

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

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|---|----------------------------|---|--|------------------------|--|
| Citation Number: FC # 6644 | | Fine amount reduced by 35% to \$1,625.00 on October 3, 2017 pursuant to Iowa Code Section 135C.43A | Date: September 7, 2017 | | |
| Facility Name: Christian Opportunity Center | | | Survey Dates: August 14-17, 2017 | | |
| Facility Address/City/State/Zip 1554 Broadway Street Pella, IA 50219 | | HL | | | |
| Rule or Code Section | Nature of Violation | Class | Fine Amount | Correction date | |

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|--------------|--|----------|-------------------|---------------------|
| 64.60 | <p>481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.</p> <p>Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.</p> <p>This rule is intended to implement Iowa Code Section 135C.2(3).</p> | I | \$2,500.00 | Upon Receipt |
| W249 | <p>483.440(d)(1) Program Implementation As soon as the interdisciplinary team has formulate 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.</p> <p>DESCRIPTION: Based on interview and record review, the facility failed to ensure staff consistently implemented client program plans. This affected 1 of 1 client (Client #2).</p> | | | |

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| | <p>Findings follow:</p> <p>1. Record review on 8/14/17 revealed Client #2 eloped from the facility van on the afternoon of 6/25/17 (Sunday) at approximately 4:30 p.m. Staff noticed Client #2 missing within about one minute and immediately began searching for him/her. Living Skills Advisor (LSA) A located Client #2 within one minute of realizing the client was missing. LSA A found Client #2 at a neighboring home, behind the facility and across a street. Client #2 had no injuries and returned willingly with the staff person.</p> <p>Client #2 was 54 years old with a diagnosis including Severe Intellectual Disability, Bipolar Disorder and possible Obsessive Compulsive Disorder. Client #2 ambulated independently. Client #2 was mostly non-verbal, without functional communication skills. Client #2 had a history of elopement and elopement attempts. The last successful elopement occurred in July 2013. Client #2 had a behavior program to decrease elopement attempts, which incorporated several restrictive measures, including a locked privacy fence in the back yard, a Roam Alert bracelet that caused the exit door to lock when Client #2 got close to the door, restricted access to scissors to prevent Client #2 from cutting off the Roam Alert bracelet, blocks on the windows to prevent egress and an increased level of supervision. According to Client #2's behavior plan, his/her level of supervision in the facility home was a "Red" level, which meant staff needed to complete visual checks every 1-3 minutes, unless the client was in his/her bedroom. If the client</p> | | | |
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| | <p>was in the front yard, staff needed to be with him/her. On outings, Client #2 needed to be in staff's visual field at all times. Neither the Individual Service Plan (ISP) nor Behavior Support Plan (BSP) made reference to the level of supervision needed when on the agency van. The ISP also noted when traveling in a vehicle, Client #2 should be encouraged to sit in the back seat. The staff person responsible for Client #2 wore a cloth band on his/her arm. Client #2's Comprehensive Functional Assessment dated 4/27/17 indicated the client needed one-on-one staff supervision when walking in the neighborhood.</p> <p>According to the website Weather Underground the temperature in Pella, Iowa on 6/25/17 at 4:35 p.m. was 72.5 degrees Fahrenheit, with scattered clouds. Client #2 was dressed appropriately for the weather. Client #2 crossed a two-lane street (Main Street), which is regularly traveled and has a posted speed limit of 35 miles per hour.</p> <p>Client #2's informed consent noted he/she did not practice safety skills when crossing roads and had entered houses in the past without being invited. In July 2013, Client #2 went across the road and entered the same neighbor's house as the incident on 6/25/17. Client #2 did not enter the neighbor's home on 6/25/17, but stood on the front porch and then on the back deck when LSA A located the client.</p> <p>When interviewed on 8/16/17 at 9:00 a.m. LSA A stated a group of clients and staff went on a van ride on the afternoon of 6/25/17, returning to the facility</p> | | | |
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| | <p>around 4:30 p.m. LSA A was assigned to Client #2 and also drove the agency van. She did not recall where Client #2 sat on the van. There were eight clients and three staff on the van, including LSA A. LSA A parked the van near the front door of the facility and began filling out the van log. She said she was somewhat aware that the front door of the van opened, but she did not notice LSA B take two of the clients off of the van and into the facility. LSA A did not see Client #2 exit the van. LSA A had just finished completing the van log when LSA B returned to the van and asked where Client #2 was. Staff then realized Client #2 was missing and immediately began searching. LSA A said she went to the front door of the facility and waited as other staff quickly searched inside. When staff could not find Client #2, LSA A ran toward the neighbor's house behind the facility because she knew the client had gone there in the past. As LSA A went through the empty lot behind the facility, she could see Client #2 standing on the front porch of the neighbor's house. She called to the client, who ran around to the back of the house. LSA A found Client #2 on the back deck of the house. Client #2 willingly returned to the facility with LSA A. The client had crossed the two-lane street, but was not injured. LSA A said Client #2 should have been in line of sight of staff while on the van. She acknowledged she wore Client #2's arm band and could not see the client since she was in the driver's seat and Client #2 was behind her. LSA A estimated less than one minute passed from when staff realized Client #2 was missing until she saw the client on the neighbor's porch. She received disciplinary action regarding the incident. She</p> | | | |
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| | <p>said staff should have communicated better with each other. Usually clients did not get off the van until the driver finished the van log and was ready to help assist and supervise the clients.</p> <p>When interviewed on 8/15/17 at 2:00 p.m. LSA B stated three staff and eight clients returned from a van ride on the afternoon of 6/25/17. Client #8 became agitated and aggressive on the van, so LSA B immediately walked Client #8 and another client into the facility. She thought the front van door was probably left open after she and the two clients got off the van. Another staff person waited inside with Client #8's medications. LSA B watched Client #8 get the medications and went back out to the van. She estimated no more than one minute passed from when she got off the van with the two clients until she returned to the van. LSA B saw that Client #2 was no longer on the van. He/she had been sitting in the front seat behind the driver. LSA B asked where Client #2 was and the staff realized the client was missing. LSA B went inside the facility to look for Client #2. LSA A looked outside and found Client #2. LSA B said LSA A was assigned to Client #2 at the time of the incident. LSA A filled out the van log paperwork when LSA B took the two clients inside the facility. LSA C was in the back of the van unhooking the wheelchair straps for the two clients in wheelchairs. LSA B said Client #2's assigned staff (LSA A) should have had her eyes on Client #2 while on the van.</p> <p>When interviewed on 8/15/17 at 2:15 p.m. LSA C stated when the van parked near the front of the facility</p> | | | |
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| | <p>after returning from the van ride on 6/25/17, she got up and began unhooking the wheelchair straps for the two clients in the back of the van in wheelchairs. LSA C saw other clients begin to stand up, but she did not realize LSA B had accompanied two of the clients off of the van. LSA C was focused on the clients she was responsible for. She said Client #2 was in the front seat, behind the driver, LSA A. LSA A was the Client #2's assigned staff person at the time. LSA B came back to the van and asked where Client #2 was. LSA A and LSA B began looking for Client #2 as LSA C stayed on the van with the other clients. LSA C said staff knew Client #2 had a high risk for elopement. At the time of the incident, it was acceptable for the driver to be responsible for Client #2, but it was no longer allowed since the elopement. Client #2's assigned staff person was responsible for keeping an eye on the client, but she was writing in the van log.</p> <p>When interviewed on 8/16/17 at 1:00 p.m. the Qualified Intellectual Professional (QIDP) confirmed the staff person responsible for Client #2 while on the van should have kept the client in the staff's visual field. The QIDP also acknowledged Client #2 did not demonstrate the skills to safely cross a street.</p> <p>When interviewed on 8/16/17 at 2:10 p.m. the Behavior Analyst said client #2 should have received the same level of supervision on the van as on an outing, which was to be in staff eyesight. At the time of the incident, it was not made clear whether the staff assigned to Client #2 could also be the driver of the van. Since the incident it was clarified the driver cannot be</p> | | | |
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| | responsible for Client #2. FACILITY RESPONSE: | | | | |
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