✓ 12/22/17 OR 12/22/17

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

PRINTED: 12/14/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G055	A. BUILDING _____ B. WING _____	C 11/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITH, HOPE, AND CHARITY	1815 WEST MILWAUKEE STREET STORM LAKE, IA 50588

(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 investigtations of 72390-C and 72305-I were completed 11/27/17 -11/29/17. Investigation #72390-C resulted in no deficiencies. The investigation of 72305-I resulted in a deficiency cited at W249.	W 000	See attached	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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 followed client programs/supervision level according to the Individual Service Plan. This affected 1 of 1 client identified in investigation 72305-I. Finding follows: Record review on 11/27/17 revealed a self-reported incident occurred on 11/7/17. The Consumer Advocate Team Investigation described at approximately 5:15 p.m. Client #1 walked into another home's back door. Client #1 played outside in the fenced in area, climbed over the fence and walked into Faith home. Client #1's supervision level was for monitoring while outside every 2-3 minutes. Staff returned the client to his/her home with the responsible staff person	W 249	POC 1/31/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Richmond, ED | 12-20-17

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	Continued From page 1 feeding another client. Review of Client #1's face sheet revealed the client born on 12/31/2002 and admitted to Faith, Hope and Charity on 6/13/2016. The Individual Service Plan listed clients' diagnoses: Severe Intellectual Disabilities, Autism, Attention Deficit Hyperactivity Disorder and a Language Disorder. Record review Client #1's Individual Service Plan (ISP), dated 10/31/17. The ISP documented staff must have knowledge of Client #1's whereabouts at all times and further directed staff would have to monitor Client #1 through the living room when he/she was in the backyard. The ISP noted, "Trial: (Client #1) can be in the backyard ALONE (no other residents present) with staff checking every 2-3 minutes. Observation of the property on 11/27/17 revealed the facility with a fenced in area around each of the four homes. The fence of Client #1's home was approximately 75 feet from Highway 7 with heavy traffic. The speed limit on the highway was 50 miles per hour. Observation on 11/27/17 at 5:10 p.m. revealed 42 cars and 2 semi-trucks passed the building on the two way highway for a 5 minute period. When interviewed on 11/27/17 at 2:50 p.m. Direct Support Staff (DSS) A reported he was responsible for Client #1. He stated he knew Client #1 should be monitored every 2-3 minutes while outside. DSS A said he assisted another consumer to eat and did not check Client #1 for 10 - 15 minutes. By that time Client #1 climbed the fence and came in through Faith home. DSS A confirmed Client #1 would not be safe on the highway alone.	W 249		

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W 249	Continued From page 2 When interview on 11/27/17 at 3:40 p.m. DSS B reported she sat in the living room of Faith home when Client #1 walked in. Client #1 was not upset; however had the potential for peer to peer aggression if not supervised by staff. Client #1 wore clothing appropriate for the weather. Record review of Client #1's Comprehensive Functional Assessment, completed 10/3/17, revealed staff would need to complete the task and be with the client to safely cross the street. According to Underground Weather the temperature on 11/7/17 was 37 degrees with no wind. When interviewed on 11/28/17 at 3:00 p.m. the Director of Social Services confirmed DSS A failed to supervise Client #1 according to his/her level of supervision. However, the client's level of supervision was increased after this incident. She also confirmed Client #1 lacked the safety skills to cross the highway alone.	W 249		

POC

W249

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 followed client programs/supervision level according to the Individual Service Plan.

1. By December 20, 2017, at the "Quarterly All Staff Meeting" the lead QIDP will be responsible to train staff regarding their responsibility to report any unsafe resident behavior, as soon as safely possible to the resident's lead staff. This will allow the lead staff to immediately address the unsafe behavior in the most appropriate manner. The minutes of the all-staff meeting will be the maintained the Executive Director.
2. By January 1, 2018 the home lead staff will be trained on addressing unsafe behavior. The training will be the responsibility of the lead QIPD. The training information and completion will be maintained by the lead QIPD.
3. Beginning at the (4)homes next monthly meeting(completed by January 31, 2018) the level of supervision will be a standing agenda item: to impress the importance of knowing and following each residents current level of supervision; to review the current level of supervision; and to address any needed changes. Each home lead is responsible to maintain the agenda and minutes of the meetings.
4. By December 14, 2017, the staff person not following the current level of supervision was given a disciplinary action. The human resource director is responsible to maintain this written action.