RINTED: 08/12/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING С 16G036 B. WING 07/01/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 WESTVIEW **OPPORTUNITY LIVING #1** LAKE CITY, IA 51449 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREEIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 000 | INITIAL COMMENTS W 000 On 07-01-20 Opportunity Living was removed from Immediate Jeopardy (IJ) as the following items were put in place: Investigations #91528-I and #91590-I were Alarm system in the home was adjusted. completed on 6/18/20 to 7/1/20 and resulted in deficiencies written at W158, W159, W191, Client's BMP was revised, additional staff W214, and W249. added to the morning shift and all staff that work in said house were trained on On 6/24/20 at 11:45 a.m., Immediate Jeopardy the client's BMP (IJ) was determined based on the facilities failure to effectively integrate, monitor, and coordinate services to meet the client's needs and to provide behavioral intervention training to all staff. The facility developed a plan to remove the IJ, which included adjusting the alarm system, revising Client #1's behavior support plan, adding an additional staff in the morning hours, and staff training. On 7/1/20 at 11:40 a.m., the IJ was removed from the facility. During the investigations, a Focused Infection W158 Facility Staffing Control Survey was also completed and resulted Opportunity Living failed to ensure that in no deficiencies written. specific staffing requirements were met W 158 W 158 FACILITY STAFFING CFR(s): 483.430 POC: Opportunity living will ensure that adaguate staff is present in each home to The facility must ensure that specific facility meet client's needs staffing requirements are met. This is accomplished by monitoring staffing daily for 2 months then monthly for 6 months Person(s) responsible: Direct Support This CONDITION is not met as evidenced by: supervisors, Compliance and Training Based on interviews and record reviews, the Specialist and Director of Health Services facility failed to comply with the Condition of Participation: Facility Staffing. The facility failed to effectively integrate, monitor, and coordinate Monitered by: Director of Residential Services services in order to meet client needs. Client #1 or designee had three elopement attempts in May and six Date of Correction: Immediately elopement attempts in June. On 6/2/20 and 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.

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/12/20 FORM APPROVI OMB NO. 0938-03	
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		16G036	B. WING		07/01/2020	
AME OF PI	ROVIDER OR SUPPLIER		S.	TREET ADDRESS, CITY, STATE, ZIP C		
PPORTU	JNITY LIVING #1			05 WESTVIEW AKE CITY, IA 51449		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE	
W 158	Continued From page	e 1	W 158			
		d actual elopements and the				
		side. The facility also failed				
1 5 1 1 4 5	-	intervention training to all				
	Based on interviews	and record reviews, the				
		ively integrate, monitor, and				
	-	n order to meet client needs.				
	See W159.					
	Based on interviews	and record reviews, the				
		le behavioral intervention				
	training to all employ					
	(IJ) was determined I to effectively integrate services to meet the behavioral intervention facility developed a p included adjusting the Client #1's behaviors	a.m., Immediate Jeopardy based on the facilities failure e, monitor, and coordinate client's needs and to provide on training to all staff. The lan to remove the IJ, which e alarm system, revising support plan, adding an morning hours, and staff				
	On 7/1/20 at 11:40 a.	m., the IJ was removed from				
	the facility.					
W 159	QIDP		W 159			
	CFR(s): 483.430(a)					
	integrated, coordinate qualified intellectual of This STANDARD is Based on interviews Qualified Intellectual	reatment program must be ed and monitored by a disability professional. not met as evidenced by: and record reviews, the Disability Professional tively integrate, monitor, and				

Facility ID: IAG0014

If continuation sheet Page 2 of 21

CENTERS FOR MEDICARE &	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE		
ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	S	COMPI	COMPLETED	
	16G036	B. WING		C 07/01/2020		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
		·	105 WESTVIEW			
OPPORTUNITY LIVING #1	SPPORTUNITY LIVING #1		LAKE CITY, IA 51449			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
during investigations Findings follow: 1. Record review rev a. Client #1's Behavi #1 had three eloper June, Client #1 had 6/5/20, 6/6/20, 6/10/ on 6/16/20. Client # for an actual eloper Report from 6/2/20 v elopement is missing b. Client #1's Data S had three elopemen elopement attempts c. Client #1's Comm 7/2/19 noted, "Anytir to go outside or atter unattended, take (Cl train him how to use does exit the home a written." When interviewed on Director of Programm facility addressed Cl in his communication his numbers by the b they document actua on a behavior report Programming Service needed a behavior s	client (Client #1) reviewed a # 91528-I and #91590-I. vealed the following: ior Reports, indicated, Client hent attempts in May. In an elopement attempts on 20, two on 6/15/20, and two 1 had one Behavior Report hent on 6/20/20. A Behavioral when Client #1 had an actual g. Summary indicated Client #1 t attempts in May and five from 6/1/20 to 6/19/20. unication Program dated me (Client #1) seems to want mpts to leave the home lient #1) to the device and it. Anytime he attempts or a behavior report must be n 6/19/20 at 10:25 a.m. the ming Services reported the ient #1's elopement behavior n plan. They keep track of behavior reports. She stated al and attempts at elopement	W 15		to have each ntegrated, ed by the QIDP will be educated out behavior t BMP(s) to fill out the taff are being aining sheet to ined correctly. rvisor (DSS), an behavior reports. ntinue for 6 DP(s) Residential	d	

Facility ID: IAG0014

If continuation sheet Page 3 of 21

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					MAPPROVED
	S FOR MEDICARE &	MEDICAID SERVICES		· · · · · · · · · · · · · · · · · · ·		0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			Сом	E SURVEY PLETED
		16G036	B. WING			C / 01/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		/01/2020
				105 WESTVIEW		
OPPORTU	JNITY LIVING #1			LAKE CITY, IA 51449		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
W 159	Continued From page	23	W 15	9		
	his plan as the last elopement Client #1 had was last July.					
	Director of Programm #1 had an actual elop went to the home and did not know until she out that she had to sig they could not wait ar changes immediately writing a new behavio address elopement. approval to get anoth sound of the alarm. When interviewed on Director of Programm	er staff and changing the 6/24/20 at 11:45 a.m. the ing Services confirmed the or and coordinate services				
	2. Record review on 6 following:					
		ral data, indicated, Client #1 pement on 6/26/20, 6/27/20,				
	indicated, he attempte	ral report dated 6/28/20, ed an elopement. or 6/26/20 and 6/27/20 could				
	indicated, "Any incide reported to (the Direc	of Nursing) immediately. A				

Facility ID: IAG0014

If continuation sheet Page 4 of 21

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPR OMB NO. 0938-	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		16G036	B. WING		C 07/01/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
OPPORTL	OPPORTUNITY LIVING #1			105 WESTVIEW LAKE CITY, IA 51449		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLE E APPROPRIATE DAT	
W 159	Continued From page	e 4	W 15	9		
W 191	Direct Support Super #1 had three attempts weekend, but she on She did not know if th report for all attempts place. When interviewed on Director of Programm facility failed to write to Client #1's attempts a		W 19	1		
	must focus on skills a toward clients' behavi This STANDARD is r Based on interviews facility failed to provid training to all employe client (Client #1) revie 91528-I and #91590-	not met as evidenced by: and record reviews, the le behavioral intervention ees. This affected 1 of 1 ewed during investigations #				
	Report dated 6/2/20, check on (Client #1) t break when I found h was off from the last t that was working was	indicated, "Staff went to to see if he was up or not for im outside. The door alarm time he went outside. Staff				
	B reported she arrive	6/19/20 at 12:25 p.m. DSP d at work at 7:00 a.m. Client le got up between 8:00 a.m.				

Facility ID: IAG0014

If continuation sheet Page 5 of 21

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	OMB NC (X3) DATE	
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMP	LETED
						С	
		16G036	B. WING			07/	01/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
OPPORTI	JNITY LIVING #1						
				L/	AKE CITY, IA 51449		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
W 191	option to stay in his b or go to the front of th in his bedroom. At ap bedroom door alarm a head out the east doo back into the home. It the door alarm for the Client #1's bedroom a building alarm. At ap 15-minute timer soun on Client #1 and four She assisted Client # walked him around to They assume someou Facility staff did not k #1 eloped. The nurse them to contact the D Services. The nurse ensure no injuries in on DSP B, Client #1 was around 9:30 a.m. Sh reset the alarm after that at 9:30 a.m. DSP B r walked back towards approximately 9:47 at 10:05 a.m., she found he was out of sight fo She thought his level 15-minute checks, build Qualified Intellectual I (QIDP) or the Direct S Since 6/2/20, they are keep him in sight to s watch the clients they	#1 got dressed, ate s teeth, and he was given an edroom and listen to music he house. He chose to stay oproximately 8:45 a.m., his sounded and he started to or. Staff brought Client #1 At approximately 9:30 a.m., e building sounded but not alarm. DSP A turned off the proximately 10:05 a.m., the ded. DSP B went to check id him outside the east door. 1 up off the ground and o the front of the building. ne turned the alarm off. now what to do after Client e came in and instructed firector of Programming also looked Client #1 over to case he fell. According to a in the front of the home e believed DSP A forgot to they brought him back inside emembered Client #1 his bedroom at .m. Between 10:02 a.m. and d him outside. She believed r approximately 15 minutes. of supervision was at she would have to ask the Disability Professional Support Supervisor (DSS). e to walk down the hall and ee where he is going. They are accountable for and reminder. To stop Client #1	W1	191	 W-191 Training Opportunity Living failed to probehavioral intervening training employees POC: QIDP(s) will train all upd and document on training sheet QIDP(s) will observe and train BMP(s) as needed Direct support supervisors will homes to check documentation train where needed New Staff will be trained by the and/or the DSS on the BMP As client BMP's are updated st trained on the changes and the monitered for 6 months. Person(s) responsible: QIDP, I Monitered by: Director of Resid Services or Designee Date of Correction: Immediate 	to all ated BMF ets. The on the be in the n and e QIDP aff will be en will be DSS dental	

Facility ID: IAG0014

If continuation sheet Page 6 of 21

		ND HUMAN SERVICES			PRINTED: 08/12/2 FORM APPROV OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		16G036	B. WING		C 07/01/2020	
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO		
OPPORTI	JNITY LIVING #1			WESTVIEW KE CITY, IA 51449		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIN HE APPROPRIATE DATE	
W 191	his chair, listen to mu mind off going outside 15-minute checks are he needed checked of also stated Client #1 bathroom between hi so his bedroom alarm reported someone wh The QIDP had her sit DSP B stated Client # communication progra he wanted to go outsi she takes him to the H not tell us you wanted communication button Additional interview of revealed DSP B repo bedroom door alarm helped him get ready of his bedroom. They did his 15-minute che When interviewed on C reported DSP A and time between 10:00 a 15-minute timer soun to check on Client #1 outside the door. Wh door alarm was off. A alarm sounded prior t who went into the offi stated it was either D believed they turned of instead of resetting it. alarms, they had one timer for 15-minute vi	ted Client #1 liked to rock in sic, and jump to get his e. DSP B does not feel a good enough. She stated on sooner than that. She walked through the s and Client #2's bedroom n will not sound. DSP B no did not care trained her. down and read everything. #1 did have a am to push a button when ide. She stated if he elopes, button and tells him you did d to go out. There is no n on the east door. n 6/22/20 at 1:32 p.m. rted they turn off Client #1's in the morning when they , while they went in and out y also turned it off when they tecks. 6/19/20 at 12:15 p.m. DSP d DSP B got ready for break t.m. and 10:05 a.m. The ded and DSP B went back . She found him right en she walked inside, the According to DSP C, an to that. She did not know ce to reset the alarm. She SP A or DSP B. She off the alarm on accident,	W 191			

If continuation sheet Page 7 of 21

	OF DEFICIENCIES	X MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-039 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		G	CON	IPLETED	
						С	
		16G036	B. WING		07	7/01/2020	
AME OF PI	ROVIDER OR SUPPLIER	, • • • <u>• •</u> •		STREET ADDRESS, CITY, STATE, ZIF	P CODE		
PPORTL	INITY LIVING #1			105 WESTVIEW			
				LAKE CITY, IA 51449		- <u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE	
W 191	Continued From page	no 7	W 19	01			
VV 191			VV I				
		noted they completed door					
		econd shift and believed they					
		r alarm test on the first shift,					
	as well. DSP C only						
		Client #1 had on 6/2/20. She					
		l elopements. She stated the					
	-	her when she started working					
		ling to DSP C, they did not s off for any reason.She					
		had accountability of Client					
		ertain Client #1 with music,					
	take on golf carts rid					-	
	-						
		n 6/23/20 at 12:45 p.m. DSP					
		DSP B got ready for break					
		ly 9:30 a.m. DSP B went					
		oom to see if he wanted					
		n outside. They did not hear					
	•	not reset the alarm when he					
		he before. DSP A could not					
		but remembered when they					
		nute timer there was about 10					
		ding to DSP A, Client #1					
	-	east door and they usually					
	_	e went out. She could not					
		Ight him in the time before he					
	-	They did not hear the bedroom					
		alarm did not go off. DSP A go through his bathroom to					
		to avoid the door alarm					
		not know why he had a					
		n and she assumed it was					
		ements. DSP A believed she					
	-	y on programs although, she					
		he had the bedroom door					
	1.	cident on 6/2/20, if Client #1					
		ake him up front to listen to					
	-	heck on Client #1 every time					
	the door alarm goes		1			1	

If continuation sheet Page 8 of 21

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING			
		16G036	B. WING		0	C 7/01/2020
	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CO	ODE	
OPPORT			LAK	E CITY, IA 51449		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
W 191	supervision is consta 15-minute checks, bu supervision. DSP A a safety skills outside a hands when walking who turned off the ala accountability for him b. Record review reve Report dated 6/20/20 out by the road outsic him back into House a didn't know he was out When interviewed on reported he worked fr House B on 6/20/20. 8:45 a.m. and 8:50 a. the corner onto Wester standing by the cars if pulled into House B p and ran over to get hi into House A and staff outside. DSP D did m and nobody came out dining room and said, walked in. DSP D as east doors. He remet white t-shirt and blue have anything on his worked in House A ar elopements.	nt. He has documented at he needed constant also stated Client #1 had no and someone held onto his outside. DSP A did not know arm or who had on 6/2/20. ealed Client #1's Incident t, indicated, "(Client #1) was de House A. B. I (walked) A. Staff acted like they	W 191			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: IAG0014

If continuation sheet Page 9 of 21

PRINTED: 08/12/2020 FORM APPROVED

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		TE SURVEY MPLETED	
						с	
		16G036	B. WING		C	7/01/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
				105 WESTVIEW			
OFFORIC	PPORTUNITY LIVING #1			LAKE CITY, IA 51449			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
W 191	Continued From pag	ae 9	W 1	91			
		id not go past her out the					
		ing to DSP E, she heard the					
		SP D brought Client #1 back					
		Client #1 was out of his					
		left, but she is not sure where					
		hought she heard him in the					
	sensory room. DSP	A or DSP F had					
	accountability for hir	n. She was unsure where					
	they were; she thoug	ght they were in the kitchen or					
	in the back of the ho	ouse. DSP E just started					
		She stated that at no time					
	· ·	door alarms off. She did not					
		t would turn the alarms off.					
	-	, Client #1's room should not					
		loor. She believes he was					
	•	was hectic at that moment					
		n up front in the sensory					
		d Client #1 was one-to-one					
		ctively seeking the door. She y recently when she brought					
	-	Client #1 waits until they are					
		. He is slow about it, but if					
	elopes one time he						
		n 6/23/20 at 11:12 a.m. DSP					
	-	hight sat at the front of the					
	-	table. DSP F walked into the					
		DSP A on the plans for the					
		ites prior DSP F took Client					
		b listen to music. Then DSP he house. No alarm					
		cked the alarm when he					
		believe he went outside the					
	· ·	e went out the front door.					
		, Client #1 was gone					
	-	minutes. There is no reason					
		bedroom door alarm off. DSP					
		ent into other client bedrooms,					
		shi into other client occioonia,					

Facility ID: IAG0014

If continuation sheet Page 10 of 21

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY
		16G036	B. WING			C 07/01/2020	
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	Y	JIIO 112020
				10	5 WESTVIEW		
OPPORTI	JNITY LIVING #1			LA	AKE CITY, IA 51449		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	x	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETIO DATE
W 191	Continued From pag	je 10	W	191			
	his bathroom and into Client #2's bedroom. He						
		n elopement prior to the					
		ey see that he tries to elope,					
	they have him stay i	n the living room. DSP D					
		ient #1's accountability. DSP					
	-	rained her on programming.					
		as changed since 6/2/20 is					
		ted he was a high level of					
		heck him every 15 minutes, was constant one-to-one					
		sually let him walk down the					
		DSP D stated they need					
	more staff if they have	-					2
	When interviewed or	n 6/23/20 at 12:45 p.m. DSP					
	A reported between	8:50 a.m. and 8:55 a.m., her					
		n the 9:00 a.m. staff to arrive.					
		e shift for the day. DSP E					
		e. Client #1 just finished					
		robably heading to his r follow him down the hallway					
		day. DSP A did not believe					
	-	elope prior to 8:50 a.m.					
		nurse leave and reset the					
		inutes later, DSP C brought					
	Client #1 inside. DS	P C told them Client #1 was					
	-	ey checked the alarms and					1
	•	believed Client #1 went out					
		e same time the nurse went					
		She witnessed the same					
		at day. The nurse left and ent #1, he was walking out of					
		ected him. DSP A did not					
		untability for Client #1.					
	_	or staff on Client #1's					
	behavioral supports	could be located.					
	When interviewed or						

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	. ,	LE CONSTRUCTION		TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			C
		16G036	B. WING		0	7/01/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
OPPORTU	NITY LIVING #1			105 WESTVIEW LAKE CITY, IA 51449		
	SUMMARY S	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETIO
W 191	Continued From pag	e 11	W 19	1		
f f f f f	Director of Programm	ning Services confirmed the staff on behavioral supports				
	2. Record review on following:	6/29/20 revealed the				
	a. Client #1's behavio	oral data, indicated, Client #1 opement on 6/26/20, 6/27/20,				
	 b. Client #1's behavioral report dated 6/28/20, indicated, he attempted an elopement. Behavioral Reports for 6/26/20 and 6/27/20 could not be located. 	ted an elopement.				
	indicated, "Any incide reported to (the Dire	r of Nursing) immediately. A				
	Direct Support Supe #1 had three attemp weekend, but she or She did not know if t	n 6/29/20 at 10:10 a.m. the rvisor (DSS) reported Client is at elopement over the aly had one behavior report. hey should write a behavior s with the new program in				
W 214	Director of Programmer facility failed to write Client #1's attempts the Behavioral Repo	n 6/29/20 at 11:18 a.m. the ning Services confirmed the the Behavioral Reports for at elopement. She stated rts are for her to monitor. RAM PLAN	W 21	4		

Facility ID: IAG0014

If continuation sheet Page 12 of 21

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		16G036	B. WING		C 07/01/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OPPORTI	INITY LIVING #1			105 WESTVIEW _AKE CITY, IA 51449		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
W 214	The comprehensive f identify the client's sp behavioral managem This STANDARD is r Based on interviews facility failed to identifi needs of clients in the Assessment (CFA). (Client #1) reviewed of #91528-I and #91590 Record review reveal 6/20/19 failed to indic of elopement. The C not "(Run) away from stray from areas when	unctional assessment must becific developmental and ent needs. not met as evidenced by: and record review, the fy the specific developmental e Comprehensive Functional This affected 1 of 1 client during investigations	W 214	 W214 - CFA Individual pro Opportunity Living failed to on behavioral supports. POC: The QIDP will review the Comprehensive Function Assessment (CFA) when so changes occur to a client's All CFA's will be reviewd for by September 15th, 2020 of thereafter Person(s) responsibile: QI Monitered by: Director of F Services or designee Date of Correction: September 	o train staff w and update ional significinat s status. or accuracy then annually DP(s) Residential	
W 249	Director of Programm facility failed to identif CFA. PROGRAM IMPLEMI CFR(s): 483.440(d)(1 As soon as the interd formulated a client's in each client must rece treatment program co interventions and sen and frequency to supp	ing Services confirmed the y elopement in Client #1's ENTATION) isciplinary team has ndividual program plan, ive a continuous active	W 249	The compliance and trainin will evaluate and monitor t twice monthly to ensure ac effectiveness of the POC	he POC	

Facility ID: IAG0014

If continuation sheet Page 13 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A, BUILDING C B. WING 16G036 07/01/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 105 WESTVIEW **OPPORTUNITY LIVING #1** LAKE CITY, IA 51449 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 249 W 249 Continued From page 13 W 249 Program implementation This STANDARD is not met as evidenced by: Based on interviews and record review, the POC: Any client with behavioral facility failed to ensure clients received needed issues that put themselves or others supports and services as outlined in the Individual safety at risk will have appropriate Support Plan (ISP). This affected 1 of 1 client programming to address safety issues. (Client #1) reviewed during investigations #91528-I and #91590-I. Findings follow: As client's programming is changed 1. Record review revealed Client #1's Incident staff will be trained on the changes by Report dated 6/2/20, indicated, "Staff went to the QIDP and/or DSS and monitered check on (Client #1) to see if he as up or not for monthly for 6 months. break when I found him outside. The door alarm was off from the last time he went outside. Staff Person(s) responsible QIDP(s), DSS that was working was (Direct Support Professional (DSP) A, DSP B, and DSP C)." Monitered by - Director of Residential Services or designee Additional record review revealed the following: Date of Correction: immediately a. The diagnosis of Client #1, age 22 at the time of the incident, included: Intellectual Disability, Cerebral Palsy, Retinopathy or Prematurity bilateral blindness, Moderate hearing loss (Left ear), and Stereotypic movement disorder. b. Client #1's annual evaluation dated 6/25/19, indicated, "Staff must be aware of where (Client #1) is at all times." According to website, wunderground.com, on 6/2/20 at 9:53 a.m. the temperature was 83 degrees Fahrenheit (F). When interviewed on 6/19/20 at 12:25 p.m. DSP B reported she arrived at work at 7:00 a.m. Client #1 was still asleep. He got up between 8:00 a.m. and 8:30 a.m. Client #1 got dressed, ate breakfast, brushed his teeth, and he was given an option to stay in his bedroom and listen to music or go to the front of the house. He chose to stay

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: IAG0014

If continuation sheet Page 14 of 21

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 08/12/2020 APPROVED 0: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		16G036	B. WING		_		_ 01/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				105 WESTVIEW			
	INITY LIVING #1			LAKE CITY, IA 51449			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG W 249	Continued From page in his bedroom. At ap bedroom door alarms head out the east doo back into the home. A the door alarm for the Client #1's bedroom a building alarm. At ap 15-minute timer sound on Client #1 and found She assisted Client # walked him around to They assume someon Facility staff did not k #1 eloped. The nurse them to contact the D Services. The nurse ensure no injuries in on DSP B, Client #1 was around 9:30 a.m. Sho reset the alarm after t at 9:30 a.m. DSP B r walked back towards approximately 9:47 a. 10:05 a.m., she found he was out of sight fo She thought his level 15-minute checks, bu Qualified Intellectual I (QIDP) or the Direct S Since 6/2/20, they are keep him in sight to s	e 14 pproximately 8:45 a.m., his sounded and he started to or. Staff brought Client #1 At approximately 9:30 a.m., building sounded but not alarm. DSP A turned off the proximately 10:05 a.m., the ded. DSP B went to check d him outside the east door. 1 up off the ground and the front of the building. ne turned the alarm off. now what to do after Client a came in and instructed irector of Programming also looked Client #1 over to case he fell. According to in the front of the home e believed DSP A forgot to hey brought him back inside emembered Client #1 his bedroom at .m. Between 10:02 a.m. and d him outside. She believed r approximately 15 minutes.	W 249				
	wear a bracelet as a from leaving the build him, redirect him to th bedroom. DSP B sta his chair, listen to mu mind off going outside	reminder. To stop Client #1 ing they block and redirect					

If continuation sheet Page 15 of 21

		ND HUMAN SERVICES				FOF	ED: 08/12/202 RM APPROVE	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G036		(X1) PROVIDER/SUPPLIER/CLIA	. ,	TIPLE CONSTRUCTION		(X3) DAT	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		B. WING			C 07/01/2020			
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		110112020		
	INITY LIVING #1			10	5 WESTVIEW			
OFFORIC				LA	KE CITY, IA 51449			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 249	Continued From page	e 15	w	249				
		on sooner than that. She						
	also stated Client #1	•						
	bathroom between hi so his bedroom alarm							
	reported someone wh							
	The QIDP had her sit							
	DSP B stated Client							
	communication progr							
	he wanted to go outs							
		button and tells him you did						
	communication butto	d to go out. There is no n on the east door.						
	Mhon interviewed on	6/10/20 at 12:15 a m DOD						
		6/19/20 at 12:15 p.m. DSP d DSP B got ready for break						
	-	a.m. and 10:05 a.m. The						
		ded and DSP B went back						
	to check on Client #1	. She found him right						
		en she walked inside, the						
		According to DSP C, an						
	-	to that. She did not know ice to reset the alarm. She						
	stated it was either D							
		off the alarm on accident,						
	instead of resetting it.							
		e timer for toileting and one						
		sual checks. DSP C stated						
		d, but they have a busy						
		on the alarms right next to						
		s loud, busy house, rely on elieved his checks needed to						
		iso believed they needed to						
		on the first shift, right now						
		n the second shift. DSP C		Ì				
	•	ner elopement attempt Client						
		he did not know he had						
	-	ted the facility did not train						
	her when she started	-						
	According to DSP C,	they do not turn the door						

Facility ID: IAG0014

If continuation sheet Page 16 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			<u> </u>	OMB NC	0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
							с
		16G036	B. WING			07/	01/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OPPORT	JNITY LIVING #1						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TIVE ACTION SHOULD BE COMPLETE CED TO THE APPROPRIATE DATE	
W 249	alarms off for any rea B had accountability of entertain Client #1 wit rides, and bus rides. When interviewed on A reported her and D time at approximately back to Client #1's roo break and found him an alarm. They did n went outside the time remember the time, b looked at the 15-minu minutes left. Accordin usually goes out the e catch him before he g remember who broug went out that day. Th alarm and the door al has never seen Client bathroom to Client #2 door alarm before. D had a bedroom door was because of his el she was trained prope she just did not know door alarm. Since the #1 tries to go outside music. They also che the door alarm goes of supervision is constan 15-minute checks, bu supervision. DSP A a safety skills outside a	son. She remembered DSP of Client #1. They try to th music, take on golf carts 6/23/20 at 12:45 p.m. DSP SP B got ready for break 9:30 a.m. DSP B went om to see if he wanted outside. They did not hear ot reset the alarm when he before. DSP A could not ut remembered when they the timer there was about 10 ng to DSP A, Client #1 east door and they usually goes out. She could not th him in the time before he hey did not hear the bedroom arm did not go off. DSP A t #1 go through his t's bedroom to avoid the SP A did not know why he alarm and she assumed it lopements. DSP A believed erly on programs although, why he had the bedroom e incident on 6/2/20, if Client take him up front to listen to eck on Client #1 every time off. She stated his level of nt. He has documented t he needs constant also stated Client #1 had no nd someone held onto his putside. DSP A did not know urm or who had	w	249	9		

Facility ID: IAG0014

If continuation sheet Page 17 of 21

ND HUMAN SERVICES				M APPROVED	
MEDICAID SERVICES				O. 0938-0391	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED		
16G036	B. WING		0	C 07/01/2020	
		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10112020	
		105 WESTVIEW			
		LAKE CITY, IA 51449			
(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOL		SHOULD BE	(X5) COMPLETION DATE		
e 17 6/19/20 at 1:00 p.m. the visor confirmed the facility #1's whereabouts at all tween Client #1's 15 minute know where he is. ealed Client #1's Incident i, indicated, "(Client #1) was de House A. B. I (walked) A. Staff acted like they utside." ew revealed the following: Elient #1, age 22 at the time ed: Intellectual Disability, iopathy or Prematurity oderate hearing loss (Left movement disorder. evaluation dated 6/25/19, t be aware of where (Client wunderground.com, on the temperature was 85 F). 6/23/20 at 9:45 a.m. DSP D rom 9:00 a.m. to 3:00 p.m. in He arrived at work between m. When he pulled around view, he saw Client #1 in the parking lot. DSP D parking lot across the street im. DSP D took Client #1 f did not know he was	W 24				
	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G036 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) A 17 6/19/20 at 1:00 p.m. the visor confirmed the facility #1's whereabouts at all tween Client #1's 15 minute cnow where he is. ealed Client #1's Incident , indicated, "(Client #1) was le House A. B. I (walked) A. Staff acted like they utside." ew revealed the following: lient #1, age 22 at the time ed: Intellectual Disability, opathy or Prematurity oderate hearing loss (Left movement disorder. evaluation dated 6/25/19, be aware of where (Client wunderground.com, on he temperature was 85 F). 6/23/20 at 9:45 a.m. DSP D om 9:00 a.m. to 3:00 p.m. in He arrived at work between m. When he pulled around view, he saw Client #1 n the parking lot. DSP D arking lot across the street m. DSP D took Client #1	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 16G036 B. WING	MEDICAID SERVICES (X1) PROVIDER/SUPPLEMCIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BULIDING 16G036 B. WING 16G036 B. WING ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY PULL SSC IDENTIFYING INFORMATION) D PREFIX TAG 217 (CA) HOUST BE PRECEDED BY PULL SSC IDENTIFYING INFORMATION) D PREFIX TAG 217 W 249 6/19/20 at 1:00 p.m. the visor confirmed the facility #1's whereabouts at all tween Client #1's 15 minute rnow where he is. W 249 aaled Client #1's Incident indicated, "(Client #1) was te House A. B. I (walked) A. Staff acted like they utside." ew revealed the following: W lient #1, age 22 at the time ed: Intellectual Disability, opathy or Prematurity oderate hearing loss (Left movement disorder. Staff acted 6/25/19, be aware of where (Client wunderground.com, on he temperature was 85 F). Staff a.m. DSP D om 9:00 a.m. to 3:00 p.m. in He arrived at work between m. When he publed around view, he saw Client #1 n the parking lot. DSP D arking lot across the street m. DSP D took Client #1	D HUMAN SERVICES OMB N MEDICAD SERVICES OMB N (21) PROVIDESUPPLERCULA 10ENTFICATION NUMBER: 16G036 0. WING 16G036 0. WING 16G036 0. WING 16G036 0. WING STREET ADDRESS, CITY, STATE, ZIP COOE 105 WESTVIEW LAKE CITY, IA 51449 ATEMENT OF DEFICIENCES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 2 17 W249 6/19/20 at 1:00 p.m. the visor confirmed the facility 4''s whereabouts at all tween Client #1's Incident i, indicated, "Client #1's uncident i, indicated fike they triside." ew revealed the following: lient #1, age 22 at the time ed: Intellectual Disability, opathy or Prematurity oderate hearing loss (Left movement disorder. evaluation dated 6/25/19, be aware of where (Client wunderground.com, on he temperature was 85 F). 6/23/20 at 9:45 a.m. DSP D om 3:00 a.m. to 3:00 p.m. in He arrived at work between m. When he pulled around view, he saw Client #1 the parking lot. DSP D arking lot across the street m. DSP D took Client #1 the DSP D took Client #1 the DSP D took Client #1 the arrived at work between m. DSP D took Client #1 the arrived at work between m. DSP D took Client #1 the parking lot. DSP D arking lot across the street m. DSP D took Client #1 the arrived at work between the temperature was 85 F).	

TATEMENT (ENTERS FOR MEDICARE & MEDICAID SERVICES TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SUR	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A, BUILDIN		COMPLETED		
		B. WING		C 07/01/2	2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP		2020
OPPORTL	INITY LIVING #1			105 WESTVIEW LAKE CITY, IA 51449		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN O	CTION SHOULD BE CA	(X5) COMPLETIO DATE	
W 249	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 24	49		
	him into the house. (not paying attention. elopes one time he w When interviewed on	recently when she brought Client #1 waits until they are He is slow about it, but if vill go again. 6/23/20 at 11:12 a.m. DSP ight sat at the front of the				

Facility ID: IAG0014

If continuation sheet Page 19 of 21

		ND HUMAN SERVICES			FOR	ED: 08/12/20 RM APPROVE
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED		
	16G036		B. WING		C 07/01/2020	
NAME OF PR	ROVIDER OR SUPPLIER	A		STREET ADDRESS, CITY, STATE, ZIP CO		
OPPOPTU				105 WESTVIEW		
OPPORTU	INITY LIVING #1		I	LAKE CITY, IA 51449		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
W 249	Continued From page	e 19	W 249			
		able. DSP F walked into the	VV 2+0			
		DSP A on the plans for the				
		es prior DSP F took Client				
	#1 to his bedroom to listen to music. Then DSP					
	D brought him into the house. No alarm					
	sounded. They chec	ked the alarm when he				
	came back in. They	believe he went outside the				
		went out the front door.				
	According to DSP F,	÷				
	•	minutes. There is no reason				
		edroom door alarm off. DSP nt into other client bedrooms,				
		that he would go through				
		o Client #2's bedroom. He				
		elopement prior to the				
		ey see that he tries to elope,				
	they have him stay in	the living room. DSP D				
	stated DSP A had Cli	ent #1's accountability. DSP				
		ained her on programming.				
		as changed since 6/2/20 is				
		ed he was a high level of				
	• •	neck him every 15 minutes,				
		was constant one-to-one sually let him walk down the				
	•	DSP D stated they need				
	more staff if they hav	-				
	When interviewed on	6/23/20 at 12:45 p.m. DSP				
	A reported between 8	3:50 a.m. and 8:55 a.m., her				
		the 9:00 a.m. staff to arrive.				
		e shift for the day. DSP E				
		e. Client #1 just finished				
		obably heading to his				
		follow him down the hallway day. DSP A did not believe				
	-	elope prior to 8:50 a.m.				
		urse leave and reset the				
		inutes later, DSP C brought				
		P C told them Client #1 was				

Facility ID: IAG0014

If continuation sheet Page 20 of 21

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		······································	OMB N	IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	16G036		B. WING		0	C 7/01/2020
	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		110112020
				105 WESTVIEW		
OPPORTU	NITY LIVING #1			LAKE CITY, IA 51449		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	they worked. DSP A of the east door at the out of the front door. thing happen later tha they checked on Client the door. They redire know who had account When interviewed on Director of Programm	y checked the alarms and believed Client #1 went out e same time the nurse went She witnessed the same at day. The nurse left and nt #1, he was walking out of ected him. DSP A did not	W 24	9		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: IAG0014

If continuation sheet Page 21 of 21