√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
	16G088	A. BUILDING _____ B. WING _____	C 08/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMAGINE THE POSSIBILITIES, INC - DIAMOND PLACE	1208 SOUTH 11TH STREET OSKALOOSA, IA 52577

(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 investigation of #70207-I resulted in a determination of Immediate Jeopardy (IJ) on 8/212/17 at approximately 3:45 p.m., based on the facility's failure to ensure client safety by providing adequate staff supervision and accountability for clients. The facility developed and implemented a plan of abatement to retrain staff regarding client supervision and protocol for transporting clients. The IJ was removed on 8/22/17 at 3:40 p.m. Deficiencies were cited at W158 (Condition of Participation Facility Staffing) and W189.	W 000	See attached Plan of Correction POC 8/22/17	
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain minimal compliance with Condition of Participation (CoP) Facilty Staffing. The facility failed to implement a staff training system to ensure adequate supervision of clients. A finding of Immediate Jeopardy (IJ) of clients' health and safety was declared on 8/21/17, which was removed on 8/22/17. Cross reference W189: Based on interviews and record review, the facility failed to provide adequate supervision for a client left unattended in a facility vehicle approximately 80 minutes. Staff members were not aware the client was still in the vehicle.	W 158		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeffrey Morris Digitally signed by Jeffrey Morris DN: cn=Jeffrey Morris, o=Imagine the Possibilities, Inc., ou, email=jjmorris@imagineia.org, c=US Date: 2017.09.11 13:37:54 -05'00'	Regional Executive Director	9/11/2017

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 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 interviews and record review, the facility failed to provide adequate supervision for a client left unattended in a facility vehicle for approximately 80 minutes. This affected one of one sample involved in the investigation of #70207-I (Client #1). Finding follows: 1. Review of facility investigation on 8/21/17 revealed Client #1 left on an agency vehicle on 8/17/17 from approximately 11:15 a.m. to 12:35 p.m. The weather was approximately 75 degrees Fahrenheit during that time, according to the website Weather Underground. The doors and windows of the vehicle were closed. Staff failed to realized Client #1 was not in the facility. Team Lead A noticed Client #1 in the vehicle when she went outside to take out trash. She immediately took Client #1 into the facility. Client #1 did not appear to suffer any ill effects from the incident. Client #1, 34 years old, had diagnoses including: profound intellectual disorder, seizure disorder (controlled), blindness and dysphagia. Client #1 was non-verbal without functional communication. He/she could ambulate mostly independently, but needed staff guidance due to blindness and some unsteadiness. Client #1 reportedly did not have the ability to open a car door and did not attempt to ambulate without staff assistance. Client #1 wore an incontinence briefs at all times. He/she received food, liquids and medication via G-tube. Client #1 had no significant behavioral issues. No	W 189		

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W 189	Continued From page 2 information regarding level of supervision could be located in Client #1's chart. 2. When interviewed on 8/21/17 at 2:00 p.m. Team Lead A stated she was Client #1's assigned staff at the time of the incident. Four staff took seven clients to the day program in agency vehicles shortly after 9:00 a.m. Direct Support Professional (DSP) A left work from approximately 9:30 a.m. to 12:45 p.m. for a personal appointment. DSP A told the other three staff the absence had been approved by the Qualified Intellectual Disability Professional/ICF/ID Director (QIDP). The seven clients and three staff returned to the facility in three agency vehicles between 11:10 a.m. and 11:15 a.m. The three staff were Team Lead A, Team Lead B and Team Lead C. Client #1 was in a car driven by Team Lead B. Team Lead B was assigned to Client #2, who required 1-to-1 staff supervision. Team Lead A assisted the two clients in her vehicle into the facility and then noticed it was time to go pick up the eighth client from another day program. She went to the back area of the facility to ask the QIDP to go pick up the eighth client. They spoke for a couple of minutes about work related issues. Team Lead A returned to the main area of the facility and got busy putting away groceries, helping with lunch preparation and assisting with lunch. She said she assumed other staff had brought Client #1 inside and the client was in his/her bedroom. Team Lead A explained Client #1 was tube fed, so was not missed during lunch time. Client #1 usually sat in a living room recliner during lunch preparation and lunch time, but sometimes was back in his/her room. Team Lead A was originally assigned to Client #1 and one other client, but became responsible for two additional clients	W 189		

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W 189	Continued From page 3 when DSP A left work. Team Lead A said the clients typically went in the same vehicles and sat in the same spots when going to and from the day program. Client #1 usually sat in the back seat of the Chevy Cruz, as he/she did on 8/17/17. Team Lead A said it was preferred to have four staff present when going to or from the day program, to assist clients from the van to the buildings, but four staff were not required. There were supposed to be transportation logs in the agency vehicles for staff to complete, but those logs only indicated if clients got on the van from the facility or day program, not if they got off the van. Staff had not been regularly completing the transportation logs. Team Lead A did not fill out a transportation log on 8/17/17. She did not think there were any of the forms on the vehicle she drove. When asked how often staff should check on Client #1, or clients in general, Team Lead A said it was her understanding staff should check on their assigned clients every 20-30 minutes. She said she was very busy with lunch and she did not check on Client #1. She assumed the client was in his/her room. Team Lead A said she took the trash outside around 12:35 p.m. and saw Client #1 sitting in the back seat of the agency car. Doors and windows were all closed. Team Lead A immediately opened the back door and checked on Client #1. The inside of the car was warm, but not hot. She said Client #1 appeared to be in a good mood as evidenced by chewing on a shoe and making singing noises. These were typical behaviors for Client #1. Team Lead A stated Client #1 did not appear to be sweaty or in any kind of distress. Client #1's cheeks looked pink and his/her face	W 189		

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W 189	Continued From page 4 felt warm. Team Lead A assisted Client #1 into the facility. The client walked as he/she usually did. Team Lead A immediately summoned the facility nurse, who assessed Client #1. Client #1 continued singing and seemed fine. When asked who was responsible for ensuring Client #1 got inside the house when the vehicles arrived from the day program, Team Lead A said she was responsible. Team Lead A said the facility temporarily suspended all group outings until staff could be retrained. 3. When interviewed on 8/21/17 at 1:30 p.m. Team Lead B stated the three Team Leads brought the seven clients back to the facility on three agency vehicles on 8/17/17, arriving between 11:10 a.m. and 11:15 a.m. DSP A was also scheduled to work and assisted in taking the clients to the day program earlier that morning, but she left around 9:30 a.m. for a personal appointment. Team Lead B thought the QIDP was aware DSP A was leaving for part of the day. Team Lead B drove the Chevy Cruz, with three clients in the car, including Client #1 and Client #2. Team Lead B was the assigned 1-to-1 staff for Client #2. Client #1 was in the back seat, as usual. The three vehicles arrived at the facility at the same time. Team Lead B got the walker out of the trunk for the third client in the car and asked that client to wait for staff to accompany him/her into the facilty. The client began walking into the facility without staff, so Team Lead B got Client #2 and they followed the third client into the facility. Team Lead B said the doors and windows on the car were closed when they went inside. She said Client #1 needed assistance when walking, primarily due to blindness. To her knowledge, Client #1 was not able to open a car door. Team Lead B went into the facility and immediately	W 189		

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W 189	Continued From page 5 began attending to Client #2, her assigned 1-to-1 client, who could be quite active. She was busy with Client #2 as the client did laundry, walked around inside the house, had lunch and noon medications and brushed teeth. Team Lead B said she assumed Client #1 was in his/her bedroom. Client #1 had a special chair in his/her room where he/she liked to sit. Team Lead B said Team Lead A was assigned to Client #1. When asked who was responsible to make sure Client #1 got out of the vehicle and into the facility, Team Lead B said all of the staff were responsible because they worked as a team. When asked how often staff should check on the clients, Team Lead B said thought staff were supposed to check on clients every 30 to 60 minutes. When asked if there were supposed to be four staff present when assisting the group of clients from vehicles to the facility or day program, Team Lead B said this was preferred, but not required at that time. She said there were transportation logs, but those were to ensure clients left the building and got on the van, not to make sure clients got off the van. Team Lead B did not fill out a transportation log that day. It was not unusual for staff to not complete the transportation logs. 4. When interviewed on 8/21/17 at 1:00 p.m. Team Lead C stated four staff were present when the group went to the day program on 8/17/17 shortly after 9:00 a.m. DSP A left for a personal appointment around 9:30 a.m. Team Lead C thought DSP A had permission from the QIDP to be absent. The three Team Leads and seven clients returned to the facility from the day program between 11:10 a.m. and 11:15 a.m. Team Lead B drove the Chevy Cruz, with Client	W 189		

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W 189	Continued From page 6 #1 in the back seat. Team Lead B was assigned to Client #2, who had 1-to-1 staff supervision. Team Lead A was assigned to Client #1. Team Lead C parked the van she was driving and assisted the two clients in her vehicle inside the facility. She did not go back outside to assist any other clients. Team Lead C began to help put away groceries and start lunch preparation. Team Lead C also passed the noon medications. She was aware of the location of the clients assigned to her. Team Lead C said Client #1 usually sat in a living room recliner during lunch preparation and lunch time. She said she looked at the clock when Team Lead A brought Client #1 in from the car and it was 12:35 p.m. The nurse assessed Client #1 and checked his/her vitals signs. Client #1 seemed to be fine. The nurse directed Team Lead C to give Client #1 extra water via G-tube. When asked how often staff should check on clients, Team Lead C said she didn't know for sure, but thought it was probably around every 30 minutes. Team Lead C was aware the QIDP had said in the past there should be four staff present when taking the group of clients to and from the buildings to vehicles, but she thought this was more of a suggestion and not a firm rule. Team Lead C said there were transportation logs that ensured clients left the building and got on the vehicles, but they forms did not indicate if the clients got out of the vehicles and went into the building. Staff did not consistently fill out the transportation logs. Team Lead C had not filled out a transportation log on 8/17/17. 5. When interviewed on 8/22/17 at 10:15 a.m. the Health Services Coordinator/Registered Nurse (RN) stated Team Lead A came to her office on 8/17/17 at 12:35 p.m. asking her to assess Client	W 189		

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W 189	Continued From page 7 #1. The RN assessed Client #1 and checked the client's vital signs. The vital signs were within normal limits for the client, other than a slightly elevated temperature of 99.4 degrees Fahrenheit. The RN directed staff to apply cool, wet clothes to Client #1's neck. The RN continued to monitor Client #1, who showed no signs of distress or agitation. Client #1 was "singing"/making happy vocal sounds. The RN checked the client's vital signs at 12:52 p.m. and his/her temperature had come down to 98.5 degrees. Client #1 was wearing a tank top and shorts at the time of the incident. The RN directed staff to give the client an extra 250 cc of water prior to the 1:00 p.m. tube feeding. She notified Client #1's physician of the incident later in the afternoon. 6. When interviewed on 8/22/17 at 8:20 a.m. the QIDP said the facility began retraining staff on the evening of 8/21/17 and the morning of 8/22/17 regarding supervision of clients and transportation protocol. At the time of the incident, the QIDP said staff should have been checking on clients every 15 minutes and she thought this was well known by staff. This information was not documented in client program plans or written anywhere to her knowledge, but the QIDP thought staff members were aware that was the expectation. The QIDP also stated she had informed the staff at a staff meeting in May 2017 there must be four staff present to transport clients to and from the day program. The QIDP provided the minutes from a staff meeting held 5/17/17. According to the minutes, four staff were required to take the clients to the day program. If there were not enough staff, the clients could do the same type of activities at the facility. The minutes only covered going to the day program, not returning, but the QIDP indicated that was the	W 189		

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W 189	Continued From page 8 intent. The QIDP stated she had not approved DSP A absence for part of the day on 8/17/17. The QIDP was not aware at the time of the incident that there were only three staff present to assist the clients into the facility from the agency vehicles. The clients typically attended the day program one or two days per week. After the incident on 8/17/17, the facility temporarily suspended group outings until they could develop protocols and train staff. There were no planned group outings from 8/18/17 through 8/22/17, so the clients didn't miss out on any planned activities. The QIDP said the facility had five Team Leads, who were also supervisors. There were two tiers of Team Leads and Team Lead A was in the top tier. The QIDP immediately retrained the three Team Lead involved in the incident on 8/17/17, regarding appropriate supervision and the need for four staff for group transportation.	W 189		

OK 9/15/17

9/19/17

imagine the POSSIBILITIES

ICF/ID | Diamond Place

Plan of Correction

Pursuant to the August 21 & 22, 2017 investigation of a self-reported incident on August 17, 2017

W158 – Facility Staffing

Corrective Action – See W189

W189 – Staff Training Program

Corrective Action

1. **Adult Day Services Transportation**
    a. Adult Day Services Transportation Guidelines and Log have been revised to include the expectation that all consumers are assigned to specific staff when transporting to and from the Adult Day Services program. The guideline and log also include steps that address the transition of consumers from building to vehicle and vice versa as related to all legs of the trip.
    b. Initial training has taken place with regard to these changes. Additionally, this process will be added to new employee training and will also be reviewed at least annually with all staff.
2. **Level of Supervision Requirements**
    a. The communication of and training on required supervision levels for each consumer, including the frequency at which visual periodic condition and status checks are to be done by assigned staff, will include the following:
        i. Required supervision levels for each consumer have been added to consumer specific training documents used when training employees on the care and service requirements for each consumer. This training is provided at the time of hire and reviewed annually with all staff. Documentation of the new hire training and annual review is included on each consumer's specific training document. Initial training on this has been completed with all staff.
        ii. This information is also included in the staff schedule book so that it can serve as a reminder to staff when checking their staff/consumer assignments at the beginning of each shift.
        iii. Level of supervision requirements are also included in each consumer's annual plan documents.
    b. The following elements have been added to guidelines regarding level of supervision:
        i. Each consumer is assigned a color. Arm bands of corresponding colors are worn by staff assigned to each consumer during each shift. If for any reason, the responsibility for any consumer transfers from one employee to another, the arm band is transferred as well. This will serve as a tangible reminder of the responsibility placed on each staff member. Training for this system is done upon hire and reviewed periodically with all staff but annually at a minimum. Initial training on this has been completed with all staff.

ii. Consumer color assignments along with the frequency of required periodic visual checks are placed in the staff schedule book along with the consumer assignment schedule to serve as a routine reminder to staff regarding the use of this system.

c. A consumer check in and check out sheet has been developed and is placed at the front door for documenting when a consumer leaves the ICF/ID for any reason. The log will include their identifying number (used in place of name for privacy), the date and time they left, where they were going, with whom they went, the date and time of their return, and the name and signature of the responsible party. Training for this log will be done upon hire and reviewed periodically with all staff but annually at a minimum. Initial training for this has been completed with all staff.

Maintenance & Monitoring

1. Quality Assurance checks for the following and will be done periodically by the QIDP or her designee:
    a. Adult Day Services transportation guideline and log
    b. Required visual checks and use of color coded arm bands

    The frequency of these checks will be as follows at a minimum:
    - weekly through November 30, 2017 (unscheduled and random)
    - monthly from December 1, 2017 and ongoing. (unscheduled and random)

Date of anticipated correction

These corrective measures were implemented effective August 22, 2017.