9/18/17 OK 9/15/17

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

PRINTED: 09/08/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G055	A. BUILDING _____ B. WING _____	C 08/23/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS During investigation 69623-I a deficiency was written at W189. During investigation 69651-I, no deficiency was written.	W 000		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff competently and effectively completed duties pertinent to ensure client safety. This affected 1 of 1 client (Client #1) identified as a result of 69623-I. Finding follows: Record review on 8/21/17 revealed a facility investigation regarding Client #1 found by the maintenance shed/back door of the facility on 6/24/17. Client #1 walked towards the parking lot. Staff A noticed Client #1 and walked with him/her back to the home. The recommendation section of the investigation noted, "The gate was not checked in the morning which if done would have prevented this incident." The Incident/Accident Report, dated 6/24/17 at 10:00 a.m., explained Staff A returned to the facility from an outing and found Client #1 outside of the gate/fenced in area of his/her home. No injuries noted.	W 189	All attached POC 9/30/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cu Reinard | TITLE: Exec. Director | (X6) DATE: 9-14-17

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

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W 189	Continued From page 1 Record review revealed Client #1, 16 years old, admitted to Faith, Hope and Charity on 8/7/2012. The client's Individual Service Plan (ISP), completed 10/25/16, listed the following diagnoses: severe to profound intellectual disability with developmental delays, attention deficit hyperactivity disorder (ADHD), pervasive developmental disorder, disruptive behavior disorder, receptive language disorder, seizure disorder and insomnia. The document noted Client #1's supervision requirements as: "...can be outside in a secure area with staff checking every few minutes." Record review also revealed Client #1's Comprehensive Functional Assessment, completed October 2016. The survival skills section revealed Client #1 required staff support in the following areas: identify crosswalk, operate crosswalk button at stoplight, know to cross the street at the crosswalk, identify stop lights and signs, understand and use stop lights and signs, yield to traffic when necessary in a parking lot, know when to look for cars and when to cross to the store." When interviewed on 8/21/17 at 1:50 p.m. Shift Leader A confirmed Client #1 walked outside for 30-45 seconds then was returned by another staff. She also admitted she did not check the gate or chain that morning as instructed per training. Interview with Staff B on 8/21/17 at 2:15 p.m. revealed she failed to check the gate lock also. She admitted the gate check was to be completed at 6:00 a.m., 2:00 p.m., and 9:00 p.m.	W 189		

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W 189	Continued From page 2 When interviewed on 8/22/17 at 9:35 a.m. Staff C stated she was assigned to Client #1 on 6/24/17. The client tried to take peers iPads and she suggested he/she go swing for a few minutes before bathing. The client went outside as she prepared the shower. She was going out to get the client when another staff brought the client to the back door stating the client was outside the fenced in area. She stated the client wore a t-shirt and blue pajama pants without shoes. She admitted she did not check the gate or chain that morning as she was trained to. She confirmed it was "a mistake on our part for not checking the gate." Observation of Client #1 on 8/21/17 at 11:15 a.m. revealed he/she walked independently to a car to leave for a visit. Client #1 opened the car door and independently sat in the seat. He/She manipulated a small toy staring at the item. Observation on 8/21/17 at 5:30 p.m. revealed a fenced in area behind the home. The fenced backyard contained a swing and a sidewalk leading to a fence type gate with a chain and pad lock. The pad lock was locked around a chain to hold the gate to the fence. The sidewalk led to a cement area between the main building and a maintenance shed. The area beyond the cement area led to a parking lot. Approximately 85 yards from the area where Client #1 stood was Highway 7, a two lane busy highway with a speed limit of 50 miles per hour. According to weather underground it was clear with a temperature of 64.4 at 9:55 a.m. in Storm Lake on 6/24/17. Record review on 8/21/17 revealed a "Gate	W 189		

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W 189	Continued From page 3 check-off" form from 6/14/17 to 6/26/17. The form instructed staff to check the gate lock at 6:00 a.m., 2:00 p.m., and 9:00 p.m. The document for 6/24/17 lacked initials for all three check times. Additionally, all three check times lacked initials for completing the checks on 6/19/17 and 6/20/17. Further record review noted a document titled, "AM Leadership Daily Duties," undated. The form included checking the gate lock and initialing the form. When interviewed on 8/22/17 at 10:20 a.m. the Residential Director stated the above Leadership form was the only policy/procedure she knew of for the gate security. She explained the form to initial contained instructions for completion. She admitted the form lacked initials for checking the gate on the above dates.	W 189		

✓ OK 9/18/17 9/15/17

FHC Plan of Correction
Investigation #69623-I
9/14/17

W 1989
The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently and competently.

This standard is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure staff competently and effectively completed duties pertinent to ensure client safety.

Plan of Correction:

1) By Sept. 1, 2017, the Director of Social Services (or designee)will be responsible to implement an oversight and monitoring program to monitor Gate Check form of each residential home for completion. The Director of Social Services will initial off on Gate Check forms to indicate this oversight and monitoring for completion. Gate Check forms are maintained by the Residential Coordinator in each homes' RC office.
2) By Sept. 13th, 2017, FHC's Residential Supports and Services Guide (RSSG) will be revised to include specific gate check procedures for assigned staff to ensure resident safety. The Executive Director is responsible for the revising the RSSG and distributing to Residential Leadership.
3) By Sept. 30th, 2017, all currently employed FHC ICF/ID shift leaders and residential coordinators will be retrained on the revised gate check procedures. Training will be documented in Residential Team meeting minutes, which are maintained by the acting Residential Director. Follow-up training for those responsible staff not in attendance at the Residential Team meeting will be completed by the acting Residential Director by Sept. 30, 2017, with documentation of training maintained by same.