√ 9/28/17 OK

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G126	A. BUILDING ____ B. WING ____	R-C 08/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK RIDGE	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 The revisit of investigation #68888-I was completed 8/23/17 - 8/28/17. The investigation of #70097-I was also conducted during this time. During the revisit, previously cited deficiencies at W158, W159, and W193 were determined to not be met and were re-cited. The revisit also resulted in a deficiency cited at W104. The investigation of #70097-I resulted in a deficiency cited at W189.	{W 000}	See ~~attached~~ POC 9/15/17	
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 interviews and record reviews, the governing body failed to adequately ensure appropriate training and oversight of staff to provide clients with sufficient supports and services to address inappropriate client behavior and ensure the health and safety of all clients residing in the facility. This potentially affected 4 of 4 clients residing in the facility, specifically Client #1. Findings follow: 1. Record review revealed the following: a. Client #1 eloped from his/her home on 6/17/17. On 6/22/17 the facility was notified of an Immediate Jeopardy due to concerns for client safety. The facility failed to update and revise	W 104		

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 104	Continued From page 1 program plans to ensure client safety. Additionally, the facility failed to ensure staff consistently demonstrated the ability to manage client needs in order to maintain client safety and well-being. b. On 6/28/17 (date of exit) the facility received the following deficiencies as the result of investigation #68888-I: W158: 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. 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. W193: Based on interviews and 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. c. Continued record review revealed a Plan of Correction submitted to the Department of Inspection and Appeals (DIA) on 7/25/17. According to the POC, the Qualified Intellectual Disability Professional (QIDP) would complete active treatment observation forms weekly. The Program Director "will complete quality assurance checks on the active treatment observation forms." Status of completion was "ongoing."	W 104		

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W 104	Continued From page 2 See W159. Continued record review revealed no documentation to support completion of quality assurance checks by the Program Director. When interviewed on 8/24/17 at 1:30 p.m. the Program Director stated she talked about the active treatment observations at the weekly meetings however she did not initial or date the forms upon review. She produced meeting minutes which lacked documentation or reference of review of the forms. She confirmed a lack of documentation of review of the forms. d. Continued review of the POC submitted 7/25/17 revealed a communication log would be developed and in each home. The log "included a printed copy of all formal programming for each person served." A sign off sheet would be located in the front of the log for each staff to sign to note any changes. Date of completion: 8/4/17. See W193. Continued record review revealed the facility failed to complete timely training of staff. Review of training logs indicated staff training began 8/16/17. When interviewed on 8/23/17 at 1:25 p.m. QIDP A explained a mandatory meeting was scheduled for 8/2/17 to train on the communication log. However, the staff including management were looking for the Client #1 due to an elopement. The mandatory training did not take place. She produced a sign in sheet with the first staff signature being on 8/16/17 (two weeks after the completion date).	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 104	Continued From page 3 Interview with the Program Director on 8/24/17 at 1:30 p.m. revealed she addressed the need to complete the training after the delay from 8/2/17. She stated she asked the following week and the training was still not done and she instructed the QIDP to complete the training with staff individually. e. Continued review of the POC submitted 7/25/17 revealed a new orientation packet for temporary agency staff was developed. A sign off sheet would be in the front of the book for temp staff to sign. Date of completion was 8/4/17. See W193. Record review on 8/23/17 revealed the sign in book for the temporary agency staff noted two signatures prior to 8/2/17. Four additional signatures were obtained after 8/15/17. When interviewed on 8/23/17 at 1:25 p.m. QIDP A explained a mandatory meeting was scheduled for 8/2/17 to train the temporary staff; however, the training was delayed due to an elopement that day. Interview with the Program Director on 8/24/17 at 1:30 p.m. revealed she addressed the need to complete the training after the delay from 8/2/17. She stated she asked the following week and the training was still not done and she instructed the QIDP to complete the training with staff individually. In summary, the facility failed to ensure adequate oversight and timely training of staff to ensure provision of supports and services to ensure the	W 104		

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W 104	Continued From page 4 health and safety of clients.	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) Facility Staffing. The facility failed to implement a staff training system to adequately manage client behavioral needs. The facility failed to adequately correct deficient practices found at W159 and W193 on 6/28/17. Additional concerns were cited at W189. Cross reference W159: Based on interviews and record review, the facility failed to thoroughly and adequately ensure coordination and monitoring of individual program plans (IPP). Cross referenceW189: Based on interview and record review, the facility staff failed to ensure all staff adequately and competently implemented emergency procedures. Staff failed to immediately contact administration on call and/or emergency services during client elopement. Cross reference W193:Based on interviews and record review, the facility failed to ensure timely and adequate training to ensure staff correctly and consistently implemented behavior strategy programs to manage inappropriate client behavior.	{W 158}		
{W 159}	483.430(a) QIDP Each client's active treatment program must be	{W 159}		

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{W 159}	Continued From page 5	{W 159}		

integrated, coordinated and monitored by a qualified intellectual disability professional.
This STANDARD is not met as evidenced by:
Based on interviews and record review, the facility failed to thoroughly and adequately ensure coordination and monitoring of individual program plans (IPP). This potentially affected 4 of 4 clients residing in the facility, specifically Client #1.

Finding follows:

Record review revealed the facility received a deficiency at W159 on 6/28/17 regarding Qualified Intellectual Disability Professional's (QIDP) failure to update and revise IPPs as necessary to ensure client safety.

Additional record review revealed the facility submitted a Plan of Correction (POC) to the Department of Inspection and Appeals (DIA) on 7/25/17. According to the POC, the QIDP would complete active treatment observation forms weekly. The Program Director would "complete quality assurance checks on the active treatment observation forms." Status of completion was "ongoing."

Further record review on 8/23/17 revealed no documentation to indicate completion of quality assurance checks.

When interviewed on 8/24/17 at 1:30 p.m. the Program Director stated she talked about the active treatment observations at the weekly meetings; however, she did not initial or date the forms upon review. She produced meeting minutes which lacked documentation or reference of review of the forms. She confirmed a lack of

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{W 159}	Continued From page 6 documentation of review of the forms.	{W 159}		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility staff failed to ensure all staff adequately and competently implemented emergency procedures. Staff failed to immediately contact administration on call and/or emergency services during client elopement. This affected 1 of 1 client (Clients #1) identified in #70097-I. Findings follow: Record review on 8/23/17 revealed an All Behavior Document, dated 8/2/17. According to the document, Client #1 became upset and left the home followed by Staff A. Staff A followed him/her on foot and eventually rode with Qualified Intellectual Disability Professional (QIDP) A. They followed in a vehicle until relieved by QIDP B who was also in a vehicle. QIDP B lost sight of Client #1. Client #1 was out of sight for approximately three hours. Client #1 received a ride from a stranger and went to Riverside. He/She hitched another ride to the Gospel Mission, where the client was located by police. Review of Client #1's Admission Record revealed the client, 28 years old, had diagnoses including: other specified intracranial injury without loss of consciousness, attention deficit hyperactivity disorder, unspecified mood (affective) disorder,	W 189		

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W 189	Continued From page 7	W 189		

borderline personality disorder and mild intellectual disabilities. Client #1 was admitted to Opportunities Unlimited on 2/4/16.

Review of Client #1's Program Procedural Format (updated on 6/28/17) revealed the client utilized walking as a coping skill. The client was assigned a 1 to 1 staff for supervision due to history of elopement. The program incorporated the use of walking a safe route-including Glen Oaks Boulevard, Outer Belt Drive or North High School track.

Record review revealed a "Mandatory meeting Agenda in regards to Elopements held 6/23/17." The document (signed by all staff) read: Protocol for losing sight of an individual (Immediately contact Residential on call, Administrator on call, Police Department).

Record review of Missing Persons policy revised 2006 also directed staff to notify the Administrator on call who would then determine if the police department should be notified.

Interview with QIDP B on 8/23/17 at 3:30 p.m. revealed she took over supervision of Client #1 from Staff A and QIDP A on Stone Park Boulevard. She talked with Client #1 who refused to return to the home. Client #1 proceeded to walk and as QIDP B attempted to pull on the road several vehicles went by. When QIDP B entered the road way she lost sight of Client #1. She searched the area for approximately 10 minutes and then called another QIDP and office personnel. She said the Program Director arrived and the police were called. The police department put out alerts, helicopters and drones to search for the client. Eventually, Client #1 was located at

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W 189	Continued From page 8 the Gospel Mission and the police and staff found him/her there. Review of Sioux City Police Department records noted a report completed on 8/2/17 which described police looking for Client #1 after the client took off walking. The client was located several hours later at the mission. Observation of the area on 8/23/17 revealed Chambers Street, 27th Street, Stone Park Boulevard were two lane paved roads with a 30 mile per hour (mph) speed limits. The road eventually forked off to gravel roads which were occasionally lined with trees/bushes. The distance was 5.4 miles according to the odometer. According to Weather Underground the temperature on 8/2/17 at 1:52 p.m. was 84.9 degrees Fahrenheit without precipitation. When interviewed on 8/24/17 at 1:30 p.m. the Program Director explained when she arrived at the scene Client #1 had last been seen about 1/2 hour after QIDP B lost sight. She learned of the elopement from a message left on her phone. She found out the police had not been contacted and did so immediately. She said valuable time was lost by not following the policy to notify the Administrator on call, and the police department. She confirmed the current policy for a missing person.	W 189		
{W 193}	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.	{W 193}		

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{W 193}	Continued From page 9	{W 193}		

This STANDARD is not met as evidenced by:
Based on interviews and record review, the facility failed to ensure timely and adequate training to ensure staff correctly and consistently implemented behavior strategy programs to manage inappropriate client behavior. This potentially affected 4 of 4 clients residing in the home, specifically Client #1.

Findings follow:

Record review revealed the facility received a deficiency at W193 on 6/28/17 due to inadequate staff training to ensure correct and consistent implementation of client behavior strategy plans to manage inappropriate client behavior. The facility failed to train staff on a client's behavior strategy plan to address elopement behavior. As a result, the client left without staff knowledge or authorization.

1. Continued record review revealed the facility's Plan of Correction (POC) submitted to DIA. According to the POC, a communication log would be developed and in each home. The log "included a printed copy of all formal programming for each person served". A sign off sheet in the front of the log for each staff to sign to note any changes. Date of completion: 8/4/17.

Continued record review revealed the facility failed to complete corrective action in a timely manner.

When interviewed on 8/23/17 at 1:25 p.m. Qualified Intellectual Disability Professional (QIDP) A explained a mandatory meeting was

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{W 193}	Continued From page 10	{W 193}		

scheduled for 8/2/17 to train on the communication log. However, the staff including management were looking for the Client #1 due to an elopement. The mandatory training did not take place. She produced a sign in sheet with the first staff signature being on 8/16/17 (two weeks after the completion date).

Interview with the Program Director on 8/24/17 at 1:30 p.m. revealed she addressed the need to complete the training after the delay from 8/2/17. She stated she asked the following week and the training was still not done and she instructed the QIDP to complete training staff individually.

2. Continued review of the facility's POC submitted to DIA indicated a new orientation packet for temporary agency staff was developed. A Sign off sheet would be in the front of the book for temp staff to sign. Date of completion was 8/4/17.

Continued record review revealed the facility failed to implement corrective action in a timely manner. Record review on 8/23/17 revealed the sign in book for the temporary agency staff noted two signatures prior to 8/2/17. Four additional signatures were obtained after 8/15/17.

Interview with a temporary agency staff, Staff B on 8/23/17 at 11:15 a.m. revealed training was not started until [8/15/17].

When interviewed on 8/23/17 at 1:25 p.m. QIDP A explained a mandatory meeting was scheduled for 8/2/17 to train the temporary staff. However, the training was delayed due to an elopement that day.

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{W 193}	Continued From page 11 Interview with the Program Director on 8/24/17 at 1:30 p.m. revealed she addressed the need to complete the training after the delay from 8/2/17. She stated she asked the following week and the training was still not done and she instructed the QIDPs to complete the training of staff individually.	{W 193}		

√9/29/17 OK

Plan of Correction
Oak Ridge Home
Investigation #: 68888-I
Revisit and Investigation #70097-I
09/22/2017

W104 483.410 Governing Body

The facility failed to adequately assure appropriate training and oversight to staff to provide client's with sufficient supports and services.

1. As stated on our plan of correction on 07/25/2017, we stated that the program director would be completing quality assurance checks of the weekly active treatment observation forms to be completed by the QIDP. Although, the observations were being completed as initially stated, however there was not adequate proof that the program director was reviewing the observations taken place. In a weekly residential/therapy leadership meeting, the weekly observations completed by the QIDP will be reviewed by the members in attendance of the meeting. In conclusion of the meeting, the program director will then sign off to verify that the observations occurred. Once the program director signs off, the observation forms will then be placed in the staff member's human resources file.
2. The Residential Manger and the Program Director will complete quality assurance checks quarterly. After review of Q notes, Progress notes and programming there will be feedback offered from both supervisors.

Status of Completion: Ongoing
Persons Responsible: QIDP's, Residential Manager, and Program Director

W158 483.430- Facility Staffing

The facility failed to specific training requirements were met.

1. There was a mandatory meeting held for residential and supported team members on 06/23/2017 to provide training on all maladaptive behavioral programming. In this meeting, the policy and procedure of any maladaptive behaviors exhibited by individuals served was reviewed. There was an acknowledgement sign off sheet given to each staff member along with a copy of all maladaptive behavior programming. Upon completion of this training, each staff member signed and dated that they attended and understand the importance as well as their role while working with maladaptive behavior. New employees of Opportunities Unlimited receive the same training upon the hiring process. The temporary staffing receives the training as well upon their first confirmed shift at Opportunities Unlimited.

Status of Completion: On going
Persons Responsible: QDIP's, Residential Manger, Program Director

W159 QIDP
The facility failed to thoroughly and adequately ensure coordination and monitor of individual's program plans.

1. As mentioned previously, we stated that the program director would be completing quality assurance checks of the weekly active treatment observation forms to be completed by the QIDP. Although, the observations were being completed as initially stated, however there was not adequate proof that the program director was reviewing the observations taken place. In a weekly residential/therapy leadership meeting, the weekly observations completed by the QIDP will be reviewed by the members in attendance of the meeting. In conclusion of the meeting, the program director will then sign off to verify that the observations occurred. Once the program director signs off, the observation forms will then be placed in the staff member's human resources file.

   Status of Completion: On Going
   Persons Responsible: QIDP's, Residential Manger, Program Director

2. Due to lack of follow through on original plan of correction to the DIA regarding a previous elopement with person served and failure to follow through with staff training regarding changes in formal programming for person served, the QIDP that was over seeing this home was put on suspension as of 6/22/2017, pending results of this investigation. She was then terminated from employment on 06/28/2017.

W193-483.430- Staff Training Program

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

1. In addition to the training conducted on 06/23/2017, Opportunities Unlimited had planned meetings for residential and other supported team members on 08/02/2017 to discuss the communication log. Due to an elopement that required numerous staff and leaders to respond to the area of the elopement, the meetings were postponed. Although the meetings were to take place prior to 08/04/2017, the facility failed to meet this deadline. The training then was rescheduled and did not take place until 08/16/2017. The facilities plan of correction for this deficiency in the future will consist of open communication with the Department of Inspection and Appeals in request for an addendum if necessary to the current plan of correction.

   Status of Completion: As Needed
   Persons Responsible: QDIP, Related Department Leader

2. Communication logs were developed and placed in each home. These include a printed copy of all formal programming for each person served within that home. There is 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 during their training period. 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. The QIDP will then review all programming monthly during the team meetings which will be held once a month.

   Status of Completion: On Going
   Persons Responsible: QIDP's and Training Coordinator

W.189-483.430- Staff Training program

The facility staff failed to ensure all staff adequately and competently implemented emergency procedures.

1. The company has modified the Incident Report and First Aid training to include the missing person policy as well as the missing person form. This is an annual renewal course for continued training for residential staff. During this course, the policy and procedure will be trained by the trainee of the course on protocol of a missing person. At the conclusion of this course, each staff will sign and date that they understand the policy and procedure for a missing person and that they acknowledge how to appropriately complete the missing person form.

   Status of Completion: On Going
   Persons Responsible: QDIP/s, Residential Manger, Human Resources