DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	850671	A. BUILDING: _____ B. WING _____	C 01/25/2021

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CALHOUN HOUSE	3911 CALHOUN AVENUE AMES, IA 50010

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R 000	Initial Comments No deficiencies were cited during the onsite infection control survey completed in November 2020. The following deficiencies were cited during the investigation of 94309-A and 94330-M.	R 000		
R 266	481-57.7(5)b General Requirements 481-57.7(135C) General requirements. 57.7(5) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to comply with requirements related to notifications to the Department found in Iowa Administrative Code 481-chapter 50. Findings include: A review of facility records revealed the facility failed to notify the Department of an elopement as required by Iowa Administrative Code rule 50.7(4). The administrator confirmed this finding. See deficiency under 50.7(4) for details.	R 266	✓ 5/19/21	
R 834	481-57.22(3)c Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the	R 834		

5/12/21

			Optimae is aware and understand that the customers service plans should be modified to add or delete goals and objectives as the resident's needs change. Additionally, any communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. • The Residential Care Facility Administrator will retrain and educate supervisors including Service Coordinators, Team Leaders, Nurse, and CMA's on the importance of making revisions in the customers service plan when there are changes in goals or objectives as discussed during interdisciplinary team meetings whether in person or via phone/virtual platform. • The Residential Care Facility Administrator will retrain supervisors including Service Coordinators, Team Leaders, Nurse, CMA's to bring to any interdisciplinary team meeting the (1) Service Plan and Discharge Plan form and the (2)Team Signature form. These forms will be used to review the customers current service plan goals and objectives when engaging in discussion about the customers progress, increase in symptoms, changes in behaviors, etc. so that the team can readily identify during each meeting if a change in fact does need to be made to the customers plan. All team members present for these meetings will acknowledge what was discussed and any applicable changes by signing the team signature page. If the meetings occur via phone/virtual platform, the signature page will be emailed/faxed/mailed to the other participants requesting their signature and the return of	5/4/2021 5/4/2021

			the form once it is signed. These forms will be kept in the customers charts at all times (see attached forms).	
			• If there are changes to a customer's service plan the responsible supervisor will complete a Customer Specific Training form with each staff member scheduled to work with the customers that reviews the changes made, why they were made, and how that may affect the staff's role in providing supports to the customer. These forms are kept in the staff personnel files (see attached form).	As need when changes to customer service plan
			• The Residential Care Facility Administrator facilitates clinical rounds at least every other week, if not every week, to review each customer served in the Residential Care Facility. During these rounds the supervisors will report any changes to a customer's service plan and verify that staff have been trained on these changes.	5/6/2021
			• A training certificate will be completed for all supervisors and filed in their personnel file (see attached).	5/4/2021

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R 834	Continued From page 1 administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure service plans addressed all need areas for 1 of 3 residents reviewed (Resident #3). Findings follow: Record review on 11/3/20 revealed Resident #3 had a service plan dated 10/8/19 - 7/31/20 which addressed seven goals. His first goal was to develop and maintain his mental and physical health by attending his scheduled appointments and being medication compliant. The second	R 834		

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R 834	Continued From page 2	R 834		

goal was to improve and manage his mental health symptoms by utilizing his coping skills effectively. Goal three was to improve his personal hygiene by following a personal hygiene routine which included showering at least every other day, applying deodorant, shaving, putting on clean clothing daily, brushing his teeth twice daily and completing laundry weekly. His fourth goal was to improve and maintain his living environment by cleaning his home. Goal five was to develop and maintain skills necessary to find a new recipe to cook that utilize different cooking appliances, shop for groceries and prepare a planned meal. The sixth goal was to develop and maintain personal wellness by exercising. Goal number seven was to develop and improve his time management skills by following through with his schedule. Resident #3 also had a support goal to remain safe and secure in his home. A new service plan was created with Resident #3's team for the period of 7/1/20 - 5/31/21 which added a goal for him to improve his social skills by participating in community events. With the exception of the new goal, there was little change in the goals or objectives on the two service plans.

A Functional Assessment was completed for Resident #3 on 6/5/20. The behavioral section of the assessment noted Resident #3 displayed verbal and physical aggression toward others, exhibited disruptive and destructive behaviors, lied, stole, touched others inappropriately, ran away, urinated in areas other than the toilet and ran through the house without clothing on. Resident #3 had also crawled into his roommate's bed at night without permission. Resident #3 twisted one peer's nipple and grabbed another female above the breast. He tried to use the entire bottle of shampoo or body wash if not given

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R 834	Continued From page 3 the correct portion or a small cup. Resident #3 did not close the door when using the toilet or taking a bath according to the assessment. A review of External Communication forms revealed the following: - On 8/13/20 the Service Coordinator contacted Resident #3's guardian to inform her a customer meeting was held and Resident #3 sat on the lap of a resident he had grabbed in the past. In the facility, there was a men's wing and a women's wing. Resident #3 had been asked to stay off the women's wing but he went down it three times that day and also tried to use a restroom on the women's wing. The Service Coordinator also informed Resident #3's guardian he needed to stop going into everyone's room and getting into their beds. - On 8/19/20 the Service Coordinator contacted Resident #3's IHH (Integrated Home Health) worker to inform her of concerns and to explore possibly moving him to a setting with fewer roommates and who were all male. They discussed the concern of Resident #3 going into other residents' rooms and getting into their beds. The Service Coordinator noted the IHH worker recalled they had discussed it being a problem several months before they wrote the assessment (completed on 6/5/20) and it was an ongoing issue with other clients being negatively impacted which they felt should not continue. - On 9/1/20 the Service Coordinator contacted Resident #3's guardian to inform her he snuck up behind another resident, grabbed her under the arms and screamed in her ears. - On 9/29/20 Resident #3's guardian was contacted after he ran around the house without any clothing on and laughed about it. Several staff attempted to intervene but he refused to get dressed for about 30 minutes. The Service	R 834		

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R 834	Continued From page 4 Coordinator also reported the day prior Resident #3 had watched a female staff person go into the bathroom and then shook the door handle to try and get into the restroom. Resident #3 also continued to go over to the female side of the building. - On 10/1/20 the Service Coordinator and Administrator contacted Resident #3's guardian to discuss his escalation of symptoms. They reviewed the concerns of the resident entering other residents' rooms at night and declining to leave. He also broke every cabinet and drawer lock in the kitchen, touched and grabbed peers multiple times daily, tried to get into the staff bathroom while a female staff was utilizing it, walked around the house naked, attempted to break into the Team Leader's office and continued to urinate in sinks and the garage. The Administrator stated the facility was unable to continue safely serving Resident #3 with all of the interfering behaviors. The facility asked for the guardian's permission to have the resident hospitalized to have an assessment completed. The guardian agreed an assessment needed to be completed to reevaluate his diagnosis, but on an outpatient basis. - On 10/14/20 another team meeting was held to discuss Resident #3's behaviors. He continued to urinate in sinks, hallways and trash receptacles instead of in the restroom. His guardian thought this urination might be caused by a medication increase but the Regional Director stated he had engaged in that behavior since his admission to the facility. Resident #3 also continued to walk into the female side of the facility. He entered common areas without clothing on and when directed to get dressed, would ignore those requests. Multiple items had been broken by Resident #3. When maintenance fixed the locks on the cabinets, Resident #3 broke them again.	R 834		

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R 834	Continued From page 5 Resident #3 urinated in his bed, had a difficult time staying in his room and had climbed out of his bedroom window. They discussed moving Resident #3 to a small facility in a different county further away but his guardian was not interested in this. They agreed to meet again on another date. - On 10/19/20, the CMA (Certified Medication Aide) was in the medication room counting pills. Resident #3 tried to enter the room several times so she informed him she was going to shut the door to finish her task. Resident #3 then pushed the door open. It hit the CMA in the face and chipped her tooth. - On 10/21/20, Resident #3's guardian contacted the Service Coordinator to ask why the resident was only given 2 cups of soap for bathing as it was not nearly enough to clean his body. The Service Coordinator explained he would use an entire bottle of body wash if it was not limited and one tub had to be repaired as it had too much soap in it. - On 10/23/20 the facility presented Resident #3 and his guardian with a 48 hour involuntary discharge notice. The Functional Assessment dated 6/5/20 identified needs which were not addressed on the service plan, but continued to be issues leading to Resident #3's discharge. Resident #3's service plan dated 7/1/20 was not modified to address the concerns identified in the External Communication forms prior to Resident #3 being given a 48 hour involuntary discharge on 10/23/20. The Service Coordinator and Administrator were interviewed on 11/4/20. They reported steps were put in place to address Resident #3's behaviors, however the service plan was not	R 834		

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R 834	Continued From page 6 amended.	R 834		
C 147	50.7(4) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the Department of an elopement regarding 1 of 3 residents reviewed (Resident #3). Findings include: Record review on 11/3/20 revealed a Critical Incident Report for Resident #3 dated 9/21/20. It noted staff went to pass Resident #3 his 7:00 PM medication but he was not in his bedroom. Staff left to go to the gas station where Resident #3 was known to frequent to see if they could locate him. On the way back from the gas station, staff noticed a police officer near the facility. The police officer stopped staff and gave a description of a person who matched Resident #3's description. When staff confirmed he was a resident of the facility, the officer stated they had received a call from a citizen who said there was a man in their yard holding his hand to his chest and they wanted to make sure he was okay. By that time, Resident #3 had returned to the facility.	C 147	When a resident, who is determined to have impaired decision-making abilities, leaves the residential care facility without the knowledge or authorization of staff this is considered "elopement"; and constitutes as a DIA reportable critical incident. • The Residential Care Facility Administrator will retrain and review what constitutes a DIA reportable critical incident with all designated persons that may be responsible for completing and reporting critical incidents including direct support professionals, Team Leaders, Service Coordinators, Nurse, CMA's. 5/4/2021 • The Residential Care Facility Administrator will retrain supervisors to thoroughly document any identified restrictions during the interdisciplinary team meeting prior to the start of services. For any customer that the team identifies has impaired decision-making abilities when out in the community without staff present, will be identified as considered elopement when he/she leaves the facility without knowledge or notifying staff. This will specifically be identified in our 5/4/2021	

			Rights Restriction Form • We have identified some specific questions to be asked and discussed during the interdisciplinary team meeting to determine the specific restriction expectations for non-supervised time (see attached rights restriction with questions highlighted in "yellow"). • We are adding Elopement as a critical event to our internal form used for customers that are not assigned to an MCO (see attached). • A training certificate will be completed for all supervisors and filed in their personnel file (see attached).	4/27/2020 5/5/2021 5/4/2021

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C 147	Continued From page 7 He was assessed by the officer who noted the resident's hand was bleeding. Staff and Resident #3 then returned to the facility where first aid was performed. The bleeding appeared to be caused by dry skin. Resident #3's Functional Assessment Part 3: Rights Restrictions dated 6/11/20 noted there was a restriction on his right to freedom of movement. The reason for this restriction was due to having been in a hospital for quite some time so the team felt it would be in his best interest to restrict his unsupervised time to two hours each day while in the community on planned outings or activities. Resident #3 was able to move around his home and bedroom freely. The document noted in the past, Resident #3 had wandered away from his home and other placements which led to the police bringing him home or Resident #3 needing to call providers to pick him up. Resident #3 also was in a new home and city. He was not familiar with the surrounding area which could cause a risk and safety concern if Resident #3 was not accompanied by staff or at a planned location for an outing or activity. The Administrator reported on 12/3/20 at 2:10 PM staff were not aware Resident #3 had left the facility on 9/21/20 and the incident was not reported to the Department.	C 147		