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 09/18/2018

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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 Investigation #77696-I was conducted on 8/22/18 to 8/28/18, resulted in a condition level deficiency written at W122 and standard level deficiencies written at W149, W189, W249, and W331. On 8/23/18 at approximately 11:45 a.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure client safety from potential abuse/neglect. The facility developed a plan to remove the IJ, which included training on safety, abuse and neglect, bed checks, and staff knowledge of all situations going on in the home. The plan also included implementation of a new client check performed by two staff before exchanging responsibility and disciplinary action.	W 000	See attached POC 10/1/18	
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections 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: Client Protections. The facility failed to provide an environment free from neglect. This potentially affected all clients residing in the Hope Home. Finding follows: Based on interviews and record review the facility failed to provide an environment free from neglect. The facility locked a client outside on 8/17/18 at approximately 9:00 p.m. to 8/18/19 at approximately 2:00 a.m. See W149.	W 122		

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 122	Continued From page 1 On 8/23/18 at approximately 11:45 a.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure client safety from potential abuse/neglect. The facility developed a plan to remove the IJ, which included training on safety, abuse and neglect, bed checks, and staff knowledge of all situations going on in the home. The plan also included implementation of a new client check performed by two staff before exchanging responsibility and disciplinary action.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide an environment free from neglect. The facility failed to ensure adequate and appropriate supervision of clients; as a result, Client #1 was locked outside of the home for approximately five hours. This affected 1 of 1 client identified as a result of facility self-reported incident #77696-I (Client #1) and potentially affected all clients living in the facility. Finding follows: See W189 and W249 for additional information. Record review revealed the following: a. The diagnosis of Client #1, age 14 at the time of the incident, included: Moderate Intellectual Disability, Attention-Deficit Hyperactivity Disorders, and Autistic Disorder.	W 149		

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W 149	Continued From page 2 b. Client #1's shift summary dated 8/17/18, indicated, Temporary Agency Staff (TA) A came in at 10:00 p.m. and received report from staff. The other 3:00 p.m. staff who had worked in Hope Home had already left the facility. Staff)reported all of the residents were in bed. After he left, TA A completed rounds. TA A noticed Client #1 not in his room and his bed still made. TA A assumed he had gone for a home visit, considering the fact sometimes this type of information did not get reported to TA A when she came in to do her overnight shifts. TA A resumed with her regular overnight tasks. TA A heard noises outside in the backyard, which sounded similar to wind pushing against the backyard door. TA A paused to listen, but did not hear anything else. At around 1:00 a.m. TA A heard a voice in the distance, so she did another round of checking beds. TA A saw Client #2 awake in his room and asked if he was the one making noises. He responded "Yes." At 2:00 a.m. TA A checked Client #3. She was dry and refused to go to the bathroom. TA A walked to the living room, where she looked out the living room window due to hearing someone trying to open the backyard door. TA A noticed Client #1 standing outside in the backyard. TA A immediately contacted nursing by calling them. TA A and nursing unlocked the backyard door to let Client #1 in. Client #1 walked straight to his room, laid down, and covered himself with his blanket. TA A noticed Client #1 shivered. c. Facility investigation, dated 8/20/18, included the following discussion points: " 1. According to (DSP C) she checked the backyard gate lock and locked the back door at 9:00 PM. Once locked the only way the door opens from either side is if the fire alarm system	W 149		

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is activated. (Client #1) has to have been out in the back yard for at least 5 hours (9:00 PM - 2:00 am).

2. The night nurse did understand and help the (TA) with our protocol. She already knew she was going to call (Child Protective Services). She stated she is a mandatory reporter.

3. (Direct Support Professional (DSP) A) said she documented the evening of Friday 8/17/18. There was no documentation completed at that time. The documentation for that night was completed on Monday 8/20/18 per the time stamped report. She lied about the documentation.

4. (Home Lead (HL) A) was notified by the Night attendant of this situation. (HL A) is not new to these situations and does understand the confidentiality and sensitivity of these issues. However staff were noting that she told her staff of the issue, which undermined the integrity of the interviews.

5. It is highly unlikely that (DSP B) conducted a bed check in Hope home, based on his statement of every 2 hours checks and his poor recall on census in Hope for that hour he was in Hope home.

6. There is no consistent way staff give report to the next shift.

7. (ICF/ID Manager) and (Registered Nurse (RN)) tested the back doors to all the homes and found all in working order."

d. Residential Services and Supports Guidebook dated 6/16, listed rights of individuals served, "Be free from abuse and neglect."

e. Record review revealed facility policy dated 4/2017 for Mandatory Reporter. The policy defined denial of critical care as "failure on the

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W 149	Continued From page 4 part of the person responsible for the care of a child to provide for the adequate food, shelter, clothing or other care necessary for the child's health and welfare when financially able to do so or when offered financial or other reasonable means to do so. Denial of critical care is the failure to provide for the child's basic needs. Iowa emphasizes seven types of denial of critical care where the child's caretaker fails to provide adequate: food and nutrition, shelter, clothing, health care, mental health care, emotional care, supervision, response to life threatening conditions (infants)." According to website, wunderground.com, on 8/18/18 at 2:00 a.m. the temperature was 63 degrees Fahrenheit (F). When interviewed on 8/22/18 at 1:50 p.m., TA A reported she worked at the facility since May and worked two to three nights a week. On 8/17/18, TA A arrived at the facility at 10:00 p.m. She stated the staff she replaced reported everyone asleep. According to TA A, communication between shifts was not good, so the first thing she completed was bed checks. During the bed checks, TA A noted Client #1's bed was empty, the covers were neatly on the bed, and the room was clean. TA A assumed Client #1 was gone on a home visit because it had happened before. She explained how she found empty beds before and confirmed the clients were on a home visit. TA A stated they had a shift communication book, but the documentation was not always accurate. She stated she should have called another staff to confirm Client #1 was out of the facility on 8/17/18. TA A reported she assisted the girls with the bathroom and/or personal cares at 12:00 a.m., 2:00 a.m., and 4:00 a.m. She assisted the	W 149		

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W 149	Continued From page 5 boys between those times, but they are more independent. She stated Client #1 usually slept through the night and was independent with the bathroom. On 8/17/18, TA A completed her regular duties. Around 12:00 a.m. and 1:00 a.m., she kept hearing things. TA A described the sounds like the wind hitting the window. TA A stopped and listened to find out where the noise came from and the noise would stop. TA A thought she was getting "creeped out." At approximately 1:00 a.m., TA A heard a voice. TA A went into Client #2's bedroom and asked him if he made the sound. Client #2 stated yes. At approximately 2:00 a.m., TA A checked Client #3, walked out of her bedroom, and heard someone pulling on the door. TA A looked out the window and observed what looked like Client #1 shivering. TA A called the nurse and went to get the keys to unlock the door. She called Licensed Practical Nurse (LPN) A and told her there was a boy in the backyard. LPN A came into the home and the fourth key they tried opened the back door. Client #1 walked straight to his bedroom and got into bed. TA A stated she checked the locked window and assisted Client #1 with a blanket. LPN A asked if Client #1 needed another blanket, but did not complete an assessment. The temperature was approximately 60 degrees and Client #1 wore shorts and a t-shirt. LPN A instructed her to notify administrator on-call and left the home. According to TA A, she tried to call the administrator on-call three times, left a message, and never got a response. At approximately 5:30 a.m., TA A talked to Home Lead (HL) A, who told her she would be in to work shortly. TA A stated she was not sure what to do, but she completed documentation about the incident. When the morning shift arrived, they instructed TA A to complete an incident report.	W 149		

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W 149	Continued From page 6 Client #1 had an assessment by a nurse at 6:00 a.m. TA A was unsure if Client #1 stopped shivering, but she stated she checked on him every 15 to 20 minutes. When interviewed on 8/22/18 at 9:45 p.m., LPN A reported during the overnight she covered for breaks in the Love and Hope homes. She stated at approximately 2:15 a.m., she was in Love home when TA A called her and stated she thought someone was outside. LPN A walked over to Hope home and assisted TA A to unlock the door. LPN A remembered the light on the door was red, indicated the door was locked. LPN A thought Client #1 wore a t-shirt and pajama pants, but remembered she observed his lower legs. LPN A stated she was able to see Client #1's lower legs and arms before he jumped into bed. LPN A denied Client #1 shivered, although he was probably chilled. LPN A stated Client #1 did not have goosebumps. The temperature was approximately 60 degrees. Client #1 ran to his bed and covered up. LPN A felt that was best assessment she could get. She thought she would not be popular if she had Client #1 uncover and undress. LPN A stated Client #1 seemed anxious to go to bed and seemed fine. When interviewed on 8/22/18 at 3:25 p.m., DSP A reported on 8/17/18 the entire shift was stressful. DSP A had responsibility for Client #1 and Client #3. During the evening meal, Client #4 got into an argument with DSP D. DSP A asked DSP D to switch clients with her and DSP D refused. Client #4 did not want DSP D as his staff and had behaviors most of the shift. Between 7:00 p.m. and 8:00 p.m., Client #4 called his parents and Client #4 became upset when his sister picked up	W 149		

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his moms phone. At 8:24 p.m., Client #4 started a movie in his bedroom. From 8:00 p.m. to 8:30 p.m., DSP A could see Client #1 outside from the window, but it got dark and DSP D asked Client #1 to come inside. Client #1 was fixated on being outside. DSP A stated usually Client #1 comes inside at night to watch his T.V. in his bedroom, but two days prior Client #1 broke his T.V. DSP A made Client #1 a foam T.V. he did a happy jump, and came in the home. Client #4's bedroom alarm went off at approximately 8:30 p.m. to 8:35 p.m. Between 8:46 p.m. and 8:50 p.m., Client #1 laid down in bed. At 8:50 p.m., DSP A walked into Client #4's bedroom and asked him if he wanted to talk about what was bothering him. DSP D walked in and Client #4 asked if he could go to the living room. DSP D had an attitude. DSP A remembered at approximately 9:00 p.m., she tucked Client #1 into bed. Client #1 got up and shut his bedroom door when DSP A told him goodnight. DSP A believed DSP C locked the back door after 9:00 p.m. because she remembered DSP C asked for the key. DSP A explained the process for checking the gait and locking the doors. She stated they check the locks on two gates in the backyard and then lock the two doors. According to DSP A, the back door would not open after locked. She stated it was possible for Client #1 to go undetected in the backyard if he stood in the corner of the yard. Although, DSP A stated DSP C was already back in the home when she walked out of Client #1's bedroom. At 9:06 p.m., DSP A checked on DSP B to ensure he was OK before she left. She explained Client #4's behavior plan to DSP B and left the home. DSP A remembered Client #1's bedroom door closed when she left the home. She stated the facility terminated her for falsifying documentation. According to DSP A, she

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W 149	Continued From page 8 assisted with a client and clocked out at 9:46 p.m. DSP A stated DSP B did not document the 9:30 p.m. bed check and the facility told her if she worked, she should have documented. DSP A stated Client #1 was quiet and walked on his tippy toes. She defined his level of supervision as three to five minute checks. She stated he is visual supervision when he is in the multi-purpose (MPR) or on the Rainbow path. In DSP A's opinion, Client #1 could have left the building when she talked to Client #4. DSP A stated staff completed bed checks every half hour. According to DSP A, when Client #1 left his bed he made it. DSP A remembered documenting in the shift communication binder before she left the home. When interviewed on 8/23/18 at 10:00 a.m., DSP C reported she checked the backyard gates and locked the back door. She stated she walked back into the home around 9:02 p.m. to 9:03 p.m. DSP C explained how at the end of the night they clean backyard, check gate locks, and lock the door. She stated it was dark outside. She could not remember if the light was working. DSP C drew the surveyor a picture of where Client #1 stood in the backyard. She stated when he stood in the corner it was hard to see him. According to DSP C, Client #1 was very quiet. DSP C explained Client #1's supervision level. She stated when Client #1 was in the backyard, staff should be within visual supervision. They could stand by the window and look out at Client #1. DSP C reported the clients she had responsibility for went to bed at approximately 8:00 p.m. At around 8:30 p.m., DSP C observed DSP A put Client #1 to bed, while she completed her books at the kiosk. DSP D walked to the bathroom with Client #4 and he started to have behaviors. DSP	W 149		

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W 149	Continued From page 9 A assisted Client #4. A little before 9:00 p.m. DSP B took accountability of DSP D's clients while she used the bathroom. Client #4 continued to have behaviors in his bedroom and DSP C turned to see if they needed help. When she turned towards Client #4, her back was towards Client #1's bedroom. After DSP C finished her books, she walked outside, checked the gates, and locked the back door. According to DSP C, she has found Client #1 outside before when checking the gates. DSP C believed Client #1 snuck outside when Client #4 had behaviors and she turned her back. She stated Client #1 was quiet when he walks and he loved outside. DSP C felt bad she did not see Client #1 outside on 8/17/18. DSP C remembered Client #1 wore shorts and a t-shirt. Before DSP C left her shift she told DSP B about Client #4's behavior, checked her clients and told DSP B they were in bed. DSP C grabbed the trash and laundry before walking out of the door and Client #4 came out of his bedroom. DSP C stated DSP A went to the living room with Client #4 and tried to tell DSP B how to handle Client #4's behaviors. DSP B would not listen and stated he was fine. DSP A stated, "Are you sure?" He replied, "Yes." They left the home at 9:09 p.m. DSP C explained the shift communication. She stated they had a folder to indicate how the shift was or if anyone was on home visits. She stated they should have only had one empty bed on 8/17/18, because that client moved to Love home. DSP C stated Client #4 throws his blanket on his bed and closes his curtain when he gets up. According to DSP C, bed checks start at 8:30 p.m. and continue every 30 minutes throughout the night. DSP C stated the PM (evening) shift complete and document on the 9:00 p.m. bed check. In DSP C's opinion, if DSP A completed the 9:00 p.m. bed check,	W 149		

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W 149	Continued From page 10 Client #1 would not have gotten outside. When interviewed on 8/22/18 at 2:15 p.m., DSP D reported on 8/17/18 she did not have Client #1 in her group. According to DSP D, Client #1 had a calm day and did not have any screaming or yelling. DSP D stated Client #1's supervision level was visual when outside. DSP D explained the bedtime routine. She stated the clients start lying down around 7:30 p.m. Once clients are in bed, they needed checked every half hour. She stated it was a normal evening. Client #1 goes to bed between 7:00 p.m. and 9:00 p.m., depending on how tired he is. On 8/17/18 at around 8:30 p.m., Client #1 was outside, looking in from the window. DSP A watched him from the kitchen table. DSP D could not remember if Client #1 came back inside. She stated she had a hard day with Client #4. His bedroom alarm went off around 8:30 p.m. and she redirected him back to bed. Client #4 asked her to use the bathroom and she walked with him. Client #4 then called his parents, but they did not answer. Client #4 went to bed around 8:50 p.m. DSP B came in and the evening staff gave him a verbal report on each client. DSP D stated she left the home at 9:00 p.m. DSP D explained the shift communication. She stated they had a binder to document on how each client's day went or if they were on a home visit. DSP D could not recall if the binder documentation was completed. According to DSP D, Client #1 wore a t-shirt and pajama pants on 8/17/18. DSP D stated Client #1 could be in his bedroom alone because his roommate has moved to Love home. DSP D stated since Client #1 had his own bedroom, his door and curtain is closed. DSP D also stated Client #1 was quiet. He is always outside; he takes a pillow and blanket outside and takes	W 149		

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W 149	Continued From page 11 naps. DSP D stated when Client #1 gets tired he always comes back inside. According to DSP D, the PM shift completed bed checks every half hour from 8:00 p.m. to 9:00 p.m. When interviewed on 8/22/18 at 8:30 p.m. DSP B reported on 8/17/18 he worked at Hope home from 9:00 p.m. to 10:00 p.m. He stated it was his second time filling in at Hope home and he did not know the client's names. He stated the PM shift reported all clients sleeping except for one and they left at 9:00 p.m. The one client was up talking to DSP B until approximately 9:30 p.m. According to DSP B, no client had behaviors, nor were they in the middle of a behavior when he arrived at 8:55 p.m. DSP B did not observe anyone locking the back door. He also did not know where to locate the keys. He stated two or three staff present when he arrived. He was not sure who was supposed to be there and who was on a home visit. He stated he completed one bed check at 9:30 p.m. and everybody was in bed. He took PM shift word that everyone was in bed, and stated he should have known how many clients were there. He stated when he completed the bed checks he used a flashlight. DSP B denied hearing anything outside. TA A relieved him at 10:00 p.m. When interviewed on 8/22/18 at 850 p.m., DSP E reported she worked in Hope home on 8/17/18 from 6:00 p.m. to 8:00 p.m. While in the home, DSP E felt like DSP D was on edge and distracted. She stated DSP D was rude, loud, sat on her phone, took personal phone calls and did not engage with her clients. She observed DSP A and DSP C doing extra work. In DSP E's opinion, when she left the home DSP A and DSP C got busy. She stated two staff had to watch seven	W 149		

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W 149	Continued From page 12 clients. DSP E explained they locked the doors at 9:00 p.m. and gates checked every shift. According to DSP E, Client #1 will sneak out of the home close to bedtime. She stated Client #1 liked to be in the backyard between 7:00 p.m. and 9:00 p.m. In public settings, Client #1 will run. He has a bracelet to track him. Client #1 will also break his screen window in his bedroom to get out. DSP E stated Client #1 should be checked every couple of minutes and should not be alone in the MPR. According to DSP E, staff should check his room before leaving the shift. Other behaviors Client #1 displays included Self-injurious behavior, property destruction, and physical aggression. Client #1's bedroom is the farthest from the front door, but able to be monitored if sitting at the kiosk. When DSP E left the home at 8:00 p.m., everyone was still awake. They are required to document in the communication binder after every shift, left open by the kiosk. They document how the shift went for each client and if they are on a home visit. In DSP E's opinion, if Client #1 stood on the side of the building staff would not see him. She stated he is even hard to see during the day when he stood next to the building. When interviewed on 8/27/18 at 4:30 p.m., ICF/ID Manager confirmed the facility neglected to provide adequate and appropriate supervision to Client #1.	W 149		
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.	W 189		

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W 189	Continued From page 13	W 189		

This STANDARD is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure staff consistently implemented bed/accountability checks to determine client accountability. This affected 1 of 1 client identified as a result of facility self-reported incident #77696-I (Client #1) and potentially affected all clients living in Hope home. Finding follows:

See W149 and W249 for additional information.

Record review revealed the following:

a. Client #1's shift summary dated 8/17/18, indicated, Temporary Agency Staff (TA) A came in at 10:00 p.m. and received report from staff. The other 3:00 p.m. staff who had worked in Hope Home had already left the facility. Staff)reported all of the residents were in bed. After he left, TA A completed rounds. TA A noticed Client #1 not in his room and his bed still made. TA A assumed he had gone for a home visit, considering the fact sometimes this type of information did not get reported to TA A when she came in to do her overnight shifts. TA A resumed with her regular overnight tasks. TA A heard noises outside in the backyard, which sounded similar to wind pushing against the backyard door. TA A paused to listen, but did not hear anything else. At around 1:00 a.m. TA A heard a voice in the distance, so she did another round of checking beds. TA A saw Client #2 awake in his room and asked if he was the one making noises. He responded "Yes." At 2:00 a.m. TA A checked Client #3. She was dry and refused to go to the bathroom. TA A walked to the living room, where she looked out the living

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room window due to hearing someone trying to open the backyard door. TA A noticed Client #1 standing outside in the backyard. TA A immediately contacted nursing by calling them. TA A and nursing unlocked the backyard door to let Client #1 in. Client #1 walked straight to his room, laid down, and covered himself with his blanket. TA A noticed Client #1 shivered.

b. Client #1's sleep chart dated 8/17/18 completed at 8:00 p.m. revealed, "Awake-out of bed." At 8:30 p.m. revealed, "Awake-in bed." No sleep chart could be located for 9:00 p.m. and 9:30 p.m.

When interviewed on 8/22/18 at 1:50 p.m., TA A reported she worked at the facility since May and worked two to three nights a week. On 8/17/18, TA A arrived at the facility at 10:00 p.m. She stated the staff she replaced reported everyone asleep. According to TA A, communication between shifts was not good, so the first thing she completed was bed checks. During the bed checks, TA A stated Client #1's bed was empty. The covers were neatly on the bed and the room was clean. TA A assumed Client #1 was gone on a home visit because it had happened before. She explained how she found empty beds before and confirmed the clients were on a home visit. TA A stated they had a shift communication book, but the documentation was not always accurate. She stated she should have called another staff to confirm Client #1 was out of the facility on 8/17/18.

When interviewed on 8/22/18 at 3:25 p.m., DSP A remembered at approximately 9:00 p.m., she tucked Client #1 into bed. Client #1 got up and shut his bedroom door when DSP A told him

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W 189	Continued From page 15 goodnight. DSP A believed DSP C locked the back door after 9:00 p.m. because she remembered DSP C asked for the key. DSP A explained the process for checking the gait and locking the doors. She stated they check the locks on two gates in the backyard and then lock the two doors. According to DSP A, the back door would not open after locked. She stated it was possible for Client #1 to go undetected in the backyard if he stood in the corner of the yard. Although, DSP A stated DSP C was already back in the home when she walked out of Client #1's bedroom. At 9:06 p.m., DSP A checked on DSP B to ensure he was OK before she left. She explained Client #4's behavior plan to DSP B and left the home. DSP A remembered Client #1's bedroom door closed when she left the home. She stated the facility terminated her for falsifying documentation. According to DSP A, she assisted with a client and clocked out at 9:46 p.m. DSP A stated DSP B did not document the 9:30 p.m. bed check and the facility told her if she worked, she should have documented. When interviewed on 8/23/18 at 10:00 a.m., DSP C reported bed checks start at 8:30 p.m. and continue every 30 minutes throughout the night. DSP C stated the PM (evening) shift complete and document on the 9:00 p.m. bed check. In DSP C's opinion, if DSP A completed the 9:00 p.m. bed check, Client #1 would not have gotten outside. When interviewed on 8/22/18 at 2:15 p.m., DSP D reported the PM shift completed bed checks every half hour from 8:00 p.m. to 9:00 p.m. When interviewed on 8/22/18 at 8:30 p.m. DSP B reported on 8/17/18 he worked at Hope home from 9:00 p.m. to 10:00 p.m. He stated it was his	W 189		

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W 189	Continued From page 16 second time filling in at Hope home and he did not know the client's names. He stated the PM shift reported all clients sleeping except for one and they left at 9:00 p.m. The one client was up talking to DSP B until approximately 9:30 p.m. According to DSP B, no client had behaviors, nor were they in the middle of a behavior when he arrived at 8:55 p.m. DSP B did not observe anyone locking the back door. He also did not know where to locate the keys. He stated two or three staff present when he arrived. He was not sure who was supposed to be there and who was on a home visit. He stated he completed one bed check at 9:30 p.m. and everybody was in bed. He took PM shift word that everyone was in bed, and stated he should have known how many clients were there. He stated when he completed the bed checks he used a flashlight. DSP B denied hearing anything outside. TA A relieved him at 10:00 p.m. When interviewed on 8/23/18 at 11:10 a.m., ICF/ID Manager reported bed checks not done as needed. She stated during DSP B's interview, he reported doing bed checks every two hours. She stated they retrained him on the spot.	W 189		
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.	W 249		

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W 249	Continued From page 17 This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure clients received needed supports and services as outlined in the Individual Support Plan (ISP), specifically required supervision. This affected 1 of 1 client reviewed during investigation #77696-I. Finding follows: See W149 and W189 for additional information. Record review revealed the following: a. Client #1's shift summary dated 8/17/18, indicated, Temporary Agency Staff (TA) A came in at 10:00 p.m. and received report from staff. The other 3:00 p.m. staff who had worked in Hope Home had already left the facility. Staff)reported all of the residents were in bed. After he left, TA A completed rounds. TA A noticed Client #1 not in his room and his bed still made. TA A assumed he had gone for a home visit, considering the fact sometimes this type of information did not get reported to TA A when she came in to do her overnight shifts. TA A resumed with her regular overnight tasks. TA A heard noises outside in the backyard, which sounded similar to wind pushing against the backyard door. TA A paused to listen, but did not hear anything else. At around 1:00 a.m. TA A heard a voice in the distance, so she did another round of checking beds. TA A saw Client #2 awake in his room and asked if he was the one making noises. He responded "Yes." At 2:00 a.m. TA A checked Client #3. She was dry and refused to go to the bathroom. TA A walked to the living room, where she looked out the living room window due to hearing someone trying to open the backyard door. TA A noticed Client #1	W 249		

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W 249	Continued From page 18 standing outside in the backyard. TA A immediately contacted nursing by calling them. TA A and nursing unlocked the backyard door to let Client #1 in. Client #1 walked straight to his room, laid down, and covered himself with his blanket. TA A noticed Client #1 shivered. b. Client #1's Individual Service Plan dated 5/1/18, indicated, "Staff will have knowledge of where (Client #1) is at all times. He can be in the back yard independently." When interviewed on 8/22/18 at 3:25 p.m., DSP A defined Client #1's level of supervision as three to five minute checks. She stated he is visual supervision when he is in the MPR or on the Rainbow path. In DSP A's opinion, Client #1 could have left the building when she talked to Client #4. DSP A stated staff completed bed checks every half hour. When interviewed on 8/23/18 at 10:00 a.m., DSP C explained Client #1's supervision level. She stated when Client #1 was in the backyard, staff should be within visual supervision. They could stand by the window and look out at Client #1. In DSP C's opinion, if DSP A completed the 9:00 p.m. bed check, Client #1 would not have gotten outside. When interviewed on 8/22/18 at 2:15 p.m., DSP D stated Client #1's supervision level was visual when outside. When interviewed on 8/22/18 at 850 p.m., DSP E reported Client #1 will sneak out of the home close to bedtime. She stated Client #1 liked to be in the backyard between 7:00 p.m. and 9:00 p.m. In public settings, Client #1 will run. He has a	W 249		

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W 249	Continued From page 19 bracelet to track him. Client #1 will also break his screen window in his bedroom to get out. DSP E stated Client #1 should be checked every couple of minutes and should not be alone in the MPR. According to DSP E, staff should check his room before leaving the shift. When interviewed on 8/22/18 at 1:20 p.m. Home Lead (HL) A defined Client #1's level of supervision as know his whereabouts at all times. She stated he is visual supervision if he in the backyard. When interviewed on 8/27/18 at 4:30 p.m., ICF/ID Manager confirmed the facility failed to follow Client #1's level of supervision.	W 249		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to complete nursing assessments as indicated. This affected 1 of 1 client reviewed during investigation #77696-I (Client #1). Finding follows: See W149 and W189 for additional information. Record review revealed the following: a. Client #1's shift summary dated 8/17/18, indicated, Temporary Agency Staff (TA) A came in at 10:00 p.m. and received report from staff. The other 3:00 p.m. staff who had worked in Hope	W 331		

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W 331	Continued From page 20 Home had already left the facility. Staff)reported all of the residents were in bed. After he left, TA A completed rounds. TA A noticed Client #1 not in his room and his bed still made. TA A assumed he had gone for a home visit, considering the fact sometimes this type of information did not get reported to TA A when she came in to do her overnight shifts. TA A resumed with her regular overnight tasks. TA A heard noises outside in the backyard, which sounded similar to wind pushing against the backyard door. TA A paused to listen, but did not hear anything else. At around 1:00 a.m. TA A heard a voice in the distance, so she did another round of checking beds. TA A saw Client #2 awake in his room and asked if he was the one making noises. He responded "Yes." At 2:00 a.m. TA A checked Client #3. She was dry and refused to go to the bathroom. TA A walked to the living room, where she looked out the living room window due to hearing someone trying to open the backyard door. TA A noticed Client #1 standing outside in the backyard. TA A immediately contacted nursing by calling them. TA A and nursing unlocked the backyard door to let Client #1 in. Client #1 walked straight to his room, laid down, and covered himself with his blanket. TA A noticed Client #1 shivered. b. Client #1's nursing assessment dated 8/18/18 at 6:10 a.m. indicated, vital signs were normal, no bug bites, no new scratches, and a brown bruise on the right elbow. When interviewed on 8/22/18 at 1:50 p.m., TA A reported she worked at the facility since May and worked two to three nights a week. On 8/17/18, TA A arrived at the facility at 10:00 p.m. She stated the staff she replaced reported everyone asleep. According to TA A, communication	W 331		

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W 331	Continued From page 21	W 331		

between shifts was not good, so the first thing she completed was bed checks. During the bed checks, TA A stated Client #1's bed was empty. The covers were neatly on the bed and the room was clean. TA A assumed Client #1 was gone on a home visit because it had happened before. She explained how she found empty beds before and confirmed the clients were on a home visit. TA A stated they had a shift communication book, but the documentation was not always accurate. She stated she should have called another staff to confirm Client #1 was out of the facility on 8/17/18. TA A reported she assisted the girls with the bathroom and/or personal cares at 12:00 a.m., 2:00 a.m., and 4:00 a.m. She assisted the boys between those times, but they are more independent. She stated Client #1 usually slept through the night and was independent with the bathroom. On 8/17/18, TA A completed her regular duties. Around 12:00 a.m. and 1:00 a.m., she kept hearing things. TA A described the sounds like the wind hitting the window. TA A stopped and listened to find out where the noise came from and the noise would stop. TA A thought she was getting "creeped out." At approximately 1:00 a.m., TA A heard a voice. TA A went into Client #3's bedroom and asked him if he made a sound. Client #2 stated yes. At approximately 2:00 a.m., TA A checked Client #3, walked out of her bedroom, and heard someone pulling on the door. TA A looked out the window and observed what looked like Client #1 shivering. TA A called the nurse and went to get the keys to unlock the door. She called Licensed Practical Nurse (LPN) A and told her there was a boy in the backyard. LPN A came into the home and the fourth key they tried opened the back door. Client #1 walked straight to his bedroom and got into bed. TA A stated she checked the

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W 331	Continued From page 22 locked window and assisted Client #1 with a blanket. LPN A asked if Client #1 needed another blanket, but did not complete an assessment. The temperature was approximately 60 degrees and Client #1 wore shorts and a t-shirt. LPN A instructed her to notify administrator on-call and left the home. According to TA A, she tried to call the administrator on-call three times, left a message, and never got a response. At approximately 5:30 a.m., TA A talked to Home Lead (HL) A, who told her she would be in to work shortly. TA A stated she was not sure what to do, but she completed documentation about the incident. When the morning shift arrived, they instructed TA A to complete an incident report. Client #1 had an assessment by a nurse at 6:00 a.m. TA A was unsure if Client #1 stopped shivering, but she stated she checked on him every 15 to 20 minutes. When interviewed on 8/22/18 at 9:45 p.m., LPN A reported during the overnight she covered for breaks in the Love and Hope homes. She stated at approximately 2:15 a.m., she was in Love home when TA A called her and stated she thought someone was outside. LPN A walked over to Hope home and assisted TA A to unlock the door. LPN A remembered the light on the door was red, indicated the door was locked. LPN A thought Client #1 wore a t-shirt and pajama pants, but remembered she observed his lower legs. LPN A stated she was able to see Client #1's lower legs and arms before he jumped into bed. LPN A denied Client #1 shivered, although he was probably chilled. LPN A stated Client #1 did not have goosebumps. The temperature was approximately 60 degrees. Client #1 ran to his bed and covered up. LPN A felt that was best assessment she could get. She	W 331		

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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 331	Continued From page 23 thought she would not be popular if she had Client #1 uncover and undress. LPN A stated Client #1 seemed anxious to go to bed and seemed fine. When interviewed on 8/23/18 at 11:45 a.m. the ICF/ID Manager confirmed the facility failed to complete a timely nursing assessment.	W 331		

10/8/18 OK 10/11/18

Plan of Correction for
Incident #77696-I
October 1, 2018

W122. 483.420 The facility must ensure that specific client protections requirement 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: Client Protections. The facility failed to provide an environment free from neglect.

POC
By October 1, 2018 The ICF/ID manager will institute a new form whereby a pair of staff will observe each resident before exchanging responsibility for each resident. Both staff will sign-off on this document.
By October 1, 2018 the Health Services Manager will ensure training of overnight staff of their need to document and bed checks.
By October 1, 2018 the Director of Mental Health and Family Services will conduct an all staff meeting to encourage all staff to assist in finding a better way to ensure safety, and ensure freedom from abuse and neglect.
By October 1, 2018 the Director of Mental Health and Family Services and the ICF/ID Manager will follow-up with leaders to further investigate options and create a universal system of accountability.

W149 483.420(d)(1) Staff Treatment of Clients. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This standard is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide an environment free from neglect. The facility failed to ensure adequate and appropriate supervision of client.

POC
By October 1, 2018 The ICF/ID manager will institute a new form whereby a pair of staff will observe each resident before exchanging responsibility for each resident. Both staff will sign-off on this document.
By October 1, 2018 the Health Services Manager will ensure training of overnight staff of their need to document and bed checks.
By October 1, 2018 the Director of Mental Health and Family Services will conduct an all staff meeting to encourage all staff to assist in finding a better way to ensure safety, and ensure freedom from abuse and neglect.
By October 1, 2018 the Director of Mental Health and Family Services and the ICF/ID Manager will follow-up with leaders to further investigate options and create a universal system of accountability.

W189 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. The standard was not met as evidenced by: Based on interview and record reviews, the facility failed to ensure staff consistently implemented bed/accountability checks to determine client accountability.

POC
By October 1, 2018 The ICF/ID manager will institute a new form whereby a pair of staff will observe each resident before exchanging responsibility for each resident. Both staff will sign-off on this document.
By October 1, 2018 the Health Services Manager will ensure training of overnight staff of their need to document and bed checks.
By October 1, 2018 the Director of Mental Health and Family Services will conduct an all staff meeting to encourage all staff to assist in finding a better way to ensure safety, and ensure freedom from abuse and neglect.
By October 1, 2018 the Director of Mental Health and Family Services and the ICF/ID Manager will follow-up with leaders to further investigate options and create a universal system of accountability.

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. The standard is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure clients received supports and services as outlined in the individual support plan, specifically required supervision.

POC
By October 1, 2018 the home lead staff will retrain staff (during a home meeting) on the current levels of supervision for each resident under their care.

W331 Nursing Services 483.460(c) The facility must provide clients with nursing services in accordance with their needs. The standard is not met as evidenced by: Based on interviews and record review, the facility failed to complete nursing assessments as indicated.

POC
By October 1, 2018 the administrative on-call staff will be trained to notify the nursing department as soon as possible of any potential health/safety issue and instruct them to complete a full assessment and vital check. The nursing staff will proceed as indicated from the assessment. (This will be in addition to the normal day-to-day assessments for injuries, etc.) (The administrative on-call is already responsible to answer any calls 24/7 from staff with regard to any potential abuse, neglect, etc.)