ok
3/2/21

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
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 annual survey completed on 12/8/20 to 1/11/20, resulted in deficiencies written at W125, W149, W159, W249, W252, W268, W287, W288, W294, W331, W348, and Iowa Code 50.9 (3). At the time of the survey, a revisit for investigation ##91528-I & 91590-I (2F4O11) was also completed. The deficiency previously cited at W159 was determined to be NOT MET and re-cited. Investigations #88025-C, #90778-1, and #91425-C were completed and resulted in no deficiencies.	W 000	POC 4/1/21	
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to protect client rights. This affected 3 of 4 sample clients (Client #1, Client #2, and Client #4). Findings follow: 1. Observations on 12/9/20 from 4:00 p.m. to 4:41 p.m. revealed Client #1 sat strapped in to a recliner in the living room with no interactions from staff. At 4:41 p.m., facility staff walked up to Client #1 and told her they were going to eat in about thirty minutes. Client #1 continued to sit in the recliner with a strap around her waist	W 125	All Temporary Health Care Plans (THCP)'s will be copied and placed in a binder at the center (the copy) the original will remain with the MAR.Each day the nurses working will look at the THCP binder to see who will go to which home to assess the clients.Once a TCHP is discontinued the copy may be placed in the shred box. Under NO circumstances will anything restrictive be placed on the THCP. All nurses were educated on these changes. Additionally, QIDP's were reeducated that a written consent is needed and must be received back as a follow-up on a verbal consent for restrictive measures. Any restriction(s) need to go through the Human Rights Committee and will be monitored by them. Date of Correction: 03/01/2021	

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

Managing Director of Operation — 02/22/2021

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
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 125	Continued From page 1	W 125		

preventing her from getting out of the chair. At 5:00 p.m., facility staff unbuckled Client #1 from the recliner and Client #1 walked into the dining room to eat. At 5:13 p.m., Client #1 finished eating. From 5:13 p.m. to 5:20 p.m., facility staff assisted Client #1 brush her teeth and change her clothes. At 5:20 p.m., facility staff walked Client #1 back to the recliner and buckled her in. Client #1 yelled and cried out until 5:25 p.m. when she started to watch the movie on television.

Observations on 12/11/20 at 10:15 a.m. revealed Client #1 buckled into her recliner, pushed up to the dining table. Facility staff stated she just ate her snack and they pushed the recliner, while Client #1 sat in the recliner, to the living room in front of the television Direct Support Supervisor (DSS) A asked if it was time to get Client #1 up to walk. At 10:17 a.m., Certified Medication Aide (CMA) A put Client #1's shoes on and unbuckled her from the recliner. CMA A walked with Client #1 to the bathroom. At 10:27 a.m., CMA A and Client #1 down the hallway and out to the front of the house. Client #1 walked towards the craft table and CMA A redirected her to walk the other way. CMA A stated, "Let's go this way there is less stuff to grab." At 10:28 a.m., Client #1 sat in her wheelchair and independently moved around the home. At 10:39 a.m., CMA A stated she needed to start administering medications. CMA A buckled Client #1 back into her recliner and took Client #1's shoes off her. At 10:42 a.m., facility staff pushed the recliner, while Client #1 sat in it, to the dining table to do crafts. Facility staff put Client #1's shoes on her. At 10:46 a.m., facility staff unbuckled Client #1 and walked with her to the medication room. From 10:46 a.m. to 10:51 a.m., Client #1 sat in the medication room and received her water. At 10:51 a.m., facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 125	Continued From page 2 staff walked Client #1 walked back to the recliner, physically redirected her into the recliner, told her to get comfortable, and buckled Client #1 into the recliner. Client #1 tried to take off her shoes, but could not get them off. Facility staff took her shoes off for her. From 10:51 a.m. to 11:33 a.m., Client #1 sat buckled in the recliner at the dining table. At 11:33 a.m., facility staff pushed the recliner, while Client #1 sat in it, to the living room. At 11:43 a.m., three other clients started to eat lunch while Client #1 sat in the recliner yelling out and crying. From 11:50 a.m. to 11:55 a.m., Client #1 continued to cry and DSS A tried to hold her hand. At 12:05 p.m., Client #1 continued to cry and facility staff told her it was her turn to eat. At 12:17 p.m., CMA A unbuckled Client #1 from the recliner and walked with her to the dining table. Client #1 did not have her shoes on. Record review revealed the following: a. Client #1's Temporary Health Care Plan dated 3/9/20 to 7/5/20 for a sore on her big left toe. The intervention included, "1) Place Triple Antibiotic Ointment on toe/open area. 2) If able to keep (Band-Aid) on sore area place Band-Aid on. 3) If need to seatbelt to keep from making sore worse. 4) Let nursing know if gets worse. 5) Make sure to take (Band-Aid/tape) off at night when going to bed." b. Client #1's "On Going" Health Care Plan for sores on her feet and redness on her big toe. The plan did not include a start date for the initial problem. The intervention included, "1) Keep off feet as much as possible. 2) Email dietician regarding (adding) protein powder. 3) Lotion (and) check feet twice daily. 4) Buckle in recliner to prevent sores on feet. 5) Place TAO (Triple	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	106 WESTVIEW LAKE CITY, IA 51449

(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 125	Continued From page 3 Antibiotic Ointment) on (Right) big toe." When interviewed on 12/10/20 at 3:15 p.m. Qualified Intellectual Disability Professional (QIDP) B reported Client #1 would get sores on her feet from taking her shoes off. She thought they had a nursing care plan in place to keep her off her feet when she refused to wear her shoes. When interviewed on 12/16/20 at 8:50 a.m. the Director of Health Services stated Client #1's nursing care plan did not include to keep her off her feet if she refused to wear her shoes. She thought the facility would implement a plan for Client #1 to walk every hour. The Director of Health Services stated Client #1 needed to be up and walking because she had arthritis, although when Client #1 walked around without shoes she developed sores on her feet. She also stated part of the issue with Client #1 walking around the home was she engaged in PICA behaviors. When interviewed on 12/16/20 at 12:35 p.m. QIDP B confirmed the facility failed to protect Client #1's rights when they had her buckled into the recliner. 2. Record review revealed Client #2's Informed Consent for restrictive measures indicated verbal consent from Client #2's guardian on 7/29/20. The consent included the psychotropic medications, Vyvance, Clonidine, Trazodone, and Zyprexa. The consent also included other restrictions, which included restraint usage, one-piece garment, and a chime on Client #2's bedroom door. Written consent from Client #2's guardian could not be located.	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 125	Continued From page 4 When interviewed on 12/10/20 at 3:15 p.m. Qualified Intellectual Disability Professional (QIDP) B confirmed the facility failed to receive written consent for Client #2's restrictive measures. 3. Record review revealed Client #4's Informed Consent for restrictive measures indicated verbal consent from Client #4's guardian on 2/10/20. The consent included the psychotropic medications, Trazadone, Risperdone, Clonidine, Zoloft and Depakote. The consent also included other restrictive measures, which included an escort, physical hold, timeout and one-piece undergarment. Written consent from Client #4's guardian could not be located. When interviewed on 12/16/20 at 1:45 p.m. QIDP A confirmed the facility failed to receive written consent for Client #4's restrictive measures.	W 125		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff followed the incident reporting policy. This affected 3 of 4 sample clients (Client #1, Client #2, and #4). Findings follow: 1. Record review revealed the following:	W 149	Incident/Behavior report form was revised and is now a single, combined form. The Incident / Behavior Report Policy was also updated. The Compliance/Training Specialist, DSS's and QIDP's will train/educate all staff how and when to fill out the amended Incident/ Behavior Report. Director of Health Service/ designee will review all Incident/Behavior reports as they are turned in for accuracy and correct documentation. This is ongoing. Date of correction: 04/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 149	Continued From page 5 a. Client #1's Temporary Health Care Plan dated 3/9/20 to 7/5/20 for a sore on her big left toe. The intervention included, "1) Place Triple Antibiotic Ointment on toe/open area. 2) If able to keep (Band-Aid) on sore area place Band-Aid on. 3) If need to seatbelt to keep from making sore worse. 4) Let nursing know if gets worse. 5) Make sure to take (Band-Aid/tape) off at night when going to bed." b. Client #1's "On Going" Health Care Plan for sores on her feet and redness on her big toe. The plan did not include a start date for the initial problem. The intervention included, "1) Keep off feet as much as possible. 2) Email dietician regarding (adding) protein powder. 3) Lotion (and) check feet twice daily. 4) Buckle in recliner to prevent sores on feet. 5) Place TAO (Triple Antibiotic Ointment) on (Right) big toe." Incident reports could not be located for Client #1's sores on her feet. When interviewed on 12/16/20 at 7:56 a.m. the Director of Health Services acknowledged the facility failed to complete incident reports for Client #1's feet injuries. 2. Record review on 12/9/20 revealed the following: a. Client #2's Behavior Report dated 9/26/20 indicated he went outside without staff. b. Client #2's Behavior Report dated 10/24/20 indicated Client #2 hit Client #15 on the arm. An incident report could not be located for Client	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 149	Continued From page 6 #2's behavior reports on 9/26/20 and 10/24/20. 3. Record review on 12/16/20 revealed the following: a. Client #4's Behavior Report dated 10/8/20 indicated Client #4 slapped another client before staff escorted him away. b. Client #4's Behavior Report dated 10/12/20 indicated Client #4 placed his hands around another client's neck causing red marks before escorted to Time-out. c. Client #4's Behavior Report dated 11/8/20 indicated Client #4 grabbed another client's private area before escorted to Time-out. An incident report could not be located for Client #4's behavior reports on 10/8/20, 10/20/20, and 11/8/20. When interviewed on 12/16/20 at 5:30 p.m. Qualified Intellectual Disabilities Professional (QIDP) A confirmed the facility failed to complete incident reports for Client #4's peer-to-peer aggressions. Additional record review revealed the facility Incident Reporting Policy dated 4/28/20, indicated, "An Incident Report (IR) must be written by staff if any client incident occurred or there is a possibility that an injury will develop from the incident." When interviewed on 12/10/20 at 2:14 p.m. the Director of Health Services acknowledged the facility failed to follow their incident report policy.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 149	Continued From page 7 She stated she kept the incident reports and the QIDPs get the behavioral reports. They did not try to match them up to ensure every behavioral report had an incident report.	W 149		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the Qualified Intellectual Disability Professional (QIDP) failed to effectively integrate, monitor, and coordinate services in order to meet client needs. This affected 3 of 4 sample clients (Client #1, Client #2, and Client #4). Findings follow: 1. Observations on 12/9/20 from 4:00 p.m. to 4:41 p.m. revealed Client #1 sat strapped to a recliner in the living room with no interactions from staff. At 4:41 p.m., facility staff walked up to Client #1 and told her they were going to eat in about thirty minutes. Client #1 continued to sit in the recliner with a strap around her waist preventing her from getting out of the chair. At 5:00 p.m., facility staff unbuckled Client #1 from the recliner and Client #1 walked into the dining room to eat. At 5:13 p.m., Client #1 finished eating. From 5:13 p.m. to 5:20 p.m., facility staff assisted Client #1 brush her teeth and change her clothes. At 5:20 p.m., facility staff walked Client #1 back to the recliner and buckled her in. Client #1 yelled and cried out until 5:25 p.m. when she started to watch the movie on television. Observations on 12/11/20 at 10:15 a.m. revealed	W 159	All Temporary Health Care Plans (THCP)'s will be copied and placed in a binder at the center (the copy) the original will remain with the MAR.Each day the nurses working will look at the THCP binder to see who will go to which home to assess the clients. Once the TCHP is discontinued the copy may be placed in the shred box. Under NO circumstances will anything restrictive be placed on the THCP. Any restriction(s) need to go through the Human Rights Committee. All nurses were educated on these changes. Person(s) responsible: Staff Nurses Monitored by: Director of Health Services Date of Correction: 03/01/2021 All sensory and PT programs were restarted on a consistent basis to ensure completion. Additionally, DSP staff will be trainined on sensory programming. Director of Health Services/Director of Day Programming/designee will audit sensory programs weekly for 4 weeks and then monthly for 4 months to ensure frequencies are being met for each respective program. Date of correction: 04/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 159	Continued From page 8 Client #1 buckled into her recliner, pushed up to the dining table. Facility staff stated she just ate her snack and they pushed the recliner, while Client #1 sat in the recliner, to the living room in front of the television. Direct Support Supervisor (DSS) A asked if it was time to get Client #1 up to walk. At 10:17 a.m., Certified Medication Aide (CMA) A put Client #1's shoes on and unbuckled her from the recliner. CMA A walked with Client #1 to the bathroom. At 10:27 a.m., CMA A and Client #1 down the hallway and out to the front of the house. Client #1 walked towards the craft table and CMA A redirected her to walk the other way. CMA A stated, "Let's go this way there is less stuff to grab." At 10:28 a.m., Client #1 sat in her wheelchair and independently moved around the home. At 10:39 a.m., CMA A stated she needed to start administering medications. CMA A buckled Client #1 back into her recliner and took Client #1's shoes off her. At 10:42 a.m., facility staff pushed the recliner, while Client #1 sat in it, to the dining table to do crafts. Facility staff put Client #1's shoes on her. At 10:46 a.m., facility staff unbuckled Client #1 and walked with her to the medication room. From 10:46 a.m. to 10:51 a.m., Client #1 sat in the medication room and received her water. At 10:51 a.m., facility staff walked Client #1 walked back to the recliner, physically redirected her into the recliner, told her to get comfortable, and buckled Client #1 into the recliner. Client #1 tried to take off her shoes, but could not get them off. Facility staff took her shoes off for her. From 10:51 a.m. to 11:33 a.m., Client #1 sat buckled in the recliner at the dining table. At 11:33 a.m., facility staff pushed the recliner, while Client #1 sat in it, to the living room. At 11:43 a.m., three other clients started to eat lunch while Client #1 sat in the recliner yelling out and crying. From 11:50 a.m. to 11:55 a.m.,	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 159	Continued From page 9 Client #1 continued to cry and DSS A tried to hold her hand. At 12:05 p.m., Client #1 continued to cry and facility staff told her it was her turn to eat. At 12:17 p.m., CMA A unbuckled Client #1 from the recliner and walked with her to the dining table. Client #1 did not have her shoes on. Record review revealed the following: a. Client #1's Temporary Health Care Plan dated 3/9/20 to 7/5/20 for a sore on her big left toe. The intervention included, "1) Place Triple Antibiotic Ointment on toe/open area. 2) If able to keep (Band-Aid) on sore area place Band-Aid on. 3) If need to seatbelt to keep from making sore worse. 4) Let nursing know if gets worse. 5) Make sure to take (Band-Aid/tape) off at night when going to bed." b. Client #1's "On Going" Health Care Plan for sores on her feet and redness on her big toe. The plan did not include a start date for the initial problem. The intervention included, "1) Keep off feet as much as possible. 2) Email dietician regarding (adding) protein powder. 3) Lotion (and) check feet twice daily. 4) Buckle in recliner to prevent sores on feet. 5) Place TAO (Triple Antibiotic Ointment) on (Right) big toe." When interviewed on 12/10/20 at 3:15 p.m. Qualified Intellectual Disability Professional (QIDP) B reported Client #1 would get sores on her feet from taking her shoes off. She thought they had a nursing care plan in place to keep her off her feet when she refused to wear her shoes. When interviewed on 12/16/20 at 8:50 a.m. the Director of Health Services stated Client #1's nursing care plan did not include to keep her off	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 159	Continued From page 10 her feet if she refused to wear her shoes. She thought the facility would implement a plan for Client #1 to walk every hour. The Director of Health Services stated Client #1 needed to be up and walking because she had arthritis, although when Client #1 walked around without shoes she developed sores on her feet. She stated the facility had not taken Client #1 to the doctor about the sores she developed on her feet. She also stated part of the issue with Client #1 walking around the home was she engaged in PICA behaviors. When interviewed on 12/16/20 at 12:35 p.m. QIDP B confirmed the facility failed to complete team meetings to discuss Client #1's on-going feet issues and a plan to get her out of the recliner. 2. Record review revealed Client #1's Annual Evaluation for Occupational Therapy dated 1/23/20, indicated, "She should attend the Sensory Therapy Room at the Center 3-5 days a week to address her sensory needs. She will need to be a one-to-one in the Sensory Therapy Room. I would like the staff to have her swing, receive brushing, and deep pressure." Additional record review revealed Client #1's data sheets for sensory therapy dated September 2020 to November 2020. The data sheets indicated Client #1 participated in sensory therapy two times in September, three times in October, and one time in November. When interviewed on 12/16/20 at 12:35 p.m. QIDP B confirmed the facility failed to complete sensory activity for Client #1 three to five times a week.	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 159	Continued From page 11 3. Record review revealed Client #1's Annual Evaluation for Physical Therapy dated 11/20/19, indicated, "She leans forward when she walks, her hip flexors are short/tight. Use the gait belt to help direct her while walking." The Physical Therapist also recommended Client #4 stretch her hip flexors three to five times a week. Additional record review revealed Client #1's data sheet for physical therapy exercises dated July 2020 to December 2020. The data sheet indicated Client #1 completed physical therapy exercises five times in July, five times in August, four times in September, five times in October, and four times in November. When interviewed on 12/16/20 at 12:35 p.m. QIDP B confirmed the facility failed to complete physical therapy exercises for Client #1 five times a week. 4. Record review revealed Client #2's Annual Evaluation for Physical Therapy dated 3/4/20, indicated, "Improve posture by increasing hip and trunk flexibility." The Physical Therapist included hamstring stretches, hip flexor stretches, trunk flexion in sitting, and calf stretches on an incline board done three to five times per week. Additional record review revealed Client #2's data sheet for his physical therapy exercises dated July 2020 to December 2020. The data sheet indicated Client #2 completed his exercises four times in July, three times in August, three times in September, six times in October, and five times in November. When interviewed on 12/16/20 at 12:35 p.m.	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 159	Continued From page 12 QIDP B confirmed the facility failed to complete physical therapy exercises for Client #2 five times a week. 5. Intermittent observations in House F from 12/9/20 to 12/15/20 revealed Client #4 spent most of the time wandering around the house. On several occasions, staff asked him to participate in activities, which he mostly refused but at no time was he offered a sensory item to engage. Record Review revealed Client #4's Annual Evaluation for Occupational Therapy dated 1/30/20. The evaluation indicated Client #4 should continue to attend sensory therapy three to five times a week to improve sensory modulation, sensory seeking behaviors, sensory defensiveness and prevent behaviors. Additional record review of Client #4's Incident Reports from September 2020 to November 2020 revealed Client #4 averaged over nine documented incidents of aggressive behaviors toward staff and/or peers per month. When interviewed on 12/16/20 at 1:45 p.m. QIDP A confirmed Client #4 had not been able to attend sensory therapy at the Center (on campus) due to Covid-19 risks. She confirmed sensory input is important for Client #4 and admitted he lacked consistent therapy since March 2020. She revealed the staff who conducted sensory activities used to come to the house to see Client #4, but missed a lot of work. She indicated staff possessed many sensory items at the house they should be using with the client. When asked if the facility trained the staff to use sensory equipment, she reported she assumed sensory	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 159	Continued From page 13 staff showed them some things they could do with Client #4, but could not be sure and admitted nothing formal was in place.	W 159		
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 observations, interviews and record reviews, the facility failed to ensure clients received needed supports and services as outlined in the Individual Support Plan (ISP). This affected 2 of 4 sample clients (Client #3 and Client #4). Findings follow: 1. Observations in House E on 12/8/20 at 5:20 p.m. and 5:35 p.m. revealed Client #3 ate alone at the dining room table without staff supervision. Observations on 12/9/20 at 7:40 a.m., during breakfast, revealed Client #3 ate alone at the dining room table without staff supervision. Observations on 12/15/20 at 4:55 p.m. and 5:13 p.m., during dinner, revealed Client #3 ate alone at the dining room table without staff supervision. Record review revealed Client #3's Behavior	W 249	The QIDP's will reeducate staff on client IPP'S, completing the programs as written and documenting the completion of the client programs. The QIDP's will review the documentation required for IPP's 1X a week for 4 weeks, then 2 times a month for 2 months to ensure staff are completing the programs as written. The QIDP's will report the progress of the above to the Director of Community Living 2X a month. Date of correction: 04/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 249	Continued From page 14 Objective Program dated 10/1/20 to 10/1/21. The program indicated Client #3 needed to use her silverware to push food onto her spoon rather than her fingers for 65% of trials. The program indicated staff should run the program during all meals. When interviewed on 12/16/20 at 1:45 p.m. the Qualified Intellectual Disabilities Professional (QIDP) A confirmed staff needed to provide Client #3 with consistent supervision during meals in order to be able to run her program by redirecting her when necessary. 2. Observations in House E on 12/9/20 at 7:50 a.m. revealed Nurse A administered Client #3's morning medication. Client #3 mentioned her medication program and asked if they were going to run it. Nurse A initially ignored the statement, but when Client #3 repeated the question, Nurse A confirmed they were not going to run the program. Nurse A removed all the medications from the cassettes, mixed them with applesauce and fed them to Client #3. Record review revealed Client #3's Behavior Objective Program dated 10/1/20 to 10/1/2021. The program indicated Client #3 needed to identify the correct dosage, frequency and the reason for specific medications with 95% accuracy. The document also indicated it should be run once daily at any medication pass. When interviewed on 12/9/20 at 7:55 a.m. Nurse A admitted she knew about the program, but chose not to run it during the medication pass. When asked why she chose not to run the program, she explained and showed on the data sheet the program only needed to be run at one	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 249	Continued From page 15 medication pass each day and she decided to let afternoon nurses run the program. The data sheet revealed nursing staff ran the program just three of the first eight days of December. 3. Observations in House F on 12/8/20 at 5:15 p.m. revealed Client #4 sat at the dining room table for dinner. Staff brought all his food and drinks to him, which included a grilled cheese sandwich. The staff attempted to assist Client #4 cut up the sandwich with a rocker knife. After one attempt, Client #4 pulled away and staff finished cutting up Client #4's sandwich. Record review revealed Client #4's Behavior Objective Program dated 5/9/20 to 5/9/21. The program indicated Client #4 would assist with cutting up a portion of the food with assistance for 65% of trials. The procedure called for staff to pause briefly and then try again if Client #4 pulled away from helping at the first attempt. After the second attempt, staff needed to pause a little longer than the first time and try again. Finally, the program indicated staff should cut the food for Client #4 if he pulled away a third time. When interviewed on 12/16/20 at 1:45 p.m. the QIDP A confirmed staff needed to follow the prompting sequence in Client #4's program before cutting up his food for him. 4. Observations in House F on 12/9/20 at 11:55 a.m. revealed Client #4 sat and ate lunch at the dining room table. Client #4 took large bites of food, one right after another without staff supervision. Client #4 finished ¾ of his lunch. Observations on 12/15/20 at 5:10 p.m. revealed Client #4 ate large bites of food with inconsistent supervision despite staff being next to him at the	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 249	Continued From page 16 table. At one point, Client #4 took a large bite and began to cough. Once he coughed, staff seated next to him asked him to slow down. Record review revealed Client #4's annual speech therapy evaluation completed on 1/30/20. The evaluation indicated staff needed to monitor the client during meals for bite size pieces and to ensure an appropriate rate of intake. When interviewed on 12/16/20 at 1:45 p.m. the QIDP A confirmed staff needed to provide consistent supervision of Client #4 during meals to ensure safety.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to record required program data as written in client program plans to ensure an accurate measurement of client progress towards specific goals. This affected 3 of 4 sample clients (Client #2, Client #3 and Client #4). Findings follow: 1. Record review revealed Client #2's Behavior Management Program for inappropriate behaviors dated 8/10/20, indicated "Inappropriate Behavior is defined as: stealing, leaving an area, stripping/pulling off or pulling apart his brief,	W 252	The QIDP's will reeducate staff on client IPP'S, completing the programs as written and documenting the completion of the client programs. The QIDP's will review the documentation required for IPP's 1X a week for 4 weeks, t hen 2 times a month for 2 months to ensure staff are completing the programs as written. The QIDP's will report the progress of the above to the Director of Community Living 2X a month. Date of correction: 04/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 252	Continued From page 17 physical aggression, dumping/smearing personal care products." The program also indicated, "Document all incidents of inappropriate behavior on a behavior report..." Additional record review revealed the following incident reports: a. On 9/15/20, Client #2 hit Client #18 on the back without injury. A behavioral report for Client #2 could not be located. b. On 10/20/20, Client #2 slapped Client #13 on the back of the neck without injury. A behavioral report for Client #2 could not be located. c. On 10/21/20, Client #2 slapped and pinched Client #17 without injury. A behavioral report for Client #2 could not be located. d. On 10/21/20, Client #2 slapped Client #13 across the face without injury. A behavioral report for Client #2 could not be located. When interviewed on 12/9/20 at 3:20 p.m. Qualified Intellectual Disability Professional (QIDP) B acknowledged the facility failed to complete the behavioral reports for Client #2. She stated Client #2 did not have a separate data sheet for his behavior program. She used the behavioral reports to count Client #2's monthly inappropriate behaviors and determine his progress. She did not review or have access to the incident reports to ensure staff documented Client #2's inappropriate behaviors on a behavioral report. 2. Record review revealed Client #3's Behavior Objective Program to complete an exercise	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 252	Continued From page 18 routine to promote weight loss. The program indicated to implement the exercise routine daily. Additional record review revealed October 2020 program data documented on 11 of 30 days and November 2020 program data documented on 19 of 30 days with Client #3 absent for one day. 3. Record review revealed Client #3's Behavior Objective Program to learn self-administration of medication. The program indicated the client needed to identify medication frequency, proper dosage and a reason for specific medications once daily. Additional record review revealed October 2020 program data documented on 19 of 31 possible days and November 2020 program data documented on 15 of 30 possible trials. The November data sheet indicated on 11/5/20 nursing did not have time to run the program. The data sheet also indicated on 11/19/20 nursing did not run the program due to a Covid-19 precaution. 4. Record review revealed Client #4 Behavior Objective Program to come to the office to receive medications with less than two verbal prompts for 90% of trials. The program needed to be run at all three medications passes each day. Additional record review revealed September 2020 program data, documented on 60 of 90 potential trials, indicated they failed to run one trial due to an outing. The October 2020 program data, documented on 61 of 93 potential trials, indicated the facility failed to run the program six times due to a nursing orientation. The	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 252	Continued From page 19 November 2020 program data documented on 51 of 66 trials before the facility had an outbreak of COVID-19 on 11/23/20. On 11/5/20, facility staff documented they had no time to run the program and on 11/8/20, the client was uncooperative. When interviewed on 12/16/20 at 1:45 p.m. QIDP A indicated she was aware of the lack of recorded program data and she understood the importance of the data collection in measuring client progress.	W 252		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) 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 staff engaged clients in activities to promote growth and independence. This affected 1 of 4 sample clients (Client #1). Finding follows: Observations on 12/9/20 from 4:00 p.m. to 4:41 p.m. revealed Client #1 sat strapped to a recliner in the living room with no interactions from staff. At 4:41 p.m., facility staff walked up to Client #1 and told her they were going to eat in about thirty minutes. Client #1 continued to sit in the recliner with a strap around her waist preventing her from getting out of the chair. At 5:00 p.m., facility staff unbuckled Client #1 from the recliner and Client #1 walked into the dining room to eat. At 5:13 p.m., Client #1 finished eating. From 5:13 p.m. to 5:20 p.m., facility staff assisted Client #1 brush	W 268	QIDP's will reeducate staff on active treatment and activities, as well as the importance for all clients to promote growth and independence. QIDP/Designee will observe 2x/week for 4 weeks and then 1x/week for 4 weeks to ensure clients are involved in activities. Date of correction: 04/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 268	Continued From page 20	W 268		

her teeth and change her clothes. At 5:20 p.m., facility staff walked Client #1 back to the recliner and buckled her in. Client #1 yelled and cried out until 5:25 p.m. when she started to watch the movie on television.

Observations on 12/11/20 at 10:15 a.m. revealed Client #1 buckled into her recliner, pushed up to the dining table. Facility staff stated she just ate her snack and they pushed the recliner, while Client #1 sat in the recliner, to the living room in front of the television. Direct Support Supervisor (DSS) A asked if it was time to get Client #1 up to walk. At 10:17 a.m., Certified Medication Aide (CMA) A put Client #1's shoes on and unbuckled her from the recliner. CMA A walked with Client #1 to the bathroom. At 10:27 a.m., CMA A and Client #1 down the hallway and out to the front of the house. Client #1 walked towards the craft table and CMA A redirected her to walk the other way. CMA A stated, "Let's go this way there is less stuff to grab." At 10:28 a.m., Client #1 sat in her wheelchair and independently moved around the home. At 10:39 a.m., CMA A stated she needed to start administering medications. CMA A buckled Client #1 back into her recliner and took Client #1's shoes off her. At 10:42 a.m., facility staff pushed the recliner, while Client #1 sat in it, to the dining table to do crafts. Facility staff put Client #1's shoes on her. At 10:46 a.m., facility staff unbuckled Client #1 and walked with her to the medication room. From 10:46 a.m. to 10:51 a.m., Client #1 sat in the medication room and received her water. At 10:51 a.m., facility staff walked Client #1 walked back to the recliner, physically redirected her into the recliner, told her to get comfortable, and buckled Client #1 into the recliner. Client #1 tried to take off her shoes, but could not get them off. Facility staff took her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 268	Continued From page 21 shoes off for her. From 10:51 a.m. to 11:33 a.m., Client #1 sat buckled in the recliner at the dining table. At 11:33 a.m., facility staff pushed the recliner, while Client #1 sat in it, to the living room. At 11:43 a.m., three other clients started to eat lunch while Client #1 sat in the recliner yelling out and crying. From 11:50 a.m. to 11:55 a.m., Client #1 continued to cry and DSS A tried to hold her hand. At 12:05 p.m., Client #1 continued to cry and facility staff told her it was her turn to eat. At 12:17 p.m., CMA A unbuckled Client #1 from the recliner and walked with her to the dining table. Client #1 did not have her shoes on. Record review revealed the following: a. Client #1's Temporary Health Care Plan dated 3/9/20 to 7/5/20 for a sore on her big left toe. The intervention included, "1) Place Triple Antibiotic Ointment on toe/open area. 2) If able to keep (Band-Aid) on sore area place Band-Aid on. 3) If need to seatbelt to keep from making sore worse. 4) Let nursing know if gets worse. 5) Make sure to take (Band-Aid/tape) off at night when going to bed." b. Client #1's "On Going" Health Care Plan for sores on her feet and redness on her big toe. The plan did not include a start date for the initial problem. The intervention included, "1) Keep off feet as much as possible. 2) Email dietician regarding (adding) protein powder. 3) Lotion (and) check feet twice daily. 4) Buckle in recliner to prevent sores on feet. 5) Place TAO (Triple Antibiotic Ointment) on (Right) big toe." When interviewed on 12/10/20 at 3:15 p.m. Qualified Intellectual Disability Professional (QIDP) B reported Client #1 would get sores on	W 268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 268	Continued From page 22 her feet from taking her shoes off. She thought they had a nursing care plan in place to keep her off her feet when she refused to wear her shoes. When interviewed on 12/16/20 at 8:50 a.m. the Director of Health Services stated Client #1's nursing care plan did not include to keep her off her feet if she refused to wear her shoes. She thought the facility would implement a plan for Client #1 to walk every hour. The Director of Health Services stated Client #1 needed to be up and walking because she had arthritis, although when Client #1 walked around without shoes she developed sores on her feet. She also stated part of the issue with Client #1 walking around the home was she engaged in PICA behaviors. When interviewed on 12/16/20 at 12:35 p.m. QIDP B confirmed the facility failed to engage Client #1 in activities to promote growth and independence.	W 268		
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure restrictive measures were not implemented for the convenience of staff. This affected 1 of 4 sample clients (Client #1). Finding follows: Observations on 12/11/20 at 10:15 a.m. revealed	W 287	The Compliance/Training Specialist, DSS's and QIDP's will reeducate staff that no client restrictions will be implemented by staff without proper programming, family/ guardian consent and approval through Human Rights committee.They will also reeducate staff on Opportunity Living's behavior management procedures. The Compliance/Training Specialist/designee will monitor and observe staff in the client homes to ensure no client restrictions are implemented without the proper programming and approvals, weekly for 4 weeks. Date of correction: 04/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 287	Continued From page 23 Client #1 buckled into her recliner, pushed up to the dining table. Facility staff stated she just ate her snack and they pushed the recliner, while Client #1 sat in the recliner, to the living room in front of the television. Direct Support Supervisor (DSS) A asked if it was time to get Client #1 up to walk. At 10:17 a.m., Certified Medication Aide (CMA) A put Client #1's shoes on and unbuckled her from the recliner. CMA A walked with Client #1 to the bathroom. At 10:27 a.m., CMA A and Client #1 down the hallway and out to the front of the house. Client #1 walked towards the craft table and CMA A redirected her to walk the other way. CMA A stated, "Let's go this way there is less stuff to grab." At 10:28 a.m., Client #1 sat in her wheelchair and independently moved around the home. At 10:39 a.m., CMA A stated she needed to start administering medications. CMA A buckled Client #1 back into her recliner and took Client #1's shoes off her. At 10:42 a.m., facility staff pushed the recliner, while Client #1 sat in it, to the dining table to do crafts. Facility staff put Client #1's shoes on her. At 10:46 a.m., facility staff unbuckled Client #1 and walked with her to the medication room. From 10:46 a.m. to 10:51 a.m., Client #1 sat in the medication room and received her water. At 10:51 a.m., facility staff walked Client #1 walked back to the recliner, physically redirected her into the recliner, told her to get comfortable, and buckled Client #1 into the recliner. Client #1 tried to take off her shoes, but could not get them off. Facility staff took her shoes off for her. From 10:51 a.m. to 11:33 a.m., Client #1 sat buckled in the recliner at the dining table. At 11:33 a.m., facility staff pushed the recliner, while Client #1 sat in it, to the living room. At 11:43 a.m., three other clients started to eat lunch while Client #1 sat in the recliner yelling out and crying. From 11:50 a.m. to 11:55 a.m.,	W 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 287	Continued From page 24 Client #1 continued to cry and DSS A tried to hold her hand. At 12:05 p.m., Client #1 continued to cry and facility staff told her it was her turn to eat. At 12:17 p.m., CMA A unbuckled Client #1 from the recliner and walked with her to the dining table. Client #1 did not have her shoes on. Record review revealed the following: a. Client #1's Temporary Health Care Plan dated 3/9/20 to 7/5/20 for a sore on her big left toe. The intervention included, "1) Place Triple Antibiotic Ointment on toe/open area. 2) If able to keep (Band-Aid) on sore area place Band-Aid on. 3) If need to seatbelt to keep from making sore worse. 4) Let nursing know if gets worse. 5) Make sure to take (Band-Aid/tape) off at night when going to bed." b. Client #1's "On Going" Health Care Plan for sores on her feet and redness on her big toe. The plan did not include a start date for the initial problem. The intervention included, "1) Keep off feet as much as possible. 2) Email dietician regarding (adding) protein powder. 3) Lotion (and) check feet twice daily. 4) Buckle in recliner to prevent sores on feet. 5) Place TAO (Triple Antibiotic Ointment) on (Right) big toe." When interviewed on 12/10/20 at 3:15 p.m. Qualified Intellectual Disability Professional (QIDP) B reported Client #1 would get sores on her feet from taking her shoes off. She thought they had a nursing care plan in place to keep her off her feet when she refused to wear her shoes. When interviewed on 12/16/20 at 8:50 a.m. the Director of Health Services stated Client #1's nursing care plan did not include to keep her off	W 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 287	Continued From page 25 her feet if she refused to wear her shoes. She thought the facility would implement a plan for Client #1 to walk every hour. The Director of Health Services stated Client #1 needed to be up and walking because she had arthritis, although when Client #1 walked around without shoes she developed sores on her feet. She also stated part of the issue with Client #1 walking around the home was she engaged in PICA behaviors. When interviewed on 12/16/20 at 12:35 p.m. QIDP B acknowledged the facility buckled Client #1 into a recliner for the convenience of staff.	W 287		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to use interventions and restrictive measures as outlined in client behavior programs. This affected 1 of 4 sample clients (Client #4). Finding follows: Record review revealed Client #4's Behavior Management Program dated 2/10/20 to 2/10/21 indicated time-out used when Client #4's aggressive behaviors escalated. The time-out should not exceed 30 minutes. Additional record review revealed the following behavioral reports:	W 288	The Compliance/Training Specialist and QIDP's will reeducate staff on the correct documentation required when use of time out is required for a client, including date/time entered and exited time out. It will be reitterated that time out cannot exceed 60 minutes or the time identified in the behavior management program. The QIDP's will also reeducate staff on specific clients' behavior programs that utilize timeout. The Director of Health Services/QIDP/ designee will review the Incident/Behavior reports upon receipt when time out is utilized, for accuracy of documentation and length of time clients are in time out. Date of correction: 04/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 288	Continued From page 26 a. On 9/12/20 at 5:50 p.m., Client #4 hit staff and taken to time-out. The facility documented Client #4 spent from 5:50 p.m. to 6:35 p.m. in time-out, a total time of 45 minutes. b. On 10/21/20 at 4:40 a.m., Client #4 displayed aggression and property destruction and taken to time-out. The facility documented Client #4 spent from 5:40 a.m. to 6:25 a.m. in time-out, a total time of 45 minutes. c. On 11/4/20 at 5:15 a.m., Client #4 became upset and aggressive before facility staff took Client #4 to time-out. The facility documented Client #4 spent from 5:45 a.m. to 6:40 a.m. in time-out, a total time of 55 minutes. When interviewed on 12/16/20 at 5:30 p.m. the Qualified Intellectual Disabilities Professional (QIDP) A confirmed the facility failed to follow Client #4's program. She stated Client #4's time-out should not exceed 30 minutes.	W 288		
W 294	TIME OUT ROOMS CFR(s): 483.450(c)(4) A record of time-out activities must be kept. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to document an accurate record of time-out use. This affected 1 of 4 sample client (Client #4). Finding follows: Record review revealed Client #4's Behavior Management Program dated 2/10/20 to 2/10/21 indicated time-out used when Client #4's aggressive behaviors escalated. The time-out	W 294	The Compliance/Training Specialist and QIDP's will reeducate staff the correct documentation required when us of time out is required for a client, including date/time entered and exited time out. It will be reitterated that time out cannot exceed 60 minutes or the time identified in the behavior management program. The QIDP's will reeducate staff on specific clients' behavior programs that utilize timeout. The Director of Health Services/QIDP/designee will review the Incident/Behavior reports upon receipt when time out is utilized for accuracy of documentation and length of time clients are in time out. Date of correction: 04/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 294	Continued From page 27 should not exceed 30 minutes. Additional record review revealed the following behavioral reports: a. On 9/11/20 at 5:36 p.m., Client #4 hit another client on top of the head and shoulder before taken to time-out. The facility failed to document the length of time Client #4 remained in time-out. b. On 9/25/20 at 9:13 a.m., Client #4 placed his hands around another client's neck before taken to time-out. The facility failed to document the length of time Client #4 remained in time-out. c. On 10/7/20 at 2:56 p.m., Client #4 was "non-stop hitting staff and attempting to hit other clients" before being blocked and redirected to time-out. Client #4 entered time-out at 3:00 p.m., but the facility failed to document the length of time Client #4 remained in time-out. When interviewed on 12/16/20 at 5:30 p.m. the Qualified Intellectual Disabilities Professional (QIDP) A confirmed each document should have contained the time Client #4 went into time-out and the time released. She indicated she thought all of them were completed, but they missed a few.	W 294	W331 All Temporary Health Care Plans (THCP)'s will be copied and placed in a binder at the center (the copy) the original will remain with the MAR.Each day the nurses working will look at the THCP binder to see who will go to which home to assess the clients. Once the TCHP is discontinued the copy may be placed in the shred box. Under NO circumstances will anything restrictive be placed on the THCP. Any restriction(s) need to go through Human Rights. Person(s) responsible: Staff Nurses Monitored by: The Director of Health Services Date of Correction: 04/01/2021	
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the	W 331	Scales have been purchased for all ICF/ID homes and placed in each home.Staff will be educated to complete weekly weights for all clients requiring them and document on the weekly weight form. Nursing staff will check weights weekly and notify dietician of any concerns. Person(s) responsible: Staff Nurses Monitored by: The Director of Health Services Date of correction: 04/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	106 WESTVIEW LAKE CITY, IA 51449

(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 331	Continued From page 28 facility failed to provide clients with nursing services in accordance with their needs. This affected 4 of 4 sample clients (Client #1 - Client #4). Findings follow: 1. Observations on 12/9/20 from 4:00 p.m. to 4:41 p.m. revealed Client #1 sat strapped to a recliner in the living room with no interactions from staff. At 4:41 p.m., facility staff walked up to Client #1 and told her they were going to eat in about thirty minutes. Client #1 continued to sit in the recliner with a strap around her waist preventing her from getting out of the chair. At 5:00 p.m., facility staff unbuckled Client #1 from the recliner and Client #1 walked into the dining room to eat. At 5:13 p.m., Client #1 finished eating. From 5:13 p.m. to 5:20 p.m., facility staff assisted Client #1 brush her teeth and change her clothes. At 5:20 p.m., facility staff walked Client #1 back to the recliner and buckled her in. Client #1 yelled and cried out until 5:25 p.m. when she started to watch the movie on T.V. Observations on 12/11/20 at 10:15 a.m. revealed Client #1 buckled into her recliner, pushed up to the dining table. Facility staff stated she just ate her snack and they pushed the recliner, while Client #1 sat in the recliner, to the living room in front of the T.V. Direct Support Supervisor (DSS) A asked if it was time to get Client #1 up to walk. At 10:17 a.m., Certified Medication Aide (CMA) A put Client #1's shoes on and unbuckled her from the recliner. CMA A walked with Client #1 to the bathroom. At 10:27 a.m., CMA A and Client #1 down the hallway and out to the front of the house. Client #1 walked towards the craft table and CMA A redirected her to walk the other way. CMA A stated, "Let's go this way there is less stuff to grab." At 10:28 a.m., Client #1 sat in her	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 331	Continued From page 29	W 331		

wheelchair and independently moved around the home. At 10:39 a.m., CMA A stated she needed to start administering medications. CMA A buckled Client #1 back into her recliner and took Client #1's shoes off her. At 10:42 a.m., facility staff pushed the recliner, while Client #1 sat in it, to the dining table to do crafts. Facility staff put Client #1's shoes on her. At 10:46 a.m., facility staff unbuckled Client #1 and walked with her to the medication room. From 10:46 a.m. to 10:51 a.m., Client #1 sat in the medication room and received her water. At 10:51 a.m., facility staff walked Client #1 walked back to the recliner, physically redirected her into the recliner, told her to get comfortable, and buckled Client #1 into the recliner. Client #1 tried to take off her shoes, but could not get them off. Facility staff took her shoes off for her. From 10:51 a.m. to 11:33 a.m., Client #1 sat buckled in the recliner at the dining table. At 11:33 a.m., facility staff pushed the recliner, while Client #1 sat in it, to the living room. At 11:43 a.m., three other clients started to eat lunch while Client #1 sat in the recliner yelling out and crying. From 11:50 a.m. to 11:55 a.m., Client #1 continued to cry and DSS A tried to hold her hand. At 12:05 p.m., Client #1 continued to cry and facility staff told her it was her turn to eat. At 12:17 p.m., CMA A unbuckled Client #1 from the recliner and walked with her to the dining table. Client #1 did not have her shoes on.

Record review revealed the following:

a. Client #1's Temporary Health Care Plan dated 3/9/20 to 7/5/20 for a sore on her big left toe. The intervention included, "1) Place Triple Antibiotic Ointment on toe/open area. 2) If able to keep (Band-Aid) on sore area place Band-Aid on. 3) If need to seatbelt to keep from making sore worse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 331	Continued From page 30 4) Let nursing know if gets worse. 5) Make sure to take (Band-Aid/tape) off at night when going to bed." b. Client #1's "On Going" Health Care Plan for sores on her feet and redness on her big toe. The plan did not include a start date for the initial problem. The intervention included, "1) Keep off feet as much as possible. 2) Email dietician regarding (adding) protein powder. 3) Lotion (and) check feet twice daily. 4) Buckle in recliner to prevent sores on feet. 5) Place TAO (Triple Antibiotic Ointment) on (Right) big toe." When interviewed on 12/10/20 at 3:15 p.m. Qualified Intellectual Disability Professional (QIDP) B reported Client #1 would get sores on her feet from taking her shoes off. She thought they had a nursing care plan in place to keep her off her feet when she refused to wear her shoes. When interviewed on 12/16/20 at 8:50 a.m. the Director of Health Services stated Client #1's nursing care plan did not include to keep her off her feet if she refused to wear her shoes. She thought the facility would implement a plan for Client #1 to walk every hour. The Director of Health Services stated Client #1 needed to be up and walking because she had arthritis, although when Client #1 walked around without shoes she developed sores on her feet. She also stated part of the issue with Client #1 walking around the home was she engaged in PICA behaviors. When interviewed on 12/17/20 at 3:56 p.m. the Director of Health Services acknowledged the facility failed to have Client #1's feet evaluated by a physician.	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 331	Continued From page 31 2. Record review revealed the following: a. Client #2's Annual Nutritional Assessment dated 4/23/20, indicated, "Weight is still above desirable range but no worse than last year. Please continue to monitor weight carefully." b. Client #2's Quarterly Nursing Assessment dated 9/17/20, indicated, Client #2 weighed 179 in January, 181 in February, 181 in March, and 190 in August. The assessment also indicated, "Weekly weights limited due to COVID 19 precautions." When interviewed on 12/16/20 at 9:19 a.m. the Director of Health Services confirmed the facility failed to complete weekly weights on Client #2. She stated the facility would fix the issue and start taking the scale to the homes. 3. Record review revealed Client #3's Quarterly Assessment dated 12/1/20 indicated Client #3 needed weighed on a weekly basis. The assessment also indicated her diet order consisted of small portions except for meat and veggies, skim milk and minimize sugary drinks. The client gained 18 pounds since January 2019 and weighed 262 pounds with an ideal weight range of 132 to 157 pounds. Additional record review revealed Client #3's weekly weight documentation indicated the facility failed to document weekly weights in March (except the first week), April, May, June (except the last week), July, and November of 2020. 4. Record review revealed Client #4's Annual Nursing Evaluation dated 1/30/20 indicated Client #4 should have weekly weights. The evaluation	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 331	Continued From page 32 also indicates Client #4 is slightly below ideal weight and could have additional food or use whole milk for weight gain. Additional record review revealed Client #4's weekly weight documentation indicated the facility documented Client #4's weight in the second week of March 2020 and not again until the second week of August 2020. The facility recorded Client #4's weight twice in August, September, and October of 2020, but failed to document a weight in November 2020. When interviewed on 12/15/20 at 3:10 p.m. the Director of Health Services confirmed the facility failed to ensure clients got weekly weights. She stated the facility kept their scale at the administration building and with COVID-19, the client's did not attend day services on a regular basis. She confirmed the facility could take the scale out to the homes and weigh each client and would start doing so.	W 331		
W 348	DENTAL SERVICES CFR(s): 483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow on-going dental care or recommendations. This affected 4 of 4 sample clients (Client #1 - Client #4). Findings follow:	W 348	Dental appointments have been completed on the client(s) identified.All client records will be reviewed quarterly by the nurse to ensure all exams are completed as recommended. The Director of Health Services has a spreadsheet that will be utilized to document that all specialist appointments are completed and when the next appointment is scheduled. Nursing staff will be educated on the excel spreadsheet, and at the beginning of each month the spreadsheet will be checked to ensure all appointments are completed in a timely manner. Person(s) responsible: Staff Nurses Monitored: by The Director of Health Services Date of Correction:04/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 348	Continued From page 33 1. Record review revealed Client #1's dental exam dated 3/15/19, indicated to follow-up in 12 months. No further dental exam could be located. When interviewed on 12/16/20 at 8:50 a.m. the Director of Health Services confirmed the facility failed to complete Client #1's dental exam. She stated Client #1's dental facility is not scheduling exams yet, due to COVID-19. She also stated there are no other Dentists that will take her. 2. Record review revealed Client #2's dental exam dated 11/21/18, indicated to follow-up in six months. No further dental exam could be located. When interviewed on 12/16/20 at 8:50 a.m. the Director of Health Services confirmed the facility failed to complete Client #2's dental exam. She stated the facility had to reschedule the appointment due to weather and they could not reschedule due to COVID-19. 3. Record review revealed Client #3's Dental Examination and Profile Report dated 2/25/20 indicated Client #3 should return in three months. 4. Record review revealed Client #4's Dental Examination and Profile Report dated 11/15/19 indicated Client #4 should return in six months. When interviewed on 12/15/20 at 3:10 p.m. the Director of Health Services confirmed neither Client #3 nor Client #4 had returned for the recommended follow up visits from their previous examinations. The Director of Health Services stated the school they have a contract with is not	W 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G036	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 348	Continued From page 34 seeing customers right now due to Covid-19. She also stated they are not sure they would feel comfortable taking them into Fort Dodge right now for appointments due to Covid-19.	W 348		

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
	IAG0014	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 203	50.9(3) Background checks 481-50.9(135C) Criminal, dependent adult abuse, and child abuse record checks. 50.9(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a facility, the facility shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure completion of background checks prior to beginning employment. This potentially affected 32 of 32 clients living at Opportunity Living #1. Findings follow: 1. Direct Support Professional (DSP) C began employment with the agency on 11/30/20. The facility completed a background check for child and dependent adult abuse on 12/2/20 with the criminal history still pending as of this review on 12/9/20. 2. DSP D began employment with the agency on 11/12/20. The facility completed a background check for child abuse, dependent adult abuse and criminal history on 11/24/20. When interviewed on 12/9/20 a 4:15 p.m. the	C 203	Clarification was determined on the Governor's Proclamation regarding the allowance and timing of background checks. Director of Human Resources/ designee will continue to ensure all background checks are completed prior to the first day of employment. "Background check completion" was added to the New Hire Orientation checklist. HR Generalist will monitor that background checks are complete before first day of employment. Date of Correction: 01/08/2021	

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
	IAG0014	A. BUILDING: _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

(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 203	Continued From page 1 Managing Director of Operations and the Human Resource Generalist confirmed the facility made a mistake by not having the check completed before hiring the employees. Both indicated the oversight occurred due to confusion over the governor's proclamation earlier in the year waiving background checks.	C 203		