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 06/13/2019

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OPPORTUNITY LIVING #1	105 WESTVIEW LAKE CITY, IA 51449

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W 000	INITIAL COMMENTS At the time of Investigation #83120-M and #83302-I deficiencies were cited at W153 for failure by staff to report potential abuse/neglect.	W 000	Abuse Quick Facts sheet was created and trained on to staff in House Meetings on 5/15/2019. Direct Support Supervisors continue to train incoming staff on the The Abuse Quick Fact sheet as they are hired. The Abuse Quick Fact sheet has been circulated in our Daily Sheet for all staff to read and be aware of beginning, Monday, May 6, 2019 - mid-June, 2019 The Abuse Quick Fact Sheet states the following: STEP 1: SEPARATE - Any person witnessing an incident of abuse of any type will IMMEDIATELY try to diffuse the situation by instructing the other staff to "take five". The witness will then ensure that the client's/member's welfare is preserved. STEP 2: REPORT - After the client/ member and alleged abuser are separated, the witness will then make the necessary contacts. (ICF) 1st Charlys Folk, 2nd Patty Sharkey, 3rd Supervisor on-call. STEP 3: CONFIDENTIAL - The witness should NOT discuss the incident with anyone other than those involved in the investigation. STEP 4: DOCUMENT -The witness should complete the "Alleged Abuse Report Form" and submit to the investigator within twenty-four (24) hours of the incident. STEP 5: QUESTIONS - The witness will then direct any questions regarding the incident or investigation ONLY to the person in charge of the investigation.	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff immediately reported abuse, neglect, and or mistreatment of clients to the administrator or designee. This affected 2 of 2 clients identified as a result of investigation #83120-M and #83302-I (Clients #2 and #5). Findings Follow: 1. Record review on 6/4/19 revealed Client #5's Behavior Report and restraint log, dated 5/5/19, completed by Direct Support Professional A (DSP A). According to the log Client #5 went to the timeout room from 12:45 p.m. to 12:48 p.m. and from 12:48 p.m. -1:00 p.m. Continued record review revealed an alleged abuse report, completed by Certified Medication Aide A (CMA A) on 5/6/19. She documented she found Client #5 locked in the time out room with a vacuum blocking the door at approximately 1:00 p.m.. CMA A noted she arrived to the home to drop something off to DSP B. Another staff told	W 153	POC 7/31/19	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	Continued From page 1 her he was in the back of the home with Client #5 in the time out room. CMA A walked back to the time out room and saw the vacuum holding the time out room door shut and DSP B nowhere around. CMA A returned to the front of the home to inquire about DSP B's whereabouts. Staff told her he was with Client #5 in the time out room and she informed them he was not there and a vacuum held the door shut. CMA A called DSP B's name and he answered from the restroom. She tried to go in, but the door was locked. DSP B informed her he was washing his hair. Record review on 6/4/19 revealed the facility Abuse Policy. The Mandatory Reporter's Instructions directed staff to immediately diffuse any incident of abuse by instructing the staff to "TAKE FIVE" and separate the client and the staff. Once the Client and staff were separated, staff were directed to "immediately" contact the appropriate supervisor to report the incident. When interviewed on 6/5/19 at 1:45 p.m. DSP A stated she saw the vacuum blocking the time out door on 5/5/19 and removed it. She stated she did not report the incident until the following day when she asked about it as part of a facility investigation. She said she is aware of the facility policy and should have reported the incident. On 6/12/19 at 12:10 p.m. DSP A confirmed the restraint log on 5/5/19 was completed by her. She said when she removed the vacuum at 12:48 p.m. she did not report the incident. When interviewed on 6/6/19 at 10:30 a.m. CMA A stated she saw the vacuum blocking the time out door on 5/5/19 at about 1:00 p.m. and removed it. She stated she wrote a note about the incident and left it for her supervisor, but did not report the	W 153	Cont. From page 1; In addition to the Abuse Quick Fact Sheet being created and trained on they Direct Support Supervisors also created an Abuse Binder that has this fact sheet in it also and has copies of the Alleged Abuse Report Form and a copy of all needed instructions. Direct Support Supervisors will re-train and document the Abuse Quick Fact training in the Wednesday, July 24, 2019 House Meetings and keep this on the House Meeting Agendas throughout the remainder of 2019. Plan of correction implementation date: July 31, 2019, Person responsible: Direct Support Supervisor Monitor: Director of Residential Services In addition to these being implemented and trained we have also devised a plan that clarifies for staff which clients they are responsible for supervising. These Accountability Bands for Supervision were designed and implemented in all 9 Houses during the House meetings on Wednesday, June 26th, 2019. The Accountability Bands for Supervision has a wrist band/lanyard for each client with their individual pictures on them. The staff that is working with said client has on that clients band/lanyard is responsible for the supervision of that client. They assure that they are safe and being assisted with whatever they need assistance to accomplish. The Direct Support Supervisors will spot check that these are being used and followed through on correctly, at least once, per shift per week. This will also be a time when they will verify that the staff understand the Accountability Bands purpose and the importance of them to follow through in there use.	

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W 153	Continued From page 2 incident to the on-call supervisor. The following day when the note was discovered an investigation was initiated. She said she is aware of the facility policy and should have reported it to the on-call supervisor. When interviewed on 6/5/19 at 3:45 p.m. DSP B stated he took Client #5 into the time out room for approximately 15 minutes. He admitted to using the vacuum to block the door and said he only did it because DSP A told him to do it. He stated he knew this was wrong and should not have done this. He stated he only did this one time and CMA A let Client #5 out of the room. He stated he told his old boss DSM A about this use of the vacuum by DSP A. When interviewed on 6/12/19 at 2:30 p.m. Direct Support Manager A (DSM A) stated she did not hear of any reports of staff using a vacuum to block the door and this would be considered abuse. She further stated she would report immediately if this accusation was ever made. She stated DSP B did not mention anything about the vacuum being used by any staff in the home to block the door. She further stated DSP B is her nephew and attempted to talk to her about the incident after he was terminated from the facility. She redirected him that it was an on going investigation and he should not be talking about it. 2. Record review on 6/4/19 revealed Client #2's Incident/Injury Report dated 5/11/19. DSP C completed the Incident Report on 5/12/19. According to report Client #2 was taken to the restroom by DSP D and put on the toilet with a safety belt at 6:15 p.m. According to Client #2's	W 153	Continued from page 2; Plan of correction implementation date: July 31, 2019 Person responsible: Direct Support Supervisor Monitor: Director of Residential Services We also created and trained on the15 and 30 minute check documentation sheets at this House Meeting with all staff. These sheets are centrally located in the Houses and require that whomever goes to the back and does the 15 check (during waking hours) and 30 minute checks (during hours of sleep) must come back up, after visually checking on the safety and security of the clients that are not in the front of the House and comes back out to the 15 and/or 30 minute Check Sheet and enters the date, the time at which they did the visual check of those not up front and sign off or initial that they were the one that verified their location and safety. At this time they would re-start the timer so that it will go off again as a reminder for the next 15/30 minute check to be done. This is required 24/7 when not all clients in the home are present in the front of the home. The 15/30 minute check forms will be collected by the Direct Support Supervisor of that home, at a minimum of weekly, and reviewed for accuracy and filed once verified that they have been done correctly. During the verification if there are any issues the staff involved will be retrained and they will assure that the next time they work that it is completely correctly. Plan of correction implementation date: July 31, 2019, Person responsible: Direct Support Supervisor Monitor: Director of Residential Services	

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plan, she was suppose to be on the toilet no longer than 15 minutes. At 8:10 p.m. DSP C went looking for Client #2 at snack time and found her still on the toilet from the time DSP D assisted her at 6:15 p.m.

When interviewed on 6/11/19 at 2:00 p.m. DSP D stated she made a mistake and forgot about putting Client #2 on the toilet. She stated she felt horrible and did not mean to leave her on the toilet.

When interviewed on 6/5/19 DSP C Stated he found Client #2 sitting on the toilet when he went to find her for snack. He further stated he did not report the incident until the following day when he completed the incident report.

Record review on 6/5/19 revealed a facility procedure for Client #2. The Procedure dated 3/7/19 titled Safety Precautions included a section for toileting. The precautions stated Client #2 liked privacy when she uses the toilet. She is more likely to void or have a bowel movement if she is alone. With the appropriate safety measures, she can sit for up to 15 minutes. She has the ability to reposition herself while she sits. The toilet in her room and work has side rails, a padded back, and a seatbelt for her protection.

When interviewed on 6/5/19 both the Direct Support Supervisor and Qualified Intellectual Disability Professional confirmed the level of supervision was not followed, the 15 min checks were not done according to policy and DSP D failed to follow the toileting procedure according to Safety Precautions Procedure. They also confirmed the reporting staff in both incidents failed to report immediately as stated in the facility

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