

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

PRINTED: 09/07/2017
FORM APPROVED
OMB NO. 0938-0391


9/14/17 OK 9/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/17/2017
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN OPPORTUNITY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1554 BROADWAY ST PELLA, IA 50219
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W 000	INITIAL COMMENTS As the result of the annual health facility survey and the investigation of incident #70049-I, deficiencies were cited as follows: Annual Survey: W249, W268 Investigation #70049-I: W249	W 000		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff consistently implemented client program plans. This affected 3 of 4 sample clients (Client #2, Client #3, and Client #4). Findings follow: 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	W 249	POC 9/22/17 All staff were retrained at the July and September staff meetings on the need to know and implement all program plans at all times. At the July meeting, special attention was paid to following supervision requirements for each individual. Specific protocol for supervision of individuals with known elopement risks when going in a vehicle with multiple individuals was revised and reviewed. All program Admin staff (QIDP, PMs, AM, HSCs, and BA) will monitor implementation of this and provide coaching to staff as needed.	9/22/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ICF/ID Administrator	(X6) DATE 9/15/17
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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 249	<p>Continued From page 1</p> <p>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 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</p>	W 249	

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W 249	<p>Continued From page 2</p> <p>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 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</p>	W 249	

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W 249	<p>Continued From page 3</p> <p>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 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.</p>	W 249			

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W 249 : Continued From page 4

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.

When interviewed on 8/15/17 at 2:15 p.m. LSA C stated when the van parked near the front of the facility after returning from the van ride on 8/25/17, 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.

When interviewed on 8/16/17 at 1:00 p.m. the

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W 249	<p>Continued From page 5</p> <p>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 can not be responsible for Client #2.</p> <p>2. Observation on 8/14/17 at 5:20 p.m. revealed LSA D approached Client #3, verbally prompted him/her to stand and walked with him/her to the restroom. LSA D returned to the restroom and assisted Client #3 back to the living room at 5:55 p.m. Client #3 remained in the restroom for 35 minutes.</p> <p>Record review on 8/16/17 revealed Client #3's staff service to maintain his/her health and safety due to rectal prolapse. The service plan directed staff to allow Client #3 to sit on the toilet for 5 minutes at a time. The plan further noted staff should "frequently check" on Client #3 while on the toilet.</p> <p>When interviewed on 8/16/17 at 11:39 a.m., the QIDP confirmed staff failed to follow Client #3's service plan.</p> <p>3. Observations at supper on 8/14/17 revealed Client #4 took multiple bites of food; sometimes</p>	W 249			

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W 249	Continued From page 6 taking large bites. Staff intermittently prompted him/her to take smaller bites. Staff failed to consistently prompt him/her to take drinks. Further observations on 8/15/17 at breakfast revealed Client #4 took up to five bites of food before staff prompted him/her to take a drink. Record review on 8/16/17 revealed Client #4's Eating Guidelines created 4/26/17. Teaching methods directed staff to cue Client #4 to take a drink after every 2-3 bites. Further record review revealed an OT evaluation of eating skills completed on 4/19/17. The evaluation noted a modified barium swallow study completed with Client #4 on 12/21/07 indicated he/she required a puree diet with regular thin liquids. The OT advised Client #4 should take a drink every 1 - 3 bites to assist with clearing his/her oral and vallecular cavity. When interviewed on 8/16/17 at 2:17 p.m., the QIDP confirmed staff should follow the eating guidelines and prompt Client #4 per the OT recommendation.	W 249		
W 268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure clients were encouraged to participate in activities of daily living, household chores and recreational activities to the greatest extent possible This	W 268	All staff were retrained at September staff meetings on encouraging people supported to participate in activities of daily living, household chores, and recreational activities to the greatest extent possible - both when there is formal programming, and at more informal times throughout their day. All ICF/ID admin level staff (PMs, AMs, QIDP, HSC, RD, BA) will provide coaching to staff as needed regarding this concept when they are observing interactions between staff and people supported.	9/22/17

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W 268	Continued From page 7 affected 3 of 4 sample clients (Clients #1, #2 and #3) and three clients added to the sample (Clients #5, #6 and #9). Findings follow: 1. Observations at North House on 8/14/17 from approximately 4:40 p.m. - 6:30 p.m. revealed staff failed to encourage clients to participate in activities to promote growth and development. Examples included, but were not limited to the following: a. 4:40 p.m. - 4:50 p.m. Client #5 sat in a chair and shook a cloth and/or put the cloth in his/her mouth. At 4:55 p.m., he/she pulled off the shirt he/she wore. LSA B stated Client #5's name and walked away. Client #5 continued to shake the cloth. b. 5:30 p.m. LSA B cut grapes in the kitchen while Client #6 sat in a wheelchair behind her. LSA D wiped the dining room tables while Client #5 and Client #7 sat in the living room with no activity. c. 5:45 p.m. LSA D pushed Client #6 into the dining room and talked to him/her while she set the table. Client #6 wheeled out of the area. d. 5:50 p.m. - 6:25 p.m. Client #3 sat on the couch while staff prepared the evening meal. No staff interacted with him/her or offered any activity. e. 6:25 - 6:30 p.m. LSA B and MA A placed food items in a processor and proceeded to puree the food. Client #3 and Client #4 sat at the dining room table. LSA B and MA A served pureed food	W 268			

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W 268	<p>Continued From page 8 to Client #3 and Client #4.</p> <p>f. 6:30 p.m. LSA B asked clients if they wanted ketchup and mustard for their sandwiches. She put the condiments on sandwiches without involving any clients.</p> <p>2. Observations at South House on 8/14/17 from approximately 4:40 p.m. to 6:20 p.m. revealed the following:</p> <p>a. 4:40 p.m. - 5:10 p.m. Client #9 wandered in and out of the kitchen as he/she appeared to want to help with meal preparation. The cook in the kitchen did not ask/prompt Client #9 to help. At 4:50 p.m. another staff person noted Client #9 had signed or indicated that he/she wanted to help cook. The cook said there was nothing else to do at that time. At 4:55 p.m. the cook operated the food processor in the kitchen, with no client assistance. A staff person told the cook again at 5:08 p.m. that Client #9 would like to help cook. The cook did not ask/prompt Client #9 to help her, but did then have Client #2 help with some of the meal preparation.</p> <p>b. 5:45 p.m. Staff poured milk and other drinks for all clients for the evening meal. Staff also added chocolate syrup to some clients' glasses of milk. Clients did not help with any of this. The milk and other drinks sat on the table until dinner started around 6:15 p.m.</p> <p>c. 6:18 p.m. Staff gave fully served plates of food to Client #1 and Client #2. Both clients then proceeded to eat independently. Both clients had the ability to help serve their food.</p> <p>3. Observation on 8/14/17 at 4:05 p.m. revealed</p>	W 268		

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W 268	<p>Continued From page 9</p> <p>Medication Aide (MA) A spooned applesauce and medication into Client #4's mouth. Further observation at supper revealed Client #4 fed himself/herself independently with a coated teaspoon.</p> <p>Record review on 8/16/17 revealed Client #4's Occupational Therapy (OT) Evaluation completed on 4/19/17. The report indicated Client #4 could eat independently with adaptive equipment and some supervision.</p> <p>When interviewed on 8/15/17 at 1:35 p.m., the Registered Nurse (RN) confirmed staff should give Client #4 a coated spoon and allow him/her to take the medication to increase independence.</p> <p>4. Observation on 8/15/17 at 7:15 a.m. revealed MA C administered morning medications to Client #1. MA C completed all steps of medication administration, including setting up the medication, adding applesauce and spooning the applesauce and medication mixture into Client #1's mouth. Client #1 had been observed to eat independently at meals. When asked why Client #1 wasn't feeding him/herself the medication, MA C stated the client probably could do this and handed the applesauce mixture and spoon to the client, who proceeded independently eat the mixture.</p> <p>Record review on 8/16/17 revealed the facility Active Treatment Guidelines. The document noted each client must receive services to acquire skills and behaviors to be as independent as possible. In addition, the document explained staff should "take advantage of training opportunities" and gave examples of doing things for themselves as much as possible such as</p>	W 268			

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W 268	<p>Continued From page 10</p> <p>defined active treatment as provision of training to develop skills to be as independent as possible. Staff direction included taking advantage of training opportunities and examples included helping prepare meals and doing things "with" the staff. Staff were advised to "INVOLVE, INTERACT at least once every 5 minutes" and "INTERVENE self- stimulator and self-injurious behavior".</p> <p>When interviewed on 8/16/17 at 12:05 p.m., the Qualified Intellectual Disability Professional confirmed staff should involve clients in tasks and encourage skill acquisition/maintenance.</p>	W 268		

