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 _____	C 07/06/2017

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

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W 000	INITIAL COMMENTS Investigations of #68069-I, #68492-I and #68495-I resulted in a determination of Immediate Jeopardy (IJ), due to concerns with client safety. The facility was notified of the IJ on 6/14/17 at approximately 11:20 a.m. The facility responded with corrective actions to address the identified problems and system practices. The IJ was removed on 6/15/17. The facility was found to be out of compliance with the following Conditions of Participation: Governing Body and Management. A deficiency was cited at W104. Facility Staffing. Deficiencies were cited at W158, W159 and W191. Additional investigationsInvestigations were completed with the following results: The inestigation of #68498-I resulted in no deficiencies cited. The investigation of #67958-I resulted in a deficiency cited at W368. The investigation of #68559-C resulted in deficiencies cited at W365 and W368.	W 000	POC 7/20/17 **W102** – The Governing Body and Management will adequately ensure staff training to promote client safety, dignity and wellbeing. They will also adequately address repeated elopement attempts by a client. Cross reference 104, 158, 159, and 191.	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	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 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) Governing Body and Management. The governing body failed to adequately ensure staff training to promote client safety, dignity and well being. The facility also failed to adequately address repeated elopement attempts by a client that potentially could have resulted in harm to the client. A finding of Immediate Jeopardy (IJ) to clients' health and safety was declared on 6/14/17. The facility provided a plan to ensure the safety of clients, which included increased supervision of clients, staff training, and increased leadership presence. Immediate Jeopardy was removed 6/15/17. Findings follow: Cross reference W104: Based on observations, interviews and record reviews, the facility failed to provide adequate direction and oversight to ensure staff training in the areas of client safety, dignity and well being. Furthermore, the facility failed to provide adequate operating direction to ensure appropriate supports and resources available to safeguard clients. Cross reference: W158: Based on interviews and record reviews, the facility failed to maintain minimal compliance with Condition of Participation (CoP) Facilty Staffing. The facility failed to implement a staff training system to adequately manage client behavioral needs. Cross reference W159: Based on interviews and	W 102		

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W 102	Continued From page 2 record reviews, Qualified Intellectual Disability Professional (QIDP) failed to adequately monitor individual program plans as necessary to ensure client safety. Cross reference W191: Based on interviews and record reviews, the facilty failed to ensure staff consistently demonstrated the ability to manage client behavioral needs to maintain client safety, dignity and well-being.	W 102		
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 observations, interviews and record reviews, the facility failed to provide adequate direction and oversight to ensure staff training in the areas of client safety, dignity and well being. Furthermore, the facility failed to provide adequate operating direction to ensure appropriate supports and resources available to safeguard clients. This affected 3 of 3 clients involved in the investigations of #68492-I (Client #1), #68495-I (Client #2) and #68069-I (Client #3). Findings follow: 1. Record review and interviews from 6/12/17 to 6/15/17 revealed Client #1 left the home without staff knowledge or approval on 2/16/17, 2/19/17, 4/09/17, 5/24/17, 5/31/17 and 6/08/17. Incidents occurring on 5/24/17, 5/31/17 and 6/08/17 were reviewed in the investigation of #68492-I. Staff	W 104	**W104** – One Vision will provide adequate direction and oversight to ensure staff training I the areas of client safety, dignity and wellbeing. They will also provide adequate operating direction to ensure appropriate supports and resources available to safeguard clients. Cross reference 159, 191	

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W 104	Continued From page 3 failed to provide appropriate supervision and/or adequate communication with one another during the incident on 5/24/17. Client #1 continued to have incidents of elopement with a supervision level of 10 minute checks. The level of supervision was increased for brief periods of time and then returned to 10 minute checks, despite the lack of success with that level of supervision. See W159 and W191 for further information. 2. Record review and interviews on 6/12/17 to 6/15/17 revealed Client #2 walked away from the yard of the home and went to a neighboring home on the evening of 5/13/17 without staff knowledge. Client #2 had been swinging in the front yard of his/her home (Bedrock home). A staff person (Licensed Practical Nurse A) at the neighboring group home returned Client #2 to his/her home. According to Client #2's individual program plan (IPP) Client #2 required an assigned staff person outside with him/her when the client walked away. This level of supervision was put into place after Client #2 walked to the same neighboring group home on 5/03/17. See W191 for further information. 3. Review of the facility investigation on 6/13/17 revealed Personal Support Professional (PSP) A removed and changed Client #3's clothing as the client objected and resisted on the evening of 4/20/17. The facilty investigated the incident and provided further training to PSP A, in addition to revising Client #3's behavior plan. The facility determined PSP A made an "inappropriate decision" to assist Client #3 with changing his/her clothing as the client said "No", but concluded the	W 104		

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W 104	Continued From page 4 incident was not abusive. Client #3 program plan directed staff not to force the client to do things. See W191 for further information.	W 104		
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) Facilty Staffing. The facility failed to implement a staff training system to adequately manage client behavioral needs. A finding of Immediate Jeopardy (IJ) clients' health and safety was declared on 6/14/17, which was removed on 6/15/7/17. Cross reference W159: Based on interviews and record reviews, Qualified Intellectual Disability Professional (QIDP) failed to adequately monitor individual program plans as necessary to ensure client safety. Cross reference W191: Based on interviews and record reviews, the facilty failed to ensure staff consistently demonstrated the ability to manage client behavioral needs to maintain client safety, dignity 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 interviews and record reviews,	W 159		

W158 – One Vision will implement a staff training system to adequately manage client behavioral needs.

Cross reference 159, 191.

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W 159	Continued From page 5 Qualified Intellectual Disability Professional (QIDP) failed to adequately monitor individual program plans as necessary to ensure client safety. This affected 1 of 1 client involved in the investigation of #68492-I (Client #1). Finding follows: Review of agency investigations revealed Client #1 left on a bicycle without staff approval on 5/24/17, 5/31/17 and 6/08/17. Client #1 had a program plan to let staff know where he/she was going. Client #1 required staff supervision when riding his/her bicycle, due to leaving the agency campus in the past on a bike without staff knowledge and needing prompting regarding safety. At the time of the three incidents, Client #1 required 10 minute supervision checks. Client #1 had access to bicycles kept at his/her group home and at the other group homes on the campus grounds. Client #1's most recent Comprehensive Functional Assessment (CFA), dated October 2016, included "Transportation/Walking". According to this section of the CFA, Client #1 did not always use crosswalks, did not look all directions before crossing a street, and was not safe in parking lots. The CFA noted, "Continues to improve in this area, especially when riding bike." Client #1 was 29 years old with a diagnosis including Moderate Intellectual Disability, Down Syndrome and Attention Deficit-Hyperactivity Disorder. Client #1 ambulated independently and was verbal. Client #1 had prior incidents of leaving the facility without staff knowledge/approval as follows: a. On 2/16/17: Staff discovered Client #1 missing	W 159	**W159 –** The ICF Leadership team (QDDP's, RD, Quality Leader and Team Coordinator) will adequately monitor individual program plans as necessary to ensure client safety by: 1) Review all high GER's and plan of action at their twice a month team meetings.	

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W 159	Continued From page 6 at 11:15 p.m. Client #1 returned within five minutes of staff noticing he/she was gone. Client #1 had gone to the main building on campus to buy soda, a distance of about one block or less. Overnight staff were retrained to remind them to complete 10 minute checks if Client #1 was still awake and outside of his/her bedroom. 2/19/17: Staff discovered Client #1 and his/her bike missing at approximately 12:45 p.m. Staff began searching and located Client #1 at a public park about two blocks away from the facility campus and 4-5 blocks from Client #1's home. The facility added a door alarm to the home exit doors after this incident. Checks were increased to 5 minutes for a short time and then returned to 10 minute checks. 4/09/17: Staff discovered Client #1 missing at approximately 12:30 p.m. Staff searched and found Client #1 on campus about 10 minutes later. It was discovered that Client #1 had gone out of a window, so window alarms were added. Checks were increased to five minutes for a short time and then returned to 10 minute checks. A summary of the three recent incidents is as follows: 1) On 5/24/17 at approximately 9:25 p.m. Client #1 left the house on a bicycle without staff knowledge. Staff located Client #1 within approximately five minutes, by the main campus building, a distance of about one city block. Client #1 had no injuries and was dressed appropriately for the weather. Client #1 returned to the group home with staff. At the time of the incident, Client #1's assigned staff was Personal Support Professional (PSP) D. She was responsible for	W 159	2) The QDDP will report to the ICF Leadership team any reportable incident that happened to an individual, twice in the last six months, and the team will review the changes that have been made, and discuss if the changes were sufficient or if more needs to be done, to hopefully prevent any more incidents of this nature. 3) The QDDP will continue to meet with their team after a high GER incident has occurred and determine the best course of action. Person responsible: QDDP Start date: Immediately	

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W 159	Continued From page 7 checking on Client #1 every 10 minutes. When interviewed on 6/13/17 at 2:20 p.m. PSP A stated he left the house around 9:20 p.m. to take something back to the nurse's office at the main building. PSP A saw Client #1 standing in the main entryway of the home, between the outer exit door and the inner exit door. PSP A said he told Client #1 to stay there and he then got on a bike and went to the main building. PSP A said he looked behind him to make sure Client #1 did not follow. PSP A returned to the facility around 9:25 p.m. and noticed Client #1 no longer stood in the entryway. PSP A asked other staff about Client #1's whereabouts and they did not know. PSP A got on a bike to go look for Client #1 and found him/her by the recycling door of the main building. PSP A estimated he found Client #1 by 9:30 p.m. PSP A said PSP D was Client #1's assigned staff at the time. He said he realized looking back on it that he should not have left Client #1 standing between the two exit doors. The inner exit door had a voice alarm when someone went in or out that announced "Front Door," but the outer exit door had no alarm. PSP A did not tell any other staff that Client #1 stood in the entry area when he left the building. When interviewed on 6/14/17 at 2:20 p.m. PSP D confirmed she was the staff person assigned to Client #1 on the evening of 5/24/17. She wore a bracelet to indicate she had responsibility for Client #1 and she signed off on a supervision sheet every 10 minutes that she had checked on Client #1. PSP D thought PSP A was going to take Client #1 out for a milkshake, which was an evening routine. PSP D charted on the supervision sheet at 9:20 p.m. "going to get shake." At 9:30 p.m. she documented "missing	W 159		

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W 159	Continued From page 8 at 9:30." At 9:40 p.m. she documented Client #1 had been found and was in his/her room. When asked on 6/14/17 if she actually saw Client #1 at 9:20 p.m. or if she thought he had already left for the milkshake, PSP D said she did not recall. She said when she heard Client #1 was missing; she thought he had left with PSP A to get a milkshake. PSP D acknowledged PSP A had not told her that he was leaving with Client #1 and had not asked for Client #1's responsibility bracelet, but she still assumed they had left. She said staff should exchange the bracelet when another staff took responsibility for Client #1, but it did not always happen. PSP D said she did not know that Client #1 had been standing in the entryway between the two exit doors and PSP A had left on an errand. When interviewed on 6/14/17 at 9:20 a.m. the Regional Director and Qualified Intellectual Disability Professional (QIDP) A, who was the QIDP at the home at the time of the incident confirmed PSP D should have clearly documented at 9:20 p.m. whether or not she saw Client #1. If another staff person took Client #1 on an outing, the responsibility bracelet should have been passed to that staff person. QIDP A said she did not believe staff always exchanged the bracelet like they should. They also agreed PSP A should not have left Client #1 standing in the entryway between the exit doors as the staff person rode off on a bike. The outer exit door does not alarm when opened. PSP A should have taken Client #1 inside, or taken the client with him, or alerted other staff of Client #1's location. QIDP A noted Client #1 sometimes liked to stand in the entryway between the two exit doors and had not eloped from there before.	W 159		

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W 159	Continued From page 9 After the elopement incident on 5/24/17, the facility increased Client #1's level of supervision to five minute checks until the next day. Client #1 then went back to 10 minute checks. The facility also trained staff not to leave Client #1 in the entryway between the exit doors, not to expect the client to wait (as the staff person leaves the house and the client is unattended) and not to ride a bike on an errand (in sight of Client #1) without the client. 2) On 5/31/17 at approximately 3:55 p.m. staff heard the exit door alarm and discovered Client #1 left the home and took a bike. Staff got on a moped to pursue Client #1, but lost sight of the client. Off duty staff, PSP E, saw Client #1 riding a bike on a city street near the facility and followed the client. PSP E called the home to notify them of Client #1's whereabouts. PSP F arrived on a moped, and both staff followed Client #1, trying to convince the client to return to the facility campus. When interviewed on 6/13/17 at 9:00 a.m. PSP E said she left work on the afternoon of 5/31/17 and saw Client #1 riding his/her bike on a street near the facility. PSP E spoke to Client #1, but the client would not return to the facility campus. PSP E called the group home on her cell phone at 3:54 p.m. to tell them of Client #1's whereabouts. PSP F arrived on a moped shortly after 4:00 p.m. Client #1 took off on the bike and said to leave him/her alone. PSP E followed in her car and PSP F followed on the moped as Client #1 drove around city streets. Client #1 moved quickly on the bike and was not being safe. At one point, Client #1 drove in front of a van. The van braked to avoid hitting Client #1. Client #1 got near Highway 18 at one point and	W 159		

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W 159	Continued From page 10 seemed to want to cross the highway, but the two staff talked him/her out of it. PSP E quit following Client #1 around 4:15 p.m. since PSP E followed with the moped and PSP E thought another staff person was on their way to help. When interviewed on 6/14/17 at 2:30 p.m. PSP F stated he was assigned to Client #1 on the afternoon of 5/31/17 and did 10 minute checks. He heard the front door alarm sound and went to check. Staff realized Client #1 was missing and had taken a bike. PSP F took the moped and began searching for Client #1, initially searching on campus. PSP F spotted Client #1 on a street near the facility. Client #1 was stopped on the bike and talking to PSP E. PSP F pulled up on the moped and Client #1 took off on the bike. PSP F said he then followed Client #1 for almost an hour as the client road the bike around city streets. PSP F said Client #1 was not safety conscious. Client #1 would start to drive through a stop sign and PSP F would yell to stop. At one point Client #1 pulled out in front of a van and the van had to brake. Client #1 wanted to cross Highway 18, but PSP F talked him/her out of it. PSP F said he followed Client #1 for at least 30 minutes after PSP E left, until they returned to the facility campus. No other staff came to help. After this incident, staff had to be with Client #1 for 24 hours and then the supervision level went back to 10 minute checks. When interviewed on 6/14/17 at 9:20 a.m. QIDP A said staff at the house quickly responded when they heard the front door alarm, but they lost sight of Client #1 by the time they began to search for him/her. After the incident, the facility increased Client #1's supervision level to visual supervision for 24 hours and then it went back to 10 minute	W 159		

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W 159	Continued From page 11 checks. The facility also did retraining on responding immediately to the door alarm, since QIDP A had been in the front area of the house and did not immediately check when the door alarm sounded. 3) On 6/08/17 at 10:20 a.m. PSP G was the assigned staff for Client #1 and heard the front door alarm sound. PSP G immediately responded, but by the time he got to the moped and was ready to go, he had lost sight of Client #1. PSP G later found Client #1 at a local grocery store, less than one mile driving distance from the facility. When interviewed on 6/13/17 at 10:15 a.m. PSP G confirmed he was the staff person assigned to Client #1 on the morning of 6/08/17. PSP G saw Client #1 sitting in the lounge and went to assist another client in the bathroom. PSP G heard the front door alarm go off a short time later. He looked out of a window and saw Client #1 leaving on a bike. By the time PSP G got to the moped parked near the house, he lost sight of Client #1. PSP G first searched campus grounds and then headed off campus to search. He found Client #1 at the Fareway grocery store on a bike in the parking lot. Client #1 returned to the facility with PSP G. PSP G said Client #1 had probably overheard staff talking about going to the grocery store. PSP G said Client #1 had 1-to-1 staff supervision since the incident on 6/13/17. He said it would not work to lock up Client #1's bike because the client would take anyone's bike, anywhere on campus. PSP G said he found Client #1 within 10 minutes. When interviewed on 6/14/17 at 9:20 a.m. QIDP A and the Regional Director confirmed since the	W 159		

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W 159	Continued From page 12 incident on 6/08/17, Client #1 had 1-to-1 supervision when awake and 30 minute checks while sleeping. The facility planned to continue the 1-to-1 level of supervision indefinitely. In summary, despite repeated elopements, the facility did not increase Client #1's level of supervision (other than temporarily) even when it became apparent that 10 minute checks were not successful. The client had a history of leaving campus and riding a bicycle on city streets, without always paying attention to safety precautions.	W 159		
W 191	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on interviews, record reviews and observation, the facilty failed to ensure staff consistently demonstrated the ability to manage client behavioral needs in order to maintain client safety, dignity and well-being. This affected 3 of 3 clients involved in the investigations of #68492-I (Client #1), #68495-I (Client #2) and #68069-I (Client #3). Findings follow: 1. Review of agency investigation revealed Client #1 left on a bicycle without staff approval on 5/24/17 at approximately 9:25 p.m. Client #1 had a program plan to let staff know where he/she was going. Client #1 required staff supervision when riding his/her bicycle, due to leaving the agency campus in the past on a bike without staff knowledge and needing prompting regarding safety. Client #1 had access to bicycles kept at his/her group home and at the other group homes	W 191	**W191** – One Vision will ensure staff consistently demonstrate the ability to manage client behavioral needs in order to maintain client safety, dignity and wellbeing by:	

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W 191	Continued From page 13 on the campus grounds. Staff located Client #1 within approximately five minutes, by the main campus building, a distance of about one city block. Client #1 had no injuries and was dressed appropriately for the weather. Client #1 returned to the group home with staff. At the time of the incident, Client #1's assigned staff was Personal Support Professional (PSP) D. She was responsible for checking on Client #1 every 10 minutes. Client #1, 29 years old, had diagnoses including: Moderate Intellectual Disability, Down Syndrome and Attention Deficit-Hyperactivity Disorder. Client #1 was independently ambulatory and verbal. Client #1 had prior incidents of leaving the facility without staff knowledge/approval. When interviewed on 6/13/17 at 2:20 p.m. PSP A stated he left the house around 9:20 p.m. to take something back to the nurse's office at the main building. PSP A saw Client #1 standing in the main entryway of the home, between the outer exit door and the inner exit door. PSP A said he told Client #1 to stay there and he then got on a bike and went to the main building. PSP A said he looked behind him to make sure Client #1 was not following him. PSP A returned to the facilty around 9:25 p.m. and noticed Client #1 was no longer standing in the entryway. PSP A asked other staff about Client #1's whereabouts and they did not know. PSP A got on a bike to go look for Client #1 and found him/her by the recycling door of the main building. PSP A estimated he found Client #1 by 9:30 p.m. PSP A said PSP D was Client #1's assigned staff at the time. He said he realized looking back on it that he should not have left Client #1 standing between the two exit doors. The inner exit door had a voice alarm	W 191	1) Looking for trends with certain staff and dealing with those staff appropriately – perhaps not working in the ICF program. 2) Staff will be retrained on level of supervision for each individual in the home they work. 3) Staff will be retrained on individual's behavior support plans, in the home that they work. 4) Teams will review scenarios to help staff think beyond what is specifically written in an individual's plan and to generalize the information they have received.	

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W 191	Continued From page 14 when someone went in or out that announced "Front Door", but the outer exit door had no alarm. PSP A did not tell any of the other staff that Client #1 was standing in the entry area when he left the building. When interviewed on 6/14/17 at 2:20 p.m. PSP D confirmed she was the staff person assigned to Client #1 on the evening of 5/24/17. She wore a bracelet to indicate she had responsibility for Client #1 and she signed off on a supervision sheet every 10 minutes that she had checked on Client #1. PSP D thought PSP A was going to take Client #1 out for a milkshake, which was an evening routine. PSP D charted on the supervision sheet at 9:20 p.m. "going to get shake". At 9:30 p.m. she documented "missing at 9:30". At 9:40 p.m. she documented Client #1 had been found and was in his/her room. When asked on 6/14/17 if she actually saw Client #1 at 9:20 p.m. or if she thought he had already left for the milkshake, PSP D said she did not recall. She said when she heard Client #1 was missing, she thought he had left with PSP A to get a milkshake. PSP D acknowledged PSP A had not told her that he was leaving with Client #1 and had not asked for Client #1's responsibility bracelet, but she still assumed they had left. She said staff should exchange the bracelet when another staff took responsibility for Client #1, but it did not always happen. PSP D said she did not know that Client #1 had been standing in the entryway between the two exit doors and PSP A had left on an errand. When interviewed on 6/14/17 at 9:20 a.m. the Regional Director and Qualified Intellectual Disability Professional A, who was the QIDP at the home at the time of the incident, confirmed	W 191	5) After each life plan, the QDDP will develop a CDS lesson and staff will review the plan and pass the test that the QDDP has written with questions pertinent to that individual's BSP, Level of Supervision, etc. 6) Behavior plans and level of supervision will continue to be reviewed at team meetings. 7) Each home will be monitored by Leadership staff and others a minimum of four times a week for four weeks. They will look for staff to be	

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W 191	Continued From page 15 PSP D should have clearly documented at 9:20 p.m. whether or not she saw Client #1. If another staff person had taken Client #1 on an outing, the responsibility bracelet should have been passed to that staff person. QIDP A said she did not believe staff always exchanged the bracelet like they should. They also agreed PSP A should not have left Client #1 standing in the entryway between the exit doors as the staff person rode off on a bike. The outer exit door does not alarm when opened. PSP A should have taken Client #1 inside, or taken the client with him, or alerted other staff of Client #1's location. QIDP A noted that Client #1 sometimes liked to stand in the entryway between the two exit doors and had not eloped from there before. 2. Review of facility investigation on 6/12/17 revealed Client #2 walked away from the yard of the group home and went to a neighboring group home on the evening of 5/13/17 without staff knowledge. Client #2 had been swinging in the front yard of his/her home (Bedrock home). A staff person (Licensed Practical Nurse A) at the neighboring group home returned Client #2 to his/her home. Client #2 was dressed in pajama pants and a tee shirt at the time of the incident. The temperature was approximately 82 degrees Fahrenheit. The distance from the front yard of Bedrock Home to the front door of Executive Cottage is approximately 80 to 90 yards. Executive Cottage is across a street and down a short way from Bedrock. The street is on the campus property and used only by staff or visitors. Additional record review revealed Client #2: 19 years old, with diagnoses including Moderate to Severe Intellectual Disability, Obsessive	W 191	running programs correctly and for appropriate level of supervision provided. They will notify the QDDP of the home and RD if they notice any issues. Person Responsible: QDDP Start date: Immediately	

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W 191	Continued From page 16 Compulsive Disorder, Autism, Generalized Anxiety Disorder and Asthma. Client #2 was independently ambulatory and did not have functional communication skills. He/she was admitted to the facility on 1/15/2017. According to the Comprehensive Functional Assessment completed January 2017, Client #2 did not look all directions before crossing a street, did not use sidewalks when available,did not walk on a street facing traffic and was not safe to independently walk in parking lots. When interviewed on 6/14/17 at 2:10 p.m. LPN A stated she passed medication at the Executive Cottage home and saw Client #2 walk in the front doors at approximately 7:10 p.m. on 5/13/17. She saw no staff with the client. LPN A walked Client #1 back to the Bedrock home and informed the staff that Client #2 had gone to Executive Cottage. LPN A said it was clear the staff at Bedrock did not know Client #2 had left. LPN A recalled hearing one of the staff say that Personal Support Professional (PSP) A had brought Client #2 back to the swing when the client tried to walk away a short time earlier. When interviewed on 6/13/17 at 2:00 p.m. PSP A said he looked out the window on the evening of 5/13/17 and saw Client #2 walking away from the swing in the front yard and away from the house. PSP A said he told Shift Supervisor (SS) A that Client #2 was walking away and he was going out to get him. PSP A went outside and directed Client #2 back to the swing in the yard. PSP A then returned to passing client medications in the medication room. He said he assumed SS A would supervise Client #2 or assign a staff to do it. At the time of the incident, PSP A thought staff were supposed to keep Client #2 in sight,	W 191		

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W 191	Continued From page 17	W 191		

whether inside the house or outside the house. A staff person should have been assigned to Client #2, but PSP A did not know who was assigned to the Client #2 at the time.

When interviewed on 6/14/17 at 1:50 p.m. SS A stated she worked at the Bedrock House on the evening of 5/13/17. Her understanding of Client #2's supervision level at that time was to be in sight of staff at all times, either indoors or outdoors. It would have been acceptable for staff to watch Client #2 from the house when he/she was on the swing in the yard. At the time of the incident, there was no staff person assigned to Client #2 because the previously assigned staff person left for an outing and left Client #2's assignment bracelet sitting on a counter. Another staff person should have been given the bracelet, which indicated responsibility for Client #2. SS A was in a bathroom assisting a client when the assigned staff person left, so she was not able to assign another staff person. She said PSP A did not tell her that he saw Client #2 walking away from the house earlier. SS A was still in a bathroom assisting a client when LPN A brought Client #2 back to the house. SS A had not been aware Client #2 was gone.

Record review revealed a General Event Report (GER), dated 5/03/17. According to the GER, Client #2 left the Bedrock Home and walked to Executive Cottage on 5/03/17 at 2:45 p.m. Executive Cottage staff walked Client #2 back to his/her home. A follow up comment by Qualified Intellectual Disability Professional (QIDP) B, dated 5/08/17, noted Client #2's level of supervision immediately increased after the incident. According to the QIDP follow up comment, Client #2 needed staff support at all

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W 191	Continued From page 18 times when he/she was outside of the home. An assigned staff person needed to be aware of Client #2's whereabouts at all times in the home and would wear a bracelet to indicate responsibility for Client #2. Further record review revealed Client #2's Individual Support Plan, last updated on 5/03/17. The updated ISP noted, "(Client #2) NEEDS STAFF SUPPORT AT ALL TIMES WHEN (HE/SHE) IS OUTSIDE OF (HIS/HER) HOME." The ISP also indicated staff needed to be aware of Client #2's whereabouts at all times when in the home, which could be done through walkie-talkie contact. According to the ISP, "THE STAFF PERSON RESPONSIBLE FOR KNOWING (CLIENT #3's) WHEREABOUTS IN (HIS/HER) HOME MUST WEAR A BRACELET". When interviewed on 6/14/17 at 9:10 a.m. QIDP A and the Regional Director said they thought Client #2's level of supervision at the time of the incident on 5/13/17 was to be in staff sight (visual supervision) at all times, whether indoors or outdoors. After reviewing the GER, dated 5/03/17, and the ISP, updated 5/03/17, they both agreed staff should have been with Client #2 when he/she was outside. They also confirmed that at the time of the incident, no staff person was assigned to Client #2 and wearing a bracelet to indicate responsibility for the client, or keeping the client in sight. They said SS A should have assigned a staff person for Client #2. They also acknowledged PSP A should have ensured Client #2 had the appropriate level of supervision after he saw the client walking away from the house and he went outside to return the client to the swing. The facility implemented changes after the elopement incident on 5/13/17. All staff were	W 191		

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W 191	Continued From page 19 retrained on Client #2's supervision level-including being with Client #2 when outside, a daily staff assignment sheet was implemented and disciplinary action was taken with PSP A and SS A. The facility also moved Client #2 to a group home with a Roam Alert System on 6/12/17. 3. Review of the facility investigation on 6/13/17 revealed PSP A removed and changed Client #3's clothing as the client objected and resisted on the evening of 4/20/17. Another staff person reported the incident. The facilty investigated the incident and provided further training to PSP A, in addition to revising Client #3's behavior plan. The facility determined PSP A made an "inappropriate decision" to assist Client #3 with changing his/her clothing as the client said "No," but concluded the incident was not abusive. Client #3 was 42 years old with diagnoses including: Moderate Intellectual Disability, Seizure Disorder and Osteopenia. Client #3 was independently ambulatory with limited verbal/communication ability. When interviewed on 6/13/17 at 3:15 p.m. PSP B stated he was working with Client #3 on the evening of 4/20/17 and tried to convince the client to change into pajamas for bed. Client #3 kept refusing and saying "No." PSP B tried waiting for 15-30 minutes in the client's bedroom and then went to get preferred staff, PSP C. PSP C was also unsuccessful in prompting Client #3 to get undressed and change into pajamas. PSP B said PSP A showed up and said something like "I got this." PSP A went to Client #3 and began removing the client's clothing as Client #3 repeatedly said "No." The situation made PSP B	W 191		

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W 191	Continued From page 20 uncomfortable, so he left the room. PSP B could hear the the continued interaction between PSP A and Client #3 on an auditory monitor. He heard Client #3 repeatedly say "No." He also heard PSP A tell Client #3 not to hit him. This indicated to PSP B that Client #3 was clearly upset and resisting PSP A. PSP B stated he did not view the incident as abuse, but PSP A was infringing on Client #3's rights. PSP A was being disrespectful to Client #3 by forcing him/her to do something he/she did not want to do. PSP A did not give Client #3 any other choices or try to see if there was something else the client needed/wanted. Shortly after getting changed into pajamas, Client #3 was incontinent of urine. PSP B suspected Client #3 might have been refusing to change clothes because he/she needed to go to the bathroom. When interviewed on 6/13/17 at 3:00 p.m. PSP C recalled the incident on the evening of 4/20/17. She said PSP B had asked for her assistance with Client #3 to change him/her into pajamas. Client #3 also refused to change for PSP C. She said PSP A came into the bedroom and began assisting Client #3 to remove clothing and put on pajamas as the client repeatedly said "No." PSP C said Client #3 was not overly resistant, but did push PSP A as least once and then PSP A backed off briefly. PSP C said PSP A did not appear to be angry and was not yelling or cursing. PSP A told Client #3 what he was doing. She did not believe that PSP A was being hurtful or overly rough with Client #3, but PSP A was not being respectful to the client's refusal to change to pajamas. PSP C said she observed the interaction for a few minutes and Client #3 gradually became more cooperative. Client #3 eventually said "Yes" and helped changed into	W 191		

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W 191	Continued From page 21 pajamas. When interviewed on 6/13/17 at 2:10 p.m. PSP A stated he had assisted Client #3 to change from clothing into pajamas on the evening of 4/20/17. PSP A said Client #3 was in a "No mood" and saying "No" to everything. Client #3 refused to change for PSP B or PSP C. PSP C said he was very familiar with Client #3 and they had a good relationship. PSP A said he removed Client #3's clothing and assisted the client into pajamas as the client said "No". PSP A said he explained what he was doing through out the process. Client #3 pushed PSP A a few times and then PSP A would briefly back off. As the process went on, Client #3 became more cooperative and began helping with the changing his/her clothes. PSP A said he had assisted Client #3 like that in the past when Client #3 refused to cooperate. PSP A did not see it as being aggressive or abusive on his part. Record review on 6/13/17 revealed Client #3's Individual Support Plan (ISP) which indicated Client #3 sometimes displayed aggressive or self-injurious behavior. According to the plan staff should make sure they were "giving (him/her) space and not overly prompting (him/her) when (he/she) is upset. When (Client #3) is upset, it is best to walk away and give (him/her) some space and time." Client #3's behavior program for mood swings and destructive behavior noted, "If (Client #3) doesn't want to do something when asked, staff will attempt again later. Staff will give (Client #3) choices whenever possible." When interviewed on 6/14/17 at 10:00 a.m. Qualified Intellectual Disability Professional B	W 191		

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W 191	Continued From page 22 confirmed staff should have followed Client #3's ISP and BSP. She had done retraining with PSP A since the incident.	W 191		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to consistently and accurately maintain medication administration records (MARs). This affected 1 of 5 sample clients (Client #4). Findings follow: Record review also noted a General Event Report (GER) dated 4/13/16 at 9:30 a.m. by Licensed Practical Nurse(LPN) B, documented: "(Client #4) had c/o (complained of) a headache and stomach ache, staff was giving Tylenol when (Client#4) began to have a generalized seizure. After 3 minutes gave Lorazepam Intensol and shortly after that (Client #4) dad arrived. Upon entering (his/her) room he stated this was unusual seizure activity and requested 911 be called." The event summary noted: "Taken by ambulance to NIMHC-ER for evaluation and then to surgery for left hemisphere brain hemorrhage. Then admitted to 6 east, ICU." According to the Therap (documentation record) the Lorazepam was given at 8:45 a.m. and 9:30 a.m. on 4/13/16. The record reflected the initial dose documented 4/13/16 at 9:16 a.m. and the second dose documented on 4/15/16 at 4:09 p.m. Both doses failed to include a follow-up response	W 365		

W365 – One Vision will consistently and accurately maintain medication administration records by:

1) Anytime a PRN is given it will be documented in Therap appropriately. A note/flag will be left on the computer stating who was given the PRN med and what time as a reminder to complete the PRN follow up. The next med aide is responsible for ensuring all PRN's have been followed up and will throw away the note/flag when this is completed.

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W 365	Continued From page 23 to the medication given. Review of agency policies on 6/13/17 revealed "Six Rights Right Documentation-a. Records initials on correct day and time on medication sheet (MAR). If PRN (as needed) medication, charts their initials and time on the front. Also charts on the back including PRN follow-up in 1-2 hours." When interviewed on 6/14/17 at 1:30 p.m. LPN B confirmed the first dose of the Lorazepam administered to Client #4 on 4/13/16 was documented timely. She confirmed she failed to document the second dose until two days later (4/15/16). She stated she "forgot" to document it that day. She reviewed the Six Rights procedure and confirmed it included as needed medications were to show a follow up.	W 365	2) The assigned nurse will monitor a minimum of once a week to ensure all PRN's have been followed up on. 3) Nurses and MA's will receive retraining on the importance of charting on time, and completing all follow ups on PRNs. 4) In the event of an emergency medical situation, the Health Services Supervisor or their designee will review the MAR and ensure all medications and follow up were documented. Person Responsible: Health Services Supervisor Start Date: Immediately.	
W 368	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. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to ensure medications were administered according to physicians' orders. This affected 2 of 2 clients (Client #4 and Client #5) requiring hospitalization in Moon Valley home. Findings follow: 1. Record review on 6/12/17 revealed Client #4's Individual Support Plan (ISP) revealed he/she used an audio monitor in his/her room for staff to listen in case of seizure activity. Client #4 had a	W 368		

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W 368	Continued From page 24 diagnosis of severe autism. On 2/1/16, Client #4 moved to Moon Valley home. A Seizure report dated 3/10/16 documented Client #4 had a seizure that lasted 45 seconds. Staff described the client's body as limp, rapid blinking of eyes and or small twitching movements and rigid body. After the seizure the client was confused, drowsy, and had been unable to walk or stand. A Seizure report dated 4/9/16 documented Client #4 had a seizure during a home visit [with family]. The report did not contain any information on description, length of time or seizure duration. Continued record review revealed Client #4's physician's orders identified the following: Lorazepam-2mg (milligrams)/ml(milliliters) concentrated solution, place 0.5 ml under tongue p.o. (oral) 3 times as needed for generalized seizures (more than 3 minutes or 2 in 6 hours) or partial seizure (2 in 30 minutes or one more than 5 minutes). May repeat two (2) times in 24 hours. Call Neurology on call if not effective, or take to local ER (emergency room). Record review on 6/12/17 revealed a Seizure record for Client #4 documented on 4/13/16 at 8:35 a.m. by Personal Support Professional (PSP) H. The record described the seizure with symptoms: "Jerky arm movements, loss of bladder control, nausea/vomiting, rigid body, unresponsive, respiration deep and fast, skin color pale, eyes upward." Behavior after the seizure was described as: "inability to walk or stand, every few minutes shivering then became relaxed and eyes were closed entire time." The report documented staff "turned person to side,	W 368		

W368 – One Vision will ensure medications are administered according to physician's orders by:

1) Prior to giving medications to an individual, the person giving meds will compare the individual with the photo ID in Therap and ask the client to state their name.
2) Admitting nurse will assure that all admitting medications are ordered, faxed to pharmacy and arrive as ordered. This includes treatments and all PRN's. Nurse will have a second nurse verify orders by initialing them. Current assigned nurse will continue to complete weekly inspections for expired and needed medications.

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W 368	Continued From page 25 placed soft material under head, maintained safe environment, contacted nurse, called nursing, notified TL (team leader) and stayed with (Client #4) the entire time." The document described the notification of the nurse, observation and support given during the seizure and the seizure medication given for the seizure. Record review also noted a General Event Report (GER) dated 4/13/16 at 9:30 a.m. by Licensed Practical Nurse(LPN) B, documented: "(Client #4) had c/o (complained of) a headache and stomach ache, staff was giving Tylenol when (Client#4) began to have a generalized seizure. [The GER incorrectly documented: After 3 minutes gave Lorazepam Intensol and shortly after that Client #4's family member arrived.] Upon entering (his/her) room the family member stated this was unusual seizure activity and requested 911 be called." The event summary noted: "Taken by ambulance to emergency room (ER) for evaluation and then to surgery for left hemisphere brain hemorrhage. Then admitted to hospital." According to the Therap (documentation record) Client #4 was administered Lorazepam on 4/13/16 at 8:45 a.m. and 9:30 a.m. The record failed to include a follow-up response to both doses of medication given. When interviewed on 6/14/17 at 1:30 p.m. and 6/21/17 at 8:30 a.m. LPN B reported she received a call of seizure like activity with Client #4. Staff reported Client #4 had been in a seizure for three minutes. LPN B told staff she would be over to assess the client. She headed over to the home, as she had been next door at another home. It had to have been five minutes the client was in	W 368	Person Responsible: Health Services Supervisor Start date: Immediately.	

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W 368	Continued From page 26 seizure when she arrived, the client laid on the floor with a pillow under his/her head. LPN B explained the client appeared exhausted and his/her leg twitched a few times. According to LPN N, the client appeared to be in a postictal state. When she initially arrived, she described the client's breathing as heavy, then easy breathing within a minute or two. LPN B stated she administered Lorazepam for the seizure activity. She wanted to do what she could to stop additional seizure activity. She stated she went next door to obtain the concentrate because none of the medication was available in the home for Client #4. LPN B stated she believed the client to be in a postictal state; shivers or twitches that occurred, she believed to be the relaxing of muscles due to muscle contracture from the seizure. She stated she based this on information she'd received from a Neurologist. Client #4's family member arrived a short time later and informed her the client continued to have seizures, it was abnormal, and they needed to call 911. Client #4's family member insisted another dose of Lorazepam be given, and she administered another dose. LPN B confirmed Client #4's PRN (as needed) Lorazepam was not available in the home. LPN B reported prior to this day she had not seen Client #4 have a seizure before. A review of video of events on 4/13/16 included the following: a. At approximately 8:30 a.m., Client #4 is administered a medication. Shortly thereafter, the client begins to seizure (at 8:32 a.m.) b. At approximately 8:36 a.m., Client #4 appears to continue to seizure.	W 368		

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W 368	Continued From page 27 c. At approximately 8:43 a.m., LPN B arrives. d. At approximately 8:48 a.m., the client continues to appear to actively seizure. e. At approximately 8:50 a.m., LPN B returns to the room with medication. f. At approximately 8:52 a.m., the mediation is administered by LPN B. g. From 9:00 a.m. - 9:25 a.m., Client #4 appears unresponsive. Involuntary movements of his/her chest, hands, arms, legs, and feet are apparent at various times. [At 9:09 LPN B is with Client #4 who appears unresponsive. At 9:19 a.m. what appears as Client #4's family member is present in his/her room.] h. At 9:25 a.m., LPN B administers medication to Client #4. i. At 9:31 a.m., emergency medical services (EMS) arrive. j. At 9:34 a.m., Client #4 is transferred to a gurney. His/her hands continue to appear contractured. k. At 9:35 a.m., Client #4 is transferred via EMS to a local hospital. The ambulance report dated 4/13/16 indicated the paramedics received a call at 9:21 a.m., and arrived at 9:31 a.m. to find Client #4 lying supine (face up) in bed unresponsive. The paramedics' impression identified the client unconscious and	W 368		

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W 368	Continued From page 28 seizure. The paramedics documented prior to transporting Client #4, one seizure lasted 90 seconds and the paramedics described Client #4 as focal motor/some rigid in nature, his/her pupils were unequal and not reactive to light. No meds were given en route to the ER. The Emergency/Urgent Care report dated 4/13/16 documented a radiology report identified Client #4 had a nondisplaced and non-depressed right occipital skull fracture, extending to the lateral margin of the foramen magnum (large oval opening); and documented "Diagnosis: Traumatic subdural hemorrhage with loss of consciousness of 1 hour to 5 hours 59 minutes." A reexamination/reevaluation dated 4/13/16 at 10:29 a.m., documented Client #4 had 2 more seizures since initial examination. Hospital Consultation report dated 4/13/16 documented on admission the patient was obtunded secondary to an intracranial hemorrhage. He/she was brought in to the ER (emergency room) where head CT (computed tomography) showed a sizable left subdural hematoma. He/She was subsequently taken to the OR and had a craniectomy of the left and [required] evacuation of the hematoma. He/she was then sent to intensive care unit (ICU). Apparently recently his/her Keppra which was low does was discontinued. The report documented he/she had a headache (which he/she rarely complains of) and [later] vomited and had a seizure. According to the Neurological Studies report dated 4/13/16 from the hospital documented the following: the patient is 22 years old with a history of epilepsy and autism spectrum admitted with	W 368		

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W 368	Continued From page 29 left subdural hematoma and recurrent seizures related to that. He/she underwent hematoma evacuation and was intubated in intensive care unit. A telephone interview occurred on 7/6/17 at 3:30 p.m., with Client #4's neurologist. The physician stated he could not answer if the Lorazepam given at 3 minutes and 5 minutes later would have made a difference in the length of the seizure. The physician reported the Lorazepam does not stop current seizures, but prevents further seizures activity. The physician reported the order for Lorazepam Intensol as written as well as the need to call the neurologist or to send to the ER (emergency room). The physician reported a type A event would be characterized by generalized tonic-clonic seizure with arching of head and back, drooling, unresponsiveness, jerking and shaking of extremities and torso. The hospital Discharge Summary dated 5/10/16 included the following information regarding Client #4's hospital course: patient was admitted on 5/4/16 and managed in the CCU (critical care unit) until 5/5/16. He/she has a number of issues including significant head trauma, status post craniotomy and replacement of bone flap. He/she had a herniation plus hematomas, subdural, subarachnoid and also an acute stroke; all of which seem to be improving considerably. He/she also suffers from seizure disorder and autism. He/she appears stable and made good progress. He/She was up and moving about on 5/3/16 but had lapse in behavior issues. He/She refused to eat or drink, putting in a feeding tube would not be tolerate by patient. By 5/8/16, patient became more agitated and non-compliant even with family. Palliative care	W 368		

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W 368	Continued From page 30 met with the patient's family and they accepted in-patient Hospice and is being discharge. Review of the pharmacy order for Lorazepam concentrate revealed the medication ordered on 4/15/16 (after the medication was given on the 4/13/16 to Client #4). Interview with RN A on 6/14/17 at 10:10 a.m. confirmed Client #4's admission date of 2/1/16. She admitted she did not ensure the Lorazepam concentrate was available for his/her seizures. 2. Record review on 6/12/17 revealed Client #5's General Event Report (GER) documented a medication error on 4/5/17 at 7:40 p.m. The report explanation read: LPN C administered the following medication to Client #5: Famotidine 20 milligrams (mgs), Haloperidol 2 mg. Hydralazine 25mgs, Lamotrigine 150 mg, Lamotrigine 25 mgs, Lisinopril 20 mgs, MAPAP 650 mgs, Quetiapine Fumarate 100 mgs, Senna-S 8.6/50 mgs, Metoprolol Tartrate 25 mgs, and Benztropine 25 mgs. The GER documented the LPN admitted the error immediately after the client left the room. The physician consulted and recommended emergency room for assessment. When interviewed on 6/12/17 at 3:40 p.m. LPN C explained she assisted another client with topical treatments and thought of that client. She failed to identify the correct client with the correct medication prior to administering the medication. Interview with LPN A on 6/13/17 at 1:30 p.m. confirmed LPN C called her right after she gave the wrong medication to Client #5. LPN A followed the ambulance to the emergency room and	W 368		

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W 368	Continued From page 31 stayed with Client #5 during part of the night. She acknowledged the client did receive medications for low blood pressure due to the meds received by mistake. The client returned to the facility the following day without any lasting effects. When interviewed on 6/14/17 at 2:30 p.m. Health Services Supervisor confirmed medication ordered should be available/charted right after administered, documented follow-up and given to the correct person. She acknowledged the two LPN's failed to follow the Six Rights and the Administration of Medication policies.	W 368		