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 10/16/2017

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 No deficiency written for investigation #70837-I. Investigation #70836-I resulted in a deficiency at W249.	W 000	See attached POC 11/6/17	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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 ensure staff consistently provided appropriate client supervision as directed by the annual evaluation. This affected 1 of 1 clients (Client #1) identified in #70836-I. Findings follow: 1. Record review on 10/9/17 revealed an Opportunity Living Incident Report completed on 7/10/17 at 8:20 a.m. by Staff A. The report described Staff A walked to the front entry and noticed Client #1 across the street. Nursing Assessment completed without any injuries noted. Client returned to the house cooperatively with the staff. Client #1-19 years old and had diagnoses including but not limited to: Intellectual Disability, legally blind, seizures, cerebral palsy and Seasonal Affective Disorder (SAD). Client #1 was	W 249		

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 249	Continued From page 1 admitted to the facility on 4/12/2016. Client #1's annual evaluation completed on 6/6/17 included the following for his/her home supervision level: He/She "has a history of leaving the home unattended. This is usually just (his/her) way of exploring (his/her) environment or because (he/she) wants to be outside. (He/She) is not attempting to run away but does not have safety skills to protect (himself/herself) should (he/she) wander outside. Staff must be aware of where (Client #1) is at all times. When not in the living or dining room area of (his/her) home (he/she) is checked on every 15 minutes and during the hours of sleep (he/she) is checked on every 30 minutes." Record review on 10/11/17 revealed Client #1's Comprehensive Functional Assessment (CFA) completed 6/6/17. The section addressing survival skills documented "not applicable" for "crosses streets safely" and "travels about community safely". According to Weather Underground the temperature was 78 degrees with no precipitation at that time on 7/10/17. When interviewed on 10/12/17 at 1:00 p.m. Staff A explained Client #1 was in the living/dining room when she went back to the bedroom area. When she returned she did not see Client #1 and noticed he/she was across the street. She remembered the client took off his/her shirt while outside. She stated Staff B was in the living room/dining room area with Client #1 when she went to the back of the house. She said the client wore shorts, a t-shirt and tennis shoes. She returned the client to the house. She was aware	W 249		

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W 249	Continued From page 2 of clients' supervision level and had been trained on the proper level of supervision the client required for safety. She admitted the client would not be safe outside because the client was "legally blind." Interview with a bus driver from a different house on 10/11/17 at 2:00 p.m. revealed he was by the bus at House E waiting to assist clients to load. He noticed a person walk out of House A holding their hands in front of them like they were looking at a phone. Then he noticed the person did not have a phone and was wandering. He did not know the client and observed the client sit for about 5 seconds in the middle of the street. The client soon got up and walked across the street towards House B. He called House A and at the same time a staff person came out of House A and assisted the client back inside the house. He guessed the client walked about 35 feet from his/her house. He denied any traffic on the street during the incident and added there was not much traffic on that street. Interview with Staff B on 10/12/17 at 10:45 a.m. confirmed he was in the living room/dining room when the client was noticed outside. He did not know how the client got outside. He thought the client had been in his bedroom. He was aware of the clients' supervision level and had been trained regarding the clients' needs. Observation on 10/9/17 at 12:00 noon revealed Client #1 completed lunch. Client #1 carried dishes to the sink and walked around the house. He/She walked around the house holding own hands in front of body to protect from walking into doors/objects. Eyes remained closed. Staff assisted and verbally prompted Client #1 to	W 249		

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W 249	Continued From page 3 maneuver in the home. Observation of the area on 10/9/17 at 1:00 p.m. revealed a residential area with a 25 mile per hour (mph) speed limit. The paved street had sidewalks and contained no other dangers beside traffic. The area between House A and B was flat and easy to view people standing in the street/sidewalk. When interviewed on 10/11/17 at 1:15 p.m. the cook explained she was in the kitchen when Client #1 was noticed across the street. She remembered Staff A noticed the client and went outside to return the client to the home. She stated Staff B was up front in the home. Another staff was in the bedroom area assisting other clients. 2. Record review on 10/9/17 revealed a facility Incident Report dated 8/21/17 at 3:35 p.m. by Staff C. She wrote Client #1 was found on the front patio. She wrote the client was in the recliner in the living room prior to walking outside. The report indicated the nurse assessed the client to find no injuries. The report also indicated the client "could not have been out there more than a couple minutes." According to Weather Underground the temperature was 80 degrees with no precipitation at the time the client left the house. When interviewed on 10/11/17 at 2:50 p.m. Staff C admitted she was in the living room/dining room area and had stepped into the kitchen when Client #1 went outside without staff supervision. She stated Staff D was up front when she went into the kitchen.	W 249		

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W 249	Continued From page 4 Interview with Staff D on 10/11/17 at 2:10 p.m. confirmed she was in the living room/dining room and stepped into the kitchen. She said she was only in the kitchen about 2 seconds and when she stepped out the nurse (Certified Med Aide/CMA) was bringing the client back inside. When interviewed on 10/9/17 at 2:10 p.m. the CMA explained she completed the med pass at House A and was walking outside when she saw Staff E (a staff from across the street) pointing to Client #1 who was standing at the side of the house. She assisted the client back inside as the staff stepped out of the kitchen. She told them the client was outside. When interviewed on 10/9/17 at 2:05 p.m. Staff E stated he looked outside of House B to see Client #1 stand by the front patio. He did not know how long the client was outside. He watched the client and as soon as he saw the CMA leave House A he pointed so she could see him/her. He added the client did not wear socks however the weather was nice. When interviewed on 10/9/17 at 2:00 p.m. the Qualified Intellectual Disability Professional (QIDP) explained Client #1 wandered out of the home the first time in May [2017]. Every staff was retrained on 5/30/17. The training sheet documented: "Staff are responsible for knowing where all clients in the home are at all times. If a staff must go to another area of the home to assist with a client and they are responsible for a client that has attempted to or has left the home without staff knowing, they must give responsibility for the client to another staff prior to going to the other area of the home. If this is not	W 249		

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W 249	Continued From page 5 done and that client leaves the home unattended, staff will be written up and suspended without pay. The decision as to who is written up will be up to the discretion of the home supervisor pending her investigation. The first incident of this occurring will result in a one day suspension. The second incident of this occurring will result in a three day suspension. The third incident of this occurring will result in termination. The majority of clients living at Opportunity Living do not have the safety skills to be outside on their home without staff supervision. This means they could and would walk into the street without making sure it was safe signed the QIDP." The remainder of the document showed staff's signatures stating understanding. The QIDP admitted both of these incidents were due to "staff error." She explained the home does have an additional staff from 6-10 and 4-8 to assist with supervision currently.	W 249		

OK Tmh

✓ 11/17/17

Opportunity Living Self-report 16G036
Plan of Correction
11/6/2017

W249 Program implementation

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.

Plan of Correction:
Staff training was completed by the Qualified Intellectual Disability Professional (QIDP) specific to those who may leave the house unattended. "Staff are responsible for knowing g where all clients in the home are at all times. If a staff must go to an area of the home to assist another client, they are responsible for communicating this to another staff who will then become responsible for the client. Those responsible for the lack of supervision of a client who leaves the home will be suspended immediately. We have also added an additional staff from 4-8 and !0-6 on the weekends when possible.

Retraining on Clients behavior program began on 7/7/2017. This was done on a regular basis at house meetings.
9/1/2017 – 4-8 coverage began on a regular basis when possible
9/30/2017 – 10-6 scheduled on a regular basis when possible.

Persons Responsible: Senior Counselor, QIDP, and Direct Support Professionals

Monitored by the Senior Counselor and the Director of Programming and Services. This will be monitored by reviewing training records to see if staff have been trained in dealing with those responsible for the clients. Work schedules will be monitored to see that sufficient coverage is available.

Plan of correction 11/6/2017

Opportunity Living Plan of Correction November 6, 2017
Citation 6685
08/23/2017
W153

Rule or Code 64.60

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Final correction date 10/26/2017