and a QIDP would be training the changes made in the program on 6/12/17. The CEO acknowledged staff should follow Client #1 on the safe route. **FACILITY RESPONSE:**			

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