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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G032	A. BUILDING ______ B. WING ______	C 08/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE VISION	1200 NORTH NINTH STREET WEST CLEAR LAKE, IA 50428

(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 A deficiency was cited at W249 as the result of the investigation of #77612-I.	W 000		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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 followed the level of supervision indicated in the client's program plan. The client left facility grounds without staff knowledge. This affected 1 of 1 sample client identified in the investigation of #77612-I (Client #1). Finding follows: Record review on 8/27/18 of a facility investigation revealed Client #1 left the facility without staff knowledge on the afternoon of Sunday, 7/18/18. He was discovered by an Occupational Therapist (OT) Consultant near the Fareway grocery store, approximately 1/4 mile from the Twilight group home, where the client lived. The OT Consultant spoke with Client #1, who then walked back to the facility on his own. Client #1 sustained no injuries during the elopement. The facility determined Personal Supported Professional (PSP) A was responsible	W 249	See attached POC 10/2/18	

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 for Client #1 at the time of the elopement and she had not been providing the required level of supervision. Client #1, 30 years old, had diagnoses including: mild intellectual disability and Fragile X Chromosome. Client #1's Individual Data form noted he liked to be outside during warmer weather months and staff needed to monitor him for his safety. Client #1 was verbal, with basic functional communication skills. His Individual Support Plan (ISP), last updated 2/28/18, noted Client #1's supervision level. Staff needed to do visual checks every 15 minutes if Client #1 was outside. According to the ISP, "If (Client #1) has appeared to be upset over the past hour staff will begin having a constant visual on (Client #1) if he is outside. This will occur for one hour following him appearing to be upset. After one hour of no apparent upsets, the constant visual when (Client #1) is outside will discontinue and the 15 minute visual checks when outside will be in effect again. Staff will visually keep an eye on him from a distance, as he does not like anyone following him too close... When (Client #1) is at home and in his room, staff do visual checks hourly during waking hours and every 2 hours on the 11p-7a shift, when (Client #1) is sleeping." The ISP also noted Client #1 was allowed to walk around the facility campus and ride his bike around the campus without supervision, as long as staff checked on his whereabouts every 15 minutes. According to the ISP, "Staff or family support is needed at all times when (Client #1) is in the community to ensure his safety." Client #1's Comprehensive Functional Assessment (CFA) dated August 2017 indicated "No" for the following areas of	W 249		

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W 249	Continued From page 2	W 249		

Transportation/Walking: uses crosswalks, looks all directions before crossing, uses sidewalks when available, walks facing the traffic, and is safe in parking lots.

At the time of the incident, Client #1 had a behavior program with target behaviors of physical aggression, self-injurious behavior, and vocal/physical outburst. The program did not include a target behavior of elopement or leaving without notifying staff. However, the behavior program noted Client #1 would often go for a walk when upset. Staff were supposed to keep an eye on him from a distance if Client #1 went for a walk when upset. According to the behavior program, "This means staff need to keep a visual eye on me at all times when I am upset and outside my home until I have not had any apparent upsets for one hour."

According to the state of Iowa climatologist the weather at Mason City, Iowa airport (nine miles from Clear Lake, Iowa) on 7/08/18 at 1:53 p.m. was 84 degrees Fahrenheit with no precipitation.

When interviewed on 8/28/18 at 3:15 p.m. the OT Consultant said she was working at the Twilight cottage on the afternoon of 7/08/18. She noticed Client #1 went out the door with his mother. A short time later Client #1 came back inside and yelled. He walked into the men's side TV room/lounge. The OT Consultant did not recall the time this occurred.
The OT Consultant finished her assessment and left the facility. When she got to her car her husband told her there was a man at the Fareway grocery store who had taken off his shoes and thrown them in the parking lot. Her husband saw the man when he passed the grocery store on the

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way to pick up the OT Consultant. Her husband questioned if the man might be a One Vision client. They drove to Fareway Center and the OT Consultant saw Client #1 standing on the sidewalk near the northeast corner of the parking lot. She looked at her phone, planning to call Client #1's house, but she didn't have their phone number. She noted the time was around 1:45 p.m. Client #1 was mad and yelling. He had taken off his sandals, socks, hat and sweatshirt and thrown them on the ground. Client #1 was wearing a shirt and shorts and was barefoot. The OT Consultant tried talking to Client #1, but he started walking back toward Twilight. The OT Consultant picked up the client's clothing items went back to the group home in her car. Client #1 walked across the facility grounds to get back to the Twilight house. He walked back to Twilight and sat on a bench outside of the house. The OT Consultant notified PSP B at the house that she had found Client #1 near Fareway. When asked to estimate how much time had passed from when she saw Client #1 come inside the house until she left the home to go to her car, the OT Consultant said maybe 10 to 15 minutes. She said she was sure it was much less than one hour. She said she never saw Client #1 walking in the road. He was either on the sidewalk or on the grass.

When interviewed on 8/29/18 at 10:30 a.m. PSP A stated she was on medication on 7/08/18 that made her groggy at the time and has affected her memory of the day's events. PSP A confirmed she worked at the Twilight home on 7/08/18 and was assigned to the male clients during her shift. She helped two female clients shower before lunch and asked other staff to keep an eye on the guys during that time. After lunch PSP A checked

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W 249	Continued From page 4 on the male clients. Client #1 had eaten in his room. He gave PSP A his plate from lunch and went back to his room. He seemed calm. PSP A saw Client #1's mother a short time after Client #1 gave her his plate. PSP A was aware that Client #1's mother was going to take him on an outing. PSP A didn't see them leave, because she assisted with a female client who insisted on having PSP A help her. PSP A assumed Client #1 was gone with his mother on an outing. PSP A didn't know that Client #1 came right back and had not actually gone on an outing with his mother. At some point in the afternoon, Client #1's mother called and said Client #1 had gotten upset in the car because she wouldn't take him to lunch, so she hadn't taken him on outing. This was when PSP A realized Client #1 was not gone on an outing with his mother. After the phone call, PSP A went to look for Client #1. He walked in from outside around this time. It is possible this was around 3:00 p.m., but PSP #1 did not recall the times of the phone call. No one told PSP A that day that Client #1 had eloped and gone up near the Fareway store. She had no idea. PSP A said she was in the women's lounge with a client from approximately 1:00 p.m. to 1:45 p.m. A male client was there sleeping. There was also a female client who only wanted PSP A to help her. PSP A said she also went over to the men's side to check on the male clients, but she didn't see Client #1. PSP A thought Client #1 was on an outing with his mother. No one told her that Client #1 had come back. PSP A knew she as supposed to check on Client #1 every hour in the house and every 15 minutes if outside, but she thought he was gone on outing with his mother. PSP A said she did check on the other male clients.	W 249		

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W 249	Continued From page 5 When interviewed on 8/28/18 at 2:30 p.m., PSP B said he worked at the Twilight home on the day of the incident. PSP B was assigned to kitchen and med room, so he prepared meals and passed medications.. He also helped out as needed. Client #1's mother came to take him for an outing around 12:30 p.m. They went outside to her car. Client #1 came back inside a short time later and went to his room at around 12:40 p.m. PSP B heard Client #1 come back inside, but didn't see him. PSP B was in the kitchen and heard Client #1 kind of grumbling when he came inside. Client #1 didn't sound real upset. PSP B was in the kitchen cleaning up from lunch and baking a cake. He also had a couple of noon medications to pass. PSP B did not recall Client #1 coming to the kitchen to get lunch. PSP B did not see or hear Client #1 again until the OT Consultant walked in the door around 1:45 or 2:00 p.m. The OT Consultant said she had found Client #1 at the grocery store and she was carrying some of his clothes. PSP B went to check and he saw Client #1 sitting outside on his bike. Client #1 did not seem upset. PSP B asked Client #1 to come inside and he said he would later. PSP B kept an eye on Client #1 from inside. Client #1 came inside about five minutes later. PSP B told PSP A about the incident since she was Client #1's assigned staff. PSP B said he had witnessed Client #1 attempt to leave in the past, but typically Client #1 would be very upset and let staff know he was upset and leaving. In the past, Client #1 made his intentions clear and staff were able to follow him. PSP B had never known Client #1 to take off without somehow alerting staff. At the time of the incident, PSP said he thought Client #1 required 15 to 30 minute checks if outside and not upset. If Client #1 was upset when outside, staff needed	W 249		

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W 249	Continued From page 6 to provide constant supervision. If Client #1 was inside the house, PSP B was not aware of any specific level of supervision. When interviewed on 8/28/18 at 2:00 p.m. PSP C confirmed she worked at the Twilight House at the time of the incident. She was assigned to two of the female clients. The house is divided into a women's side and men's side, with a common dining room and kitchen in the middle. Client #1 came into the dining room from outside around 12:30 p.m. He got a big salad and a couple dinner rolls for lunch. PSP C sat at a table with another client who ate lunch. The other clients had eaten. Client #1 said something about his mom, but he didn't seem mad or upset. He took lunch to his bedroom, which was typical. Between 1:00 and 1:30 p.m. PSP C saw Client #1 and another client come from the men's area and walk through the dining room. They greeted PSP C, who was in the dining room. Both were friendly; neither one seemed upset or angry. Client #1 and the other client went out the side door to the parking lot area. The door chime sounded when they went outside. PSP C said she was estimating the time. PSP C didn't see Client #1 again until she left her shift at 3:00 p.m. Client #1 stood outside with his bike and he waved at PSP C as she left. He had no staff with him. PSP C did not know that Client #1 had left/eloped until she was told the next day. PSP C was fairly sure PSP A was in the women's lounge when Client #1 and the other male client went outside. PSP A should have been able to hear the door chime, which is a different sound than the main front door beeping sound. But PSP A didn't call out or ask who went out the door. PSP C doesn't think she told PSP A that the two male clients went out the door, she probably should	W 249		

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W 249	Continued From page 7 have told her. PSP C said PSP A was in the women's lounge from approximately 1:00 p.m. to 1:45 p.m. PSP C did not recall seeing PSP A leave the women's area to go check on the male clients. There was one male client in the women's lounge off and on. A total of five male clients lived at the Twilight home. No staff were in the men's lounge/wing from approximately 1:00 p.m. to 1:45 p.m. PSP C acknowledged the staff person assigned to the male clients should spend most of their time in the men's lounge/wing, or wherever most of the male clients were located. PSP C was aware of Client #1's supervision level at the time of the incident. The facility interviewed Client #1's mother on 7/09/18 regarding the incident. Client #1's mother said she had planned to take Client #1 on an outing on the afternoon of 7/08/18. She picked him up from the house, but barely backed out of the parking lot when Client #1 became upset because his mother was not taking him to McDonalds. His mother pulled back into the parking lot and Client #1 got out of the vehicle. Client #1's mother left in her vehicle as Client #1 stood outside of the home. Later in the afternoon, Client #1's mother called the house to explain to staff why she had not taken her son on the outing. She said the time on her phone when she called the Twilight house and spoke to staff on 7/08/18 was 2:57 p.m. When interviewed on 8/29/18 at 11:00 a.m. the Qualified Intellectual Disability Professional (QIDP) said Client #1 had not eloped without staff knowledge in the past. Client #1 was admitted to the facility in August, 2016. He had left the house and yard when upset in the past, but he had been clearly upset so staff had been supervising him	W 249		

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W 249	Continued From page 8 and were able to follow the client when he left. The QIDP confirmed PSP A was assigned to the five male clients at the time of the incident on 7/08/18, which included Client #1. His assigned staff was supposed to check on him every hour if in the house, every 15 minutes if outside and calm and provide constant visual supervision if outside and upset. Client #1 was allowed to walk or ride his bike around the agency campus on his own, with 15 minute staff checks. He needed supervision and support of staff or family when in the community. In summary, PSP A, who was assigned to Client #1 on the afternoon of 7/08/18, mistakenly thought Client #1 had gone on an outing with his mother and was not at the facility. PSP B and PSP C were aware Client #1 had returned shortly after going out the door with his mother, but they did not communicate this information to PSP A. PSP A did not check on Client #1 as directed per his ISP, because she thought he was on an outing. Assigned staff PSP A likely saw Client #1 around 12:30 p.m. when he finished lunch and did not see him again until his mother called around 3:00 p.m. PSP C said she saw Client #1 go outside between 1:00 and 1:30 p.m. and admitted she did not inform his assigned staff. Client #1 was discovered by the OT Consultant about 1/4 mile from the facility around 1:45 p.m., near a street and parking lot.	W 249		

OK 10/8/18

W 249

All staff will provide the appropriate level of supervision for individuals supported, as outlined in their individual support plans. The QDDP reviewed individuals level of supervision with the staff and will continue to do this monthly at team meetings. (for a minimum of six months). Staff were retrained on the use and importance of walkies. The QDDP will monitor use of the walkies by having a walkie on her desk and listening for appropriate conversation and giving feedback as necessary. (for a minimum of two months). Staff were retrained on the importance of responding to door alarms. The QDDP will monitor when she hears the alarm go off, if staff respond appropriately with use of the walkie. (for a minimum of two months). The QDDP will do a minimum of two walk throughs a week in her home and ensure staff have walkies on, respond to door alarms, and are aware of where individuals are and their level of supervision. (for a minimum of two months).

Person responsible: QDDP

Date of implementation: Immediately

√ 10/8/18

Jane Iverson
Regional Director
10/4/18