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

PRINTED: 07/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G126	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2017
NAME OF PROVIDER OR SUPPLIER OAK RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2007 RAVENS COURT SIOUX CITY, IA 51104		
(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 Investigation of #68888-I, resulted in a determination of Immediate Jeopardy (IJ), due to concerns with client safety. The facility was notified of the IJ on 6/22/17 at approximately 2:30 p.m. The facility responded with corrective actions to address the identified problems and system practices. The IJ was removed on 6/23/17. The facility was found to be out of compliance with the following Conditions of Participation: Facility Staffing. Deficiencies were cited at W159 and W193.	W 000	See attached 		
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain minimal compliance with Condition of Participation (CoP) Facility Staffing. The facility failed to implement a staff training system to adequately manage client behavioral needs. A finding of Immediate Jeopardy (IJ) to clients' health and safety was declared 6/22/17, which was removed on 6/23/17. Cross reference W159: Based on interviews and record reviews, Qualified Intellectual Disability Professional (QIDP) failed to update and revise program plans as needed to ensure client safety. Cross reference W193: Based on interviews and	W 158			

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 158	Continued From page 1 record reviews, the facility failed to ensure staff consistently demonstrate the ability to manage client needs in order to maintain client safety and well-being.	W 158			
W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, Qualified Intellectual Disability Professional (QIDP) failed to update and revise program plans as needed to ensure client safety. This affected 1 of 1 client involved in the investigation of #68888-1 (Client #1). Finding follows: 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" 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 after 2 hours and he/she returned home with police. Review of Client #1's Program Procedural Format (updated on 6/12/17) revealed the client utilized walking as a coping skill. The program	W 159			

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W 159	Continued From page 2 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." 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 him/her to cope when he/she was upset. The QIDP stated the previous QIDP changed the program on 6/12/17 and failed to train any of the staff. She reiterated staff were supposed to follow Client #1 because the client was putting themselves 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. 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.	W 159			
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and	W 193			

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W 193	<p>Continued From page 3</p> <p>techniques necessary to administer interventions to manage the inappropriate behavior of clients.</p> <p>This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff were adequately trained to correctly and consistently implement behavior strategy plans/programs to manage inappropriate client behavior. This affected 1 of 1 clients (Client #1) involved in investigation 68888-I. Findings follow:</p> <p>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 after 2 hours and he/she returned home with police.</p> <p>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.</p> <p>Review of Sioux City Police Department records</p>	W 193			

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W 193	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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."</p>	W 193		

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W 193	<p>Continued From page 5</p> <p>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 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.</p> <p>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.</p> <p>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 call at 8:15 p.m. and from where the client was</p>	W 193		

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W 193	<p>Continued From page 6</p> <p>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)."</p> <p>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.</p> <p>When interviewed on 6/22/17 at 1:15 p.m. Staff D (who currently worked with Client #1 in the home) 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.</p> <p>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</p>	W 193			

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W 193	<p>Continued From page 7</p> <p>the staff call other homes to watch Client #1 walk on the boulevard. She added "no staff" need to be with (him/her).</p> <p>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.</p> <p>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 train any of the staff. She reiterated staff are supposed to follow Client #1 because the client put him/herself in "harms way."</p> <p>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.</p>	W 193			

Plan of Correction
Oak Ridge Home
Investigation #: 68888-1
7/25/2017

OK
8/14/17

✓
8/16/17

W158 483.430 Facility Staffing

The facility failed to ensure that specific training requirements were met.

1. Upon being placed on immediate jeopardy mandatory meetings with all Opportunities Unlimited staff were reviewed campus wide for all maladaptive behavioral programming, to review policies and procedures on safety as well as accountability with persons served. All staff signed into the meetings and everyone received each specific program for each person served to physically read and review with the QIDP's teaching and taking any questions from staff. Each staff member then signed and dated that they attended and understand their role within the company to keep our person served safe at all times.

Status of Completion: Completed

Persons Responsible: QIDP's, Training Coordinator, and Program Director

2. Upon being placed on immediate jeopardy Opportunities Unlimited devised interim training for temporary agency staff. One on one training of maladaptive behavioral programming was completed with all temporary staff currently assigned to the agency. Further training will now be completed with temporary agency staff through an initial orientation and then they will be responsible for reviewing formal programming in the home they are assigned to prior to each of their shifts.

Status of Completion: 8/4/17

Persons Responsible: QIDP's

W159 483.430(a) QIDP

The facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by a qualified intellectual disability professional.

1. Due to lack of follow through on original plan of correction submitted to the Department of Inspections and Appeals regarding a previous elopement of same persons served and failure to follow through with staff training regarding changes in formal programming for person served, the QIDP that was overseeing this home was put on suspension as of 6/22/17 pending results of this investigation. She was then terminated from employment on 6/28/17.

Status of Completion: Completed

Persons Responsible: Program Director and Human Resources Coordinator

2. Upon learning of immediate jeopardy, facility implemented one on one service for person served. Formal programming was reviewed and interim QIDP modified previous formal programming regarding remaining in supervised areas and developed and added new formal programming specific to one on one intervention and elopement activity.

Status of Completion: Completed

Persons Responsible: QIDP and Program Director

3. Program Director will be reviewing and ensuring that the QIDP care plans are in place and training is completed fully in compliance with all guidelines. This will be completed with quality assurance checks on a monthly basis. In addition, the Program Director will complete quality assurance checks on the active treatment observation forms which are completed by the QIDP's and the Training Coordinator on a weekly basis to observe staff for active treatment and program follow through. The active treatment observation forms are aimed to monitor each staff at least quarterly.

Status of Completion: On Going

Person Responsible: Program Director

W193 483.403(e)(3) Staff Training Program

The facility failed to ensure that staff was able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

1. Communication logs will be developed and placed in each home. This will include a printed copy of all formal programming for each person served within that home. There will be a program sign off sheet for each person served that staff will be responsible for checking prior to each shift and ensuring that they have reviewed for any changes and signing accordingly. This practice will be taught to new employees in their orientation packets and again in a training class taught called "Intro to Programming". Any time new programming is implemented or formal programming is amended in any way a new sign off sheet and a copy of the new programming will be placed in the communication log for staff to review and sign off on.

Status of Completion: By 8/4/17 and On Going Thereafter

Persons Responsible: QIDP's and Training Coordinator

2. The QIDP's and the Training Coordinator will complete active observation on a weekly basis to observe staff for active treatment and program follow through. A specific form for this is to be completed with each observation. The active treatment observation forms are aimed to monitor each staff at least quarterly and will be placed in their personnel files.

Status of Completion: On Going

Persons Responsible: QIDP's and Training Coordinator

3. A new orientation packet has been put together for basic training to temporary agency staff. Included in the packet is review of the communication log practice and they will be responsible for signing off on formal programming for persons served upon their first shift and reviewing it thereafter for each shift worked. This sign off sheet will be located in the temporary staff agency documentation book.

Status of Completion: By 8/4/17 and On Going Thereafter

Persons Responsible: QIDP's and Training Coordinator

