4/11/18 OK 1/9/18

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

PRINTED: 12/06/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G074	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #3	**612 EIGHTH STREET ROCKWELL CITY, IA 50579**

(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 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure guardian written informed consent obtained for the use of medication during a procedure. This affected 2 of 2 sample clients (Client #6 and #7). Finding follows: 1. Record review on 11/21/17 revealed on 4/18/17 Client #6's neurologist ordered an Electroencephalogram (EEG) and prescribed two milligrams of Ativan be given one hour prior to the medical test and another two milligrams given thirty minutes prior to the appointment, if needed. The neurologist noted the medication ordered for anxiety. Review of Client #6's Medication Administration Record (MAR) revealed Client #6 received two milligrams of Ativan on 5/12/17, prior to his/her EEG. Further record review revealed verbal telephone consent obtained from Client #6's guardian on 4/18/17; however, the record lacked guardian written informed consent or approval by the Human Rights Committee for the use of Ativan prior to the EEG.	W 124	See attached POC 12/6/17	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G074	A. BUILDING ______ B. WING ______	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #3	612 EIGHTH STREET ROCKWELL CITY, IA 50579

(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 124	Continued From page 1 2. Record review on 11/21/17 revealed on 6/22/17 Client #7's neurologist ordered an EEG and prescribed Ativan prior to the appointment. According to the order, Client #7 was to receive two milligrams of Ativan thirty minutes prior to the appointment and another two milligrams five to ten minutes later if the client was not sedated. Review of Client #7's MAR revealed on 7/7/17 Client #7 received two milligrams of Ativan prior to his/her EEG. The record lacked guardian verbal or written informed consent and did not include approval by the Human Rights Committee for the use of Ativan with Client #7 prior the EEG. Review of facility policies revealed "Opportunity Living Informed Consent Policy," last reviewed 11/24/15. According to the policy, informed consent should be obtained for medical treatments, restrictive programming, and/or the use of behavior modifying medications. The policy noted verbal consent could be accepted, but must be followed by a signed consent. When interviewed on 11/21/17 at 3:30 p.m., the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility failed to obtain guardian written informed consent from Client #7's guardian prior to the appointment. She stated she was not employed at the facility when Client #6 underwent the procedure, but confirmed the record lacked guardian written informed consent for the use of Ativan prior to the appointment. When interviewed on 11/22/17 at 8:50 a.m., the Director of Nursing (DON) confirmed the facility	W 124		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G074	A. BUILDING ______ B. WING ______	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #3	**612 EIGHTH STREET ROCKWELL CITY, IA 50579**

(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 124	Continued From page 2 did not have guardian written informed consent for the use of Ativan for Client #6 or Client #7. She stated she was not aware written informed consent was needed for the one time procedure. She explained the neurologist wanted both clients sedated to obtain accurate readings from the EEG.	W 124		
W 216	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include physical development and health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to review and update client Comprehensive Functional Assessments (CFAs) on an annual basis. This affected 2 of 4 sample clients (Client #2 and #6) who resided in South Home. Findings follow: 1. Record review on 11/21/17 revealed Client #2's CFA, dated 10/21/16. The record lacked a current CFA for Client #2. 2. Record review on 11/21/17 revealed Client #6's CFA, dated 9/19/16. A current CFA for Client #6 could not be located. When interviewed on 11/21/17 at approximately 3:30 p.m., the Qualified Intellectual Disabilities Professional (QIDP) confirmed the CFAs for Client #2 and Client #6 had not been reviewed or updated within the last year.	W 216		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAG0013	A. BUILDING: ______ B. WING ______	11/22/2017

NAME OF PROVIDER OR SUPPLIER: **OPPORTUNITY LIVING #3**

STREET ADDRESS, CITY, STATE, ZIP CODE: **612 EIGHTH STREET, ROCKWELL CITY, IA 50579**

(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) COMPLETE DATE
C 147	50.7(4) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility staff failed to report elopement of a client to the Department of Inspections and Appeals (DIA) within 24 hours, or the next business day. This affected 1 of 8 sample clients (Client #16). Finding follows: Review of facility incident reports (IRs) on 11/20/17 revealed a facility IR, dated 8/10/17. The report described an incident where Direct Support Professional A (DSP A) and DSP B assisted another client [in North Home] to bed and when they came out of that client's room they observed Client #16 walk back into the North home. Both DSP A and DSP B were unaware Client #16 left the facility and went to South Home. DSP A stated she had supervision of Client #16 on this evening however assumed another staff supervised Client #16 while she assisted another client to bed. She further stated she was not aware Client #16 left the house as she did not hear the door alarm sound when Client #16 exited the building.	C 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAG0013	A. BUILDING: ______ B. WING ______	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #3	612 EIGHTH STREET ROCKWELL CITY, IA 50579

(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) COMPLETE DATE
C 147	Continued From page 1 When interviewed on 11/21/17 at 9:00 a.m., Direct Support Professional (DSP) A confirmed she worked second shift on 8/10/17. She said she assisted another client with a brief change and putting her/him to bed when Client #16 walked to the facility's South Home next door. She did not realize Client #16 left the home/facility until he/she walked back in the door with a staff from the South home. She further stated she did not hear the door alarm sound. When interviewed on 11/21/17 at 9:40 a.m., Direct Support Professional (DSP) B confirmed she worked second shift on 8/10/17. She said she assisted Staff DSP A with putting another client to bed. Staff DSP B stated she did not realize Client #16 left the facility until a staff from the South home walked in the door with Client #16. She further stated she did not hear the door alarm sound [when the client left]. When interviewed on 11/21/17 at 11:30 a.m., Direct Support Professional (DSP) D stated he recalled the incident with Client #16 coming into the South home. Staff DSP D reported he had been in the living room assisting another client when Client #16 came into the living room and took something. Staff DSP D reported Staff DSP C returned Client #16 to his/her home (North). When interviewed on 11/21/17 at 10:30 a.m., Direct Support Professional (DSP) C stated she did not recall the incident with Client #16 but stated Client #16 had entered the home without staff before. Record review on 11/20/17 revealed Client #16's Annual Staffing Conference Report dated 10/6/16 revealed " The gazebo area is fenced in and is thus safe for Client #16. Client #16 will walk	C 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAG0013	A. BUILDING: ____ B. WING ____	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #3	612 EIGHTH STREET ROCKWELL CITY, IA 50579

(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) COMPLETE DATE
C 147	Continued From page 2	C 147	See attached	

through the gated gazebo area of North and South homes, and enter South home. However, staff supervision and presence is required when outdoors".

Annual Evaluation Living Unit report, dated 10/6/16 revealed Client #16 will leave the home unattended but is in [staff] sight while keeping him/her safe. Client #16 is known to take other's items and hides them, even from the other homes.
Client 16's annual report identified under supervision/elopement revealed due to the lack of survival skills & possibly that Client #16 could exit the home and cross the street (if she sees something visually appealing in the area);staff supervision & presence is required when outdoors.

Record review on 11/20/17 revealed a facility policy called Opportunity Living Elopement Policy. The policy included "Elopement incidents will be appropriately communicated to the proper authorities, investigated and intervened in promptly." The policy further noted, "Prevention of Client/consumer elopement is every staff members responsibility. Prevention of elopement happens when there is appropriate accountability for clients/consumers, when there is knowledge of the client's/consumer's tendencies and when there is active communication taking place between staff and clients/consumers. The policy revealed if a client is missing Department of Inspections and Appeals should be contacted.

When interviewed on 11/20/17 at 1:25 p.m., Qualified Intellectual Disabilities Professional (QIDP) A confirmed staff from South Home found Client #16 in South Home according to the incident report. She stated Client #16 did not

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAG0013	A. BUILDING: ______ B. WING ______	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #3	**612 EIGHTH STREET ROCKWELL CITY, IA 50579**

(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) COMPLETE DATE
C 147	Continued From page 3 leave the gated area between North and South Homes and she did not think this was an elopement therefore it did not need to be reported. When interviewed on 11/21/16 at 2:30 p.m., the Director of Programming and Services stated he didn't report the incident to the Department because there were no injuries and the client never left the facility, as he/she remained in a secured fenced area between the two homes. They did not consider this an elopement.	C 147		

✓ 1/11/18

Opportunity Living Plan of Correction November 6, 2017
Citation 6711
12/06/2017
C147

<u>C147 50.7(4)</u>

When a resident elopes from a facility. For the purpose of this sub rule, elopes means when a resident who has impaired decision making ability leaves the facility without the knowledge or authorization of the staff.

Plan of Correction:

Staff training was completed by the Qualified Intellectual Disability Professional (QIDP) specific to those who may leave the house unattended including proper reporting procedure for elopement policy, "Staff are responsible for knowing where all clients are at all times. If a staff must go to an area of the home to assist another client, they are responsible for communicating this to another staff who will then become responsible for the client. Those responsible for the lack of supervision of a client and or does not report the elopement according to Opportunity Living policy will be suspended immediately. We have also added an additional staff from 4-8 during the week as well as 10-6 on the weekends.

<u>Persons Responsible</u>: Senior Counselor, QIDP, and Direct Support Professionals

<u>Monitored by the Senior Counselor and the Director of Programming and Services</u>. This will be monitored by reviewing training records to see if staff have been trained Dependent Adult abuse within the required time. We have also added an additional staff from 4-8 and !0-6 on the weekends when possible.

Final correction date 12/06/17

Opportunity Living III Plan of Correction December 18, 2017
11/20-11-22/17

W216: Individual Program Plan (CFR's

Based on interview and record review, the facility failed to review and update client Comprehensive Assessments (CFA" s) on an annual basis.

Plan of Correction:
Random Chart Audits will be done in all three licensures will be done on a monthly basis. These audits will be for those areas that are required to be in the client record.

Persons Responsible: Senior Counselor, QIDP, and Direct Support Professionals

Monitored by the Senior Counselor and the Director of Programming and Services. This will be monitored by reviewing random client records on a monthly basis to ensure CFA's are being completed in a timely manner

Final correction date 11/29/2017