✓ 7/18/18 ok 7/16/18

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

PRINTED: 06/15/2018
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 05/31/2018

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 Investigations #76076-I and #76081-C were conducted on 5/23/18 - 5/31/18. The investigations resulted in a condition level deficiency written at W102 and standard level deficiencies written at W104 and W189. On 5/24/18 at approximately 11:30 a.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure the client's environment is safe and staff personal possessions kept locked. The facility developed a plan to remove the IJ, which included designating an area for staff to lock their personal possessions for their entire shift.	W 000	See attached POC 6/1/18	
W 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to comply with the Condition of Participation: Governing Body. This was evidenced by facility failurey to: a) develop written policy/procedure, which direct staff how to provide clients with a safe environment, b) provide necessary tools/equipment for a safe environment, and c) provide necessary training on safe environments. This potentially affected all clients residing at Faith, Hope, and Charity. Findings follow: 1. Based on interviews and record reviews, the	W 102		

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 102	Continued From page 1 facility failed to develop policy/procedure to ensure client safety. As a result, facility staff left personal possessions, which included potentially harmful medication, in an area of the home accessible to clients. See W104. 2. Based on interviews and record reviews, the facility failed to provide training to ensure provision of a safe environment, including on where to keep personal possessions. See W189. On 5/24/18 at approximately 11:30 a.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure the client's environment is safe and staff personal possessions kept locked. The facility developed a plan to remove the IJ, which included designating an area for staff to lock their personal possessions for their entire shift.	W 102		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: 1. Based on interviews and record reviews, the facility failed to develop policy/procedure to ensure client safety. As a result, facility staff left personal possessions, which included potentially harmful medication, in an area of the home accessible to clients. This directly affected 1 of 1 client (Client #1) and potentially affected all clients residing at home. Finding follows:	W 104		

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W 104	Continued From page 2 Record review revealed the following: a. Client #1's incident report dated 5/20/18 at 1:30 p.m., documented, "(Client #1) was found outside with a bottle of a staff medication pills. Staff removed the bottle from (Client #1's) hands and picked up pills from floor. (Nursing) was called to come check on (Client #1). Prior to the incident (Client #1) was wondering by the door opening and closing with the button. Staff redirected (Client #1) to the living room while staff finished cleaning kitchen." b. Facility's internal investigation, dated 5/25/18, noted, "(Client #1) was within her level of supervision. It is unknown if (Client #1) actually took the pills out of the purse. In addition to this, (Client #1) does not have fine dexterity to unzip and zip a purse. If she would have gotten the pills out of the purse, she would have made it very apparent that she had them. (Client #1) would have most likely shook the bottle and would not have hid it from staff..." c. Client #1's Comprehensive Functional Assessment dated 8/11/17, indicated Client #1 needed full assistance from staff to make safe choices. d. Client #1's discharge summary dated 5/21/18, indicated, "This patient is seen in ER (Emergency Room) after (patient) wandered outside for unknown amount of time, and was found with empty bottle of hycosamine (used for gastrointestinal disorders) .125 that belonged to staff member. Unknown (how) many pills left in bottle per staff. No other suspected pills or other substances ingested. She has a history of	W 104		

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blackout like seizures but no tonic clonic movements. Client #1 did recently see neurology to have (anti-seizure) meds (medication) adjusted and has been doing ok. Client #1 will be admitted for 24 hr (hours) of monitoring for worsening seizures due to anticholinergic effect of the meds ingested. Since admission there has been no observed seizure activity, no GI (Gastrointestinal) distress. Has yet to have breakfast this AM (morning). Poison control suggested client be observed for 24 hrs after ingestion due to increased risk of seizure. Will allow client to return to the facility this afternoon. Valium suppository should be available in case of prolonged seizure. Due to mental status there is unlikely value in follow up unless there are new concerns which should be dealt with immediately."

e. The diagnosis of Client #1, included: moderate intellectual disability, Angelman's Syndrome (chromosome disorder), and seizure disorder.

When interviewed on 5/24/18 at 8:49 a.m., Direct Support Staff (DSS) A reported she had accountability of Client #1 and two other clients on 5/20/18. DSS A explained Client #1's supervision level as staff should know Client #1's whereabouts and when he/she is in the backyard, staff should check on Client #1 every five minutes. If three or more clients were outside, staff should be outside with him/her. DSS A stated staff knew to keep an eye on Client #1 when he/she was in the kitchen or the MPR (Multipurpose Room), although he/she could be in the living room and staff could be somewhere else. After lunch on 5/20/18, DSS A reported she kept an eye on Client #1 while she finished cleaning up the kitchen. At approximately 1:00

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p.m., Client #1 tried to go outside. DSS A instructed other staff Client #1 needed shoes before he/she could go outside. DSS B was in the backyard with Client #3. DSS A stated she assisted Client #2 pack for home visit. Assistant Lead (AL) B walked into the home to take Client #2 to home visit. AL A, AL B, DSS A, Client #1, and 3 other clients stood by the door until AL B left with Client #2 and two other clients. According to DSS A, Client #1 did not attempt to get into staff's purse while she stood by the door. After the group left, DSS A assisted Client #1 with shoes and sent her to the backyard. Client #1 did not have anything in hands when walking outside. DSS A explained Client #1 would not hide anything from staff and DSS A would have observed Client #1 chewing on an object. DSS A sat at a table in the kitchen, so she could see the backyard. At approximately 1:15 p.m., AL B called the home because a client noticed Client #1 had toy when they drove by the backyard. DSS A walked outside, took the toy away from Client #1, and gave her one of their toys. DSS A walked back inside to complete her documentation. DSS A stated she completed some documentation and checked on Client #1. Client #1 walked from the swings towards the back door. DSS A believed she was coming inside and continued her documentation. Between 1:15 p.m. and 1:30 p.m., AL A informed DSS A she completed Client #1's checks. At approximately 1:30 pm., DSS A walked outside and Client #1 had a medicine bottle in her hand. DSS A stated the lid was off the empty bottle. DSS A found approximately 10 pills on the ground. They notified the nurse right away. According to DSS A, she never observed Client #1 in staff's personal items. DSS A stated, when she first started the facility was strict about

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locking up personal items. DSS A also stated the facility never told her not to bring personal items into work and stated for approximately a year or longer, they have not had a place to lock up items.

When interviewed on 5/30/18 at 8:30 a.m., DSS B reported 5/20/18 was her first shift back to work in a while. DSS B hung her purse on the hooks inside the door to the home. She did not usually bring her purse into work, but she knew she needed to take her medication. According to DSS B, the prescription medication bottle was zipped in her purse and secured with the child lock. She worked with DSS A and AL A, and each accountable for three clients. DSS B's group included Client #2 and Client #3. DSS B recalled, at different times throughout the shift, she was at different locations of the home, including outside with Client #2 and Client #3. DSS B assisted Client #2 and Client #3 with baths. She stated Client #3 was chaotic and tried to aggress most of the morning. DSS B stated she never observed Client #1 near her personal items. DSS B explained Client #1's supervision level. She stated staff should know Client #1's whereabouts and check him/her every three to five minutes. Inside the home, staff should keep a closer eye on Client #1 because he/she will get into other's personal belongings, such as toys. DSS B stated she focused more on her clients that day, instead of what others were doing. They had lunch at approximately 11:15 a.m. to 11:30 a.m. DSS B remembered lunch was normal, but maybe a little more chaotic because they had extra clients in the home. DSS B stated the majority of the clients ate at the same time. Client #3 stayed in his/her bedroom until most clients finished eating, then he/she ate. They finished lunch at

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W 104	Continued From page 6 approximately 11:45 a.m. to 12:00 p.m. DSS A assisted Client #2 pack for his/her home visit. DSS B stated staff helped each other out with supervision and accountability. According to DSS B, the only time DSS A would have asked her to watch her group is when she assisted Client #1 in the shower. At approximately 1:00 p.m., a group left to drop Client #2 off for a home visit and DSS A checked on Client #1 outside. She confirmed at approximately 1:40 p.m. to 1:45 p.m., Client #1 had her prescription medication bottle. DSS B did not recall the name or the amount of medication in the bottle, because the physician just changed her prescription. DSS B assisted DSS A pick up the medication off the ground and notified nursing. DSS B recalled approximately seven or eight pills on the ground. She stated DSS A notified administration on-call and filled out an incident report. DSS B recalled she took a dose of medication at 10:00 a.m. and was to take the medication again at 2:00 p.m. According to DSS B, someone was in the kitchen the entire shift to ensure clients stayed out of the kitchen and could have eyes on the bedrooms. DSS B was unsure how Client #1 retrieved the medication bottle. DSS B reported other staff indicated during the shift Client #1 walked past the door, but never had anything in his/her hands. DSS B stated Client #1 did not have the medication bottle prior to Client #1 found with bottle. DSS B never witnessed Client #1 ever going through staff stuff. DSS B could not remember training on locked medication or personal possessions. She stated she never brought medication into work before 5/20/18. DSS B confirmed training on a new procedure to lock personal possessions in the office. When interviewed on 5/24/18 at 10:20 a.m., AL A	W 104		

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reported on 5/20/18 she received a call from Faith Home they were short staffed. At approximately 6:30 a.m. to 7:00 a.m., Client #4 came to Hope Home for the morning shift. AL A stated Client #4 cried non-stop, he/she wanted to go into a bedroom, and he/she got into the refrigerator. She also stated Client #4 walked outside to disrobe and it was loud in the home. At approximately 8:00 a.m., a client from Charity Home also went to Hope Home for the morning shift. AL A reported she worked with DSS A and DSS B, each accountable for three clients. She stated DSS A and DSS B's groups had a good morning. AL A recalled Client #1 completed his/her normal routine, which consisted of going outside and into his/her bedroom. She stated Client #1 had a sensory program completed every hour and a half. According to AL A, Client #1 was outside most of the shift and staff watched him/her from the window most of the time. AL A stated there were no more than two clients outside at the same time. At approximately 1:00 p.m., Client #5 returned from church and Client #4 returned to Faith Home. At approximately 1:15 p.m. to 1:20 p.m., they started cleaning to get ready for the next shift and DSS A completed her documentation. AL A checked on Client #1 and he/she stood on the bench outside with toys in his/her hands. AL A went outside to ensure Client #1's toys were him/hers. Approximately two to three minutes later, DSS A checked on Client #1 and found him/her with a prescription medication bottle. AL A asked DSS B if the bottle was empty and she replied, "No." They notified nursing and checked mouth. AL A stated DSS A found many pills on the ground. A Nurse walked in and checked Client #1's vitals, they took Client #1 to his/her bedroom to change, and took him/her to the emergency room (ER).

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W 104	Continued From page 8 AL A remembered, while mopping before lunch, Client #1 stood next to the door and "messed with" the purse. DSS A redirected him/her away from the area before Client #1 accessed the purse. AL A stated when Client #1 got a hold of something he/she usually made a bigger mess. AL A also stated Client #1 did not place items in his/her pockets or try to hide items. According to AL A, on other occasions, Client #1 attempted to play with staff's personal possessions. Staff normally redirected him/her away. On 5/20/18, AL A did not know DSS B had medication in her purse. DSS B told AL A the purse was zipped. AL A stated all of the clients are curious, and some staff hid their purses by hanging a sweater over them. AL A believed staff completed all client checks during the shift. AL A explained how staff used to be able to lock personal items up in the medication room, but the facility changed the key. The AL's and HL's only had access to their office in the home. AL A stated the facility instructed staff to use the hooks on the wall for their personal items. AL A recalled when she started, three years ago, the facility verbally instructed her to lock up prescription medications. AL A stated DSS B had been off work for a while because she was sick. AL A did not know if DSS B ever attended a meeting when they discussed where to keep personal items. She stated staff used the cupboard in the kitchen to keep keys, drinks, and other items out of sight. AL A explained Client #1's level of supervision. She stated staff should know Client #1's whereabouts at all times and check on Client #1 every five minutes when she was in the backyard. She also stated Client #1 had a room monitor in bedroom. AL A remembered she heard the monitor sound multiple times on 5/20/18 and staff redirected Client #1 when the monitor sounded.	W 104		

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W 104	Continued From page 9 When interviewed on 5/24/18 at 9:04 a.m., Registered Nurse (RN) A worked 6:00 a.m. to 6:00 p.m. on 5/20/18. RN A reported the incident occurred at approximately 1:45 p.m. to 2:00 p.m. When RN A walked into the home, staff handed her the prescription medication, which contained approximately seven to eight pills. RN A could not read the label on the bottle, because Client #1 had the bottle in his/her mouth. RN A described some of the pills as dissolved and she observed white residue around Client #1's mouth. RN A told her co-worker to get vitals on Client #1 and RN A ran to the front of the facility to call Poison Control. RN A found a pill that contained letters and a number, which Poison Control used to look up the name of the medication. Poison Control instructed RN A to go straight to ER. RN A left a message for Client #1's mother and took the nurse phone with her to ER. Client #1's mother called RN A back while they waited in the ER. RN A stated she stayed at the hospital until 9:00 p.m. Once RN A informed the ER Physician of the name of the medication, they decided Client #1 needed monitored for 24 hours. The medication could cause dehydration and Client #1's seizure threshold to lower. RN A described Client #1 at the hospital as, stable and energetic. RN A stated Client #1 also urinated, as they were concerned with dehydration. The ER Physician continually asked how long Client #1 was unsupervised. RN A could not answer the Physician. RN A worked as a staff before she became a nurse. According to RN A, when the facility admitted Client #1, he/she was busier. She stated Client #1's attention span is better now. RN A also stated Client #1 always had things in his/her mouth, they kept a closer eye on him/her when Client #1 was around things he/she	W 104		

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could retrieve. The facility never informed RN A that staff could give their medication to the nurses to lock up. She stated staff used to lock items up in the utility closet.

When interviewed on 5/23/18 at 4:10 p.m. DSS C reported she arrived to her shift on 5/20/18 at 2:00 p.m. DSS C stated she walked in, everyone told her Client #1 got into DSS B's prescription medication and she needed to take Client #1 to ER. According to DSS C, it was hard to figure out the name of the medication and how many pills Client #1 took. While at the hospital, Client #1 had labs drawn and admitted her for 24 hours. DSS C stated the medication Client #1 took could cause seizures, hallucinations, and dehydration. DSS C stayed at the hospital until 6:00 p.m. When at the hospital, Client #1 grabbed DSS C's hand and brought her hand to her face. Client #1 seemed tired from DSS C rubbing face. When Client #1 got a room, she jumped on the bed. DSS C arrived at the hospital on 5/21/18 at 6:00 a.m. and observed Client #1's mouth and lips dry. She stated Client #1 was extremely thirsty. The hospital brought breakfast and Client #1 drank continuously. DSS C left the hospital at 10:40 a.m. and Client #1 lay in bed with her cup against her. DSS C stated the facility continuously reminded staff not to bring medication or anything that could cause harm to work. DSS C recalled, in the past, she brought an inhaler to work. She informed nursing and locked the inhaler in the office or the utility closet. DSS C stated food and drinks were the only other items she placed out of sight. Staff did not eat anything until the clients went to bed around 8:00 p.m. DSS C stated it was common sense to lock up medication. The facility instructed staff to keep personal items on the hooks inside the door. DSS C explained

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Client #1's supervision level. She stated when Client #1 was in MPR, staff had to keep eyes on him/her. When Client #1 was outside, staff checked on him/her every three to five minutes. DSS C usually went outside with Client #1 because she had a history of PICA. According to DSS C, Client #1 stopped PICA because staff had eyes on her so much. If other clients were outside staff had to be outside with Client #1. DSS C stated staff did not let the clients sit at the kitchen table, but while Client #1 was inside the home staff had eyes on her. DSS C explained Client #1 had a wandering program and when she walked by the door staff redirect her. DSS C stated Client #1 placed items in her mouth for sensory.

When interviewed on 5/23/18 at 3:40 p.m., AL B reported on 5/20/18 she worked 1:00 p.m. to 10:00 p.m. AL B arrived to work at 1:00 p.m. to take Client #2 on a home visit and two other clients rode along with her. AL B did not recall seeing Client #1 when she walked into the home. AL B explained Client #1's supervision. She stated staff should keep eyes on Client #1 at all times when inside the home. When Client #1 was outside, staff should check on him/her every five minutes. AL B stated if other clients were outside with Client #1, staff should watch her from the window or be outside with her. According to AL B, Client #1 wandered, was touchy and placed items in mouth. AL B stated Client #1 did not eat items. AL B explained how not all staff had access to the locked AL and HL's office in the home. Staff could place items in the office when the AL or HL worked. She stated staff kept purses hung by the door. AL B remembered when she started she was trained, on a possible policy, to keep medication locked up or not bring

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	16G055	A. BUILDING _____ B. WING _____	C 05/31/2018

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 104	Continued From page 12 it to work. AL B stated the facility had not retrained her on the policy, nor retrained since 5/20/18. AL B also stated, on 5/21/18, her supervisor informed her and documented in the communication book, no more medication at work. She stated staff read and sign the communication book. On 5/20/18 was the first time she heard of Client #1 getting into someone's purse. Client #1 lingered around the hooks to walk out the door, but never touched items. According to AL B, Client #1 liked bigger items such as, cups and markers. When interviewed on 5/30/18 at 10:55 a.m. the ICF/ID Manager acknowledged the facility failed to develop written policy/procedure and provide an area to lock up personal items to ensure client safety.	W 104		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(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 reviews, the facility failed to provide training on safe environments, including on where to keep personal possessions. As a result, facility staff left personal possessions, which included potentially harmful medication, in an area of the home accessible to clients. This potentially affected all clients residing at Faith, Home, and Charity. Finding follows:	W 189		

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W 189	Continued From page 13 Refer to W104 for additional information. Observation on 5/23/18 at 4:45 p.m., in the Hope Home, revealed purses hung on the wall hooks, inside the door. Record review revealed the following: a. Client #1's incident report dated 5/20/18 at 1:30 p.m., indicated, "(Client #1) was found outside with a bottle of a staff medication pills. Staff removed the bottle from (Client #1's) hands and picked up pills from floor. (Nursing) was called to come check on (Client #1). Prior to the incident (Client #1) was wondering by the door opening and closing with the button. Staff redirected (Client #1) to the living room while staff finished cleaning kitchen." b. Facility's internal investigation dated 5/25/18, included discussion points, "(Client #1) was within (his/her) level of supervision. It is unknown if (Client #1) actually took the pills out of the purse. In addition to this, (Client #1) does not have fine dexterity to unzip and zip a purse. If (he/she) would have gotten the pills out of the purse, (he/she) would have made it very apparent that (he/she) had them. (Client #1) would have most likely shook the bottle and would not have hid it from staff..." When interviewed on 5/23/18 at 3:00 p.m., the Home Lead (HL) A reported they used to have a locked break room for staff to store personal items, but the locked room currently contained medication. HL A communicated to staff in the past to leave medication in their vehicles or with nursing. She stated staff should not bring the medication into work. She recalled the facility	W 189		

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W 189	Continued From page 14 trained all staff with a memo, sent out last year. When interviewed on 5/23/18 at 3:40 p.m. Assistant Lead (AL) B explained how not all staff had access to the locked AL and HL's office in the home. Staff could place items in the office when the AL or HL worked. She stated staff kept purses hung by the door. AL B remembered when she started she was trained, on a possible policy, to keep medication locked up or not bring it to work. AL B stated the facility had not retrained her on the policy, nor retrained since 5/20/18. AL B also stated, on 5/21/18, her supervisor informed her and documented in the communication book, no more medication at work. She stated staff read and sign the communication book. On 5/20/18 was the first time she heard of Client #1 getting into someone's purse. Client #1 lingered around the hooks to walk out the door, but never touched items. According to AL B, Client #1 liked bigger items such as, cups and markers. When interviewed on 5/23/18 at 4:00 p.m., AL C recalled HL verbally trained her on prescriptions medication. She stated staff could ask nursing to hold the medication or keep it in the car. AL C kept her backpack around the medication room. When interviewed on 5/23/18 at 4:10 p.m. Direct Support Staff (DSS) C stated the facility continuously reminded staff not to bring medication or anything that could cause harm to work. DSS C recalled, in the past, she brought an inhaler to work. She informed nursing and locked the inhaler in the office or the utility closet. DSS C stated food and drinks were the only other items she placed out of sight. Staff did not eat anything until the clients went to bed around 8:00	W 189		

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W 189	Continued From page 15 p.m. DSS C stated it was common sense to lock up medication. The facility instructed staff to keep personal items on the hooks inside the door. When interviewed on 5/24/18 at 8:49 a.m., DSS A stated, when she first started the facility was strict about locking up personal items. DSS A also stated the facility never told her not to bring personal items into work and stated for approximately a year or longer, they have not had a place to lock up items. When interviewed on 5/24/18 at 9:04 a.m., Registered Nurse (RN) A reported the facility never informed RN A that staff could give their medication to the nurses to lock up. She stated staff used to lock items up in the utility closet. When interviewed on 5/24/18 at 10:20 a.m., AL A explained how staff used to be able to lock personal items up in the medication room, but the facility changed the key. The AL's and HL's only had access to their office in the home. AL A stated the facility instructed staff to use the hooks on the wall for their personal items. AL A recalled when she started, three years ago, the facility verbally instructed her to lock up prescription medications. AL A stated DSS B had been off work for a while because she was sick. AL A did not know if DSS B ever attended a meeting when they discussed where to keep personal items. She stated staff used the cupboard in the kitchen to keep keys, drinks, and other items out of sight. When interviewed on 5/30/18 at 8:30 a.m., DSS B could not remember training on locked medication or personal possessions. She stated she never brought medication into work before	W 189		

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W 189	Continued From page 16 5/20/18. DSS B confirmed training on a new procedure to lock personal possessions in the office. When interviewed on 5/30/18 at 10:55 a.m., the ICF/ID Manager confirmed the facility failed to train staff on where to keep personal items to ensure safety of clients.	W 189		

OK 7/19/18

Violation 481-64.60 (135C) Federal regulations adopted – conditions of participation.
W102 483.410 Condition of participation: Governing body and management (a) Standard: Governing body

W104 483.410(a)(1) the governing body must exercise general policy, budget, and operating direction over the facility.

W189 483.430(e)(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.

Based on interviews and record reviews, the facility failed to comply with the Condition of Participation: Governing Body. This was evidenced by facility failure to: a) develop written policy/procedure, which direct staff how to provide clients with a safe environment, b) provide necessary tools/equipment for a safe environment, and c) provide necessary training on safe environments. This potentially affected all clients residing home.

Plan of Correction
On May 24, 2018 a corrective action was imposed whereby all personal possessions of staff were kept and store in a locked staff office. Staff were given keys to the locked office. This was enforced on May 24, 2018. Staff were trained in the new protocol as they arrived for their next shift by the leadership in each home.
On June 1, 2018 a policy was established that addresses staff personal belongings. It states: All staff will keep all of their personal belongings, including but not limited to purses, coats, backpacks, lunch bags/sacks, fanny packs, food and/or drinks in the designated locked location of their work site. Visitors of the children will keep their personal possession on their person at all times when in the facility. Current coat hangers by the doors are for clients only. Matt Buley, the CEO of Hope Haven, wrote this into policy. The training conducted above is reflective of this policy. There is a notification for visitors and volunteers in their sign-in log book.
A more permanent solution to the safety of the clients includes the use of locked lockers for staff use.

✓ 7/19/18