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 06/27/2018

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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	W 000		
W 249	As the result of the investigations of #76541-I and 76542-I a deficiency was cited at W249. 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 interviews and record review, the facility failed to provide appropriate supervision, in accordance with individual program plans. This affected 2 of 2 clients involved in the investigations of #76541-I and 76542-I (Client #1 and Client #2). Findings follow: 1. Review of facility investigation for incident #76541-I on 6/25/18 revealed a staff person found Client #1 unattended in the facility parking lot on 6/02/18 between 5:00 p.m. and 6:00 p.m. Client #1 had no injuries. Staff estimated they last saw Client #1 in her living unit five minutes or less prior to being found in the parking lot. According the the web site Weather Underground, the temperature between 5:00 p.m. and 6:00 p.m. on 6/02/18 in Storm Lake was 71-72 degrees Fahrenheit with no precipitation.	W 249	See attached POC 7/25/18	

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

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Client #1 was 12 years old with a diagnosis of moderate intellectual disabilities with developmental delays, Down Syndrome, autism, and congenital heart defect. Client #1 was independently ambulatory and mostly non-verbal, without functional communication skills. According to to Client #1's Individual Service Plan (ISP) dated 10/3/17, her level of supervision was listed as,"Staff must have knowledge of where she is at all times. She can be in the back yard with staff monitoring from the window." The level of supervision was updated as needed and as of the 6/02/18, Client #1's level of supervision continued to be the same as noted in the ISP. According to the ISP, Client #1 had a behavior program with target behaviors of loud vocalizations, physical aggression, self-injurious behavior and running away. Her ISP noted the frequency of target behaviors were low. The behavior program had been revised so the target behavior of running away was changed to "wandering attended" and "wandering unattended." "Wandering attended" indicated staff had Client #1 in sight as she walked or ran away from them. "Wandering unattended" meant Client #1 left staff supervision without the staff following her. Client #1 also had a Procedure Plan to push the Big Mac switch near the door leading to the Multi-Purpose Room (MPR) to request to leave the Hope Home and go to the MPR. Facility staff used different colored bracelets to indicate which clients they were assigned to.

According to Client #1's Comprehensive Functional Assessment dated 9/08/17, the client required full physical prompts to look for cars in a parking lot and to yield to traffic.

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Client #1 resided in the Hope Home at the facility. The facility was divided into four living units, or homes, with a large recreation room (MPR) in the middle. The MPR contained play equipment. A wide hallway lead from the MPR to the front of the building, with administrative offices, a large entry door, a staff break room and a side exit door near the break room. A large parking lot was located in front of the building. The distance from the Hope Home to the side exit door near the break room was approximately 165 feet. The distance from the side exit door to where Client #1 was found near the parking lot (per DSP A) was approximately 75 feet. The facility sat near a two lane highway,where the speed limit changed from 45 miles per hour to 55 miles per hour. Client #1 was found the distance of approximately one city block from the highway.

When interviewed on 6/25/18 at 4:15 p.m. the Shift Leader reported she was assigned to Client #1 and Client #2 at the time of the incident. She took Client #2 and another client outside to eat during dinner time, around 4:45 p.m. Client #1 stayed inside and ate at the kitchen table. The Shift Leader said she asked Direct Support Professional (DSP) A to watch Client #1 and DSP A said OK. The Shift Leader acknowledged she should have given Client #1's supervision bracelet to DSP A, but she did not. Whichever staff was responsible for the client should be wearing the client's bracelet. In her facility statement on 6/02/18, the Shift Leader said she came back inside with Client #2 and learned DSP A had gone on break. Shortly after coming back into the unit, DSP A called/paged the unit and said Client #1 had been in the parking lot. During the DIA interview, the Shift Leader said she come inside with Client #2 after he finished eating

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W 249	Continued From page 3	W 249		

dinner. She thought Client #1 was in her room at that time. The Shift Leader went to the bathroom with Client #2 to assist the client to clean up from a toileting accident. The Shift Leader said she did not ask anyone to supervise Client #1 while she was in the bathroom assisting Client #2. The Shift Leader was just coming out of the bathroom when she heard the call/page from DSP A saying Client #1 had been in the parking lot. The Shift Leader said she knew Client #1 had a history of wandering, but had typically stayed in the building. The Shift Leader stated she was aware Client #1's level of supervision was for staff to know her whereabouts. The Shift Leader said she thought Client #1 was in her bedroom.

When interviewed on 6/26/18 at 2:00 p.m. DSP A stated she left the Hope Home after dinner, around 5:15 p.m., to go on break. When DSP A left the unit, the Shift Leader was in the backyard with clients. Client #1 was in her bedroom. DSP A said the Shift Leader had gone outside to the back yard to eat dinner with two clients. She did not recall that the Shift Leader had asked her to supervise Client #1 when she went outside. DSP A went to the break room and ate her dinner. She heard Client #1 vocalizing in the hallway near the break room. DSP A then heard the side exit door open and close, which was not far from the break room. DSP initially continued eating, but realized she had not heard a staff person. She got up to check and when she looked out the door, she saw Client #1 standing near the parking lot. Client #1 was in an a paved area between the main building and the large garage building, which was a combination side walk and a driveway area. The area was not routinely used for driving or parking. DSP A brought Client #1 back to the break room and called Hope Home.

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W 249	Continued From page 4	W 249		

She said Client #1 had no observed injuries. DSP A estimated about 10 minutes had passed from when she left Hope Home until she saw Client #1 in the sidewalk/driveway area.

When interviewed on 6/25/18 at 4:30 p.m. the Assistant Lead reported she worked in the Hope Home at the time of the incident. She said the Shift Leader took Client #2 and another client to the back yard to eat dinner. Client #1 ate dinner inside at the kitchen table. The Shift Leader told the staff she was going outside with the other two clients. The other staff were then aware they needed to supervise Client #1, but the Shift Leader did not pass off Client #1's bracelet to any of the staff. After dinner, Client #1 had been pressing the Big Mac switch by the door to go to the MPR. The staff were busy and told Client #1 to sit down. Client #1 sat on the bench by the door. DSP A went on a break. DSP A later called/paged on the phone and said Client #1 had been in the parking lot. The Assistant Lead estimated it had been about five minutes since she had seen Client #1 sitting on the bench by the door. She said at the time of the incident, staff were supposed to know Client #1's whereabouts at all times.

When interviewed on 6/26/18 at 9:35 a.m. DSP B confirmed worked in the Hope Home at the time of the incident. She said it happened after dinner, around 6:00 p.m. The Shift Leader had taken two clients to the back yard to eat dinner. The Shift Leader was assigned to Client #1. DSP B did not recall the Shift Leader asking any staff to supervise Client #1 or giving a staff person Client #1's bracelet. After dinner, DSP A went on break. Client #1 went to her room after dinner, but then came out and pointed at the door that led to the

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MPR. DSP B asked Client #1 to wait until they had more staff. Client #1 sat on a bench by the door. DSP B went to the bathroom to assist another client. She estimated she was in the bathroom five minutes or less. DSP B was coming out of the bathroom when she heard DSP A page over the unit phone. DSP A said she had found Client #1 in the parking lot.

When interviewed on 6/26/18 at 3:20 p.m. DSP C confirmed she worked in the Hope Home at the time of the incident. She was a very new staff person at the time. The Shift Leader was assigned to Client #1. She had taken a couple other clients to the back yard to eat dinner, while Client #1 stayed inside to eat. DSP C did not recall if the Shift Leader had asked any of the other staff to supervise Client #1. After dinner, various clients were running in and out of the door to the back yard. The Shift Leader was still in the back yard with clients. Client #1 sat on the bench by the door that led to the MPR. She had been saying "Daddy" and putting on her shoes. Staff attempted to redirect her. DSP A went on a break after the clients finished dinner. A while later, DSP A called or paged Hope Home and said she found Client #1 in the parking lot. DSP C thought this was around 5:40 or 5:45 p.m. She estimated she had seen Client #1 sitting on the bench by the door less than five minutes prior to the call/page from DSP A.

When interviewed on 6/26/18 at 1:00 p.m. the Qualified Intellectual Disability Professional (QIDP) acknowledged Client #1's level of supervision at the time of the incident were for staff to know her whereabouts. If a staff person went outside with other clients and left assigned Client #1 inside, then the assigned staff person

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W 249	Continued From page 6 should ask another staff to take over supervision for Client #1. The QIDP confirmed Client #1 had a history of wandering, as noted in the behavior program. When interviewed on 6/26/18 at 2:35 p.m. the ICF/ID Manager stated Client #1 had a history of wandering, but it had only been inside the building until an incident this past winter. On that morning, Client #1 had been waiting for her school bus with a group of clients and staff near the main building entry door. Client #1's staff person had her attention focused on another client and Client #1 went out the door without staff noticing. This was the only other time Client #1 had wandered away from the building. At the time of the incident on 6/02/18, the staff person responsible for Client #1 was supposed to know her whereabouts. When the Shift Leader took the other client to the back yard, she should asked another staff person to accept responsibility for Client #1 and passed off the client's bracelet. Since the incident, Client #1's level of supervision has been increased to eyesight when in common areas. A review of a facility report on 6/26/18 revealed Client #1 went out the front entry door on the morning of 1/09/18 while staff and clients waited to get on school buses. A staff person noticed Client #1 missing and a teacher's aide brought Client #1 inside, stating the client had been wandering in the parking lot. 2. Review of facility investigation for incident #76542-I on 6/25/18 revealed Client #2 climbed over the fence that separated Hope Home and Faith Home back yards on the morning of	W 249		

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6/08/18. A staff person supervised Client #2 from a window had briefly stopped observing the client. Client #2 climbed over the fence and displayed unprovoked aggression toward Client #3. Faith Home staff intervened and notified Hope Home staff, who promptly arrived to take Client #2 back to his living unit. Client #3 had no visible injuries.

Client #2 was 15 years old with a diagnosis including severe intellectual disability, autism spectrum disorder, attention deficit/hyperactivity disorder, unspecified anxiety and language disorder. Client #2 had very limited verbal communication. He ambulated independently. According to Client #2's ISP dated 10/31/17, he liked to be outside. The ISP provided information regarding level of supervision. and directed staff to be aware of Client #2's whereabouts at all times. Staff needed to monitor the client from a window when he was in the back yard. If other clients were present, staff also needed to be present. Client #2's level of supervision was routinely reviewed. As of 6/02/18, his level of supervision was, "Staff must have knowledge of (Client #2's) whereabouts at all times. Staff will remain in close proximity when he is around others." and "(Client #2) can be in the back yard alone with staff monitoring from the living room or bedroom windows. When (Client #2) is in the back yard with other residents, his staff must be outside with him, remaining in close proximity." Client #2 had a behavior program with target behaviors including aggression, self-injurious behavior, climbing, non-compliance, wandering-attended and wandering-unattended.

When interviewed on 6/27/18 at 8:00 a.m. DSP D reported she was assigned to Client #2 on the morning of 6/08/18 at the time of the incident.

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She and DSP C worked in the Hope Home with just two clients. Client #2 was in the fenced back yard of Hope Home, with no other clients. DSP D observed him from a client bedroom window. Client #2 moved to a different part of the yard out of her sight, so DSP D headed toward the living room. DSP C asked her a question, so DSP D went to the kitchen area to briefly talk to DSP C, which lasted about a minute. She also grabbed a jacket and sandwich from the kitchen area. DSP D decided to go outside with Client #2, so she wanted her jacket. This only took a few seconds. She headed toward the living room to go out the back door when Faith Home staff called and said Client #2 was in their back yard being aggressive. DSP D went to the Faith Home back yard and brought Client #2 back to the Hope Home unit. The incident happened around 9:10 a.m. She said she and other staff were aware that Client #2 had climbed the fence in the past. She had also seen Client #2 sit/perch on top of the fence before. She said it was common knowledge that Client #2 could get on top of the fence and could climb over the fence.

When interviewed on 6/26/18 at 3:20 p.m. DSP C reported she worked with DSP D on the morning of 6/08/18 at the time of the incident. There were only two clients on the unit, so each staff was assigned to one client. DSP D was assigned to Client #2. Client #2 was outside in the fenced back yard. DSP D watched the him from a client bedroom window. DSP C asked a question of DSP D, so DSP D came to the kitchen area to talk to DSP C for about one minute. DSP D was then heading toward the living room to monitor Client #1 from the window, when Faith Home staff called and said Client #2 was in their back yard, aggressing toward clients.

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W 249	Continued From page 9 When interviewed on 6/26/18 at 9:50 a.m. DSP E stated she worked at Faith Home on the morning of 6/8/18. Two clients went outside to the back yard. DSP E went with them and then went back inside to grab sunscreen. (Both clients were allowed to be in the fenced back yard with 2-3 minute checks.) When DSP E came back outside with the sunscreen, she saw Client #2 sitting on the ground under a swing. DSP E was not familiar with Client #2 or his programs. She said Client #2 got up and pulled Client #3's ponytail and pushed the client's head down toward the table. Client #3's head did not make contact with the table. Client #3 did not show any sign of pain and there was no visible injury. DSP E got between Client #2 and Client #3. She then opened the back door and asked her co-worker to call the Hope Home. A Hope Home staff person came right over. Client #2 did not aggress toward the other client in the Faith Home back yard. When interviewed on 6/26/18 at 2:35 p.m. the ICF/ID Manager stated staff should have been constantly monitoring Client #2 from a window when he was in the back yard on the morning of 6/08/16. Client #2 had a history of aggression toward peers. A staff person trained on Client #2 should have been present when he was around other clients. The ICF/ID Manager knew of one other time Client #2 had climbed the fence. In the fall of 2017, Client #1 climbed the fence and walked in the back door of Faith Home. The facility increased his level of supervision for a while, but there were no further incidents, so it went back to monitoring from a window. The ICF/ID Manager said she was not aware of any further incidents of Client #2 climbing the fence or	W 249		

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W 249	Continued From page 10 sitting on the fence, until the incident on 6/08/18. Since the incident, Client #2's level of supervision was increased and a staff person now must be present when Client #2 is in the back yard. The facility was also discussing what to do about the fence to lessen the Client #2's ability to climb it. Review on 6/26/18 of a prior facility investigation, revealed Client #1 had climbed the fence on 11/07/17 without staff knowledge and walked in the back door of Faith Home. A Faith Home staff walked Client #1 back to Hope Home. Staff should have been monitoring Client #1 from the window at the time. Client #1 did not aggress toward a peer during that incident.	W 249		

✓ 8/10/18

Plan of Correction for Incidents #76541-I and #76542-I

W249

Program Implementation 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 of frequency to support the achievement of the objectives identified in the individuals program plan.
This standard is not met as evidenced by: Based on interviews and record review, the facility failed to provide appropriate supervision, in accordance with individual's program plans.

POC

A safe and appropriate level of supervision was changed to meet the needs of the clients. This was completed and activated by the ICF/ID manager as of July 25, 2018.
Going forward the individual levels of supervision will be monitored by the respective QIDP for the client and will be addressed/reviewed at the bi-weekly home meeting. Any new identified needs/strengths will be changed and trained as soon as possible. When there is a potential safety issue with regard to a client's level of supervision the staff witnessing will ensure safety at the time and notify supervisor for further investigation.