

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

PRINTED: 01/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

*✓ RR 1/27/17 CAC 1/27/17*

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>16G003 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>01/10/2017 |
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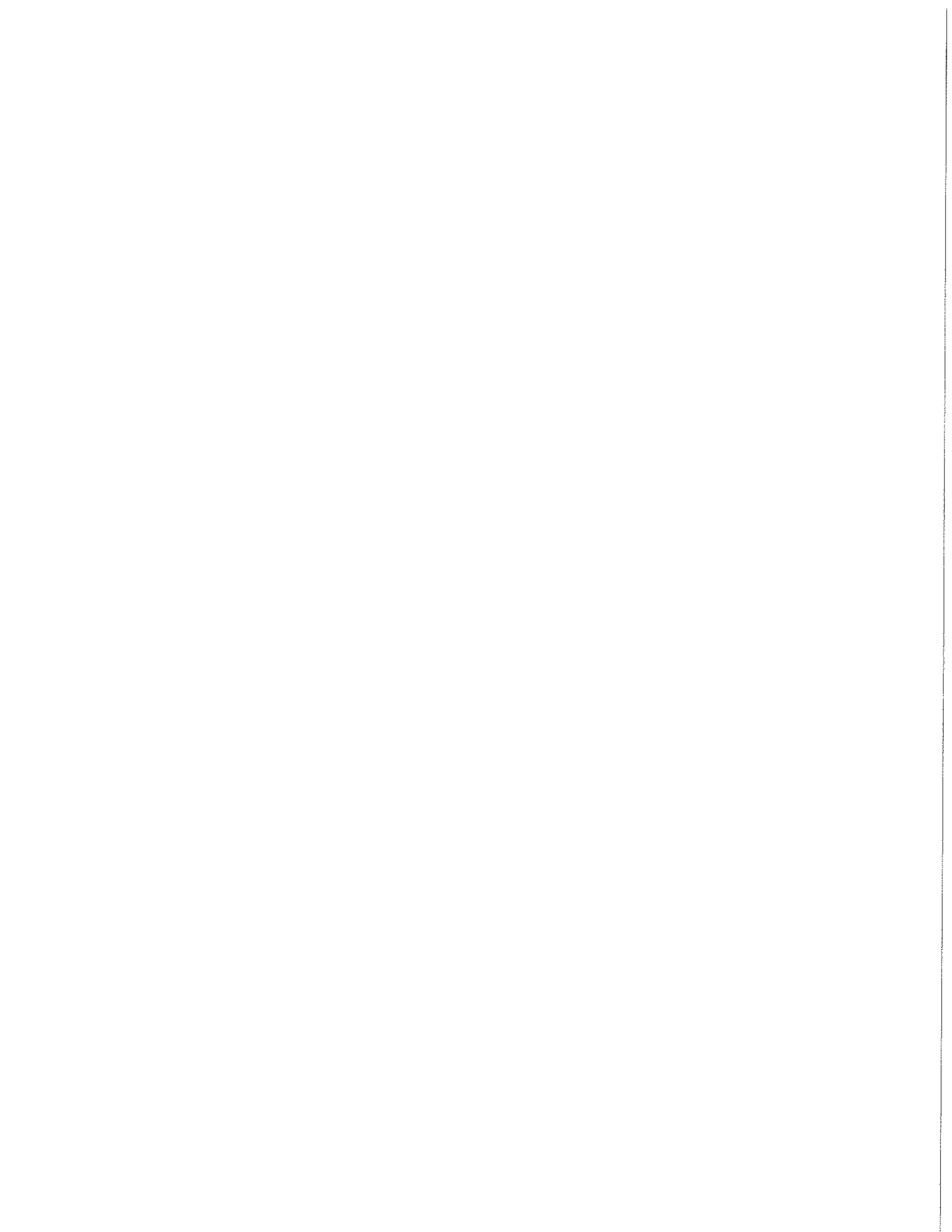
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| NAME OF PROVIDER OR SUPPLIER<br><br>GLENWOOD RESOURCE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>711 SOUTH VINE STREET<br>GLENWOOD, IA 51534 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF 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 |
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| W 000 | <p>INITIAL COMMENTS</p> <p>The following complaint survey was completed 10/31/16 - 1/10/17 and included the following 24 investigations:</p> <p>#62570-I, 62572-I, 63292-I, 63881-M, 64234-I, 64240-I, 64252-M, 64253-I, 64279-I, 64397-I, 64438-C, 64457-I, 64459-I, 64464-I, 64465-I, 64557-M, 64559-I, 64578-M, 64579-M, 64593-C, 64603-M, 64924-I, 64989-I, 65017-I.</p> <p>Condition-level deficiencies were cited at W102 and W122.</p> <p>These findings led to a determination of Immediate Jeopardy (IJ) on 11/15/16 at approximately 9:30 a.m., based on the facility's failure to protect clients from abuse and mistreatment. The facility was notified at approximately 10:00 a.m. The facility developed and implemented a plan to remove the IJ. The plan included increased supervision in the homes on evenings and weekends and retraining of staff. The plan also included oversight, follow-up, and observations by Department of Human Services (DHS) Division of Mental Health and Disability Services, to be completed at least twice monthly. The IJ was removed on 12/6/16 at 1:00 p.m.</p> <p>Standard-level deficiencies were cited at W104, W125, W127, W149, W159, W193, and W268.</p> | W 000 | <p>See attached</p> <p><i>POC</i></p> <p><i>1/13/17</i></p> |  |
| W 102 | <p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p>  | W 102 |   |  |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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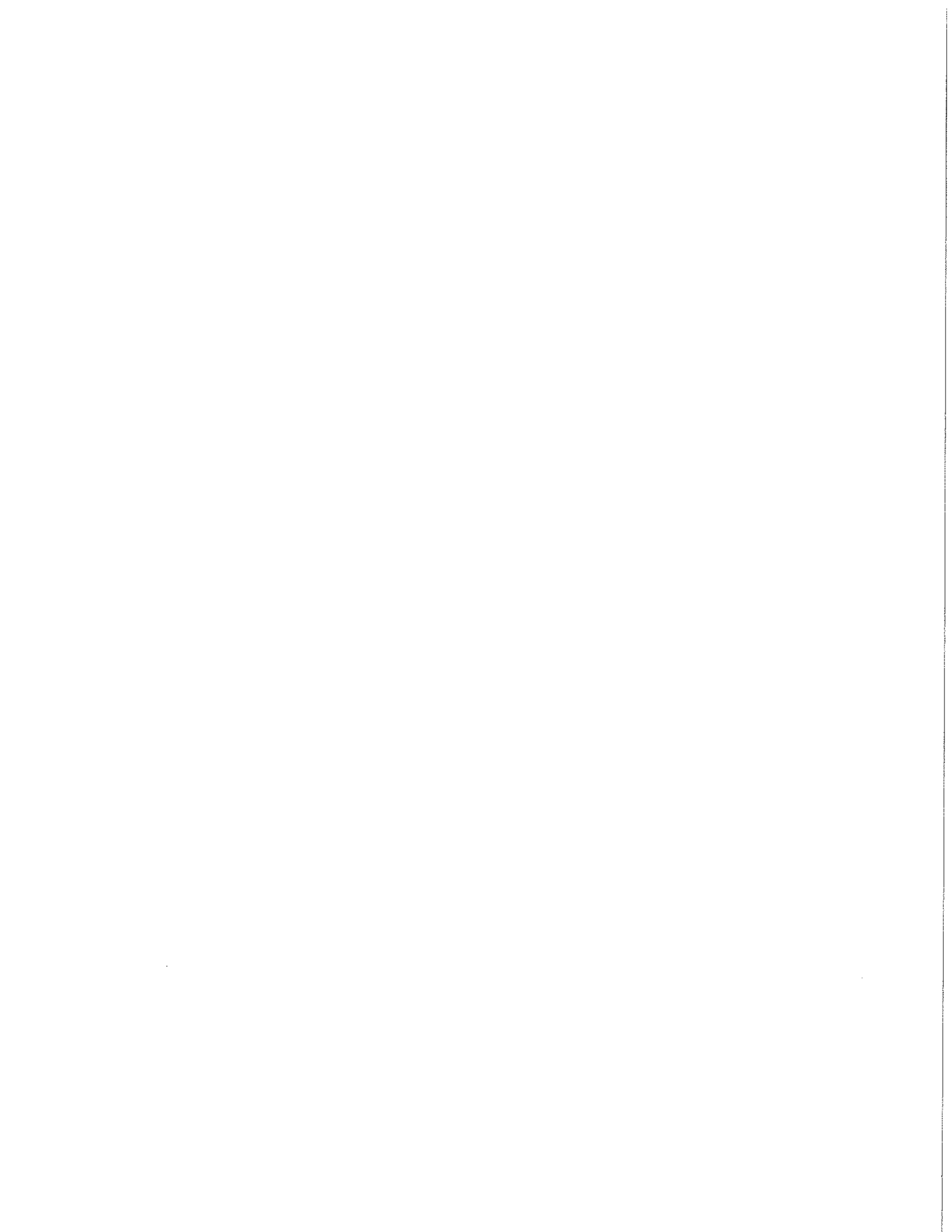
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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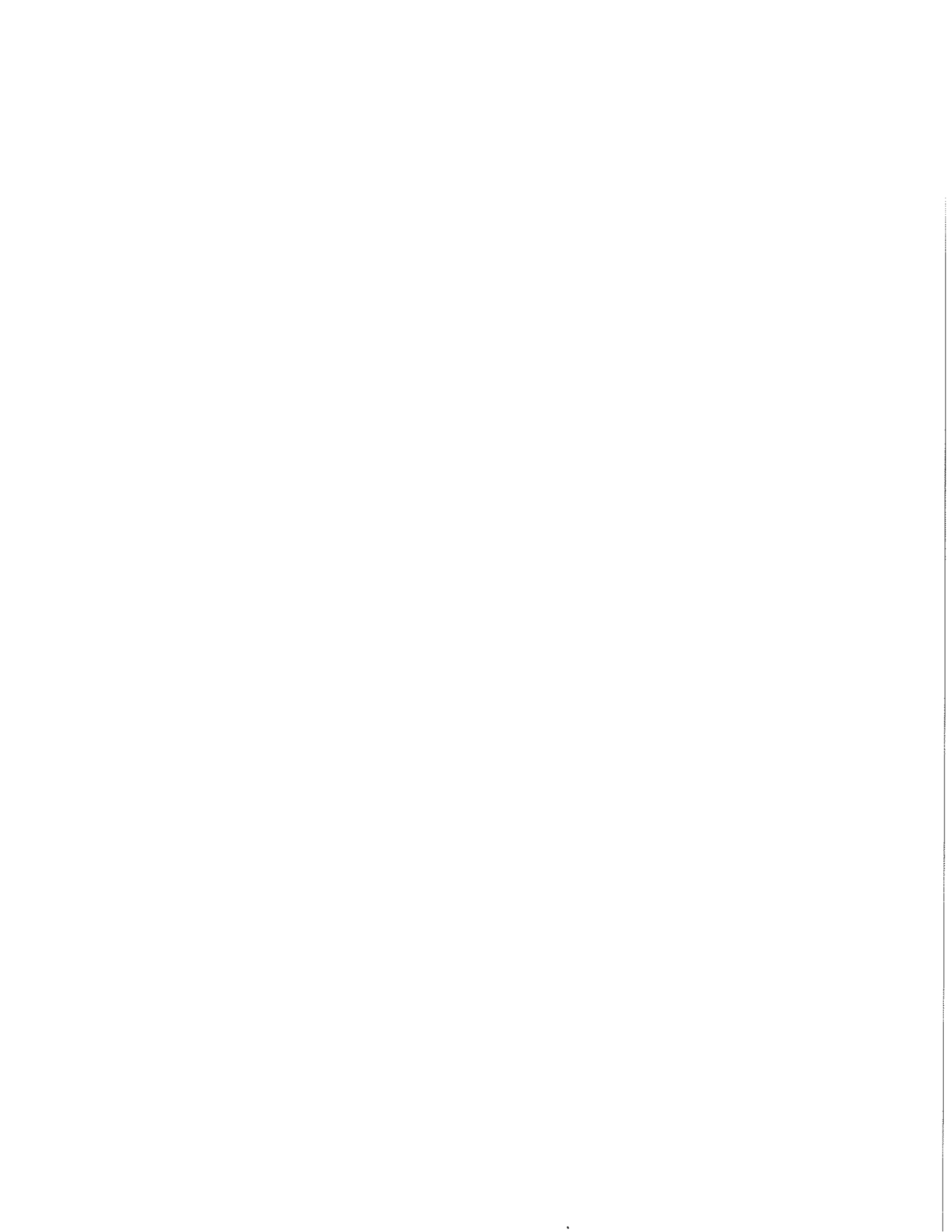
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| W 102   | Continued From page 1<br><br>This CONDITION is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to maintain minimal compliance with the Condition of Participation (CoP) - Governing Body and Management. The governing body failed to provide adequate operating direction to effectively ensure individuals received proper treatment, services, and supports. The governing body failed to ensure consistent provision of individual civil and human rights, including the right to be free from abuse. Facility staff failed to provide adequate safeguards to ensure client treatment with dignity and respect.<br><br>Cross reference W104: Based on interviews and record review, the facility failed to consistently provide adequate management and operating direction to ensure appropriate implementation of policy and procedure regarding health and safety of clients. The facility failed to provide adequate managerial structure to ensure oversight of policies and procedures to prevent client abuse, ensure a safe environment (for staff and clients), and prevent retaliation amongst employees.<br><br>Cross reference W122: Based on interviews and record review, the facility failed to maintain minimum compliance with the Condition of Participation (CoP) Client Protections. Based on interviews and record reviews, the facility failed to ensure clients were free from abuse and mistreatment. Based on interviews and record reviews, facility staff failed to report allegations of abuse and mistreatment of clients immediately. The facility failed to provide adequate supports to ensure consistent implementation of policies and | W 102   |   |                      |   |



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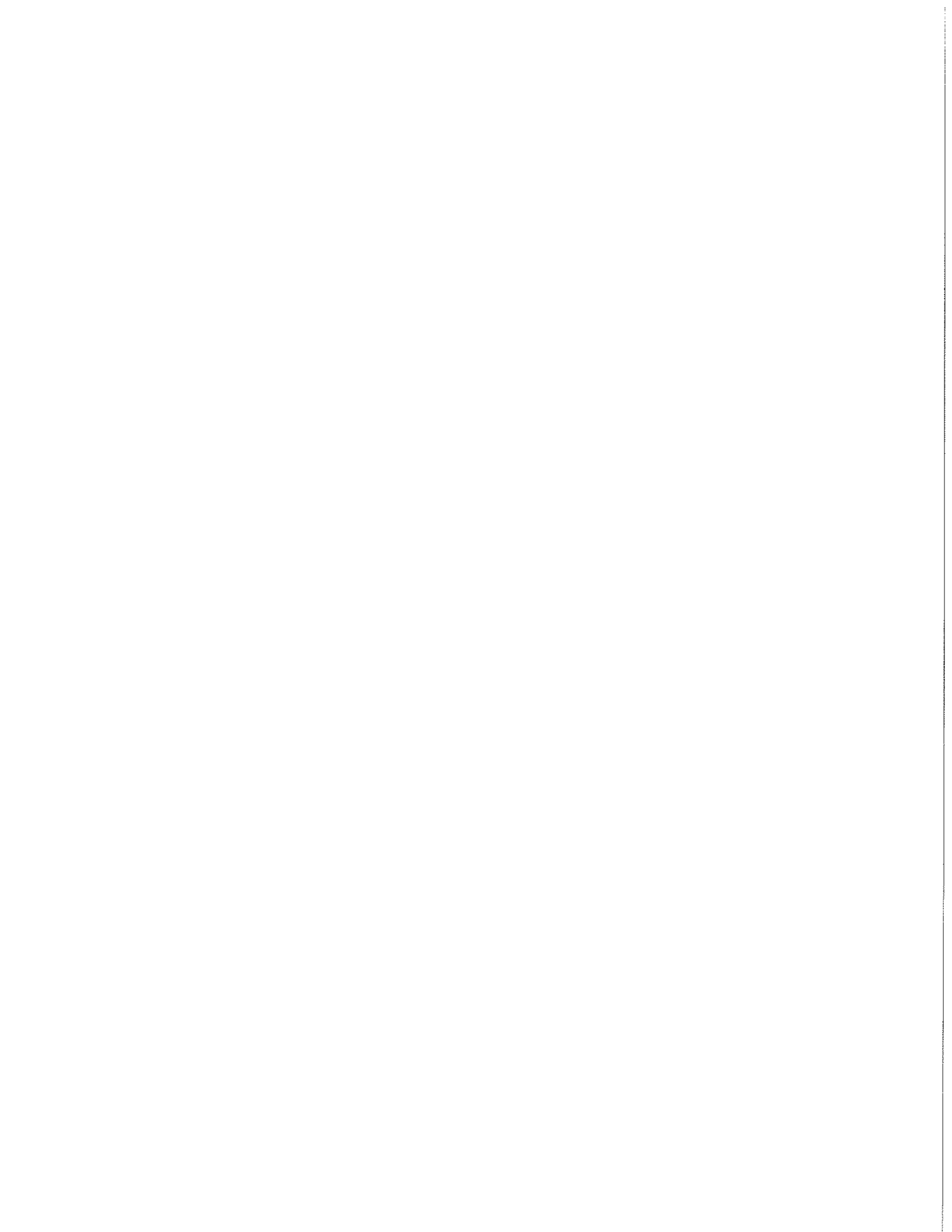
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| W 102  | Continued From page 2  | W 102  |   |                      |   |
| W 104  | <p>procedures and oversight to ensure an environment conducive to protecting clients from abuse and mistreatment and encourage clients to exercise their human rights. These findings led to a determination of Immediate Jeopardy (IJ). 483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to consistently provide adequate management and operating direction to ensure appropriate implementation of policy and procedure regarding health and safety of clients. The facility failed to provide adequate managerial structure to ensure oversight of policies and procedures to prevent client abuse, ensure a safe environment (for staff and clients), and prevent retaliation amongst employees. This potentially affected 227 of 227 clients residing at Glenwood Resource Center (GRC).</p> <p>Findings follow:</p> <ol style="list-style-type: none"> <li>1. Cross reference: W125, W127, W149, W153, W193, W268</li> <li>2. See W153 for additional information.</li> </ol> <p>a. When interviewed on 11/15/16 at 2:00 p.m. Resident Treatment Worker (RTW) K revealed she did not report incidents immediately because she was scared. RTW K reported she feared retaliation and did not feel safe.</p> | W 104  |   |                      |   |



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| W 104   | <p>Continued From page 3</p> <p>b. When interviewed on 11/21/16 at 11:45 a.m. RTW M stated she did not report any of the multiple incidents where RTW H and RTW I used a butter knife to hit clients, or became physical with clients. RTW M stated she was intimidated and scared of RTW H. RTW H made comments about people who turned people in. She reported there was a rule in the house and they made others feel uncomfortable and not want to report anything.</p> <p>c. When interviewed on 11/21/16 at 5:00 p.m. RTW L stated she forwarded a copy of a video of RTW M hitting Client #15 while RTW H held him/her down to her friend and coworker, RTW K, who provided the video to the facility at a later time. RTW L reported being afraid of retaliation by coworkers. She explained she did not want to be labeled a "NARC."</p> <p>d. When interviewed on 11/21/16 at 1:13 p.m. RTW B reported on 9/23/16 he assisted Client #1 with cleaning the bathroom. Client #1 yelled and threw the mop bucket. According to RTW B, RTW A walked into the bathroom and grabbed Client #1 by the arms. RTW A told Client #1 the other clients were sleeping. RTW B left the bathroom because he did not want to be around the interaction. RTW A heard Client #1 yell, but Client #1 often yelled when asked to mop. RTW B stated after RTW A left he went back into the bathroom and Client #1 mopped. RTW B confirmed he failed to report the incident because RTW A threatened new staff, including RTW B. RTW B stated RTW A told him if he said anything or did anything, they would get him fired. According to RTW B, RTW A bragged about getting a previous staff fired and RTW B had a lot</p> | W 104   |   |                      |   |

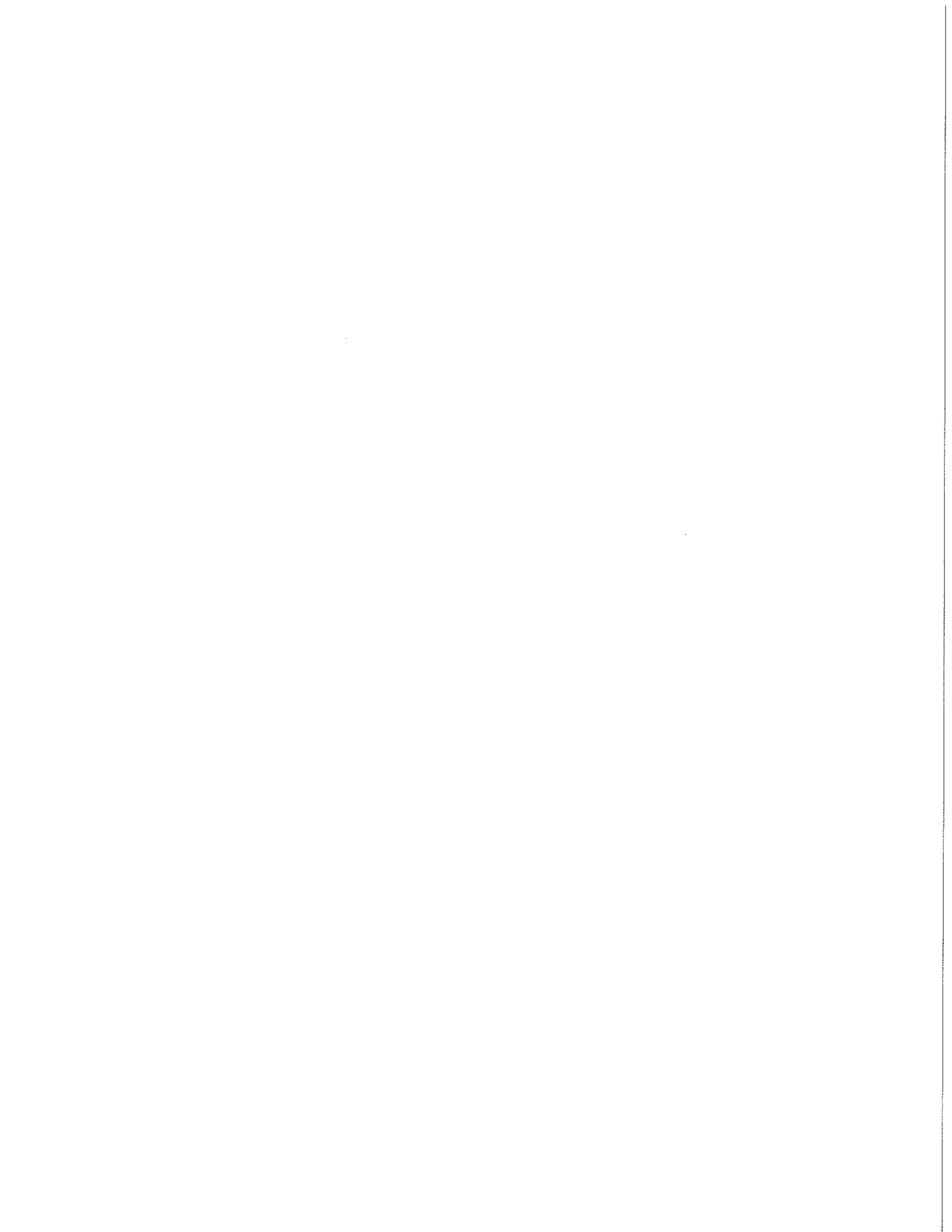




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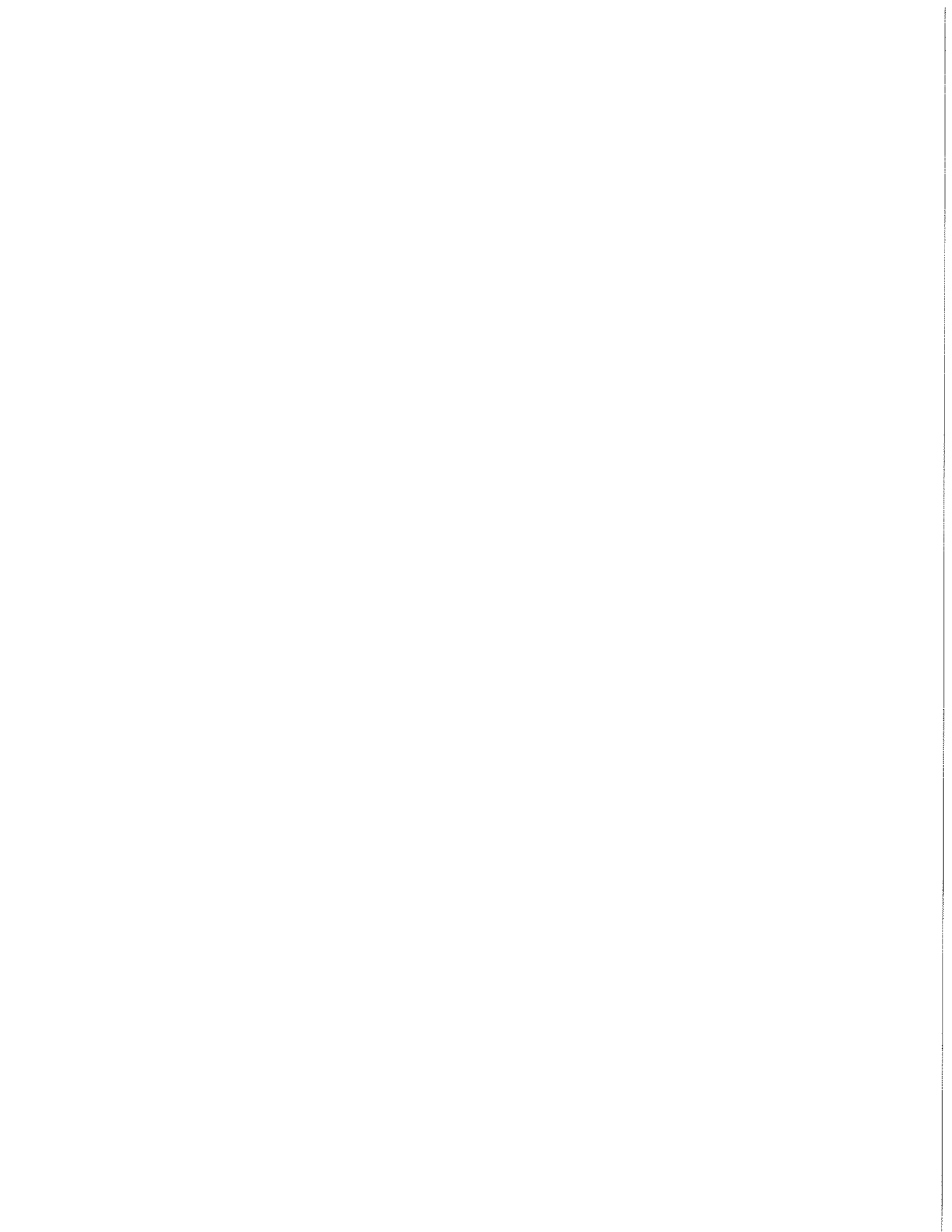
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| W 104   | <p>Continued From page 4 on the line.</p> <p>Record review revealed Employee Handbook dated November 2014, Violence-Free Workplace, indicated, "...The Department recognizes that violence at work can seriously affect employee work performance and morale. Threats, intimidation, harassment, or acts of violence will not be tolerated. All employees are expected to treat each other with courtesy, dignity, and respect. The Department is committed to a violence-free workplace, and its goal is to prevent violence in the workplace. The Department therefore wishes to make clear that it considers acts and threats of violence to constitute serious violations of Department and State policy. The Department will take appropriate measures to address behaviors that threaten or endanger the health, safety, or well-being of employees, clients or visitors..."</p> <p>3. Former RTW (FRTW) A's Exit Information Questionnaire, dated 9/22/16, noted, "...I was providing one-on-one supervision in a residential wing of my house when I overheard yelling coming from a different part of the house. I wasn't able to see or hear exactly what was going on, but voices were raised, seemingly upset. I remained with my charge, but later on I overheard several of my coworkers (again, from another room) talking about how one of them had been wrestling or something with a resident, and that the resident had received a minor injury as a result. They discussed how, even though they had been present, they each had a plausible alibi, and therefore couldn't have been around when the injury occurred, and one of them was told to write up an incident report explaining how a nonverbal resident had attacked the injured</p> | W 104   |   |                      |   |



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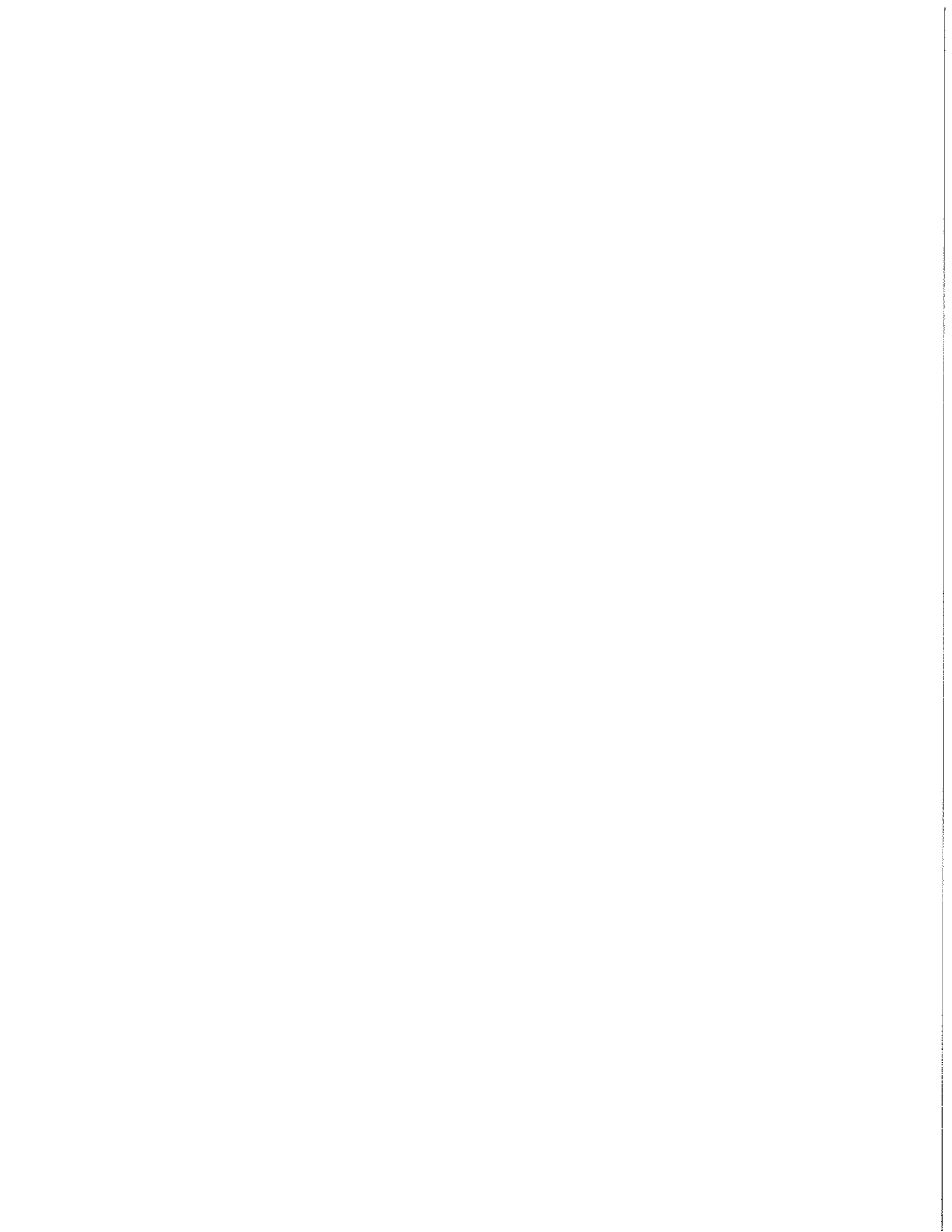
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| W 104  | <p>Continued From page 5</p> <p>resident, resulting in the injury. I couldn't tell exactly who was and wasn't involved, and in what capacity. I couldn't tell exactly who was and wasn't involved, and in what capacity. I neither saw the incident, the injury, nor the incident report. What I did know was, if what I seemed to have overheard was actually what happened, it would only be a matter of time before someone would ask me to falsify an incident report to cover up the borderline abusive behavior of my coworkers..."</p> <p>Record review revealed Employee Handbook dated November 2014, General Standards of Conduct and Work Rules, directed, "... Employees shall not make false, misleading or malicious statements concerning themselves, other employees, clients, and supervisors, or falsify forms or work documents, or intentionally enter false information into automated systems, or intentionally give false or misleading information, or omit information significant to the Department..."</p> <p>4. See W127 for additional information.</p> <p>Record review revealed the following:</p> <p>a. The incident management policy and procedure, dated 11/2/07, directed: "... No staff, volunteer, or contractor shall behave in an abusive or neglectful manner toward individuals..." Incident management principles included: "Abuse shall not be tolerated." General Personnel Practices included: "All persons who provide services to individuals as staff, volunteers, or contractors with GRC shall treat people with dignity, respect, and concern for safety. No staff, volunteer, or contractor shall</p> | W 104  |   |                      |   |



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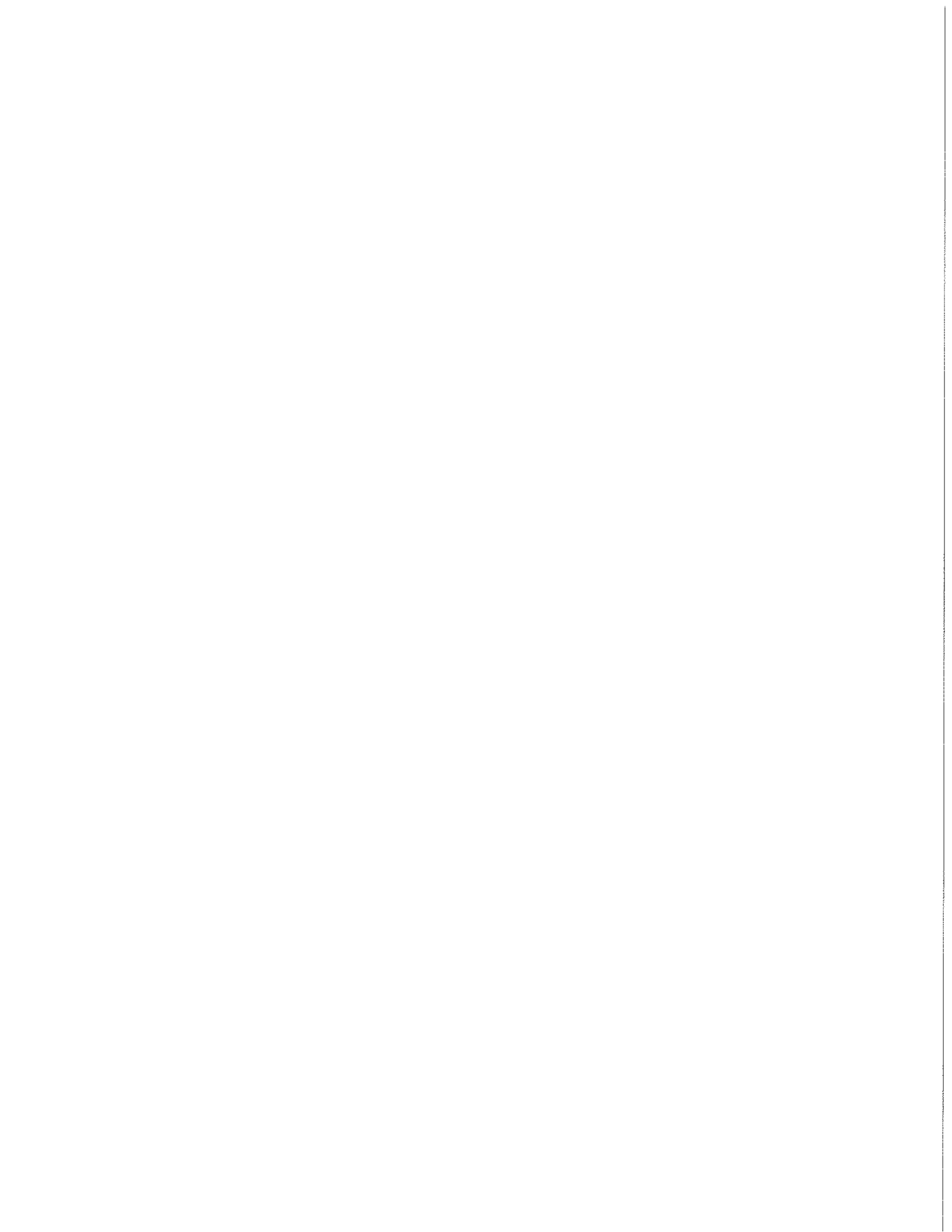
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| W 104   | <p>Continued From page 6</p> <p>behave in an abusive or neglectful manner toward individuals. No staff, volunteer, or contractor shall violate the Iowa Code provisions related to child abuse, abuse or neglect of dependent adults or sexual abuse."</p> <p>b. General Standards of Conduct and Work Rules, also included, "Employees shall treat other employees, guests, visitors, and Department clients with dignity and respect... Employees shall not mistreat, abuse, coerce, neglect or exploit employees, visitors or clients, whether verbally, physically, sexually or financially. When physical contact is a part of an employee's duties, each contact will be performed in a professional manner... Abuse of an employee's position or authority by requesting, forcing or engaging clients, other employees or visitors in consensual or nonconsensual sexual relations or sexually-related activities including sexually suggestive remarks is considered serious misconduct and shall result in disciplinary action up to and including discharge from employment and/or legal action against the employee..."</p> <p>5. See W268 for additional information.</p> <p>Record review revealed the following:</p> <p>a. Employee Handbook, dated November 2014, included General Standards of Conduct and Work Rules, which directed: "...Employees shall avoid boisterous or inappropriate discussions and behavior... Employees are expected to maintain appropriate control of themselves, even under provocation. The use of abusive, profane, argumentative, offensive, or threatening language or attempts to inflict bodily harm or mental anguish will not be tolerated... Employees shall</p> | W 104  |   |   |



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| W 104   | <p>Continued From page 7</p> <p>not engage in illegal or disorderly conduct including, but not limited to, roughhousing, pushing, throwing objects, immoral or indecent conduct, or participate in any activity, misconduct or behavior in the workplace and/or while on duty, which may have a negative effect on the Department's reputation and/or community standing..."</p> <p>b. Employee Handbook, dated November 2014, included Code of Conduct, which directed: "Employees are expected to conduct themselves in a manner that creates and maintains respect for the DHS, their co-workers and the individuals served. Employees are expected to maintain high standards of behavior in both their personal and official activities. The Department prohibits any unethical or illegal conduct by an employee on or off duty that affects or has the potential to affect the Department. Employees have a duty to report unethical or illegal activity, relating to state employment, to their Supervisor, Appointing Authority or Department Director..."</p> <p>c. Incident management policy, dated 11/2/07, directed, " All persons who provide services to individuals as staff, volunteers, or contractors with GRC shall treat people with dignity, respect, and concern for safety. No staff, volunteer, or contractor shall behave in an abusive or neglectful manner toward individuals..."</p> <p>6. See W125 for additional information.</p> <p>Record review revealed the facility's incident management policy, dated 11/2/07, provided the following personnel practice: "Individuals shall be encouraged and educated to assert the legal and</p> | W 104   |   |                      |   |

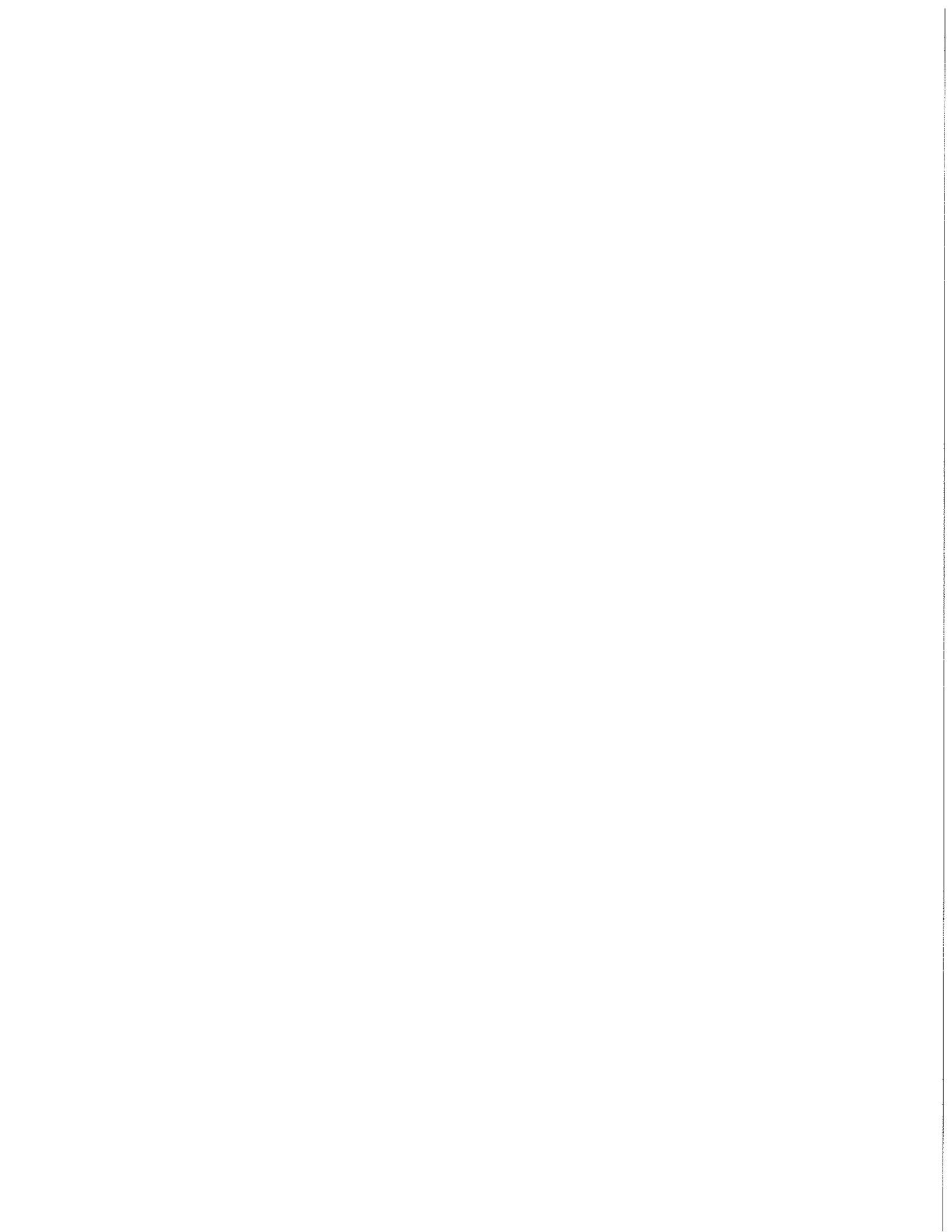




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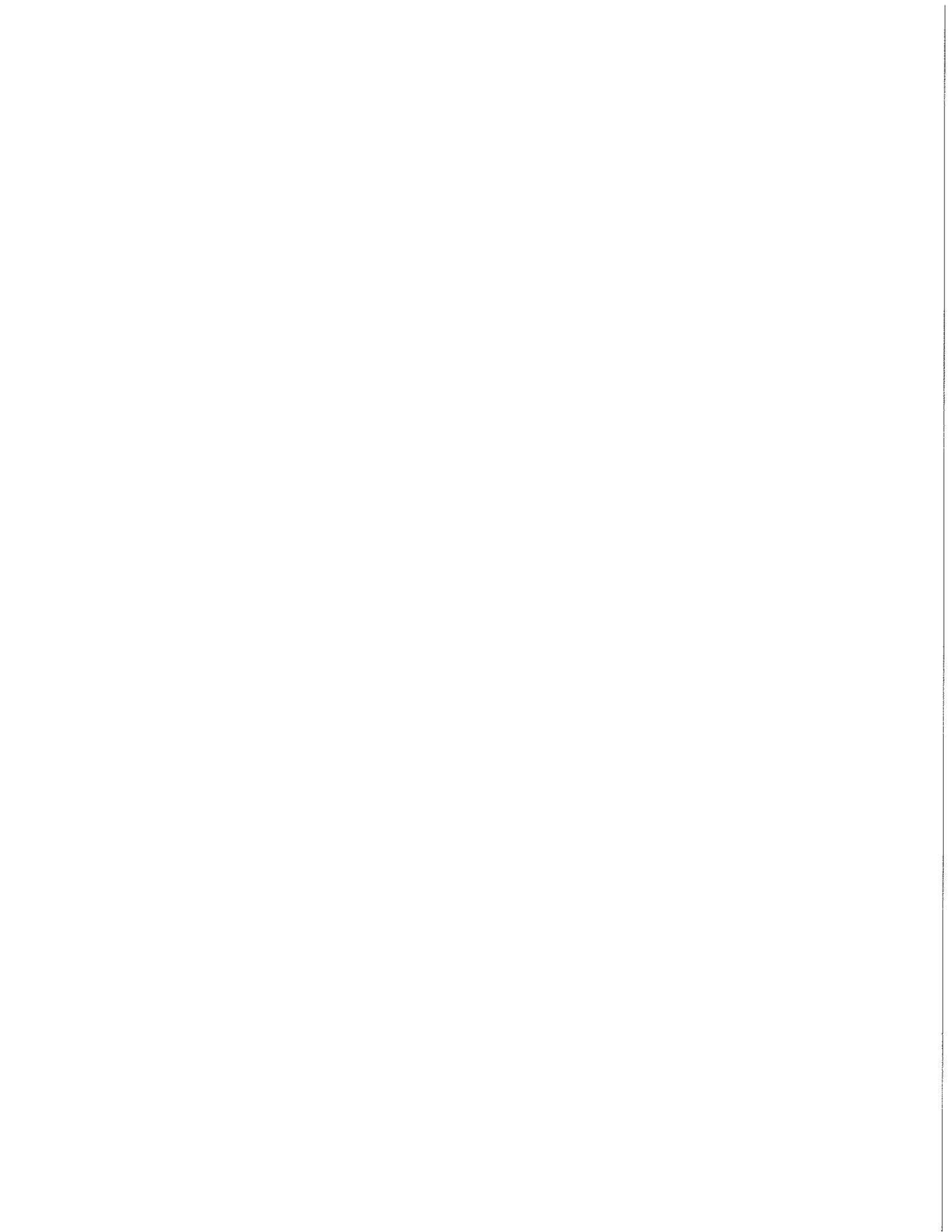
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| W 104   | <p>Continued From page 8</p> <p>civil rights they share with all United States citizens, including the right to be a dignified, self directed existence in a safe and humane environment, free from abuse and neglect."</p> <p>Record review revealed individuals rights policy, dated 10/18/06, noted, "Individuals Residing at GRC Possess the Rights to... Exercise their rights as an individual and as a citizen or resident of the United States... Have a dignified existence with self-determination, making choices about aspects of their lives significant to them... Be free from physical, psychological, sexual or verbal abuse, neglect and exploitation... Be free from unnecessary drugs and restraints... Receive care in a manner maintaining their dignity and respecting their individuality and to be treated with consideration, respect and full recognition of their dignity and individuality..." The policy further directed: "...An individual's rights shall not be limited or abridged without due process under the laws of the State of Iowa or a restrictive intervention program approved under this policy with written consent of the individual or the individual's parent, legal guardian or legal representative..."</p> <p>Record review revealed the human rights policy and procedure; dated 11/25/08, documented: "...Individuals receiving services shall have the same legal and civil rights of all United States citizens, including the right to a dignified, self-directed existence in a safe and humane environment... Individuals shall be acknowledged as having full possession of these rights..." The procedures provided the following guidance for rights restrictions: "...GRC prohibits the intentional violation of an individual's rights without due process, or the failure to report such violation..."</p> | W 104   |   |                      |   |



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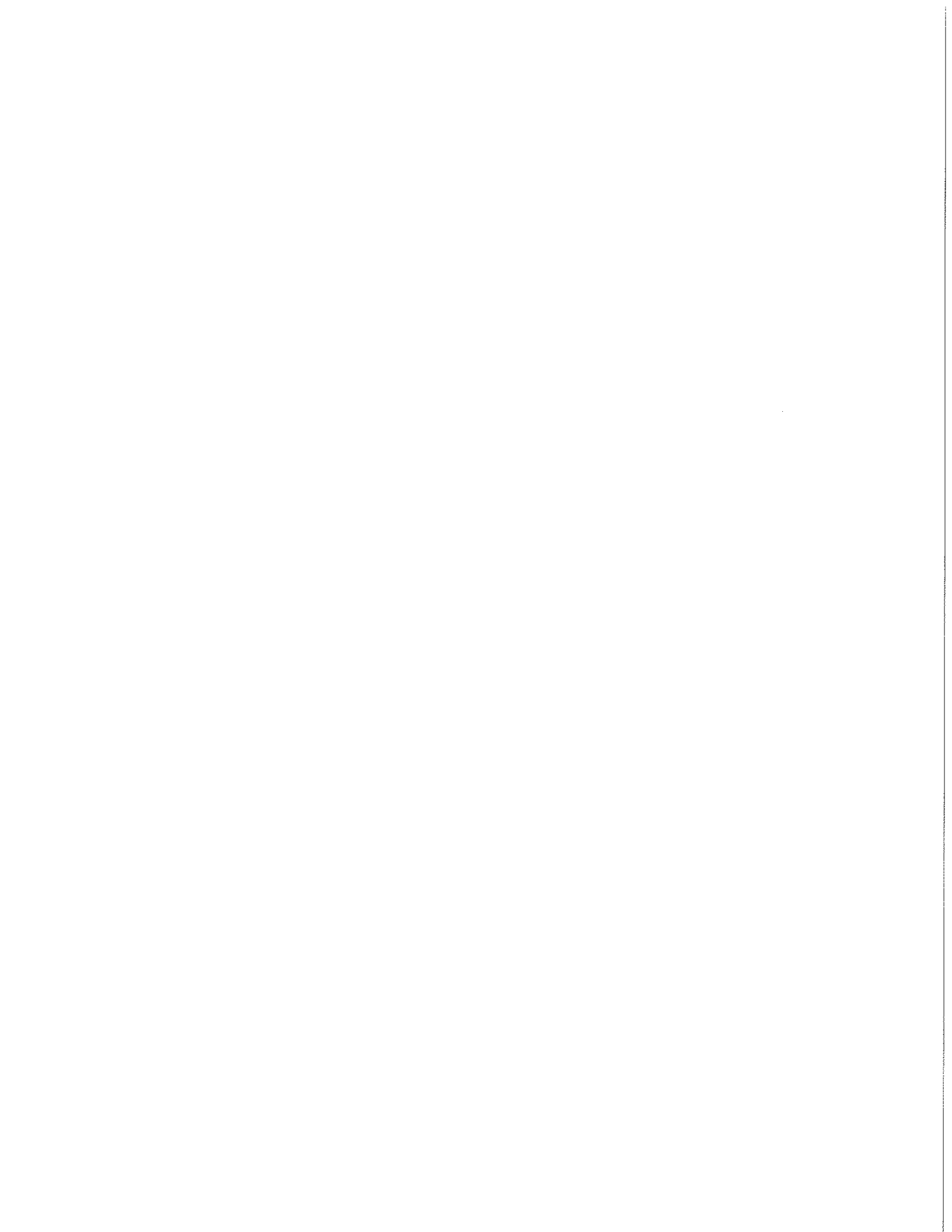
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| W 104  | Continued From page 9<br>All employees shall be responsible for protecting and promoting individual rights and support individuals in exercising their rights independently and, if necessary, with staff assistance... Any employee, volunteer or contractor who has been found to have violated the rights of an individual shall be subject to sanctions up to and including dismissal or termination of contract..." The procedures also provided the following guidance regarding violation reporting and response: "... All employees witnessing or having knowledge of a rights violation are required to report the rights violation orally to their direct line supervisor, unless the allegation involves the supervisor, in which case the report shall be made to the supervisor's supervisor... Retaliation shall not occur for good faith reporting..." | W 104  |   |                      |   |
| W 122  | 483.420 CLIENT PROTECTIONS<br><br>The facility must ensure that specific client protections requirements are met.<br><br>This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to maintain minimum compliance with the Condition of Participation (CoP) Client Protections. Based on interviews and record reviews, the facility failed to ensure clients were free from abuse and mistreatment. Based on interviews and record reviews, facility staff failed to report allegations of abuse and mistreatment of clients immediately. The facility failed to provide adequate supports to ensure consistent implementation of policies and procedures and oversight to ensure an environment conducive to protecting clients from abuse and mistreatment   | W 122  |   |                      |   |



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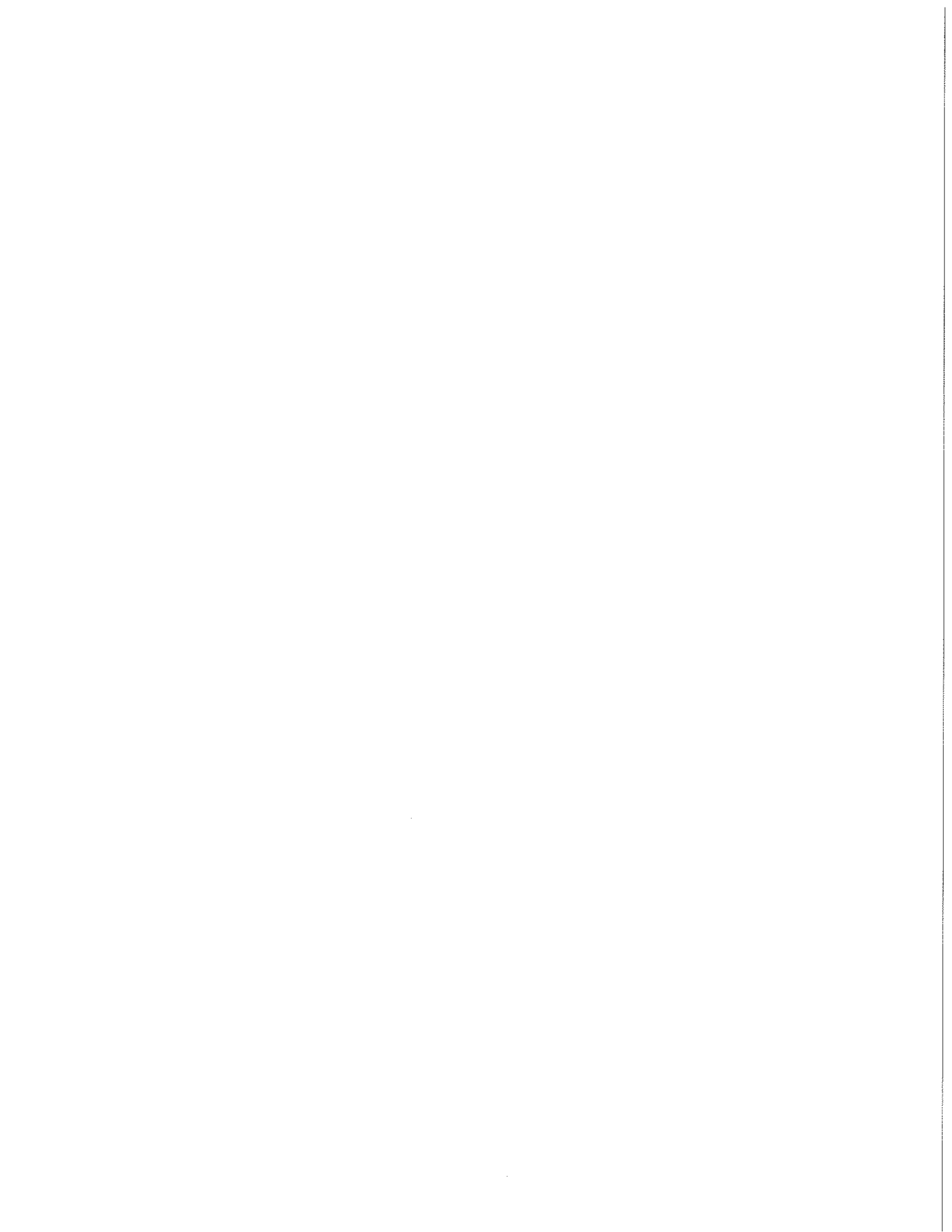
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| W 122   | <p>Continued From page 10 and encourage clients to exercise their human rights. These findings led to a determination of Immediate Jeopardy (IJ).</p> <p>On 11/15/16 at approximately 9:30 a.m. IJ was determined based on the facility's failure to protect clients from abuse and mistreatment. The facility was notified at approximately 10:00 a.m. The facility developed and implemented a plan to remove the IJ. The plan included increased supervision in the homes on evenings and weekends and retraining of staff. The plan also included oversight, follow-up, and observations by Department of Human Services (DHS) Division of Mental Health and Disability Services, to be completed at least twice monthly. The IJ was removed on 12/6/16 at 1:00 p.m.</p> <p>Cross reference W125: Based on interviews and record review, the facility failed to consistently and adequately ensure the individual, civil and human rights of all clients. The facility failed to ensure individuals' right to live in an environment free from abuse and mistreatment. Facility staff failed to encourage client autonomy to make choices and decisions. Facility staff failed to encourage client freedom to move about their environments.</p> <p>Cross reference W127: Based on interview and record review, the facility failed to ensure the development and implementation of adequate systems to identify and prevent abuse and/or mistreatment of clients. The facility failed to proactively assure clients were free from threats to their physical and psychological health.</p> <p>Cross reference W149: Based on interviews and record review, the facility failed to ensure</p> | W 122  |   |   |



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| W 122   | Continued From page 11<br>consistent implementation of facility policy to adequately protect clients from abuse and mistreatment. The facility's structure failed to provide adequate monitoring to prevent client abuse and ensure timely reporting of allegations of client abuse.   | W 122   |   |                      |  |
| W 125   | Cross reference W153: Based on interviews and record review, facility staff failed to immediately report allegations of abuse and mistreatment to the administrator or designee in accordance with facility policy. As a result, allegations of mistreatment and abuse were not reported timely to the Iowa Department of Inspections and Appeals (DIA) in accordance with state law.<br><b>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</b><br><br>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.<br>This STANDARD is not met as evidenced by:<br>Based on interviews and record review, the facility failed to consistently and adequately ensure the individual, civil, and human rights of all clients. The facility failed to ensure individuals' right to live in an environment free from abuse and mistreatment. Facility staff failed to encourage client autonomy to make choices and decisions. Facility staff failed to encourage client freedom to move about their environments. This affected 15 of 28 sample clients (Clients #1, #2, #3, #4, #5, #6, #7, #8 #15, #16, #20, #22, #23, #24, and #25) and potentially affected 227 of 227 clients residing at Glenwood Resource Center | W 125   |   |                      |  |

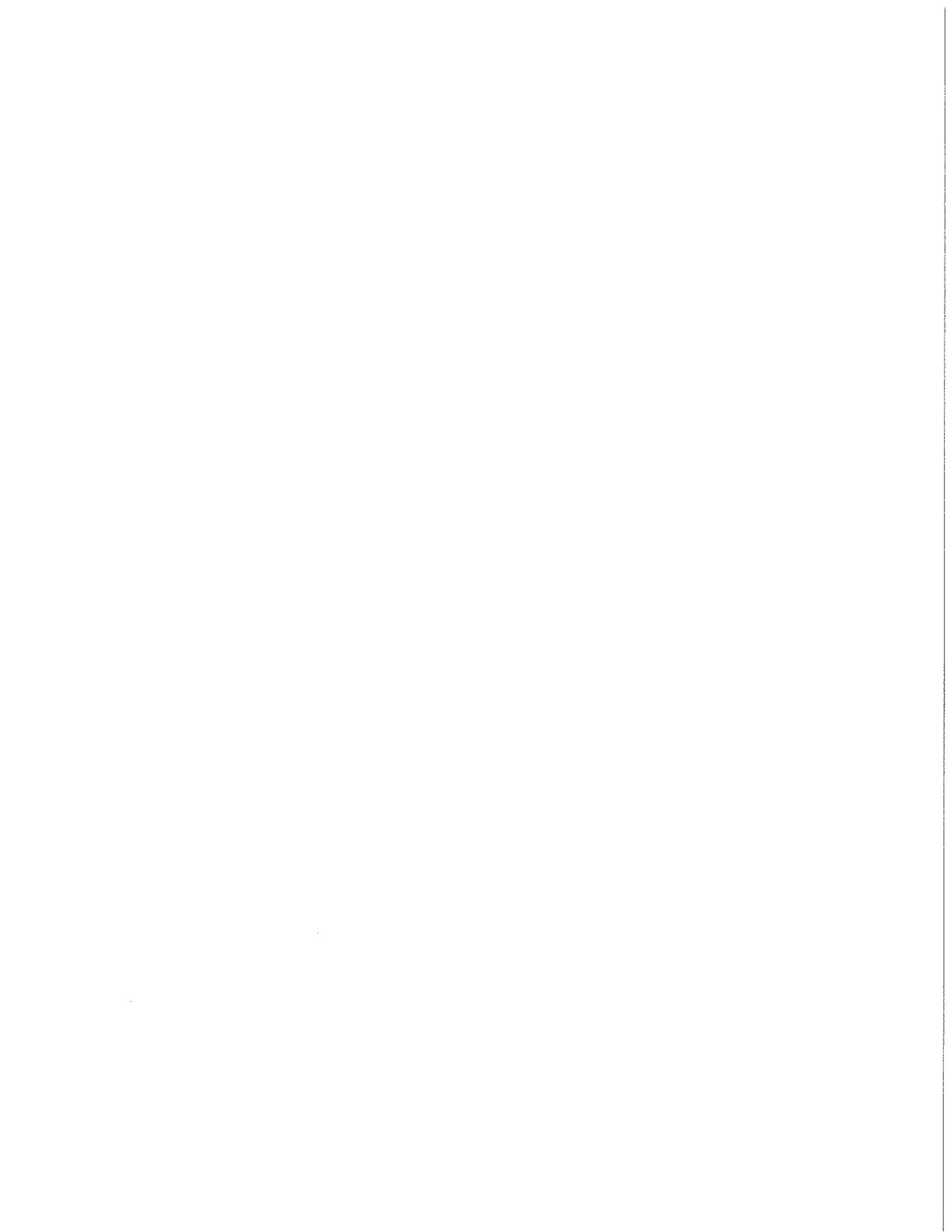




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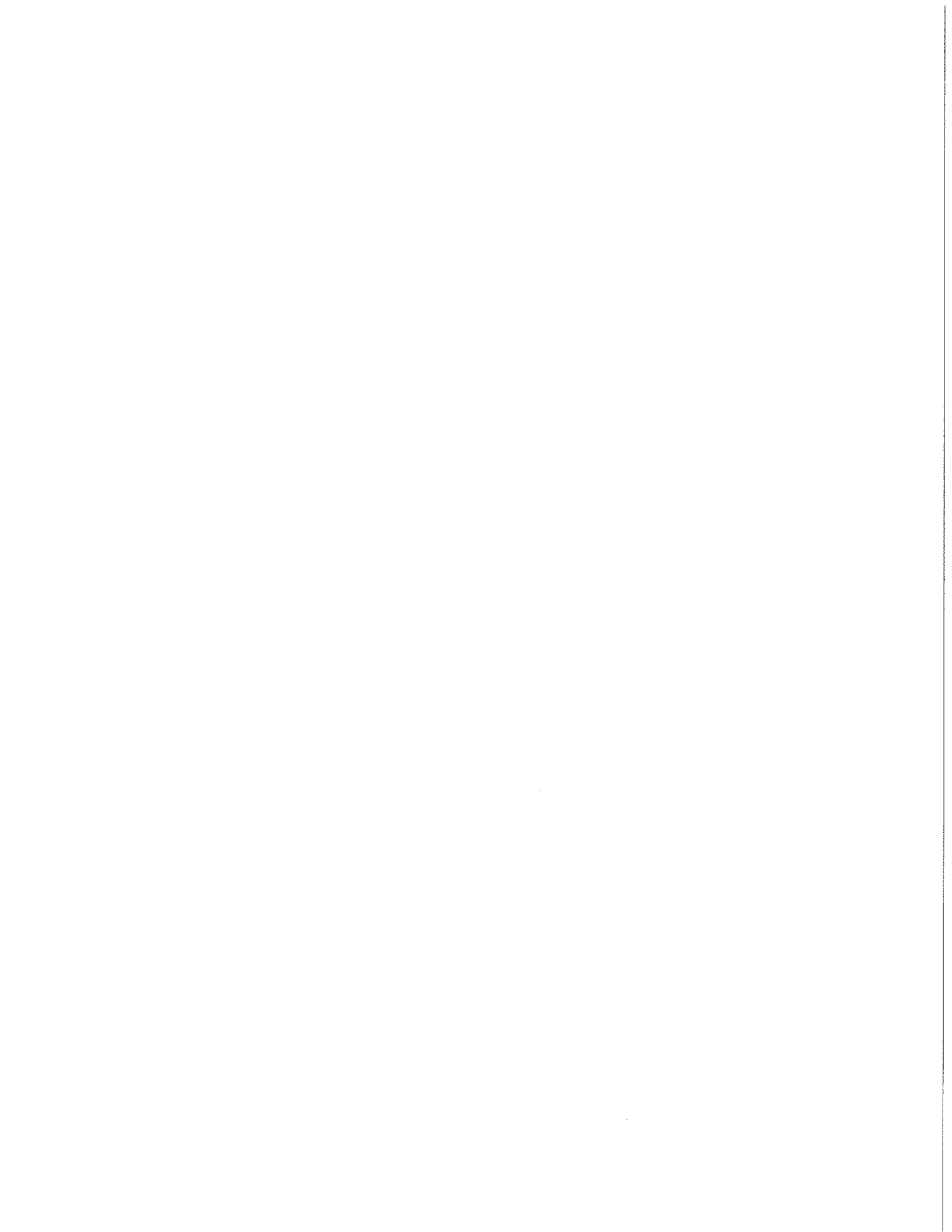
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| W 125   | <p>Continued From page 12 (GRC).</p> <p>Findings follow:</p> <p>Cross Reference: W127, W149, W268</p> <p>1. When interviewed on 11/15/16 at 2:00 p.m. Resident Treatment Worker (RTW) K recalled she worked overtime at House 253 on 11/6/16 from 10:00 a.m. - 2:00 p.m. RTW K reported the following occurred during that time:</p> <p>a. Client #15 stood from the couch, and RTW H hit him/her on the head with a butter knife. Client #15 sat back down on the couch with tears in his/her eyes, held his/her head, curled up in the fetal position, and began rocking.</p> <p>b. Client #16 stood from the couch and was hit on the head with a spoon or butter knife by RTW J. RTW K reported the hit to the head could be heard. Client #16 grabbed his/her head and sat back down.</p> <p>c. Client #15 again stood from the couch, and RTW H hit him/her on the head. Client #16 stood and was also hit on the head, though RTW K could not see who hit Client #16. RTW K reported she saw Client #15 being hit, heard both clients being hit, and heard their reactions. She reported both clients held their heads, rocked, and cowered.</p> <p>d. RTW J asked Client #20 if RTW U liked to engage in oral sex or anal intercourse with other men. Client #20 refused to answer the question. RTW J stood closer to Client #20 and RTW U stood directly behind the client, where he could not be seen. RTW J, again, asked Client #20 if</p> | W 125   |   |                      |   |



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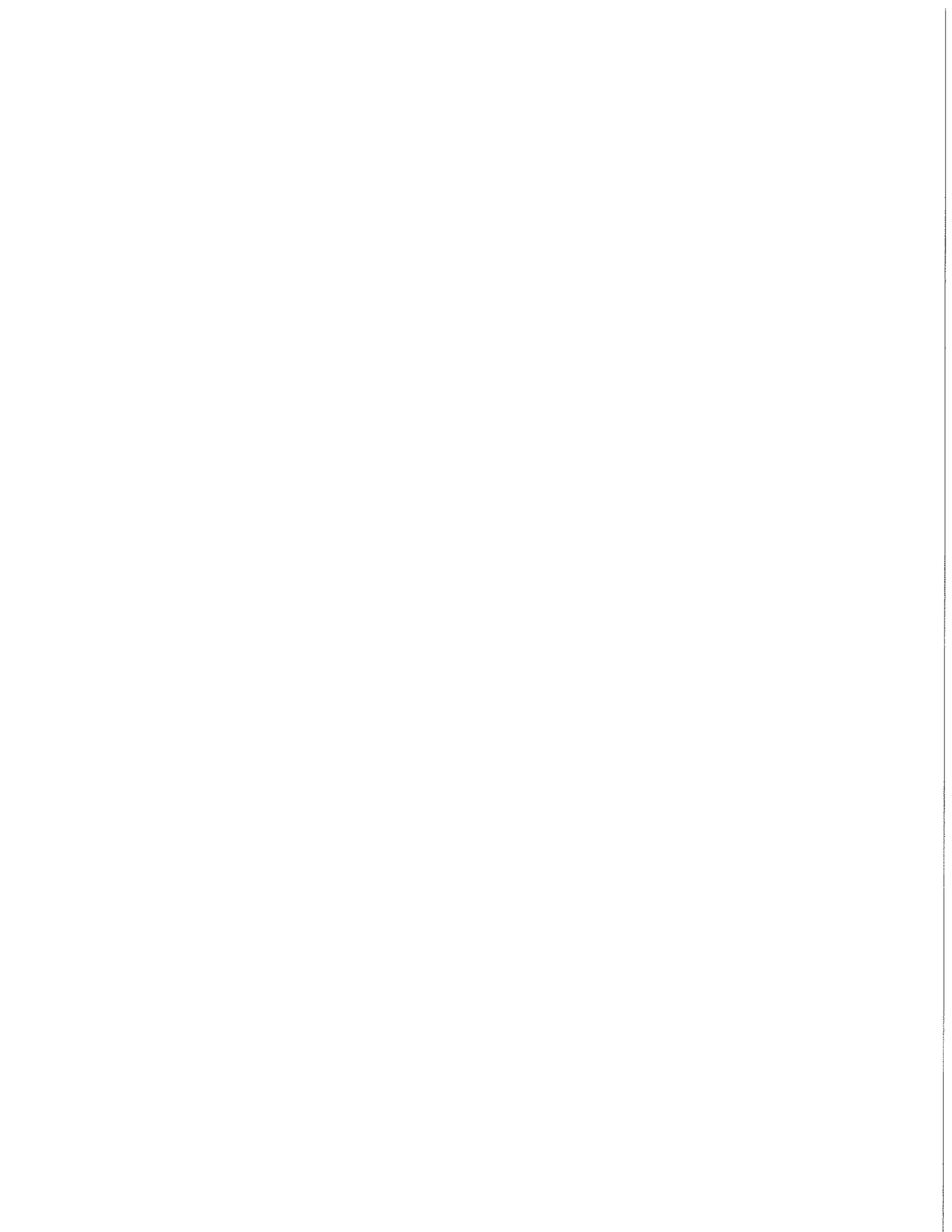
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| W 125   | <p>Continued From page 13</p> <p>RTW U liked to engage in oral sex or anal intercourse with other men. Client #20 continued to refuse, and RTW J continued to tell him/her to answer. Client #20 shook his/her head no, became very upset, and began to cry as staff continued to pressure him/her to answer the question about RTW U.</p> <p>e. Client #20 refused to put his/her clothing protector on. RTW U told the client he/she needed to put it on, and the client continued to refuse. RTW U told Client #20 he/she could not eat if he/she did not put the clothing protector on. Client #20, again, refused and RTW U said, "You better do it." Client #20 put the clothing protector on.</p> <p>2. When interviewed on 11/21/16 at 5 p.m. RTW L stated on 11/10/16 she was pulled to work at House 253 from 2:00 p.m. - 6:00 p.m. RTW L recalled the following occurred during that time:</p> <p>a. RTW M hit Client #15 on the head with a butter knife while RTW H held him/her down on the couch.</p> <p>During the interview, RTW L shared a video clearly showing RTW M striking Client #15 on the head with an object and saying, "Are we good?" The video also clearly showed RTW H holding Client #15 by the neck on the couch to prevent the client from getting up while RTW M hit him/her.</p> <p>b. RTW J grabbed Client #23 by the neck, pushed the client's face into the counter, and held the client there for approximately 30 seconds. RTW J then commented to the client, "I told you to stay out of there." This occurred because</p> | W 125   |   |                      |   |



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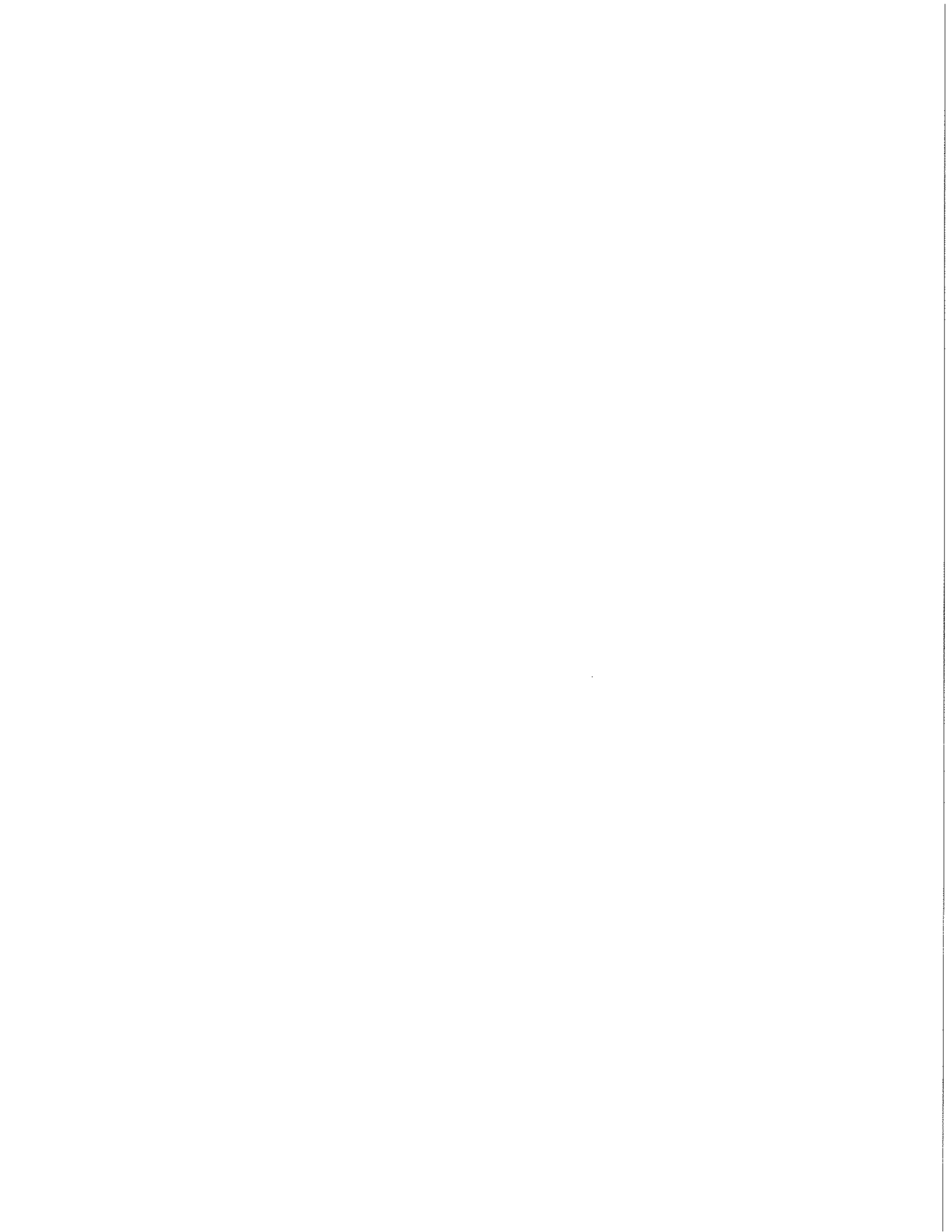
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| W 125  | <p>Continued From page 14</p> <p>Client #23 reached into the cupboard to get a bag of chips.</p> <p>c. Client #15 rocked in a recliner and refused to stop when redirected. RTW H walked across the room, grabbed Client #15 by his/her legs, and pulled him/her from the recliner to the floor. RTW H told Client #15 he/she would have to sit on the floor if he/she didn't stop. RTW H left the immediate area and returned to the client for whom he had accountability. RTW L stated a few minutes later Client #15 began to rock in the recliner again. RTW H came across the room, stood behind Client #15, and hit him/her in the back of the head with his fist three times.</p> <p>3. When interviewed on 11/28/16 at 11:00 a.m. RTW N stated on 11/6/16 he witnessed RTW I use a butter knife to hit Client #15 and Client #16 while working at House 253. RTW N further stated when she hit the clients with a butter knife she would say, "Knock it off!"</p> <p>4. When interviewed on 11/22/16 at 3:15 p.m. Client #17 stated he/she witnessed RTW I use a butter knife to hit Client #15. He/she stated she used the butter knife to calm Client #15 down. Client #17 stated RTW I would say, "Are we Done?" Client #17 reported he/she witnessed this multiple times.</p> <p>5. Record review revealed Type 1 Incident Investigation Report, dated 9/26/16. The report documented multiple scratches, scrapes, and bruises to Client #1's neck, back, and shoulders. When asked what happened, Client #1 stated, "The PM's held me down and shot me."</p> <p>During interview on 11/21/16 at 1:13 p.m. RTW B</p> | W 125  |   |   |



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| W 125   | <p>Continued From page 15</p> <p>reported on 9/23/16 he assisted Client #1 with cleaning the bathroom. Client #1 yelled and threw the mop bucket. According to RTW B, RTW A walked into the bathroom and grabbed Client #1 by the arms. RTW A told Client #1 the other clients were sleeping. At that point, RTW B reported he left the bathroom because he did not want to be around the interaction. RTW B heard Client #1 yell, but Client #1 often yelled when asked to mop. RTW B stated after RTW A left he went back into the bathroom and Client #1 mopped.</p> <p>6. Record review revealed Client #3's Incident Report, dated 8/22/16, documented while Client #3 sat in the day room another peer hit him/her in the face and his/her eyes were reddened.</p> <p>Further record review revealed facility Type 1 Incident Investigation Report, dated 10/13/16, indicated, "On 10/13/16 at 5:00 PM QM (Quality Management) (Department) was informed of new information that indicates an incident report filed for the client on 8/22/16 at 9:15 PM by (RTW C) was not factual and that the injury noted to the client's eye which was attributed to a peer to peer aggression incident, was instead the result of staff actions which resulted in an injury."</p> <p>When interviewed on 11/17/16 at 2:27 p.m. Former RTW (FRTW) A reported the evening prior to his resignation, RTW A sat in the day room with a client who required one-on-one supervision. According to FRTW A, he heard what sounded like wrestling in the dining room. FRTW A described chairs being moved and Client #3 repeatedly saying, "Stop! Leave me alone." When the wrestling stopped, FRTW A heard Client #3 say, "Why did you do that? Look</p> | W 125   |   |   |

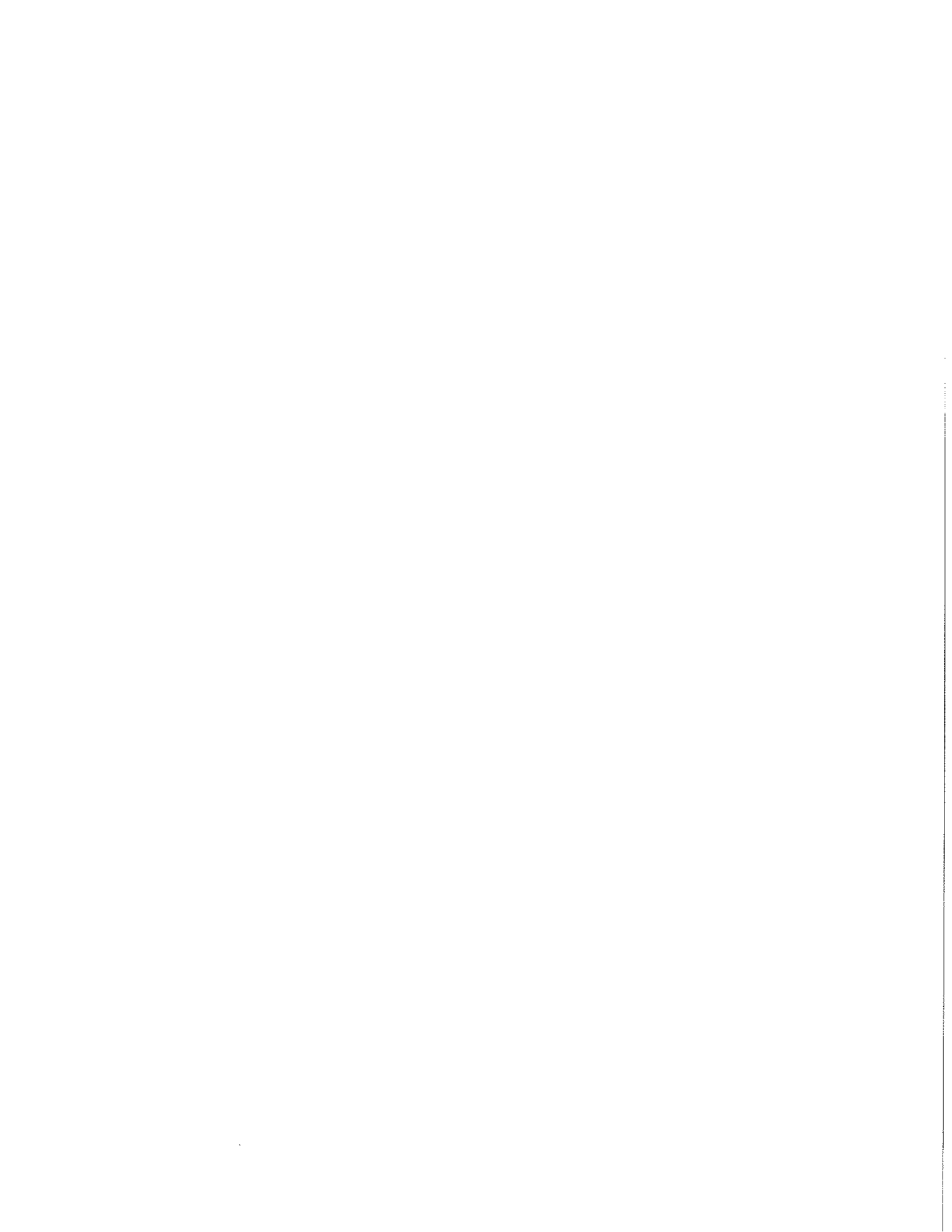




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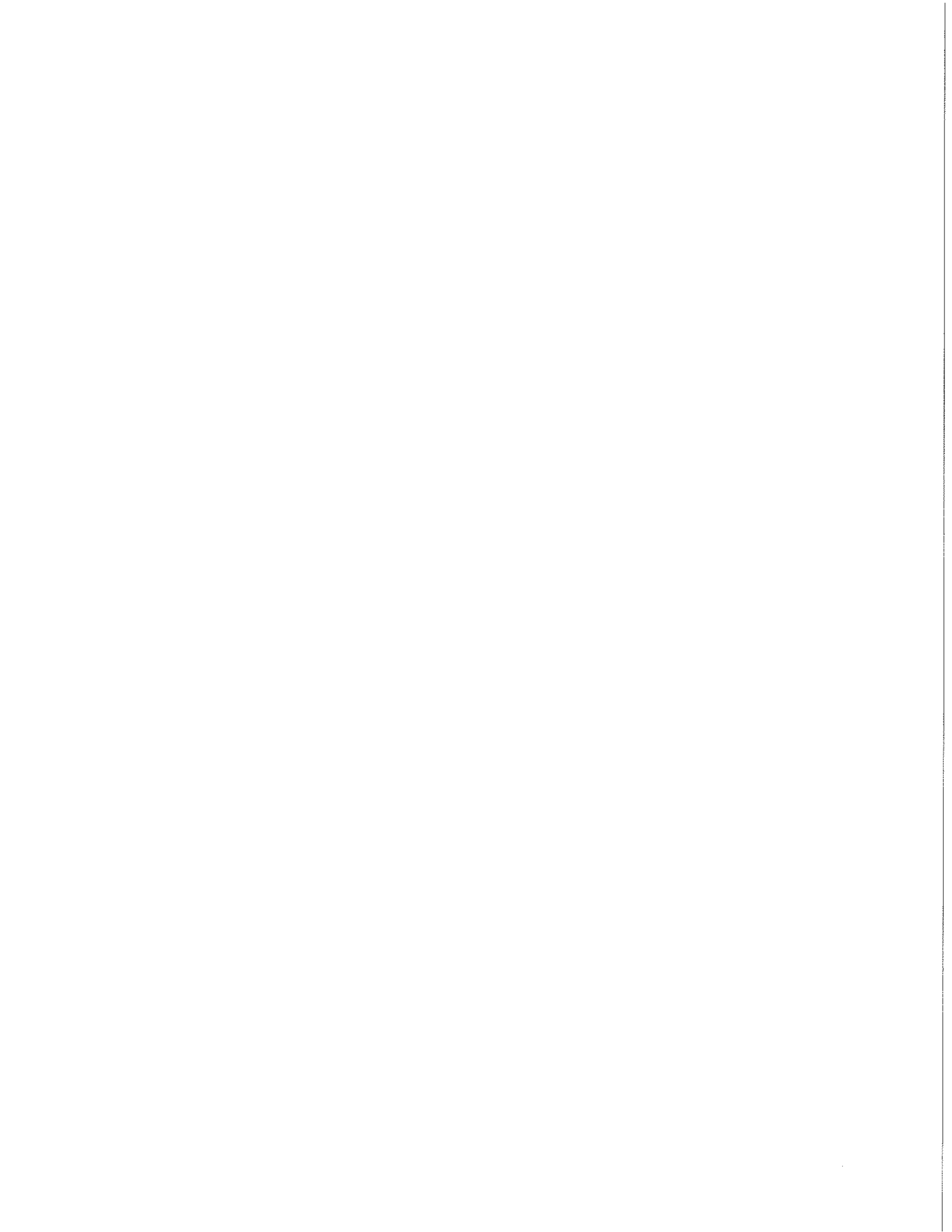
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| W 125  | <p>Continued From page 16</p> <p>at my arm!" FRTW A stated two or three staff discussed the incident in the dining room. According to FRTW A, the staff discussed their alibis and falsified the incident.</p> <p>When interviewed on 11/15/16 at 3:30 p.m. Client #3 reported RTW C and RTW D picked on clients. He/she stated they nitpicked and told them they could not have any snacks. According to Client #3, RTW C and RTW D swore at the clients until they got worked up. Client #3 stated after the clients were worked up, RTW C and RTW D told them they could not go on an outing because they were on restrictions. Client #3 reported when he/she got a pop out of the cupboard, RTW C said, "What are you doing you f***ing retard?" Client #3 stated RTW D walked in and said the same thing.</p> <p>7. Record review revealed Facility Type 1 Incident Investigation Report, dated 8/16/16. "(Client #6) and another peer were involved in (a) physical altercation that resulted in (Client #6) being scratched on (his/her) chin. (His/her) ears were scratched. (He/she) also had some redness on his cheek. (Client #6) and (his/her) peer fought until they were separated by staff." Through the course of another investigation an allegation was made against RTW D.</p> <p>During facility interview on 10/10/16 at 3:19 p.m., Client #6 reported "...he/she threw two balls at (Client #4) one a small orange ball and then the other a squishy sensory ball. At first (Client #6) reported (he/she) decided to throw the balls on (his/her) own. Then (Client #6) stated (RTW D) told (him/her) to throw a ball at (Client #4). (Client #6) reported (he/she) decided to throw the first ball the orange one. Then (RTW D) told</p> | W 125  |   |                      |   |



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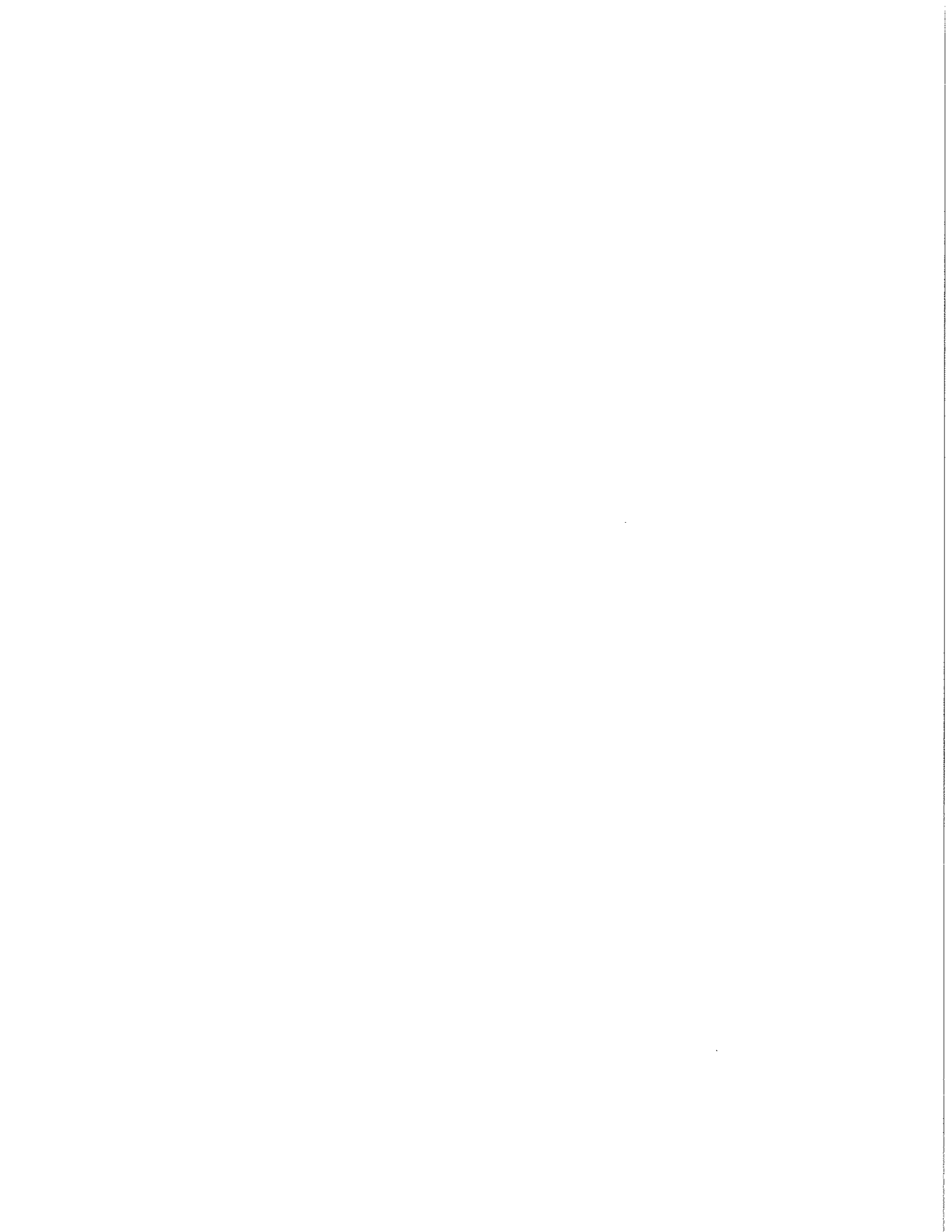
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| W 125   | <p>Continued From page 17</p> <p>(him/her) to throw the second ball at (Client #4). (Client #6) asked (RTW D) if (he/she) throws the ball at (Client #4) will (he/she) get marked on (his/her) data and (RTW D) explained no... (Client #6) said (RTW D) told (him/her) to throw the ball at (Client #6) to teach (him/her) a lesson not to tease the other 248 individuals."</p> <p>When interviewed on 12/6/16 at 4:28 p.m. Client #4 reported listening to music and RTW D told Client #8 and Client #6 to throw things at him/her.</p> <p>8. Record review revealed Facility Type 1 Incident Investigation Report, dated 9/26/16. The report indicated, "(Client #5) reported to me at the cafeteria that staff members tease (Client #1). (He/she) said that when (he/she) is screaming and yelling they don't stop. (He/she) said they threaten to take (his/her) CD's and also hide them from (him/her) when (he/she) is upset. (Client #8) heard (Client #5) telling me and (he/she) said that PM's do mess with (him/her). (Client #5) said it's (RTW A, RTW B, and RTW D). (Client #8) said that it's (RTW A and RTW D). (RTW D) not (RTW B)." The facility determined the allegation to be substantiated.</p> <p>When interviewed on 11/15/16 at 4:15 p.m. Client #5 reported he/she witnessed RTW D's issues with Client #1. Client #5 stated RTW D provoked Client #1 to have issues more than RTW A and RTW B. Client #5 woke up one day because of Client #1 yelling. Client #5 stood in his/her doorway and watched RTW D provoke Client #1 and saw Client #1 throw things. According to Client #5, RTW D put Client #1 into a restraint. Client #5 stated the Resident Treatment Supervisor (RTS) and the Treatment Program Manager (TPM) were not there. Client #5</p> | W 125   |   |                      |   |



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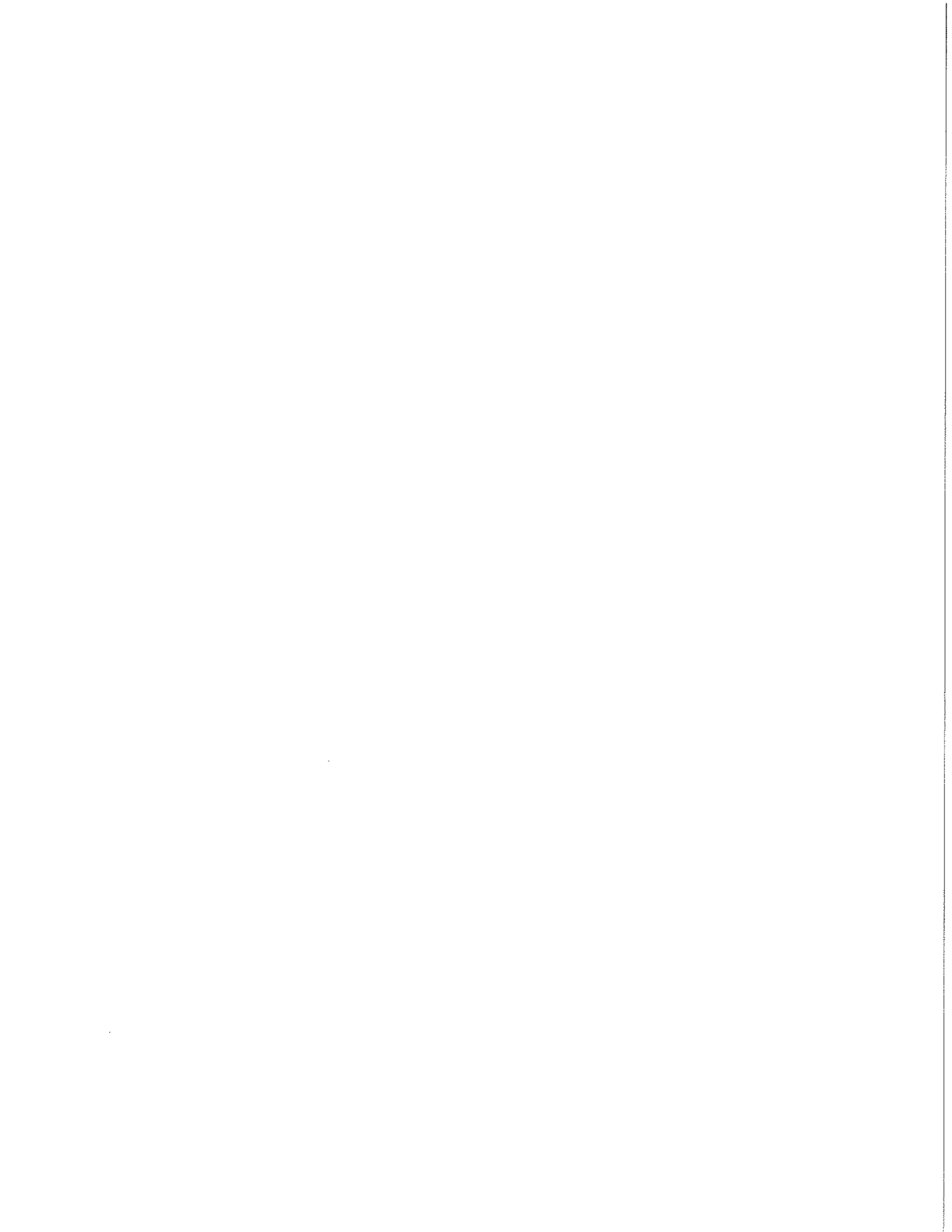
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>16G003 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>C<br>01/10/2017 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GLENWOOD RESOURCE CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>711 SOUTH VINE STREET<br>GLENWOOD, IA 51534                            |   |
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| W 125  | <p>Continued From page 18</p> <p>reported RTW A and RTW B joked around, but they were not the main aggressors towards Client #1. RTW D messed with certain clients once the RTS and TPM left. Client #4 stated RTW D also messed with Client #3. Client #3 asked RTW D to stop, but RTW D thought it was funny. Client #5 reported RTW A and RTW B messed with clients sometimes, but not to get someone to "blow." When clients told RTW A and RTW B to stop, they would stop, but RTW D went on and on.</p> <p>When interviewed on 11/15/16 at 3:30 p.m. Client #3 reported RTW C and RTW D picked on clients. He/she stated they nitpicked and told the clients they could not have any snacks. According to Client #3, RTW C and RTW D swore at the clients until they got worked up. Client #3 stated after the clients became worked up, RTW C and RTW D told them they could not go on an outing because they were on restrictions. Client #3 reported RTW C and RTW D picked on Client #1 a lot.</p> <p>When interviewed on 11/15/16 at 3:40 p.m. Client #7 reported morning shifts were fine, but evening shifts were "chaos." Client #7 stated RTW A threatened and swore at clients. Client #7 also stated RTW A and RTW D teased Client #1. RTW D told Client #1, "Look, look (Client #8) has your 80's CD.," when RTW D had the CD. According to Client #7, RTW D tried to make Client #1 "blow." Client #1 tipped furniture and RTW D ran into Client #1's bedroom and hid the CD. Client #1 asked where the CD was and RTW D said he did not know. Client #7 stated Client #1 became upset, then RTW D gave Client #1 his/her CD back. RTW A came in laughing and Client #1 got mad and broke things. Client</p> | W 125  |   |   |



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| W 125   | <p>Continued From page 19</p> <p>#7 reported staff egged Client #1 on and on and Client #1 threw things at staff. He/she threw the laundry hamper and broke it. RTW A got physical with Client #1 and hurt him/her; described as staff used a pressure point on the neck to make Client #1 stop. Client #7 explained RTW D observed this and did something, but Client #7 could not remember what. Client #7 stated they mostly picked on other clients. Client #7 reported they used profanity and told sexually inappropriate jokes. Client #7 explained RTW A used the "F word" and the "B word" when Client #7 is around, and RTW D talked about sexually inappropriate things, such as women's vaginas. Client #7 believed he/she reported it to investigations. Client #7 did not want the RTWs to return to work because he/she did not like them getting clients upset.</p> <p>9. Record review revealed the following:</p> <p>a. FRTW A's Exit Information Questionnaire, dated 9/22/16, noted, "...Resident's various diagnoses and histories were discussed in front of other residents and non-involved staff..."</p> <p>b. Facility Type 1 Incident Investigation Report, dated 10/17/16. The report indicated, "On 10/17/16 an incident was reported to QM indicating that new information had been received that alleges (Client #2) was present when (RTW A) made remarks in front of the client related to the client's diagnosis, stating, "This is (Client #2), (he/she) is schizophrenic, how are those voices, (Client #2)?" The alleged date of the incident was 8/19/16 on PM shift but it has yet to be confirmed. Other persons were alleged to have been present at the time of the incident."</p> | W 125   |   |                      |   |

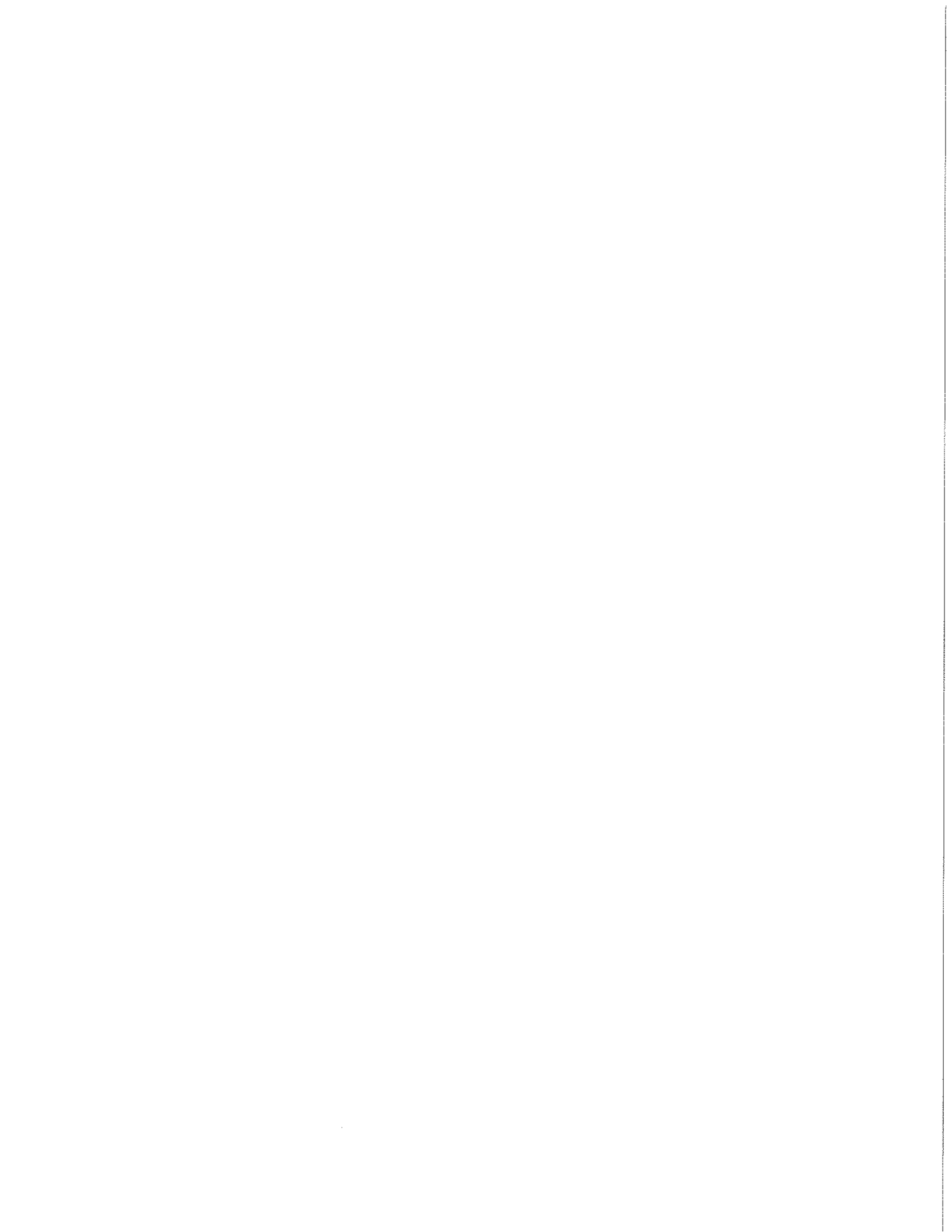




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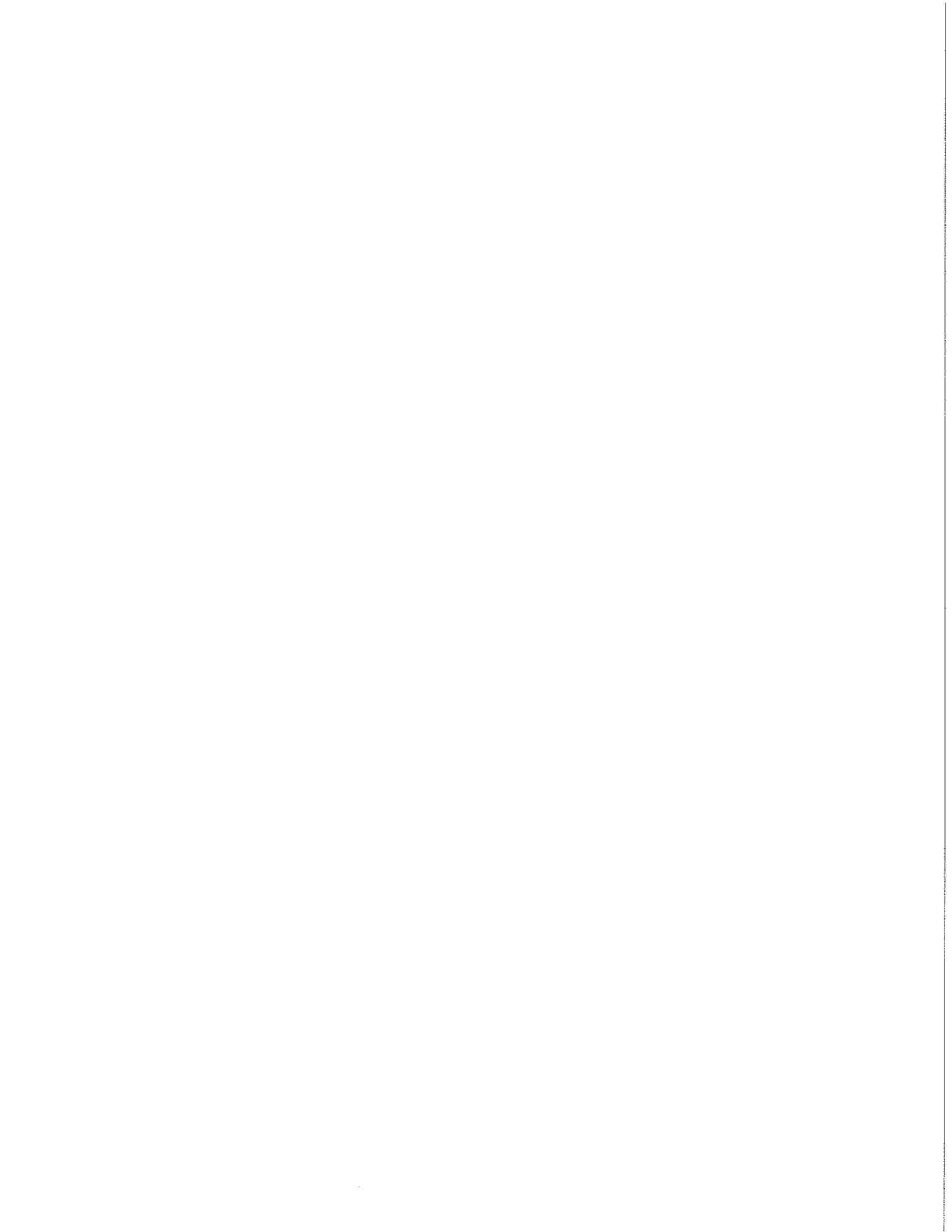
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| W 125  | <p>Continued From page 20</p> <p>When interviewed on 11/17/16 at 2:27 p.m. FRTW A reported RTW A gave him a rundown of everyone in the house. RTW A talked about their problems in the living room with other people around. According to FRTW A, RTW A did not follow the Health Insurance Portability and Accountability Act of 1996 (HIPAA). FRTW A recalled Client #2 diagnosed with schizophrenia and Client #2 was asked if he/she heard voices. FRTW A stated staff jokingly talked to Client #2 about voices and Client #2 would shut down and go back to his/her bedroom.</p> <p>10. When interviewed on 11/14/16 at 4:40 p.m. RTW Y recalled an incident occurred at House 470 on p.m. shift. RTW Y stated RTW Z made a special snack, cake with whipped cream. When Client #22 went to the kitchen to get cake, RTW Z "airplaned" a spoon with whipped cream toward Client #22, acting like he was going to put it in his/her mouth. Instead, RTW Z smeared the whipped cream on Client #22's face. The client became upset, and yelled at RTW Z. RTW Z told Client #22 he/she needed to apologize before he/she got cake. Client #22 refused to apologize to RTW Z, put his/her dishes away, and went to bed. RTW Y stated Client #22 did not get snack that night. She stated she reported the incident to her supervisor about a week later.</p> <p>11. Record review on 11/14/16 revealed the facility's Type 1 investigation report, completed 11/1/16. The report described on 10/25/16 a community member reported to GRC that they witnessed a GRC staff member strike a client in the back of the head while outside the van in the parking lot of the Dollar General Store after the client picked something up from the ground and put it in his/her mouth. The facility identified the</p> | W 125  |   |   |



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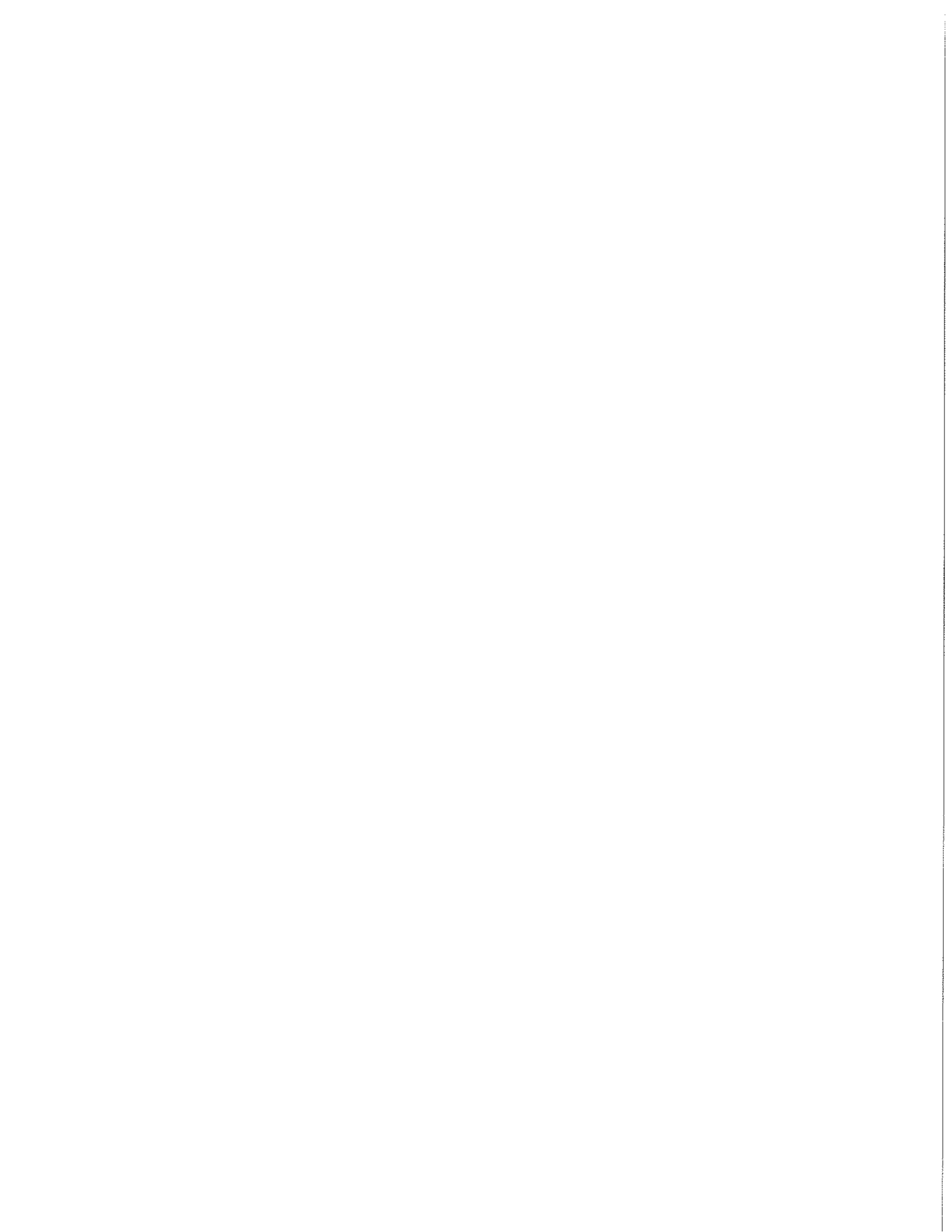
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| W 125   | <p>Continued From page 21 client to be Client #24.</p> <p>When interviewed on 11/18/16 at 8:37 a.m., Community Member A reported she observed five GRC clients and three GRC staff in the Dollar General Store. She saw RTW AA leave the store with most of the clients. She reported she left the store right after RTW AA and the clients and witnessed RTW AA hit the back of a client's head. She believed the client picked something up from the ground and put it in his/her mouth prior.</p> <p>When interviewed on 11/18/16 at 3:40 p.m., Community Member B reported she witnessed a GRC staff come out of the Dollar General Store with approximately 4 clients. One of the clients picked something up off of the ground and put it in his/her mouth. One of the staff then tried to get something out of the client's mouth. She reported the staff grabbed the client by the shirt hard, and pulled him/her toward her. Staff then smacked the client on the back of the head.</p> <p>When interviewed on 11/18/16 at 3:50 p.m., Community Member C reported he witnessed a staff member grab the shirt of a client and hit the client in the back of the head. He reported the staff hit the client because he/she put something in his/her mouth.</p> <p>12. When interviewed on 11/2/16 at 12:58 p.m. Food and Nutrition Services (FNS) Worker A reported she previously worked as a RTW. FNS Worker A recalled on 8/6/16 and 8/7/16 RTW CC and RTW DD split responsibility of Client #25. RTW CC took the first part of the shift and RTW DD took the second part of the shift. According to FNS Worker A, on both days RTW CC sat knee to knee to Client #25 and pushed him/her</p> | W 125   |   |                      |   |



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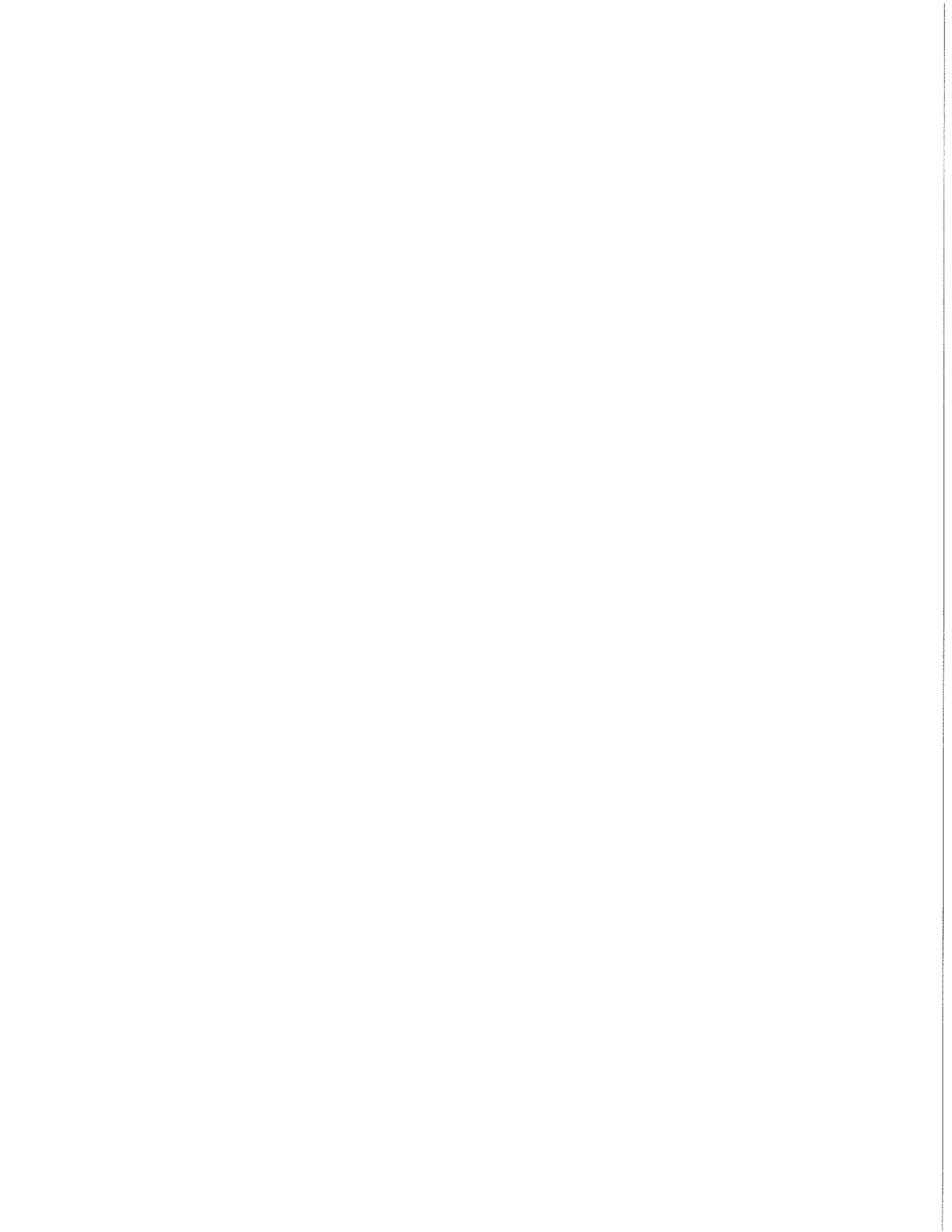
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| W 125   | <p>Continued From page 22</p> <p>down when he/she tried to get up. RTW CC walked Client #25 a few times, but complained about him/her. FNS Worker A reported RTW DD also sat in front of Client #25, on an office chair, and restricted him/her from getting up. FNS Worker A witnessed Client #25 push RTW CC and RTW DD away while she walked through the living room. FNS Worker A recalled RTW CC and RTW DD pushed Client #25 at his/her gait belt area or grabbed onto Client #25's gait belt and pulled him/her down to a sitting position. At times, RTW DD sat with her back towards Client #25. On one of the two nights, FNS Worker A assisted another client down the hall when she heard RTW DD raise her voice and say, "Don't touch me you perv." According to FNS Worker A, RTW DD was on the phone and Client #25 pulled her hair. FNS Worker A stated she also heard Client #25 grunting and trying to get up. FNS Worker A told a nurse, RTW CC and RTW DD would not let Client #25 get up, but the nurse instructed FNS Worker A Client #25 needed to sit when he/she received his/her medications. FNS Worker A also reported RTW CC or RTW DD were doing Snapchat, took pictures of Client #25 and called him/her a name. FNS Worker A voiced her concern when the overnight staff arrived, but RTW CC and RTW DD stated Client #25 had trouble walking throughout the shift. According to FNS Worker A, Client #25 should be walked whenever he/she attempted to get up, unless he/she received medication. FNS Worker A stated Client #25 should walk the hallway 25 times a shift.</p> <p>Record review on 11/3/16 revealed the following:</p> <p>a. Client #25's Individual Support Plan, dated 1/12/16, indicated Client #25 must "be able to</p> | W 125   |   |                      |   |



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| W 125   | <p>Continued From page 23<br/>walk around the house as much as (he/she) wants."</p> <p>b. Client #25's Mobility Program indicated "(Client #25)will ambulate for 25 minutes on the AM shift and 25 minutes on the PM shift..." Justification for Client #25's program included, "Maintaining (Client #25's) ability to walk will help to maintain (his/her) independence while promoting musculoskeletal, cardiovascular, gastrointestinal, and pulmonary health. (Client #25) is considered overweight and oftentimes needs much encouragement to be active and maintain positive health. This skill will promote a healthy, active lifestyle allowing for maintenance of functional mobility skills and independence with ADL's leading to improved transition into the community."</p> <p>When interviewed on 11/2/16 at 3:14 p.m. RTS D confirmed staff failed to follow Client #25's plan. RTS D stated staff should not restrict Client #25 from getting up to walk. She stated she believed FNS Worker A because she recently had to talk to RTW CC about her work performance.</p> <p>Record review revealed the facility's incident management policy, dated 11/2/07, provided the following personnel practice: "Individuals shall be encouraged and educated to assert the legal and civil rights they share with all United States citizens, including the right to be a dignified, self directed existence in a safe and humane environment, free from abuse and neglect."</p> <p>Record review revealed individuals rights policy, dated 10/18/06, noted, "Individuals Residing at GRC Possess the Rights to... Exercise their rights as an individual and as a citizen or resident</p> | W 125   |   |                      |   |

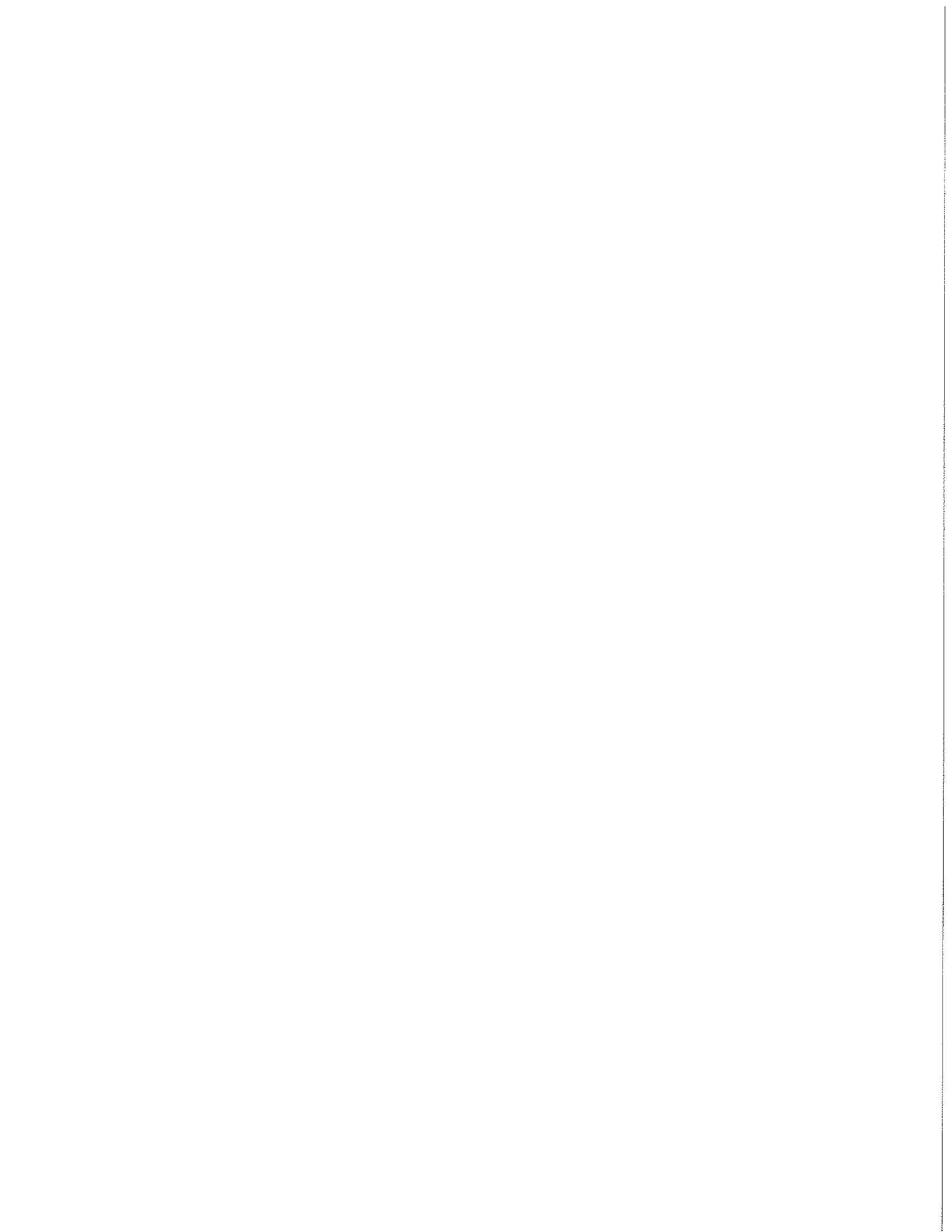




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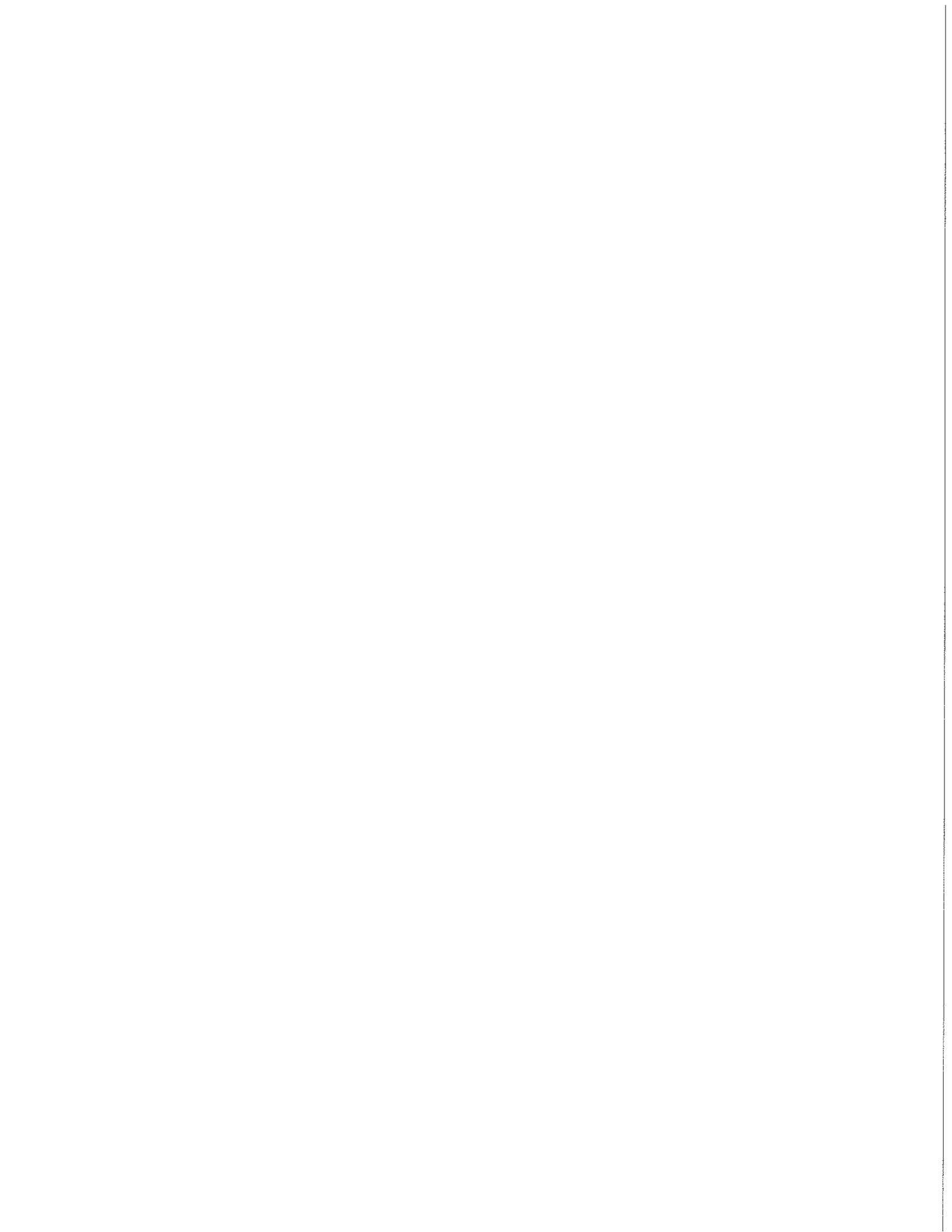
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| W 125   | <p>Continued From page 24</p> <p>of the United States... Have a dignified existence with self-determination, making choices about aspects of their lives significant to them... Be free from physical, psychological, sexual or verbal abuse, neglect and exploitation... Be free from unnecessary drugs and restraints... Receive care in a manner maintaining their dignity and respecting their individuality and to be treated with consideration, respect and full recognition of their dignity and individuality..." The policy further directed: "...An individual's rights shall not be limited or abridged without due process under the laws of the State of Iowa or a restrictive intervention program approved under this policy with written consent of the individual or the individual's parent, legal guardian or legal representative..."</p> <p>Record review revealed the human rights policy and procedure, dated 11/25/08, documented: "...Individuals receiving services shall have the same legal and civil rights of all United States citizens, including the right to a dignified, self-directed existence in a safe and humane environment... Individuals shall be acknowledged as having full possession of these rights..." The procedures provided the following guidance for rights restrictions: "...GRC prohibits the intentional violation of an individual's rights without due process, or the failure to report such violation... All employees shall be responsible for protecting and promoting individual rights and support individuals in exercising their rights independently and, if necessary, with staff assistance... Any employee, volunteer or contractor who has been found to have violated the rights of an individual shall be subject to sanctions up to and including dismissal or termination of contract..." The procedures also provided the following guidance</p> | W 125  |   |   |



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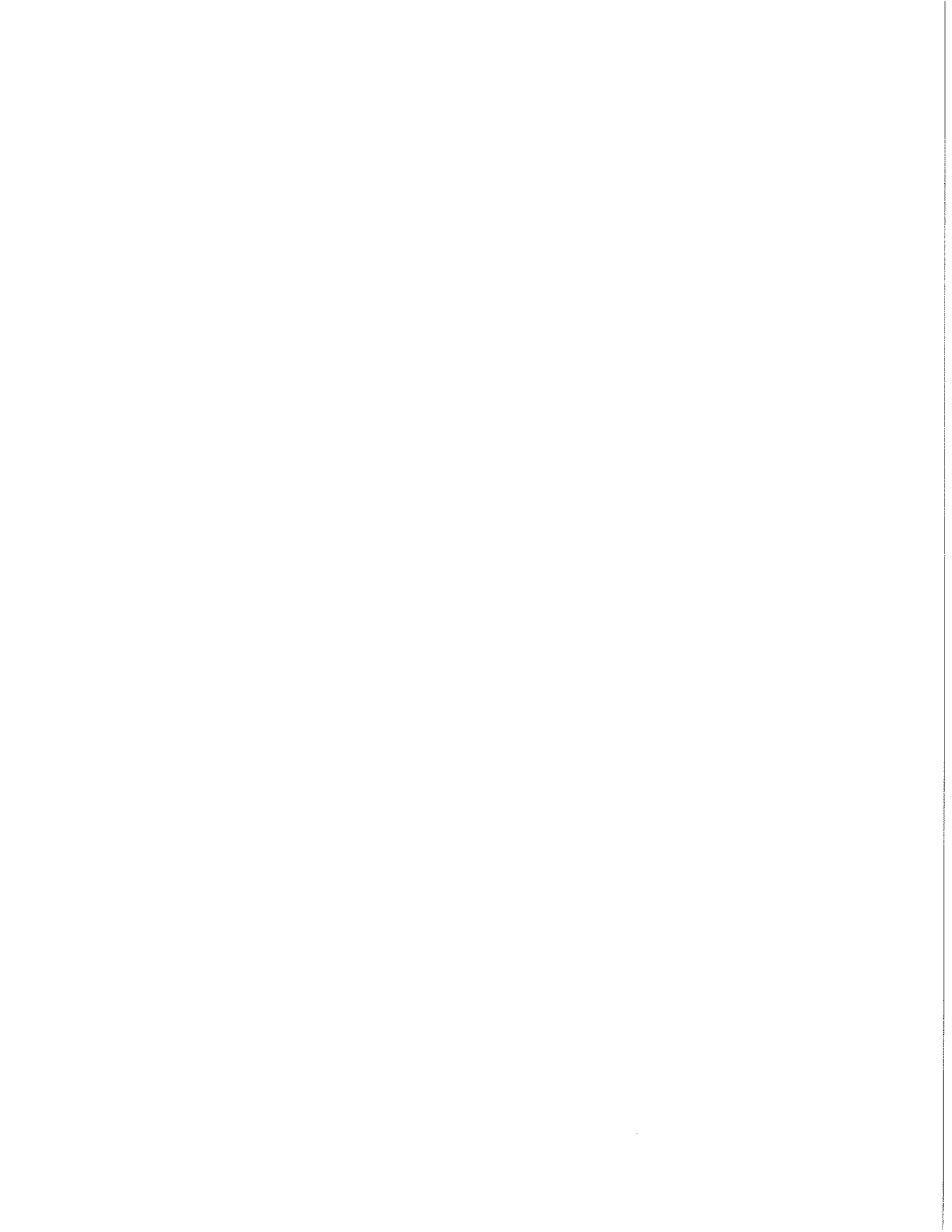
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| W 125   | Continued From page 25<br>regarding violation reporting and response: "...All employees witnessing or having knowledge of a rights violation are required to report the rights violation orally to their direct line supervisor, unless the allegation involves the supervisor, in which case the report shall be made to the supervisor's supervisor... Retaliation shall not occur for good faith reporting..."<br><br>On 11/15/16 at approximately 9:30 a.m. Immediate Jeopardy (IJ) was determined based on the facility's failure to protect clients from abuse and mistreatment. The facility was notified at approximately 10:00 a.m. The facility developed and implemented a plan to remove the IJ. The plan included increased supervision in the homes on evenings and weekends and retraining of staff. The plan also included oversight follow-up and observations by Department of Human Services (DHS) Division of Mental Health and Disability Services, to be completed at least twice monthly. The IJ was removed on 12/6/16 at 1:00 p.m. | W 125   |   |                      |   |
| W 127   | 483.420(a)(5) PROTECTION OF CLIENTS RIGHTS<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure the development and implementation of adequate systems to identify and prevent abuse and/or mistreatment of clients. The facility failed to proactively assure clients   | W 127   |   |                      |   |



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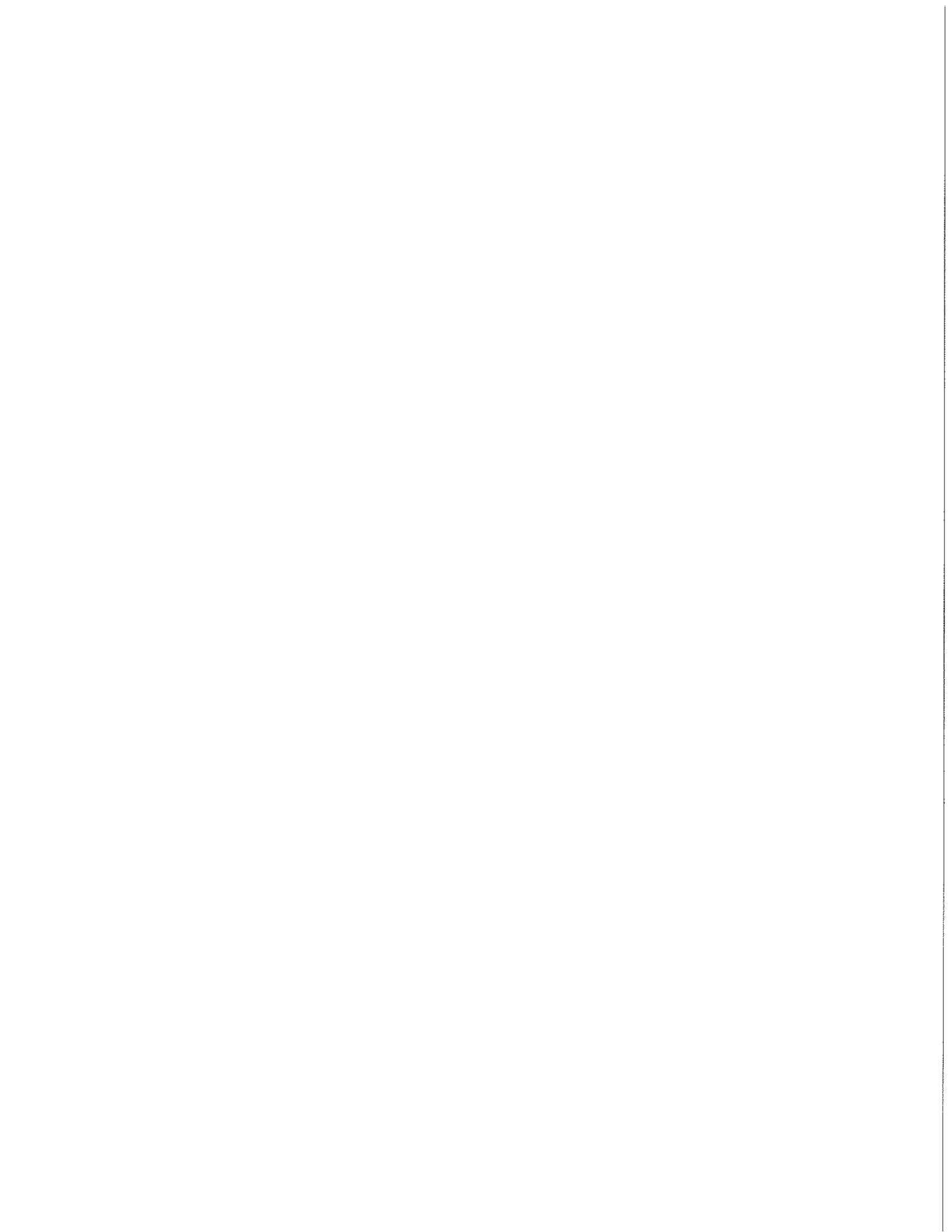
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| W 127   | <p>Continued From page 26</p> <p>were free from threats to their physical and psychological health. This affected 15 of 28 sample clients (Clients #1, #3, #4, #6, #7, #15, #16, #17, #18, #19, #20, #22, #23, #24, and #25) and potentially affected 227 of 227 clients residing at Glenwood Resource Center (GRC).</p> <p>Findings follow:</p> <ol style="list-style-type: none"> <li>1. When interviewed on 11/15/16 at 2:00 p.m. Resident Treatment Worker (RTW) K recalled she worked overtime at House 253 on 11/6/16 from 10:00 a.m. - 2:00 p.m. RTW K recalled as she sat with her assigned client during snack, the conversation among the staff in the area turned sexual in nature. The conversation occurred between RTW H and RTW J in front of Clients #15, #16, #17, #18, #19, and #20. RTW K recalled RTW H asked RTW J if he would like to engage in anal intercourse with his wife, RTW I. As this conversation continued, RTW H spoke of how he would like to engage in anal intercourse with RTW K. As snack ended, Client #15 and Client #16 were told to sit on the couch. Client #15 stood from the couch, and RTW H hit him/her on the head with a butter knife. Client #15 sat back down on the couch with tears in his/her eyes, held his/her head, curled up in the fetal position, and began rocking. Client #16 then stood from the couch and was hit on the head with a spoon or butter knife by RTW J. RTW K reported the hit to the head could be heard. Client #16 grabbed his/her head and sat back down. RTW K recalled this occurred in the midst of on-going inappropriate conversation regarding anal intercourse and male genitals. Client #15 again stood from the couch, and was hit on the head by RTW H. Client #16 stood and was also hit on the head, though RTW K could not see who</li> </ol> | W 127  |   |                      |



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FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>16G003</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/10/2017</b> |
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| W 127   | Continued From page 27<br>hit Client #16. RTW K reported she saw Client #15 hit, heard both clients hit, and heard their reactions. She reported both clients held their heads, rocked, and cowered. In the midst of these activities, RTW K reported an additional conversation occurred between RTW I and RTW J regarding laundry and how it was a "woman's job." RTW N also participated in this conversation and encouraged Client # 17 and Client #18 to push the laundry basket towards RTW I. RTW I responded to the clients, "If you do it, I'll kick your ass." RTW K recalled RTW H and RTW J then began to ask Client #19, "Does Grandma make you horny?," referring to RTW H's wife, RTW I. RTW H and RTW J repeatedly asked Client #19 this, until he/she said, "Grandma makes me horny." RTW K recalled, at that point, RTW J asked Client #20 if RTW U liked to engage in oral sex or anal intercourse with other men. Client #20 refused to answer the question. RTW J stood closer to Client #20 and RTW U stood directly behind the client, where he could not be seen. RTW J, again, asked Client #20 if RTW U liked to engage in oral sex or anal intercourse with other men. Client #20 continued to refuse, and RTW J continued to tell him/her to answer. Client #20 shook his/her head no, became very upset, and began to cry as staff continued to pressure him/her to answer the question about RTW U. RTW K reported RTW I then asked her to go take a break with her. RTW K and RTW I went outside to break and RTW K asked if RTW I liked her job. RTW K reported RTW I replied they liked the weekends because they could do whatever they wanted without supervisors. At that point, it was time for lunch. Client #20 refused to put his/her clothing protector on. RTW U told the client he/she needed to put it on, and the client continued to | W 127   |   |                      |   |

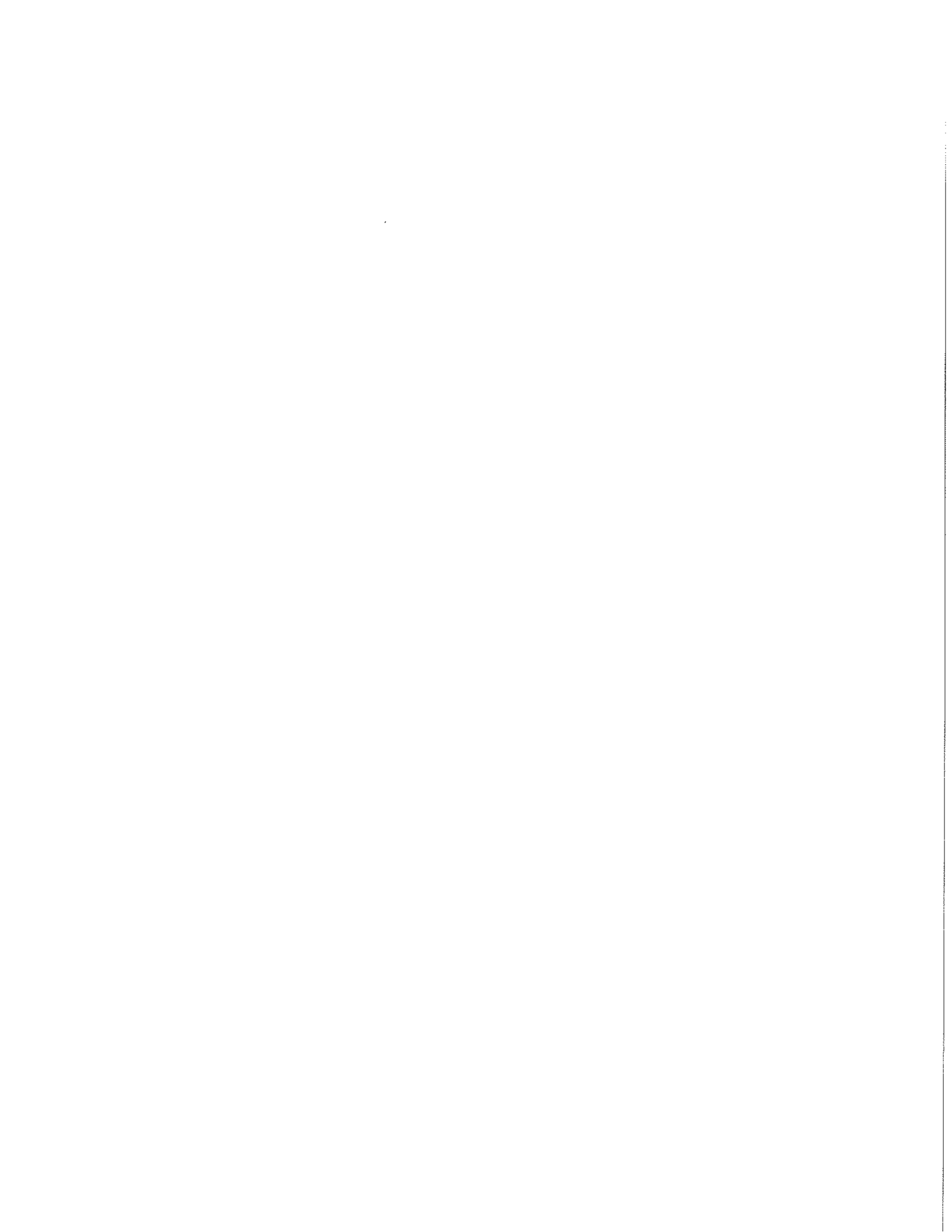




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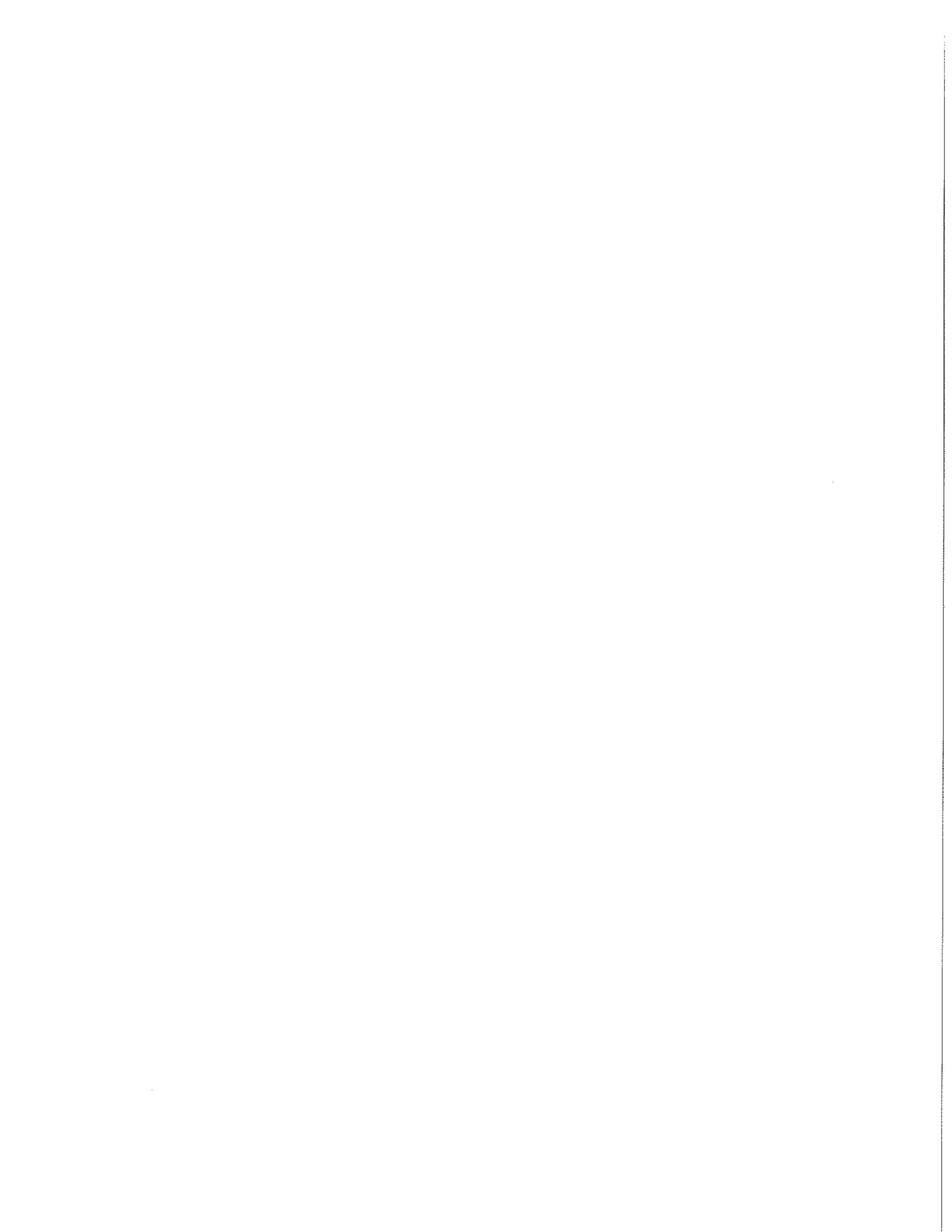
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| W 127   | <p>Continued From page 28</p> <p>refuse. RTW U told Client #20 he/she could not eat if he/she did not put the clothing protector on. Client #20, again, refused and RTW U said, "You better do it." Client #20 put the clothing protector on. Finally, towards the end of lunch, RTW H called RTW K to the living room. As she entered, she noticed RTW H sitting next to Client #19 with his leg laying over the client and Client #19 red-faced and sobbing. RTW K asked RTW H what was wrong, and he replied he told Client #19 that Grandma (RTW I) was never coming back. RTW K recalled Client #19 sobbed, hugged RTW H's leg, and rocked.</p> <p>Further interview with RTW K revealed she did not report these incidents immediately because she was scared. RTW K reported she was scared of retaliation and did not feel safe.</p> <p>2. When interviewed on 11/21/16 at 5:00 p.m. RTW L stated on 11/10/16 she was pulled to work at House 253 from 2:00 p.m. - 6:00 p.m. While in House 253 that day, she witnessed RTW M hit Client #15 on the head with a butter knife while RTW H held him/her down on the couch. She stated she used her cell phone to record the incident.</p> <p>During interview with RTW L, she shared a video clearly showing RTW M striking Client #15 on the head and saying "Are we good?" The video also clearly showed RTW H holding Client #15 by the neck on the couch to prevent the client from getting up as he/she was hit.</p> <p>When interviewed on 11/21/16 at 11:45 a.m. RTW M confirmed she and RTW H were the two staff in the video. She confirmed she hit Client #15 with a butter knife and stated, "Are we</p> | W 127   |   |                      |   |



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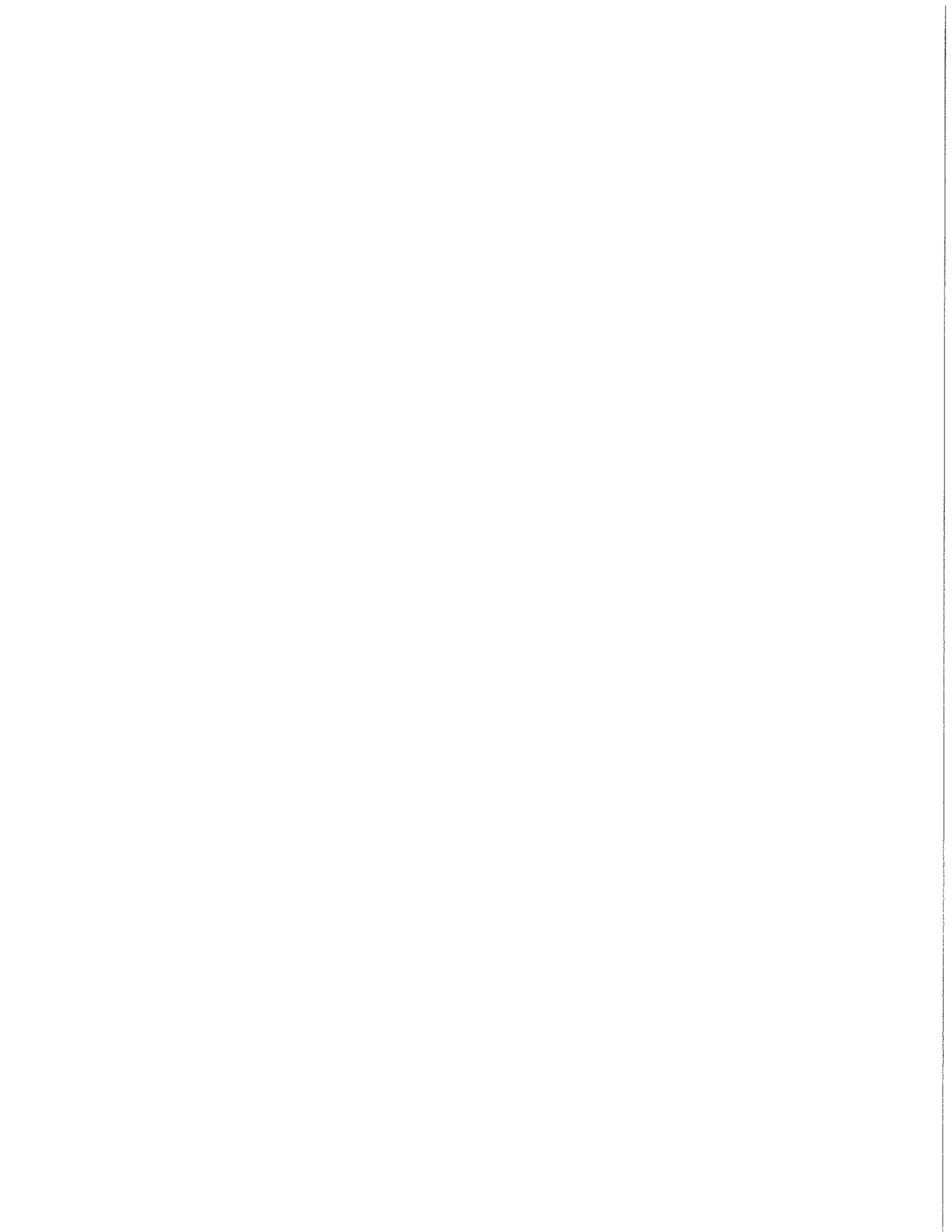
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| W 127   | <p>Continued From page 29</p> <p>good?" She stated she had seen others use the butter knife in this same manner, including RTW I who used this technique on Client #15 multiple times and referred to it as the "Reset Button." RTW M stated she did not report any of the multiple incidents when RTW H and RTW I used a butter knife to hit clients or got physical with the clients. RTW M stated she was intimidated and scared of RTW H, and explained he had made comments about people who turned people in. She stated there was a rule in the house; they made other staff feel uncomfortable and not want to report anything.</p> <p>When interviewed on 11/21/16 at 10:00 a.m., the Director of Quality Management (DQM) stated all clients at the facility should be treated with dignity and respect and at no point should staff ever use threats of physical abuse, physically abuse clients, intimidate clients, or swear and talk about inappropriate sexual acts around the clients. She further stated RTW H, RTW I, RTW J and RTW M were all suspended from employment for substantiated psychological, verbal and mental abuse. She confirmed the facility failed to keep the clients free from physical and psychological abuse.</p> <p>3. Record review on 12/12/16 revealed a facility investigation initiated 11/23/16 alleged Resident Treatment Worker J grabbed Client #23 by the back of the neck and pushed his/her face into the counter. RTW J held the client's face to the counter for approximately 30 seconds and commented, "Don't do that again!" Client #23 had taken a bag of chips from the cupboard and stood by the counter with the bag of chips. The facility substantiated physical and psychological abuse.</p> | W 127   |   |                      |   |



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| W 127   | Continued From page 30<br><br>4. When interviewed on 11/21/16 at 5:00 p.m. RTW L stated she observed Client #15 rocked in a recliner and refused to stop when redirected. RTW H walked across the room, grabbed Client #15 by his/her legs, and pulled him/her from the recliner to the floor. RTW H told Client #15 he/she would have to sit on the floor if he/she didn't stop. RTW H left the immediate area and returned to the client for whom he had accountability. RTW L stated a few minutes later Client #15 began to rock hard in the recliner again. RTW H came across the room, stood behind Client #15, and hit him/her in the back of the head with his fist three times.<br><br>5. When interviewed on 11/28/16 at 11:00 a.m. RTW N stated on 11/6/16 he witnessed RTW I use a butter knife to hit Client #15 and Client #16 while working at House 253. RTW N further stated when RTW I hit the clients with a butter knife she would say, "Knock it off!" RTW N then stated he had a bad day a few months back and slapped Client #15 in the back of the head.<br><br>6. When interviewed on 11/22/16 at 3:15 p.m. Client #17 stated he/she witnessed RTW I use a butter knife to hit Client #15. He/she stated she used the butter knife to calm Client #15 down. Client #17 stated RTW I would say, "Are we done?" Client #17 stated he/she witnessed this multiple times.<br><br>7. When interviewed on 11/21/16 at 7:00 p.m. Client #18 stated he/she witnessed RTW H, RTW I, RTW J and RTW M all use a butter knife to hit Client #15. He/she further stated, "I wish they would not do that." When asked again who they hit with a butter knife Client #18 stated Client #15. | W 127   |   |                      |   |



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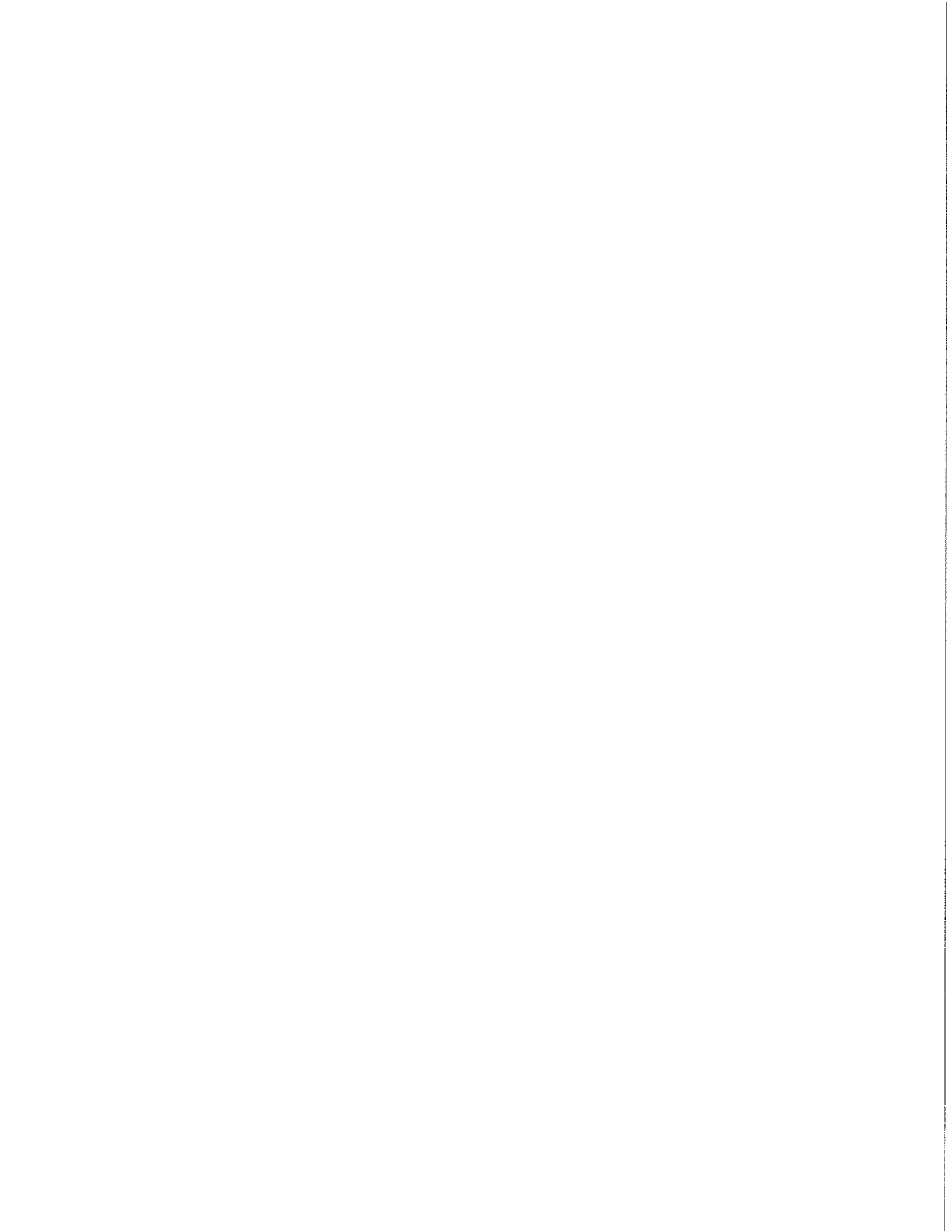
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| W 127 | <p>Continued From page 31</p> <p>When asked if he/she had ever witnessed a staff put anyone's head on the counter he/she stated "Yes," and explained RTW J did this to Client #15. When asked if anyone else ever used a butter knife or forcefully put anyone's head on the counter Client #18 stated, "No."</p> <p>8. Record review revealed Type 1 Incident Investigation Report, dated 9/26/16. The report indicated, "Staff notified this RTS (Resident Treatment Supervisor) of an unknown injury to (Client #1) on (his/her) neck, shoulders, and back. Upon further follow up to house 248 (Client #1) was asked to show us the area noted. (He/she) had multiple scratches, scrapes, and bruises to (his/her) neck, back, and shoulders. When asking (Client #1) what happened, (he/she) stated, 'The PM's held me down and shot me.'"</p> <p>When interviewed on 11/7/16 at 12:36 p.m. Client #1 reported he/she did not know how the bruises happened. Client #1 then recalled RTW A did it in the bathroom, but could not recall what happened.</p> <p>When interviewed on 11/7/16 at 12:47 p.m. RTW B reported he was appalled by Client #1's bruises. He stated he did not know how Client #1 received the bruises. According to RTW B, he did not notice Client #1's bruises when he assisted Client #1 with his/her shower on 9/22/16 and 9/23/16. RTW B reported he did not know of anyone, nor had he witnessed anyone place their hands on Client #1.</p> <p>During additional interview on 11/21/16 at 1:13 p.m. RTW B reported on 9/23/16 he assisted Client #1 with cleaning the bathroom. Client #1 yelled and threw the mop bucket. According to</p> | W 127 |  |  |
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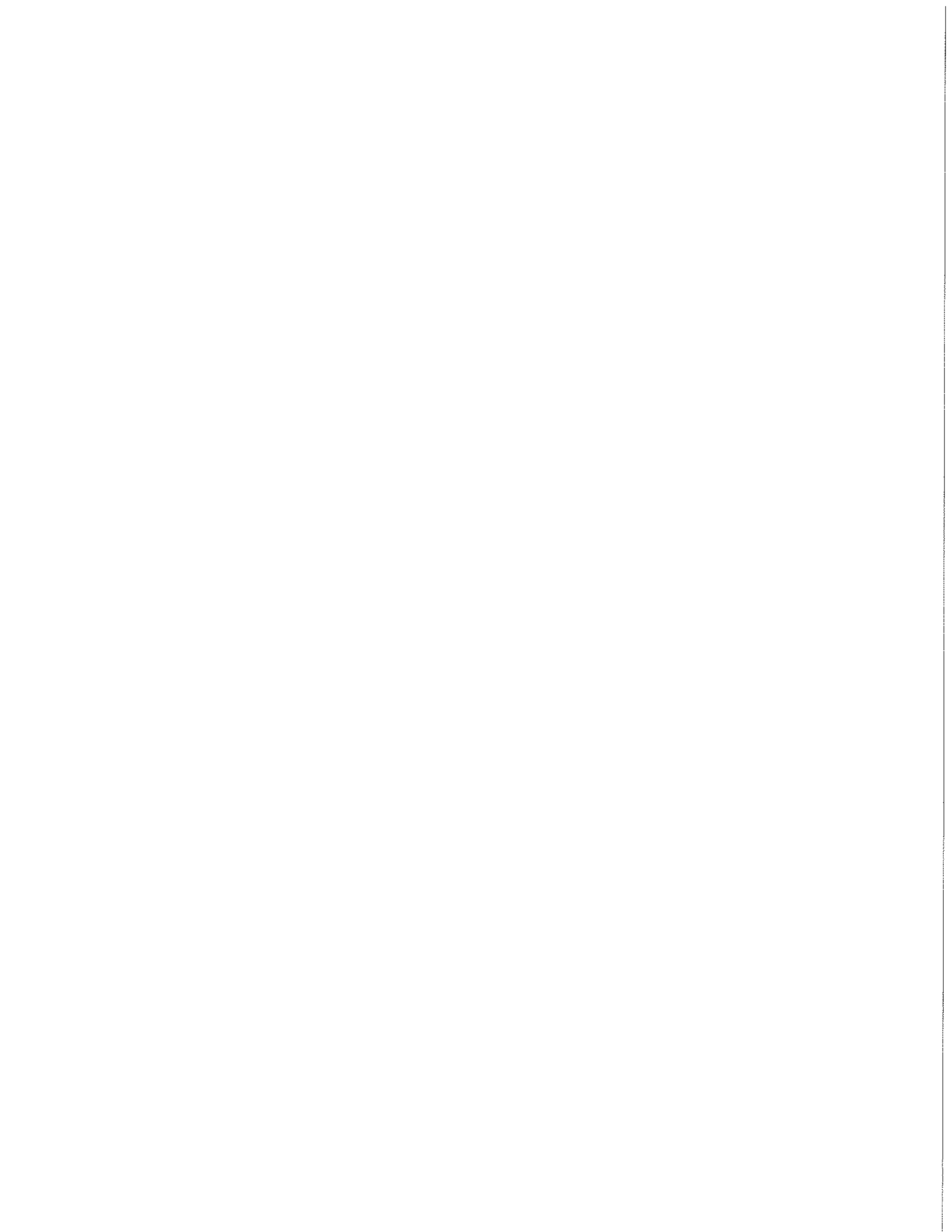




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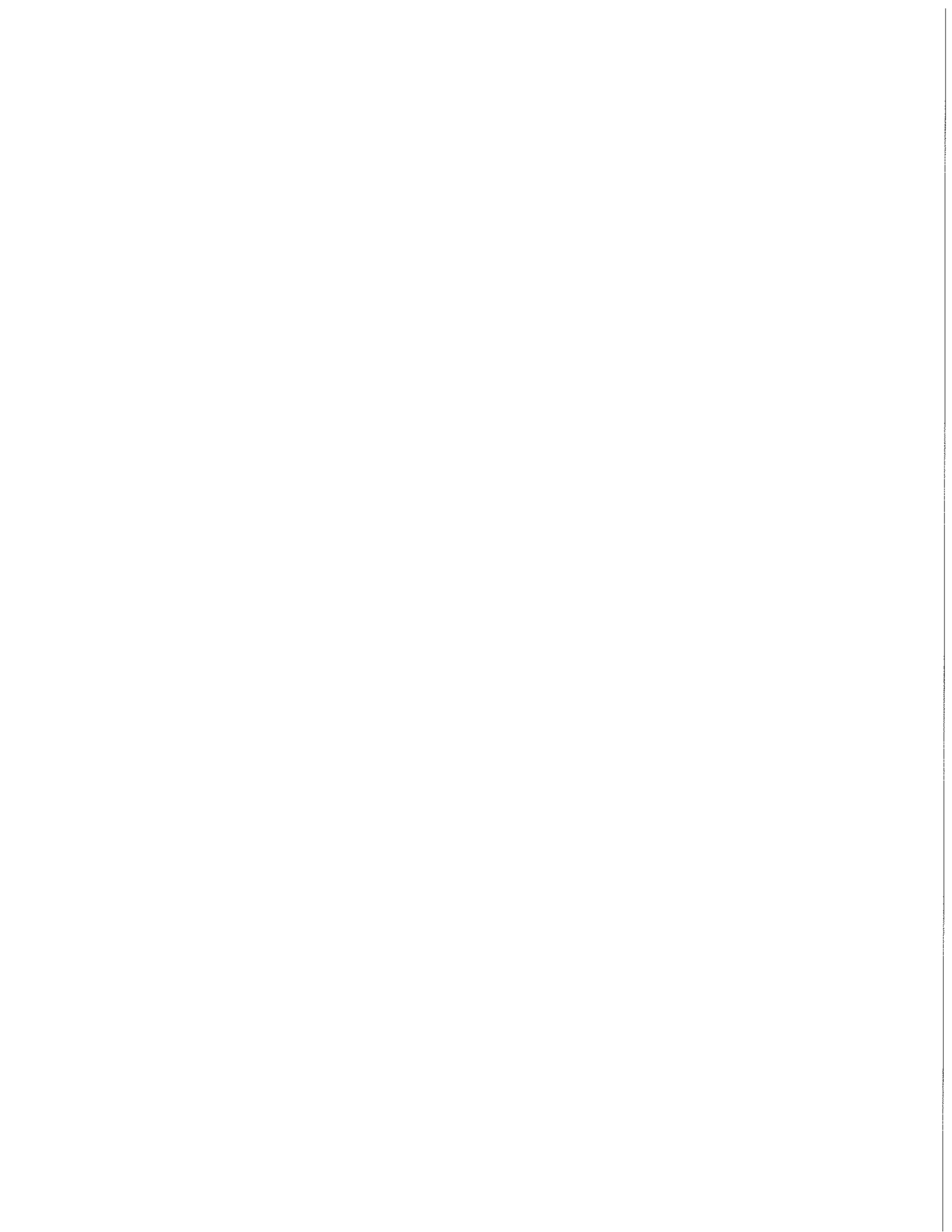
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| W 127   | <p>Continued From page 32</p> <p>RTW B, RTW A walked into the bathroom and grabbed Client #1 by the arms. RTW A told Client #1 the other clients were sleeping. RTW B left the bathroom because he did not want to be around the interaction. RTW A heard Client #1 yell, but Client #1 often yelled when asked to mop. RTW B stated after RTW A left he went back into the bathroom and Client #1 mopped. RTW B confirmed he failed to report the incident because RTW A threatened new staff, including RTW B. RTW B stated RTW A told him if he said anything or did anything, other staff would get him fired. According to RTW B, RTW A bragged about getting a previous staff fired and RTW B had a lot on the line. RTW B stated he believed Client #1's bruising came from RTW A and did not know where else the bruising would have come from.</p> <p>When interviewed on 11/15/16 at 2:34 p.m. RTW Q reported she worked with RTW A on one occasion at House 248. RTW A came across as the boss and acted like he ran the place. RTW Q worked at House 248 after RTW A was suspended out of the house. She assisted Client #1 in the shower and saw his/her bruises. RTW Q stated Client #1 told her RTW A did that. RTW A assured Client #1 that she would make sure he/she was safe. RTW Q recalled Client #1 repeated RTW A's name over and over again.</p> <p>9. Record review revealed the following:</p> <p>a. Client #3's Incident Report, dated 8/22/16, described while Client #3 sat in the day room another peer hit him/her in the face and his/her eyes were reddened.</p> <p>b. Former Resident Treatment Worker (FRTW)</p> | W 127  |   |   |



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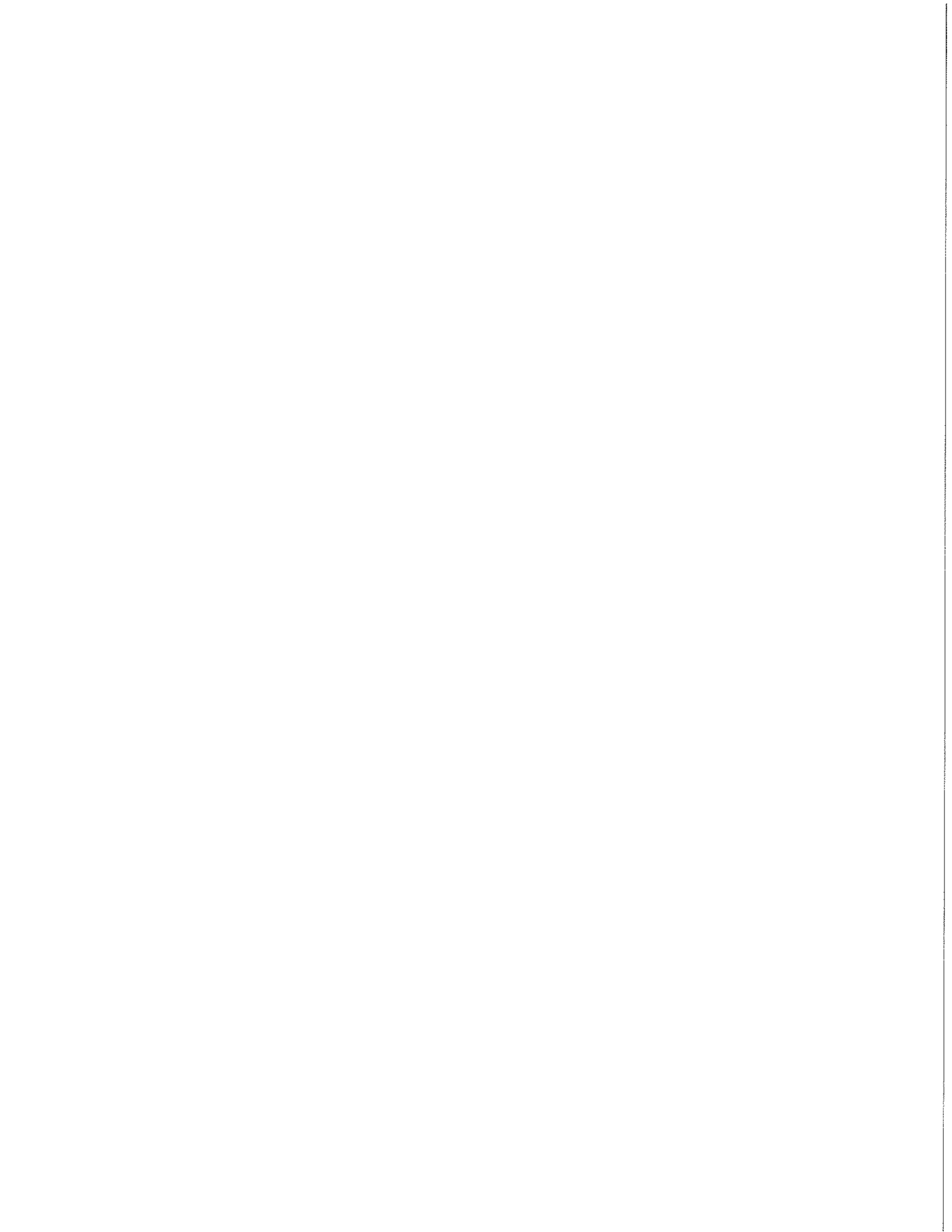
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| W 127  | <p>Continued From page 33</p> <p>A's Exit Information Questionnaire, dated 9/22/16, noted, "...I was providing one-on-one supervision in a residential wing of my house when I overheard yelling coming from a different part of the house. I wasn't able to see or hear exactly what was going on, but voices were raised, seemingly upset. I remained with my charge, but later on I overheard several of my coworkers (again, from another room) talking about how one of them had been wrestling or something with a resident, and that the resident had received a minor injury as a result. They discussed how, even though they had been present, they each had a plausible alibi, and therefore couldn't have been around when the injury occurred, and one of them was told to write up an incident report explaining how a nonverbal resident had attacked the injured resident, resulting in the injury. I couldn't tell exactly who was and wasn't involved, and in what capacity. I neither saw the incident, the injury, nor the incident report. What I did know was, if what I seemed to have overheard was actually what happened, it would only be a matter of time before someone would ask me to falsify an incident report to cover up the borderline abusive behavior of my coworkers..."</p> <p>c. Facility Type 1 Incident Investigation Report, dated 10/13/16, documented, "On 10/13/16 at 5:00 PM QM (Quality Management) was informed of new information that indicates an incident report filed for the client on 8/22/16 at 9:15 PM by (RTW C) was not factual and that the injury noted to the client's eye which was attributed to a peer to peer aggression incident, was instead the result of staff actions which resulted in an injury." According to the report, no immediate protections were implemented at the time of the incident as no allegation of potential abuse was made until</p> | W 127  |   |                      |   |



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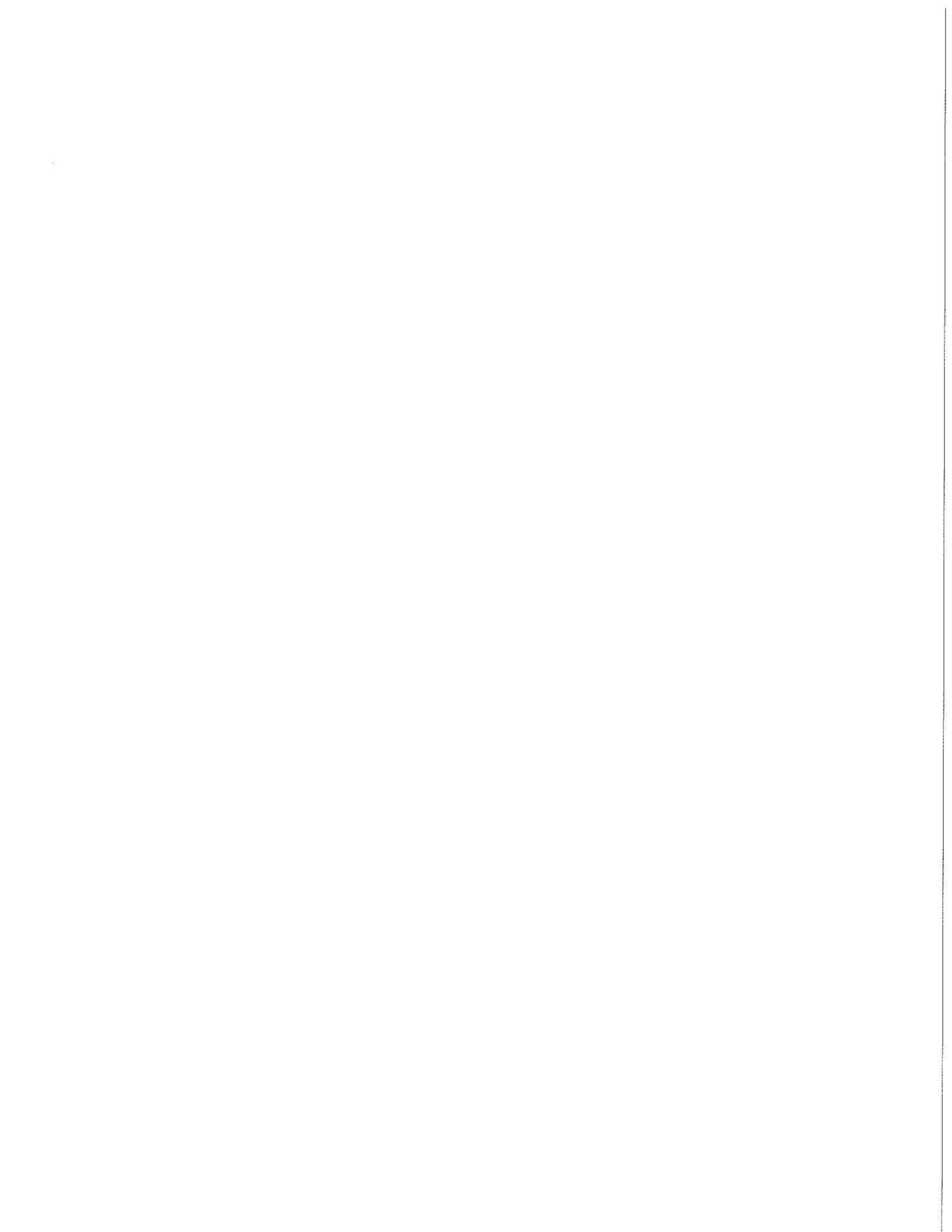
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| W 127   | <p>Continued From page 34</p> <p>10/13/16. The facility suspended RTW C on 10/13/16. RTW A and RTW D were suspended prior to 10/13/16 due to another investigation. The facility determined the incident to be substantiated.</p> <p>When interviewed on 11/17/16 at 2:27 p.m. FRTW A reported one big event forced him to resign. He stated the evening prior to his resignation, FRTW A sat in the day room with a client who needed one on one supervision. According to FRTW A, he heard what sounded like wrestling in the dining room, and described chairs being moved and Client #3 repeatedly saying, "Stop! Leave me alone." When the wrestling stopped FRTW A heard Client #3 say, "Why did you do that? Look at my arm!" FRTW A recalled two or three staff discussed the incident in the dining room. FRTW A believed RTW A explained he had accountability for another client who received one to one supervision, could not have been in the area and did not see the incident happen. FRTW A also believed RTW A told another staff that they were supposed to be with their other clients. FRTW A stated the staff concluded a non-verbal client hurt him/her, discussed their alibis, and falsified the incident. FRTW A believed this would happen again and did not want to be asked to falsify an incident. FRTW A confirmed he failed to report the incident because he was afraid someone would come after him. He reported RTW A asked him A if he was a snitch during his first shifts with RTW A. FRTW A told RTW A he had never been in a position to snitch. RTW A explained to FRTW A that he was not to turn in senior staff or he would get fired. RTW A told him they would be able to find out who turned the senior staff in and there would be retaliation as a result. FRTW A felt it</p> | W 127  |   |   |



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| W 127   | <p>Continued From page 35</p> <p>best to leave and send out the information as soon as possible.</p> <p>When interviewed on 11/15/16 at 3:30 p.m. Client #3 reported RTW C and RTW D picked on clients. He/she stated they nitpicked and told them they could not have any snacks. According to Client #3, RTW C and RTW D cussed at the clients until they got worked up. Client #3 stated after the clients got worked up, RTW C and RTW D told them they could not go on an outing because they were on restrictions. Client #3 reported when he/she was getting a pop out of the cupboard, RTW C said "What are you doing you f***ing retard?" Client #3 stated RTW D walked in and said the same thing.</p> <p>10. Record review revealed Facility Type 1 Incident Investigation Report, dated 8/16/16, documented "(Client #6) and another peer were involved in (a) physical altercation that resulted in (Client #6) being scratched on (his/her) chin. (His/her) ears were scratched. (He/she) also had some redness on his cheek. (Client #6) and (his/her) peer fought until they were separated by staff." Through the course of another investigation an allegation of abuse was made against RTW D regarding this incident.</p> <p>During facility interview on 10/10/16 at 3:19 p.m., Client #6 reported, "...he/she threw two balls at (Client #4) one a small orange ball and then the other a squishy sensory ball. At first (Client #6) reported (he/she) decided to throw the balls on (his/her) own. Then (Client #6) stated (RTW D) told him to throw a ball at (Client #4). (Client #6) reported (he/she) decided to throw the first ball the orange one. Then (RTW D) told (him/her) to throw the second ball at (Client #4). (Client #6)</p> | W 127   |   |                      |   |





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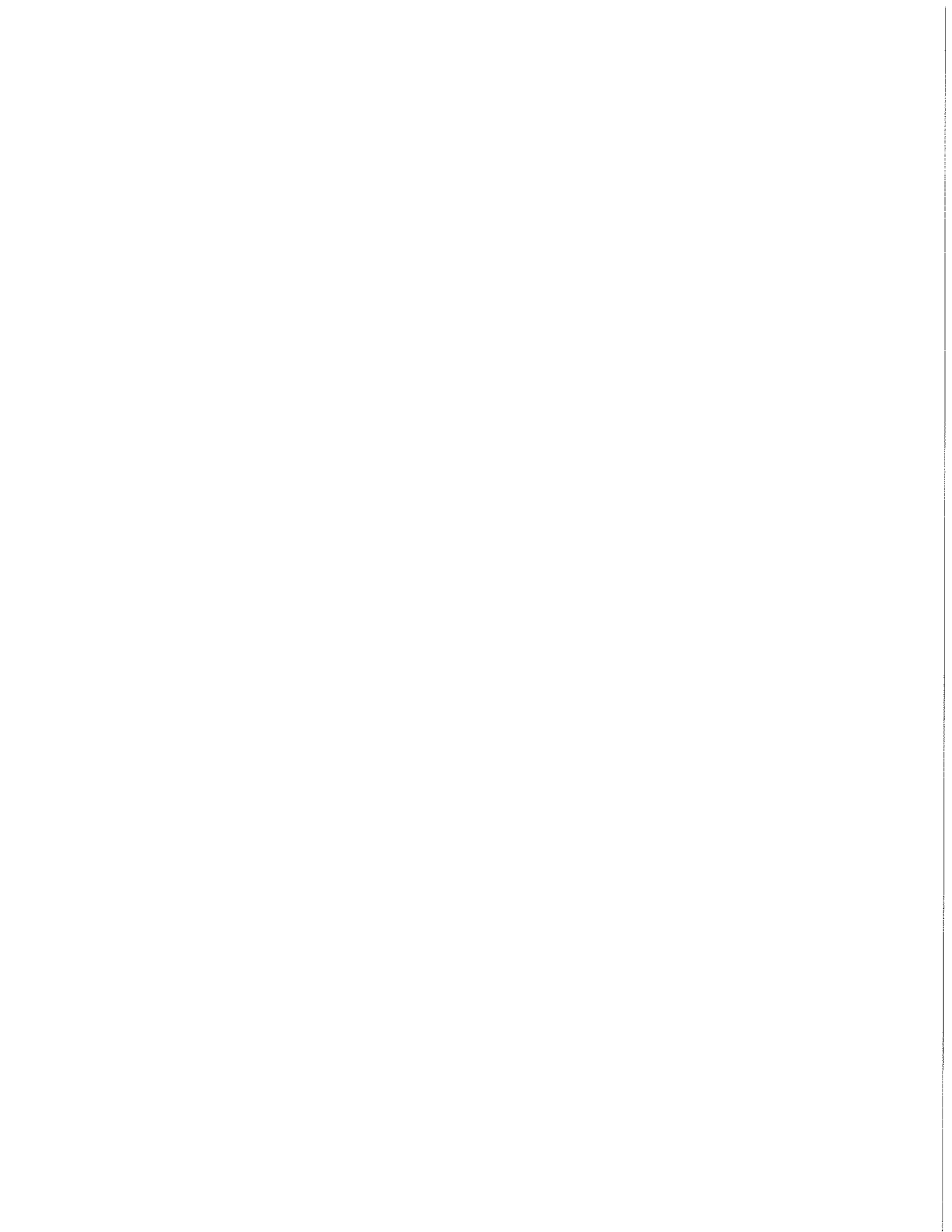
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| W 127   | <p>Continued From page 36</p> <p>asked (RTW D) if (he/she) throws the ball at (Client #4) will (he/she) get marked on (his/her) data and (RTW D) explained no... (Client #6) said (RTW D) told (him/her) to throw the ball at (Client #6) to teach (him/her) a lesson not to tease the other 248 individuals." The allegation was substantiated by the facility.</p> <p>When interviewed on 12/6/16 at 4:28 p.m. Client #4 reported listening to music and RTW D told Client #8 and Client #6 to throw things at him/her.</p> <p>11. Record review revealed Facility Type 1 Incident Investigation Report, dated 9/26/16. The report documented, "(Client #5) reported to me at the cafeteria that staff members tease (Client #1). (He/she) said that when (he/she) is screaming and yelling they don't stop. (He/she) said they threaten to take (his/her) CD's and also hide them from (him/her) when (he/she) is upset. (Client #8) heard (Client #5) telling me and (he/she) said that PM's do mess with (him/her). (Client #5) said it's (RTW A, RTW B, and RTW D). (Client #8) said that it's (RTW A and RTW D). (RTW D) not (RTW B)." The facility determined the allegation to be substantiated.</p> <p>When interviewed on 11/15/15 at 4:15 p.m. Client #5 reported he/she witnessed RTW D's issues with Client #1. Client #5 stated RTW D provoked Client #1 more than RTW A and RTW B did. Client #5 woke up one day because of Client #1 yelling. Client #5 stood in his/her doorway, watched RTW D provoke Client #1, and saw Client #1 throw things. According to Client #5, RTW D put Client #1 into a restraint. Client #5 stated the Resident Treatment Supervisor (RTS) and the Treatment Program Manager (TPM) were not there. Client #5 reported RTW A and RTW B</p> | W 127   |   |                      |   |



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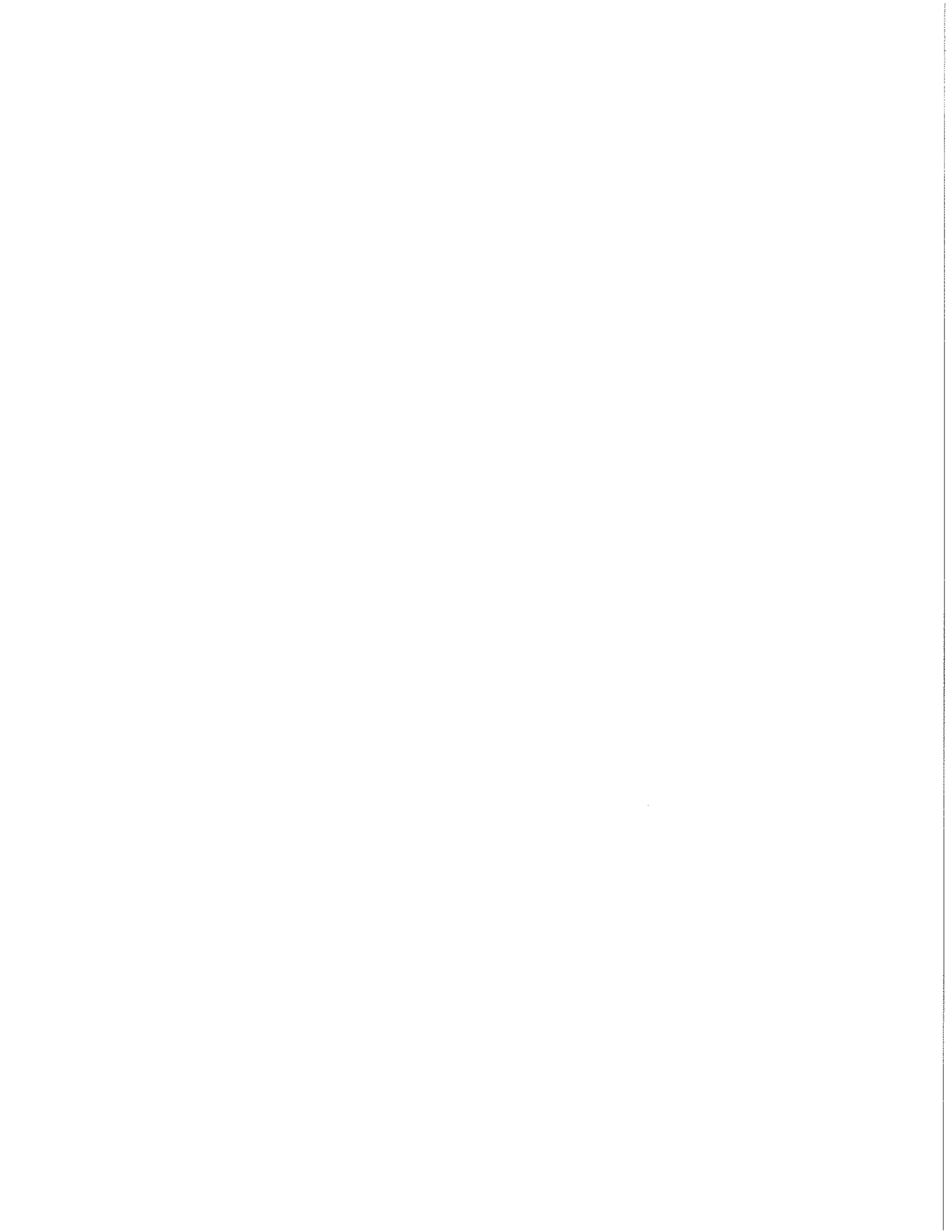
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| W 127   | <p>Continued From page 37</p> <p>joked around with Client #1, but they were not main aggressors towards Client #1. RTW D messed with certain clients once the RTS and TPM left. Client #5 stated RTW D also messed with Client #3. Client #3 asked RTW D to stop, but RTW D thought it was funny. Client #5 reported when told to stop, RTW A and RTW B would, but RTW D would go on.</p> <p>When interviewed on 11/15/16 at 3:30 p.m. Client #3 reported RTW C and RTW D picked on clients. He/she stated they nitpicked and told them they could not have any snacks. According to Client #3, RTW C and RTW D swore at the clients until they got worked up. After the clients got worked up, RTW C and RTW D told them they could not go on an outing because they were on restrictions. Client #3 reported RTW C and RTW D picked on Client #1 a lot.</p> <p>When interviewed on 11/15/16 at 3:40 p.m. Client #7 reported morning shift was fine, but evening shift was "chaos." Client #7 stated RTW A threatened and swore at clients and reported RTW A and RTW D teased Client #1. RTW D told Client #1, "Look, look (Client #8) has your 80's CD." RTW D had the CD. According to Client #7, RTW D tried to upset Client #1. Client #1 tipped furniture and RTW D ran into Client #1's bedroom and hid the CD. Client #1 asked where the CD was and RTW D said he did not know. Client #7 stated Client #1 became upset, then RTW D gave Client #1 his/her CD back. RTW A came in laughing and Client #1 broke things. Staff egged it on and on and Client #1 threw things at staff. He/she threw the laundry hamper and broke it. RTW A got physical with Client #1 and hurt him/her; described as RTW A used a pressure point on the neck to make Client</p> | W 127  |   |   |



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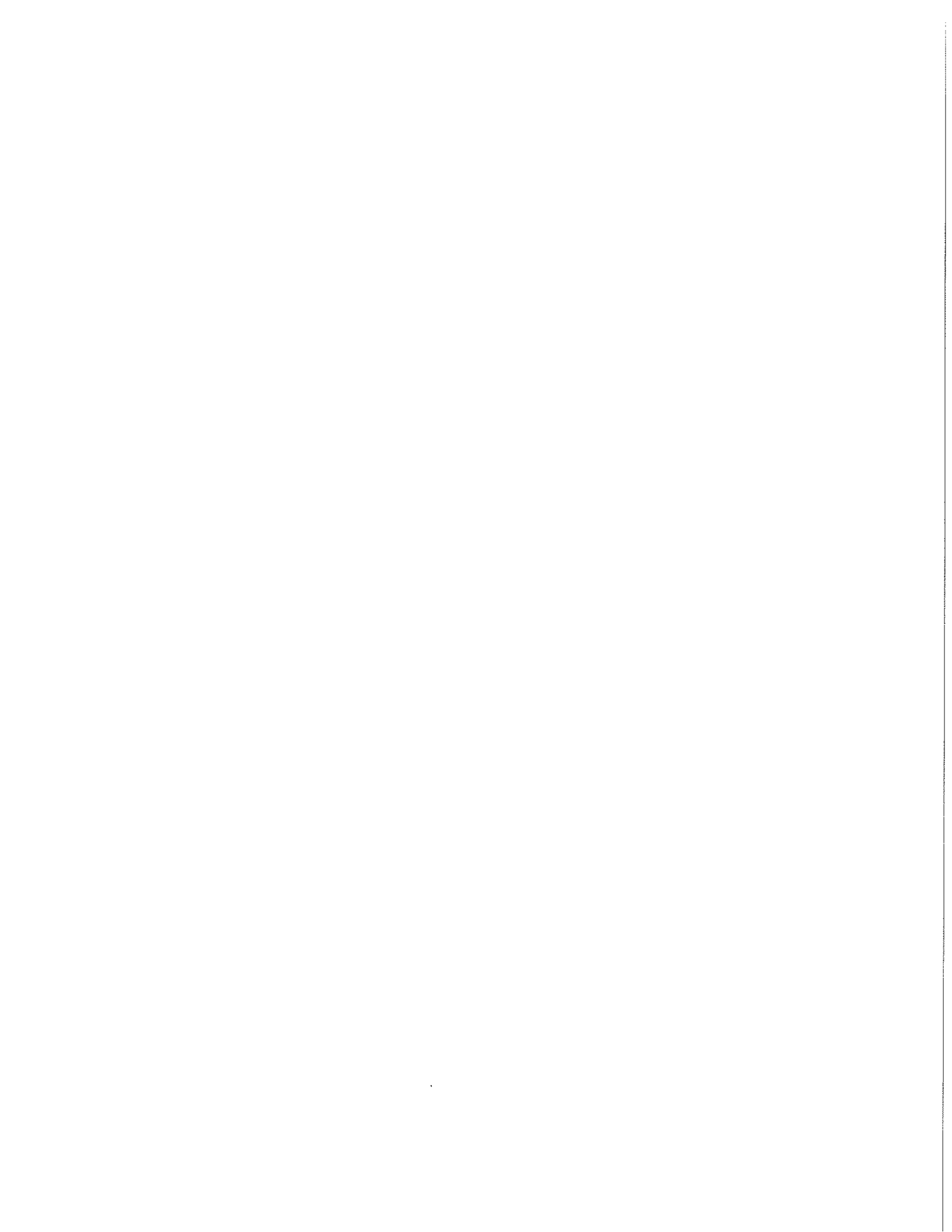
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| W 127   | <p>Continued From page 38</p> <p>#1 stop. RTW D observed this and did something, but Client #7 could not remember what. Client #7 stated staff mostly picked on other clients. Client #7 reported staff used profanity and told sexually inappropriate jokes. Client #7 reported RTW A used the "F word" and the "B word," and RTW D talked about sexually inappropriate things, such as women's vaginas. Client #7 believed he/she reported it to investigations. Client #7 did not want them to return to work because he/she did not like them getting clients upset.</p> <p>12. When interviewed on 11/14/16 at 4:40 p.m. RTW Y recalled an incident occurred at House 470 on p.m. shift. RTW Y stated RTW Z made a special snack, cake with whipped cream. When Client #22 went to the kitchen to get cake, RTW Z "airplaned" a spoon with whipped cream toward Client #22, acting like he was going to put it in his/her mouth. Instead, RTW Z smeared the whipped cream on Client #22's face. The client became upset, and yelled at RTW Z. RTW Z told Client #22 he/she needed to apologize before he/she got cake. Client #22 refused to apologize to RTW Z, put his/her dishes away, and went to bed. RTW Y stated Client #22 did not get snack that night. She stated she reported the incident to her supervisor about a week later.</p> <p>Record review revealed the facility's Type 1 investigation report. According to the report, the incident allegedly occurred 10/6/16 and was reported to the supervisor on 10/12/16 at 2:40 p.m.</p> <p>13. Record review on 11/14/16 revealed the facility's Type 1 investigation report, completed 11/1/16. The report described on 10/25/16 a</p> | W 127  |   |   |



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| W 127   | <p>Continued From page 39</p> <p>community member reported to Glenwood Resource Center (GRC) that they witnessed a GRC staff member strike a client in the back of the head while outside the van in the parking lot of the Dollar General Store after the client picked something up from the ground and put it in his/her mouth. The facility determined the alleged physical abuse occurred against Client #24. The facility substantiated physical abuse against RTW AA.</p> <p>When interviewed on 11/18/16 at 8:37 a.m., Community Member A reported she observed five GRC clients and three GRC staff in the Dollar General Store. She saw RTW AA leave the store with most of the clients. She reported she left the store right after RTW AA and the clients and witnessed RTW AA hit the back of a client's head. She believed the client picked something up from the ground and put it in his/her mouth prior.</p> <p>When interviewed on 11/18/16 at 3:40 p.m., Community Member B reported she witnessed a GRC staff come out of the Dollar General Store with approximately four clients. One of the clients picked something up off of the ground and put it in his/her mouth. One of the staff then tried to get something out of the client's mouth. She reported the staff grabbed the client by the shirt hard, and pulled him/her toward her. Staff then smacked the client on the back of the head.</p> <p>When interviewed on 11/18/16 at 3:50 p.m., Community Member C reported he witnessed a staff member grab the shirt of a client and hit the client in the back of the head. He reported the staff hit the client because he/she put something in his/her mouth.</p> | W 127   |   |                      |   |

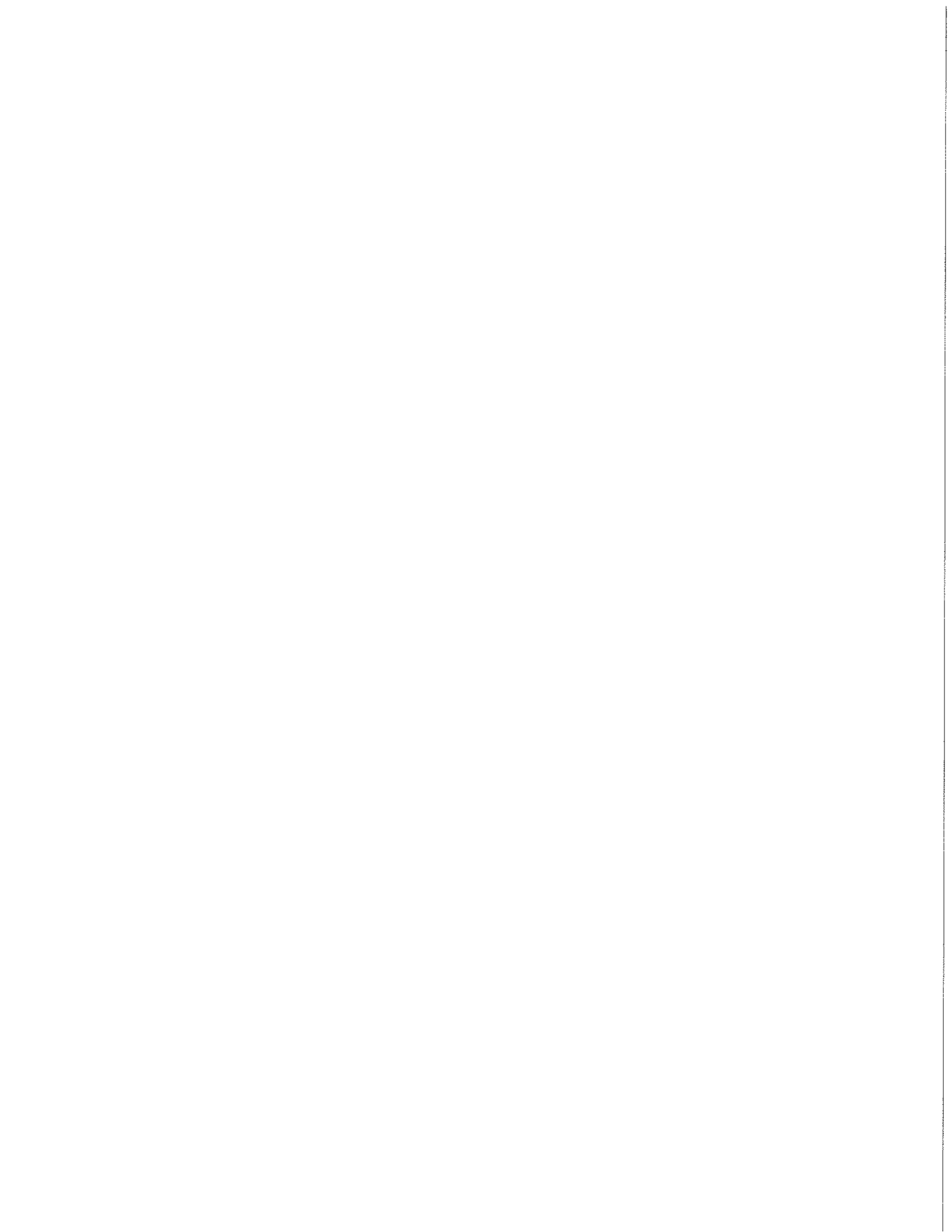




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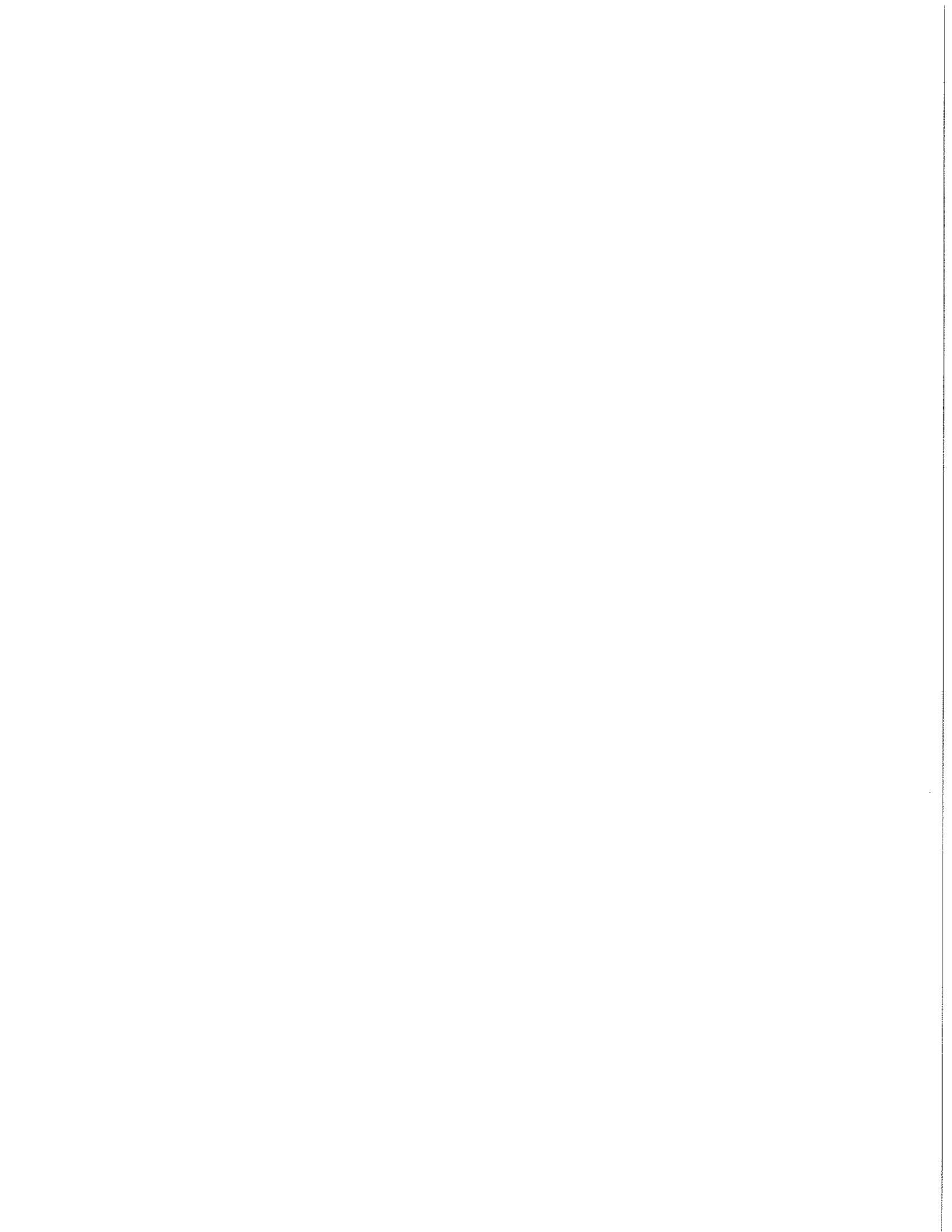
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| W 127   | Continued From page 40<br>14. When interviewed on 11/2/16 at 12:58 p.m. Food and Nutrition Services (FNS) Worker A reported she previously worked as a RTW. FNS Worker A recalled on 8/6/16 and 8/7/16 RTW CC and RTW DD split responsibility of Client #25. RTW CC took the first part of the shift and RTW DD took the second part of the shift. According to FNS Worker A, on both days RTW CC sat knee to Client #25 and pushed him/her down when he/she tried to get up. RTW CC walked Client #1 a few times, but complained about him/her. FNS Worker A reported RTW DD also sat in front of Client #1, on an office chair, and restricted him/her from getting up. FNS Worker A witnessed Client #25 push RTW CC and RTW DD away while she walked through the living room. FNS Worker A recalled RTW CC and RTW DD pushed Client #25 at his/her gait belt area or grabbed onto Client #25's gait belt and pulled him/her down to a sitting position. At times, RTW DD sat with her back towards Client #25. On one of the two nights, FNS Worker A assisted another client down the hall when she heard RTW DD raise her voice and say, "Don't touch me you perv." According to FNS Worker A, RTW DD was on the phone and Client #25 pulled her hair. FNS Worker A stated she also heard Client #25 grunting and trying to get up. FNS Worker A told a nurse, RTW CC and RTW DD would not let Client #25 get up, but the nurse instructed FNS Worker A Client #25 needed to sit when he/she received his/her medications. FNS Worker A also reported RTW CC or RTW DD used Snapchat, took pictures of Client #25 and called him/her a name. FNS Worker A voiced her concern when the overnight staff arrived, but RTW CC and RTW DD stated Client #25 was having trouble walking throughout the shift. According to FNS Worker A, Client #25 should be | W 127   |   |                      |   |



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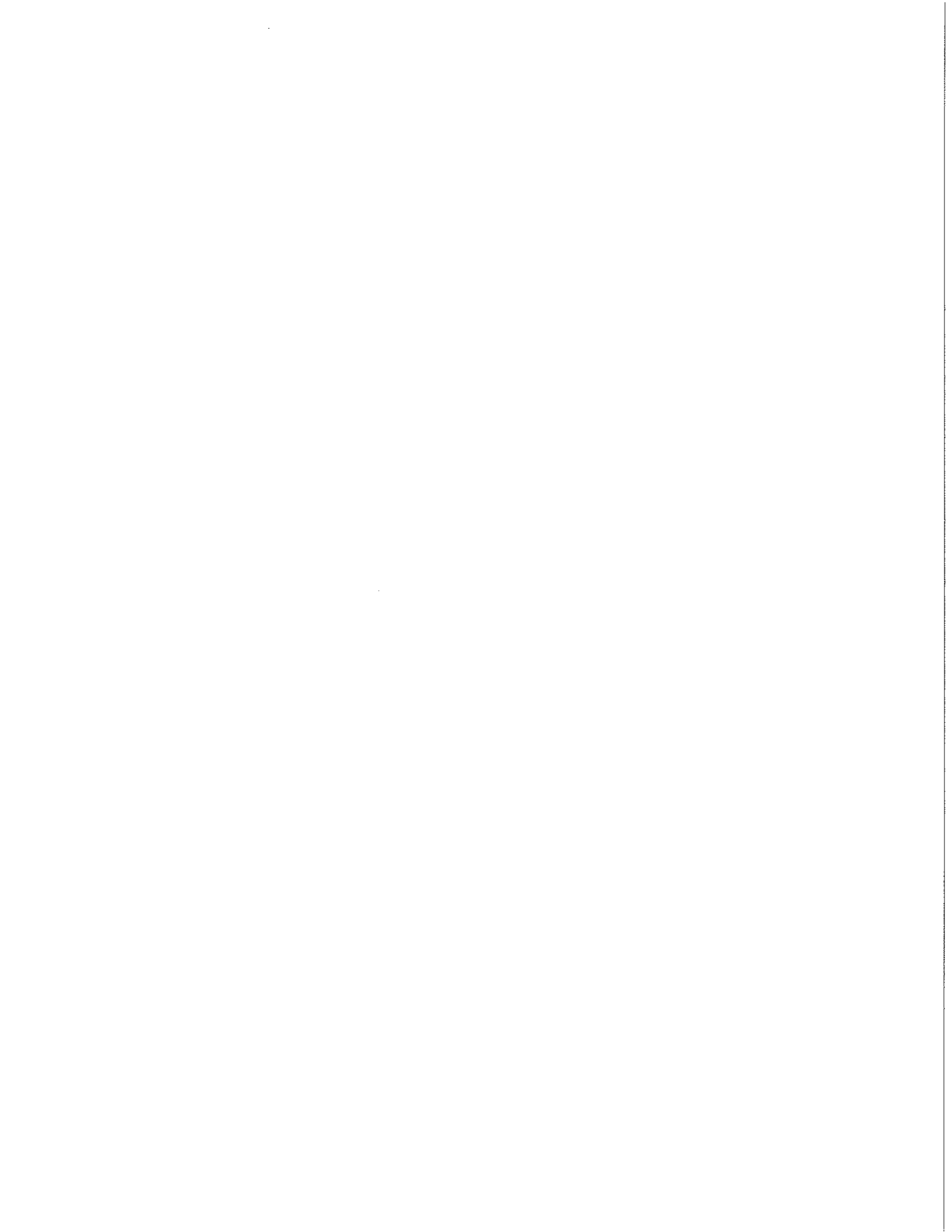
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| W 127   | <p>Continued From page 41</p> <p>walked whenever he/she attempted to get up, unless he/she received medication. FNS Worker A stated Client #25 should walk the hallway 25 times a shift. FNS Worker A confirmed she waited until 8/8/16 to report the incident to her supervisor. She believed RTW CC and RTW DD would have known if she reported to the RTS on duty on 8/6/16 and 8/7/16.</p> <p>When interviewed on 11/2/16 at 3:14 p.m. RTS D staff should not restrict Client #25 from getting up to walk. She stated she believed FNS Worker A because she had recently had to talk to RTW CC about her work performance.</p> <p>Record review revealed Individuals Rights Policy, dated 10/18/06, noted "Individuals Residing at GRC Possess the Rights to... Be free from physical, psychological, sexual or verbal abuse, neglect and exploitation... Receive care in a manner maintaining their dignity and respecting their individuality and to be treated with consideration, respect and full recognition of their dignity and individuality... An individual's rights shall not be limited or abridged without due process under the laws of the State of Iowa or a restrictive intervention program approved under this policy with written consent of the individual or the individual's parent, legal guardian or legal representative..."</p> <p>Record review revealed the facility's incident management policy, effective 11/2/07. The policy directed, "No staff, volunteer, or contractor shall behave in an abusive or neglectful manner toward individuals. Principles included: "Abuse shall not be tolerated." General Personnel Practices included: "All persons who provide services to individuals... shall treat people with</p> | W 127   |   |                      |   |



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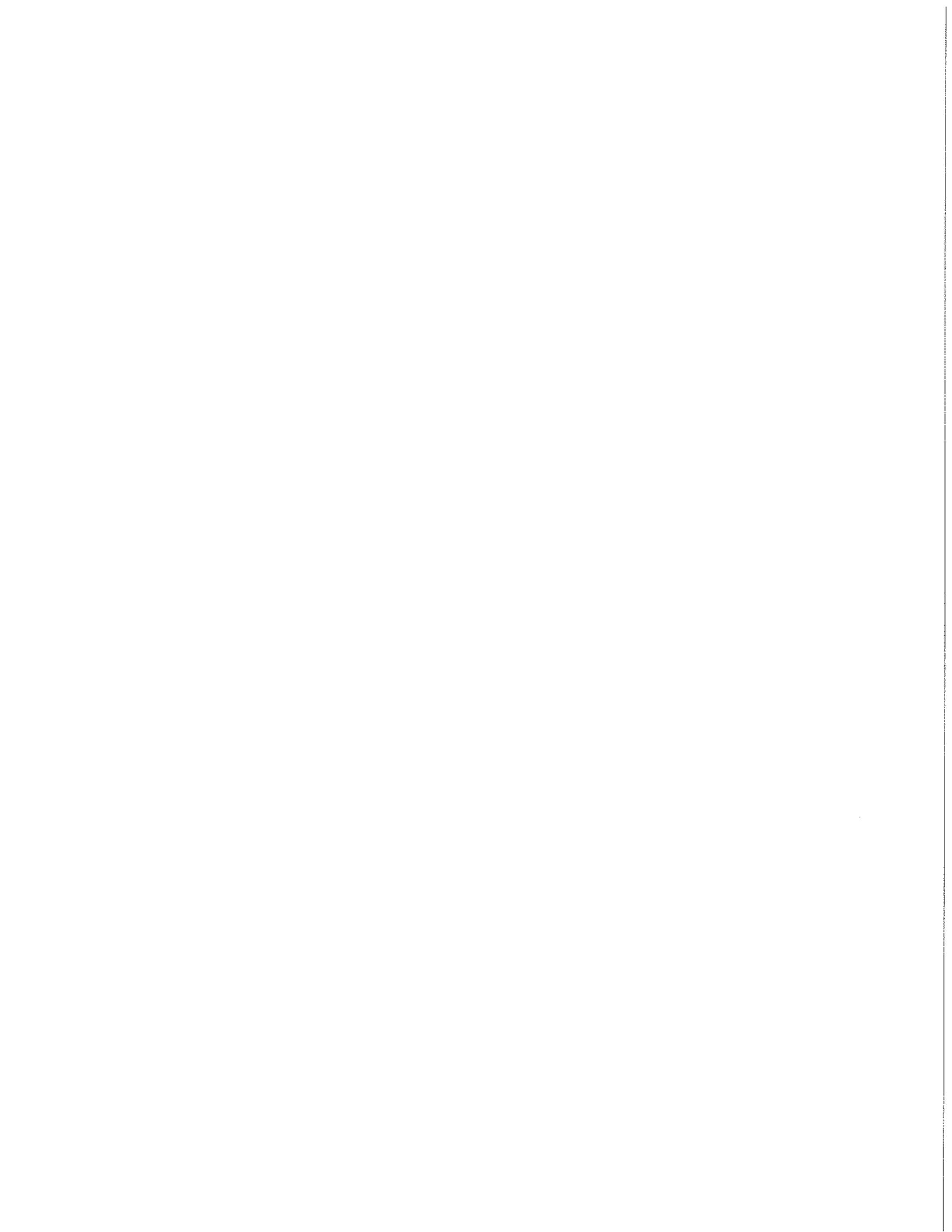
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| W 127   | Continued From page 42<br>dignity, respect, and concern for safety. No staff, volunteer, or contractor shall behave in an abusive or neglectful manner toward individuals..."  | W 127   |   |                      |   |
| W 149   | On 11/15/16 at approximately 9:30 a.m. Immediate Jeopardy (IJ) was determined based on the facility's failure to protect clients from abuse and mistreatment. The facility was notified at approximately 10:00 a.m. The facility developed and implemented a plan to remove the IJ. The plan included increased supervision in the homes on evenings and weekends and retraining of staff. The plan also included oversight follow-up and observations by Department of Human Services (DHS) Division of Mental Health and Disability Services, to be completed at least twice monthly. The IJ was removed on 12/6/16 at 1:00 p.m.<br><br>483.420(d)(1) STAFF TREATMENT OF CLIENTS<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on interviews and record review, the facility failed to ensure consistent implementation of facility policy to adequately protect clients from abuse and mistreatment. The facility's structure failed to provide adequate monitoring to prevent client abuse and ensure timely reporting of allegations of client abuse. This potentially affected 227 of 227 clients residing at Glenwood Resource Center (GRC).<br><br>Findings follow: | W 149   |   |                      |   |



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| W 149   | <p>Continued From page 43</p> <p>Cross Reference: W127, W153</p> <p>1. Record review revealed the facility's incident management policy, effective 11/2/07. The policy directed, "No staff, volunteer, or contractor shall behave in an abusive or neglectful manner toward individuals. Principles included: "Abuse shall not be tolerated." General Personnel Practices included: "All persons who provide services to individuals... shall treat people with dignity, respect, and concern for safety. No staff, volunteer, or contractor shall behave in an abusive or neglectful manner toward individuals..."</p> <p>2. Record review revealed Human Rights policy and procedure, dated 11/25/08, included, "...Individuals receiving services shall have the same legal and civil rights of all United States citizens, including the right to a dignified, self-directed existence in a safe and humane environment... Individuals shall be acknowledged as having full possession of these rights. Any restriction or encumbrance on an individual's rights shall be based on: A court order that specifically limits particular rights (involuntary commitment guardianship, ect.), the written consent of the individual, a restrictive intervention process approved before such encumbrance occurs, except in the case of an emergency..." The procedures provided the following guidance regarding rights restrictions: "...GRC prohibits the intentional violation of an individual's rights without due process, or the failure to report such violation... All employees shall be responsible for protecting and promoting individual rights and support individuals in exercising their rights independently and, if necessary, with staff</p> | W 149   |   |                      |   |

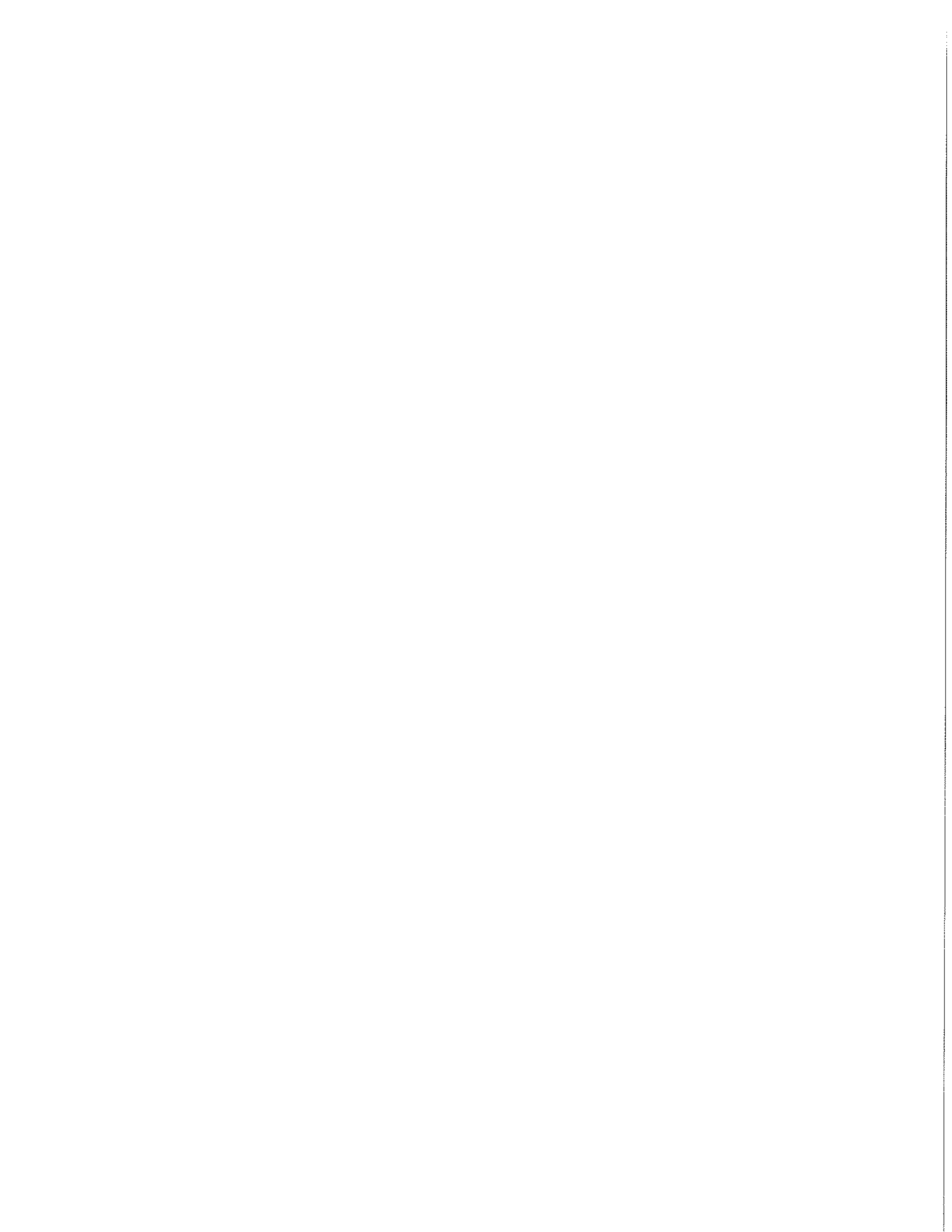




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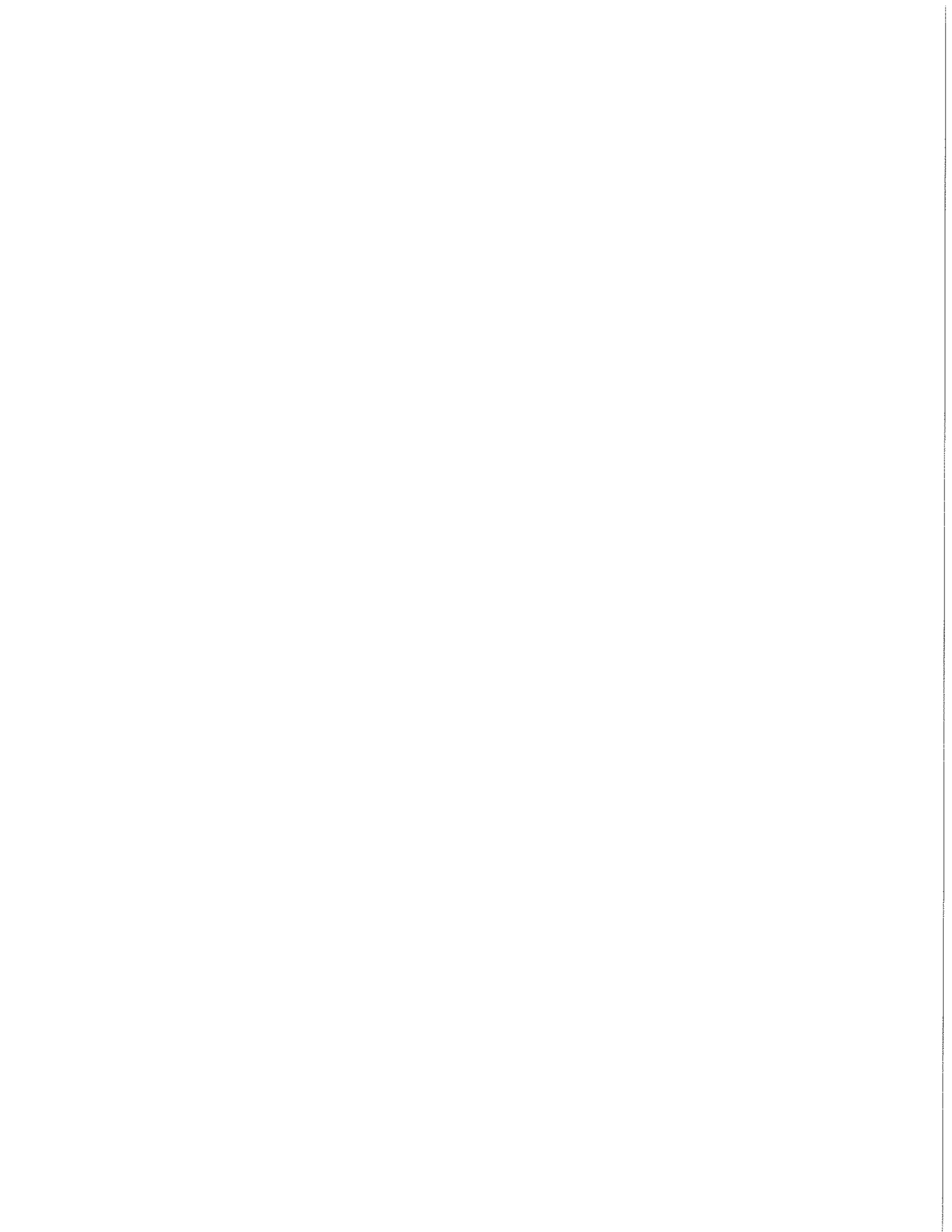
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>16G003</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/10/2017</b> |
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| W 149   | <p>Continued From page 44</p> <p>assistance... Any employee, volunteer or contractor who has been found to have violated the rights of an individual shall be subject to sanctions up to and including dismissal or termination of contract..." The procedures section also indicated: "...All employees witnessing or having knowledge of a rights violation are required to report the rights violation orally to their direct line supervisor, unless the allegation involves the supervisor, in which case the report shall be made to the supervisor's supervisor..."</p> <p>3. Record review revealed Individuals Rights Policy, dated 10/18/06, included: "Individuals Residing at GRC Possess the Rights to... Exercise their rights as an individual and as a citizen or resident of the United States, except as may be specifically limited by the constitution, statue or court order... Have a dignified existence with self-determination, making choices about aspects of their lives significant to them... Be free from physical, psychological, sexual or verbal abuse, neglect and exploitation... Be free from unnecessary drugs and restraints... Receive care in a manner maintaining their dignity and respecting their individuality and to be treated with consideration, respect and full recognition of their dignity and individuality..."</p> <p>4. Record review revealed the facility's incident management policy, effective 11/2/07. The policy instructed, "All staff... have a responsibility to assure individual safety and protection from harm and therefore shall report all incidents immediately." The policy included staff reporting requirements, which directed, "Staff shall immediately verbally report all incidents, including</p> | W 149   |   |                      |   |



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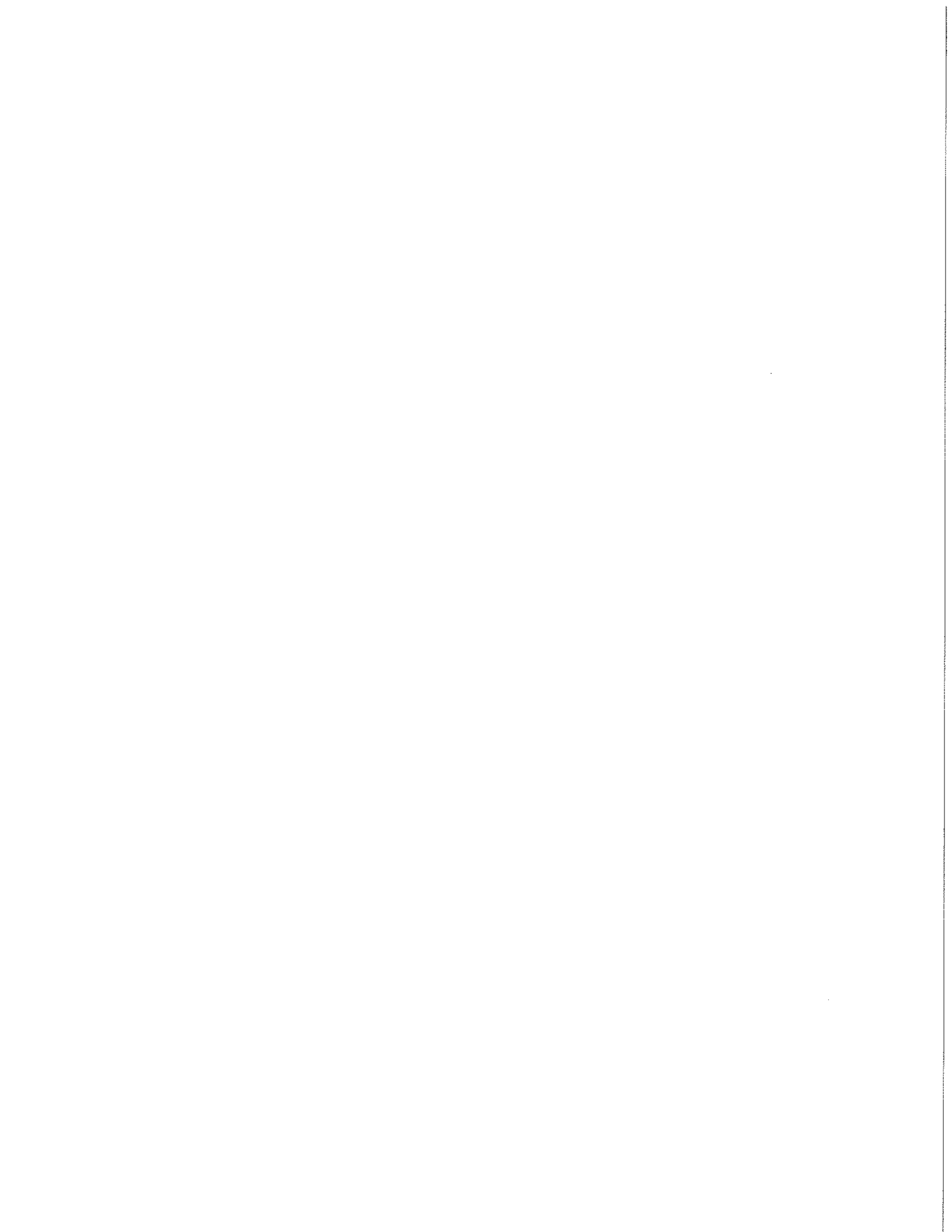
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| W 149   | Continued From page 45<br>those that may be reported to the staff by a volunteer or contractor, to the staff's direct line supervisor or supervisor on duty." The requirements further directed, "The staff that suspects, has knowledge of, or receives a report of abuse shall report the allegation to DIA (Iowa Department of Inspections and Appeals) within 24 hours of knowledge of the incident..."  | W 149   |   |                      |   |
| W 153   | <b>483.420(d)(2) STAFF TREATMENT OF CLIENTS</b><br><br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>This STANDARD is not met as evidenced by:<br>Based on interviews and record review, facility staff failed to immediately report allegations of mistreatment and abuse to the administrator or designee in accordance with facility policy. As a result, allegations of mistreatment and abuse were not reported timely to the Iowa Department of Inspections and Appeals (DIA) in accordance with state law. This affected 16 of 28 sample clients (Clients #1, #2, #3, #15, #16, #17, #18, #19, #20, #21, #22, #23, #25, #26, #27, #28).<br><br>Findings follow:<br><br>1. When interviewed on 11/15/16 at 2:00 p.m. Resident Treatment Worker (RTW) K recalled she worked overtime at House 253 on 11/6/16 from 10:00 a.m. - 2:00 p.m. RTW K recalled as she sat with her assigned client during snack, the conversation among the staff in the area turned | W 153   |   |                      |   |



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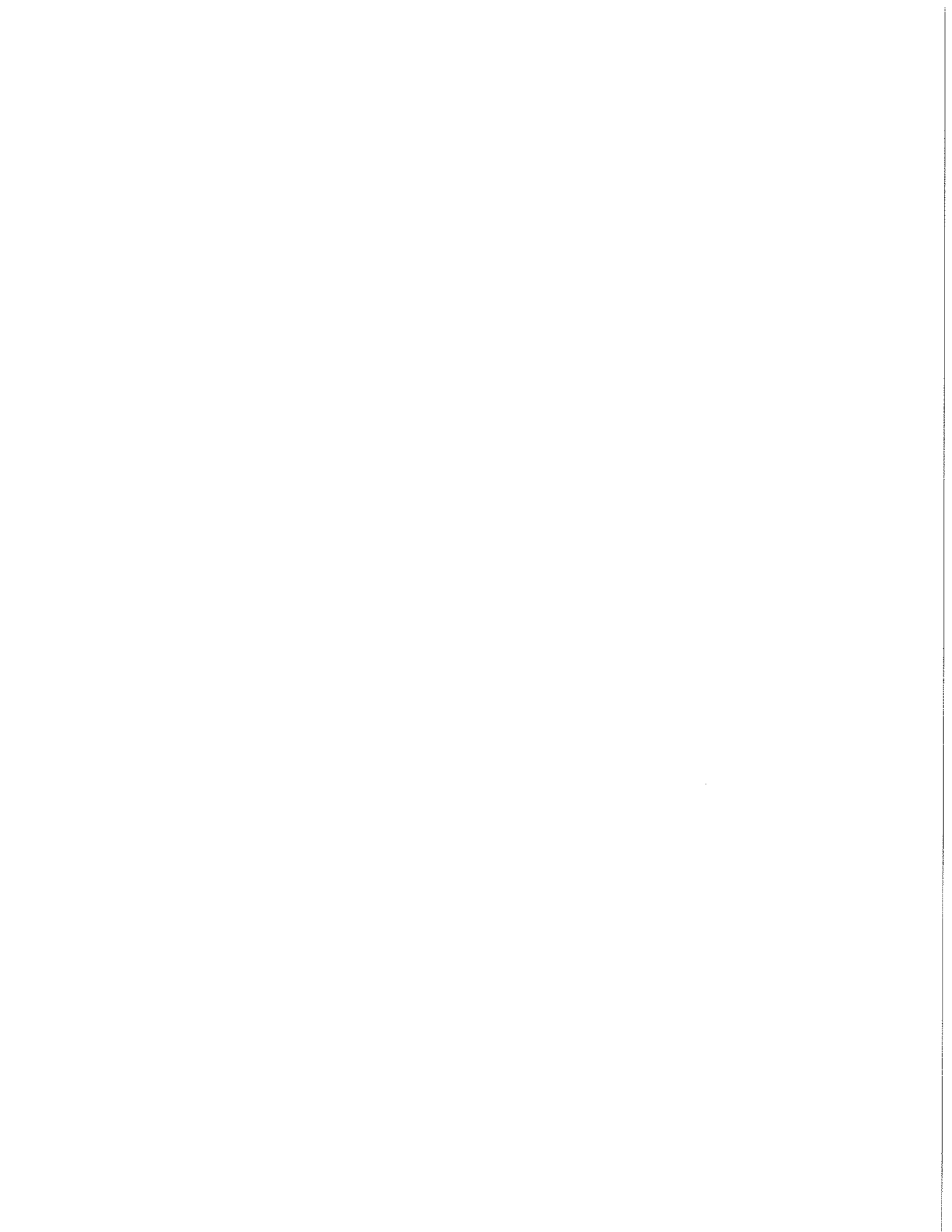
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| W 153   | Continued From page 46<br>sexual in nature. The conversation occurred between RTW H and RTW J in front of Clients #15, #16, #17, #18, #19, and #20. RTW K recalled RTW H asked RTW J if he would like to engage in anal intercourse with his wife, RTW I. As this conversation continued, RTW H spoke of how he would like to engage in anal intercourse with RTW K. As snack ended, Client #15 and Client #16 were told to sit on the couch. Client #15 stood from the couch, and RTW H hit him/her on the head with a butter knife. Client #15 sat back down on the couch with tears in his/her eyes, held his/her head, curled up in the fetal position, and began rocking. Client #16 then stood from the couch and was hit on the head with a spoon or butter knife by RTW J. RTW K reported the hit to Client #16's head could be heard. Client #16 grabbed his/her head and sat back down. RTW K recalled this occurred in the midst of on-going inappropriate conversation regarding anal intercourse and male genitals. Client #15 again stood from the couch, and was hit on the head by RTW H. Client #16 stood and was also hit on the head, though RTW K could not see who hit Client #16. RTW K reported she saw Client #15 hit, heard both clients hit, and heard their reactions. She reported both clients held their heads, rocked, and cowered. In the midst of these activities, an additional conversation occurred between RTW I and RTW J regarding laundry and it being a "woman's job." RTW N also participated in this conversation and encouraged Client #17 and Client #18 to push the laundry basket towards RTW I. RTW I responded to the clients, "If you do it, I'll kick your ass." RTW K recalled RTW H and RTW J then began to ask Client #19, "Does Grandma make you horny?" referring to RTW H's wife, RTW I. RTW H and RTW J repeatedly asked Client #19 | W 153   |   |                      |   |



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| W 153   | Continued From page 47<br>this, until he/she said "Grandma makes me horny." RTW K recalled, at that point, RTW J asked Client #20 if RTW U liked to engage in oral sex or anal intercourse with other men. Client #20 refused to answer the question. RTW J stood closer to Client #20 and RTW U stood directly behind the client, where he could not be seen. RTW J, again, asked Client #20 if RTW U liked to engage in oral sex or anal intercourse with other men. Client #20 continued to refuse, and RTW J continued to tell him/her to answer. Client #20 shook his/her head no, became very upset, and began to cry as staff continued to pressure him/her to answer the question about RTW U. RTW K reported RTW I then asked her to go take a break with her. RTW K and RTW I went outside to break and RTW K asked if RTW I liked her job. RTW K reported RTW I replied they liked the weekends because they could do whatever they wanted without supervisors. At that point it was time for lunch. Client #20 refused to put his/her clothing protector on. RTW U told the client he/she needed to put it on, and Client #20 continued to refuse. RTW U told Client #20 he/she could not eat if he/she did not put the clothing protector on. Client #20, again, refused and RTW U said, "You better do it." Client #20 put the clothing protector on. Finally, towards the end of lunch, RTW H called RTW K to the living room. As she entered, she noticed RTW H sitting next to Client #19 with his leg laying over the client and Client #19 red-faced and sobbing. RTW K asked RTW H what was wrong, and he replied he told Client #19 that Grandma (RTW I) was never coming back. RTW K recalled Client #19 sobbed, hugged RTW H's leg, and rocked.<br><br>Record review revealed the facility's Type 1 | W 153   |   |                      |   |

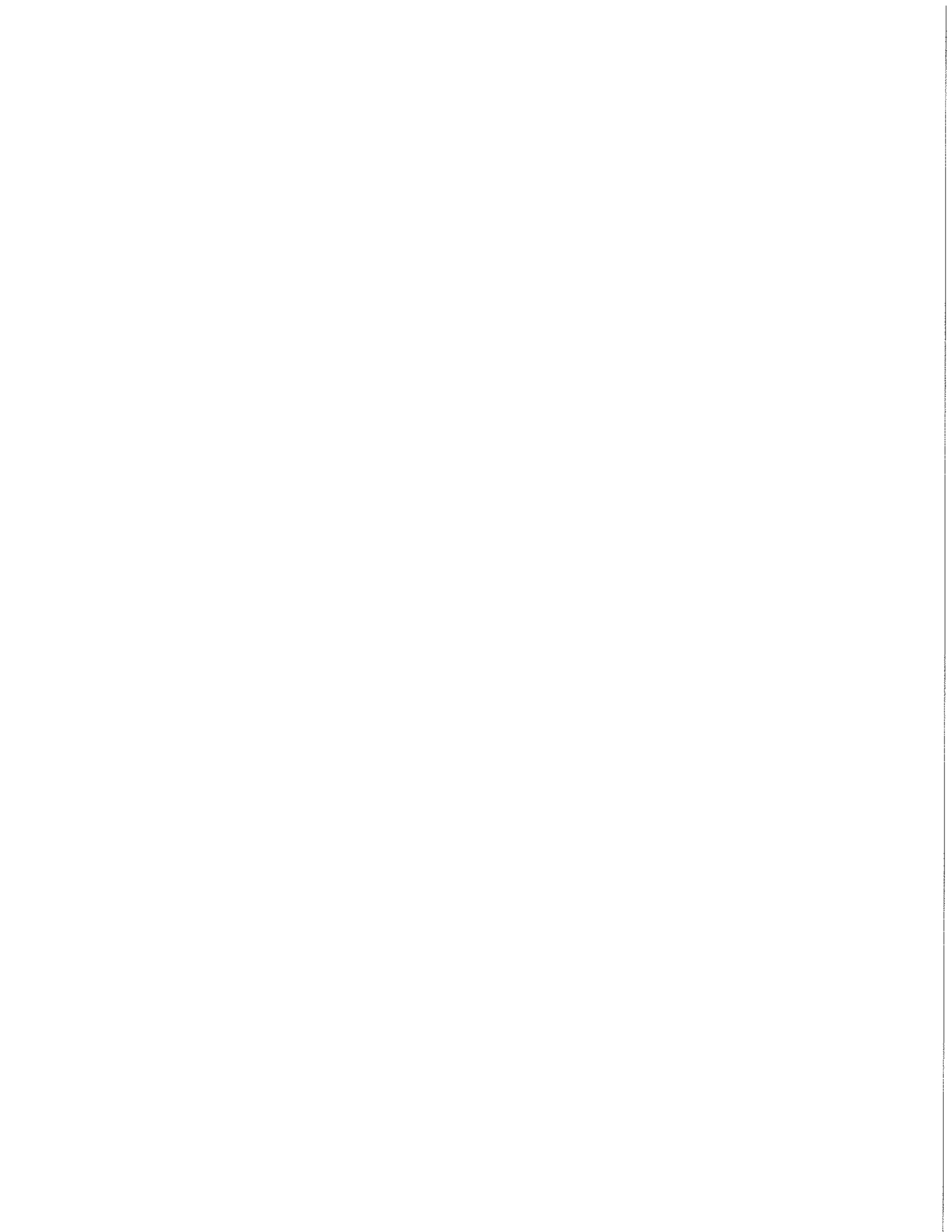




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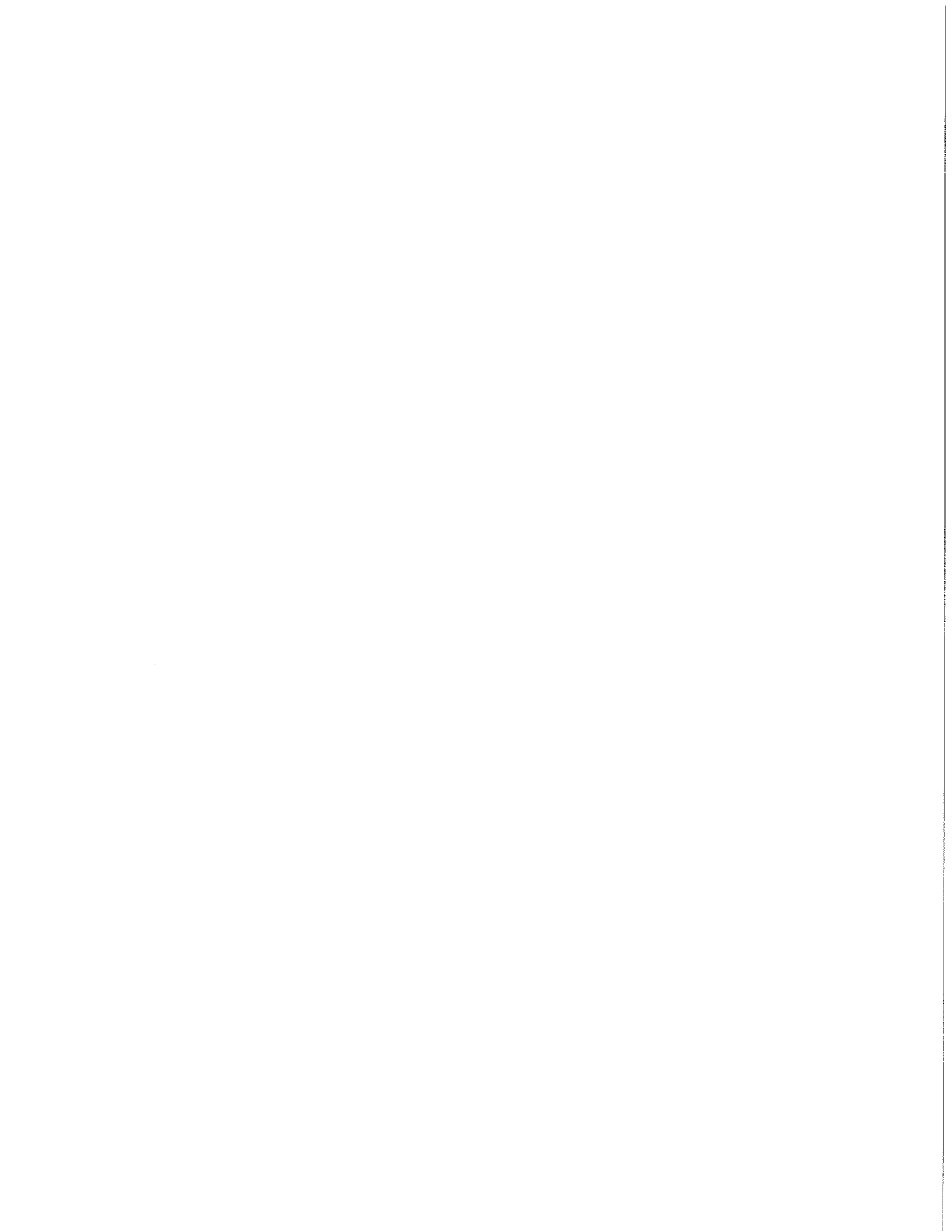
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| W 153   | <p>Continued From page 48</p> <p>Investigation Reports indicated RTW K reported the incidents to the facility on 11/14/16.</p> <p>Further interview with RTW K revealed she did not report the incidents immediately because she was scared. RTW K reported she feared retaliation and did not feel safe.</p> <p>2. When interviewed on 11/21/16 at 5 p.m. RTW L stated on 11/10/16 she was pulled to work at House 253 from 2:00 p.m. - 6:00 p.m. While in House 253 that day, she witnessed RTW M hit Client #15 on the head with a butter knife while RTW H held him/her down on the couch. She stated she used her cell phone to record the incident. RTW L stated she failed to report the incident because of fear of retaliation by coworkers and not wanting to be labeled a "NARC." RTW L stated she instead forwarded a copy of the video to her friend and coworker, RTW K, who provided the video to the facility at a later time.</p> <p>During the interview, RTW L shared a video clearly showing RTW M striking Client #15 on the head with an object and saying, "Are we good?" The video also clearly showed RTW H holding Client #15 by the neck on the couch to prevent the client from getting up while he/she was hit.</p> <p>3. Record review on 12/12/16 revealed a facility investigation initiated, 11/23/16. The report documented on 11/10/16, RTW L witnessed RTW J grab Client #23 by the neck, push the client's face into the counter, and hold the client there for approximately 30 seconds. RTW J then commented to the client, "I told you to stay out of there." This occurred because Client #23 reached into the cupboard to get a bag of chips.</p> | W 153   |   |                      |   |



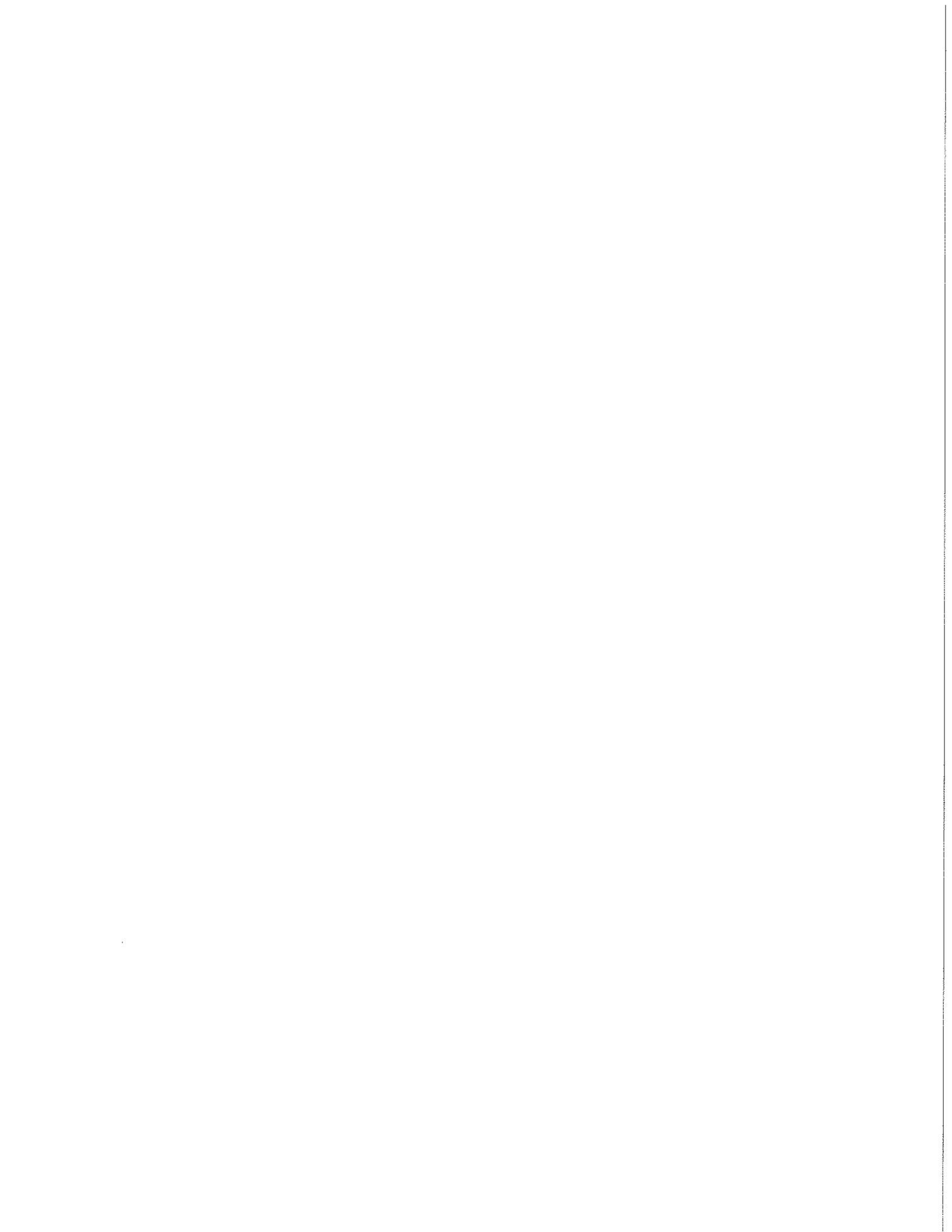
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| W 153   | <p>Continued From page 49</p> <p>The investigation also referenced a type written document by RTW L sent to the Superintendent on 11/19/16. According to the email, he forwarded the document to the Director of Quality Management (DQM) on 11/20/16. In the document RTW L alleged an act of abuse occurred on 11/10/16.</p> <p>When interviewed on 12/13/16 at 11:10 a.m. DQM confirmed RTW L failed to report the allegation of abuse immediately per policy. She acknowledged the RTW L failed to follow facility policy by reporting late.</p> <p>4. Record review revealed Type 1 Incident Investigation Report, dated 9/26/16, documented, "Staff notified this RTS of an unknown injury to (Client #1) on (his/her) neck, shoulders, and back. Upon further follow up to house 248 (Client #1) was asked to show us the area noted. (He/she) had multiple scratches, scrapes, and bruises to (his/her) neck, back, and shoulders. When asking (Client #1) what happened, (he/she) stated, "The PM's held me down and shot me."</p> <p>When interviewed on 11/7/16 at 12:47 p.m. RTW B reported he was appalled by Client #1's bruises. He stated he did not know how Client #1 received the bruises, and did not notice the bruises when he assisted Client #1 with his/her shower on 9/22/16 and 9/23/16. RTW B reported he did not know of anyone, nor had he witnessed anyone place their hands on Client #1.</p> <p>During an additional interview on 11/21/16 at 1:13 p.m. RTW B reported on 9/23/16 he assisted Client #1 with cleaning the bathroom. Client #1 yelled and threw the mop bucket. According to</p> | W 153  |   |   |



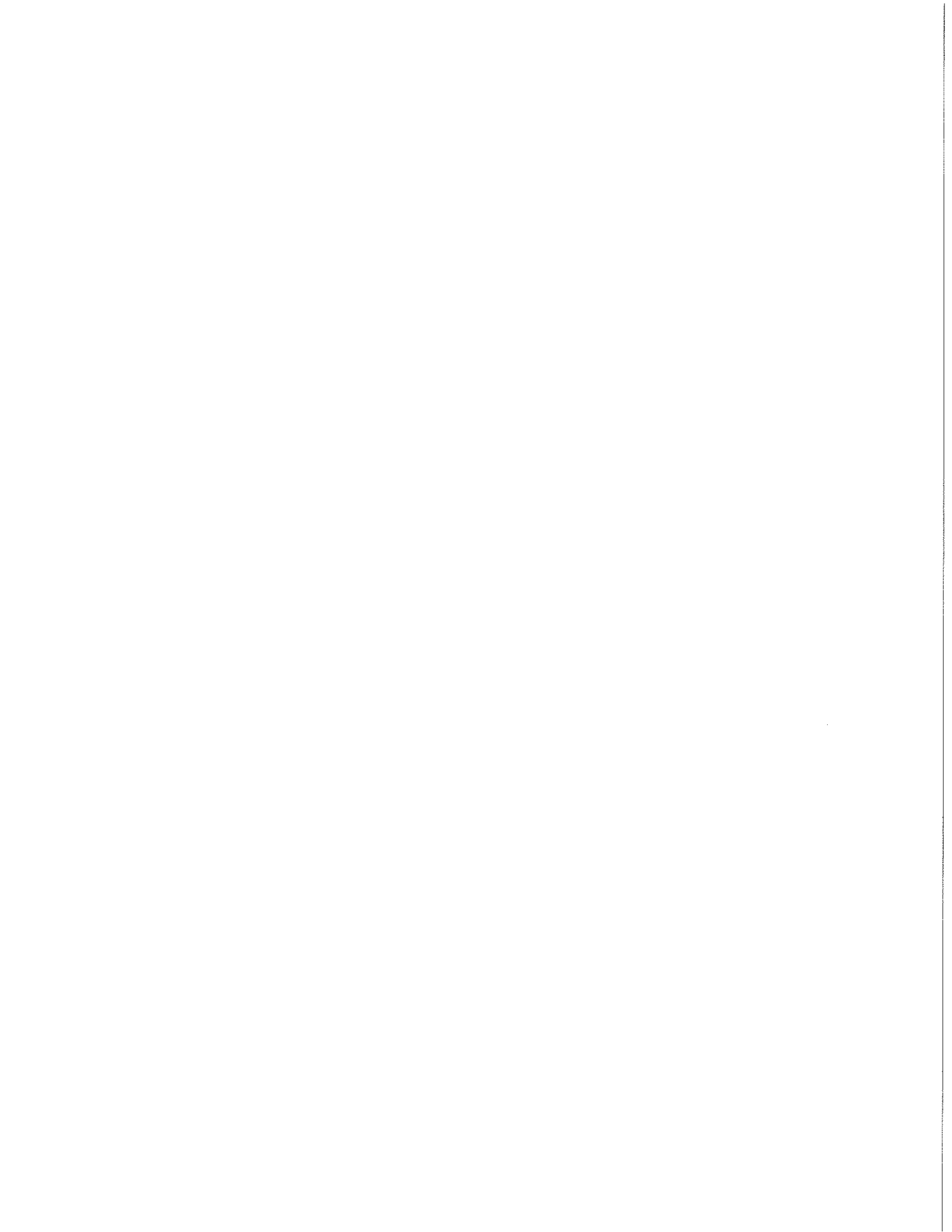
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| W 153   | <p>Continued From page 50</p> <p>RTW B, RTW A walked into the bathroom and grabbed Client #1 by the arms. RTW A told Client #1 the other clients were sleeping. RTW B left the bathroom because he did not want to be around the interaction. RTW B heard Client #1 yell, but Client #1 yelled when asked to mop. RTW B stated after RTW A left he went back into the bathroom and Client #1 mopped. RTW B confirmed he failed to report the incident because RTW A threatened new staff, including RTW B. RTW B stated RTW A told him if he said anything or did anything they would get him fired. According to RTW B, RTW A bragged about getting a previous staff fired and RTW B had a lot on the line. RTW B stated he believed Client #1's bruising came from RTW A and did not know where else the bruising would have come from.</p> <p>5. Record review revealed the following:</p> <p>a. Client #3's Incident Report, dated 8/22/16, documented, while Client #3 sat in the day room another peer hit him/her in the face and his/her eyes were reddened.</p> <p>b. Former resident treatment worker (FRTW) A's Exit Information Questionnaire, dated 9/22/16, noted, "...I was providing one-on-one supervision in a residential wing of my house when I overheard yelling coming from a different part of the house. I wasn't able to see or hear exactly what was going on, but voices were raised, seemingly upset. I remained with my charge, but later on I overheard several of my coworkers (again, from another room) talking about how one of them had been wrestling or something with a resident, and that the resident had received a minor injury as a result. They discussed how, even though they had been present, they each</p> | W 153   |   |                      |   |



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| W 153   | <p>Continued From page 51</p> <p>had a plausible alibi, and therefore couldn't have been around when the injury occurred, and one of them was told to write up an incident report explaining how a nonverbal resident had attacked the injured resident, resulting in the injury. I couldn't tell exactly who was and wasn't involved, and in what capacity. I neither saw the incident, the injury, nor the incident report. What I did know, if what I seemed to have overheard was actually what happened, it would only be a matter of time before someone would ask me to falsify an incident report to cover up the borderline abusive behavior of my coworkers..."</p> <p>c. Record review revealed facility Type 1 Incident Investigation Report, dated 10/13/16. The report noted, "On 10/13/16 at 5:00 PM QM (Quality Management) (Department) was informed of new information that indicates an incident report filed for the client on 8/22/16 at 9:15 PM by (RTW C) was not factual and that the injury noted to the client's eye which was attributed to a peer to peer aggression incident, was instead the result of staff actions which resulted in an injury."</p> <p>When interviewed on 11/17/16 at 2:27 p.m. FRTW A reported one big event forced him to resign. He stated the evening prior to his resignation, RTW A sat in the day room with a client who needed one on one supervision. According to FRTW A, he heard what sounded like wrestling in the dining room. FRTW A described chairs being moved and Client #3 repeatedly saying, "Stop, leave me alone." When the wrestling stopped FRTW A heard Client #3 say, "Why did you do that? Look at my arm!" FRTW A stated two or three staff discussed the incident in the dining room. FRTW A believed RTW A explained he had accountability for</p> | W 153   |   |                      |   |

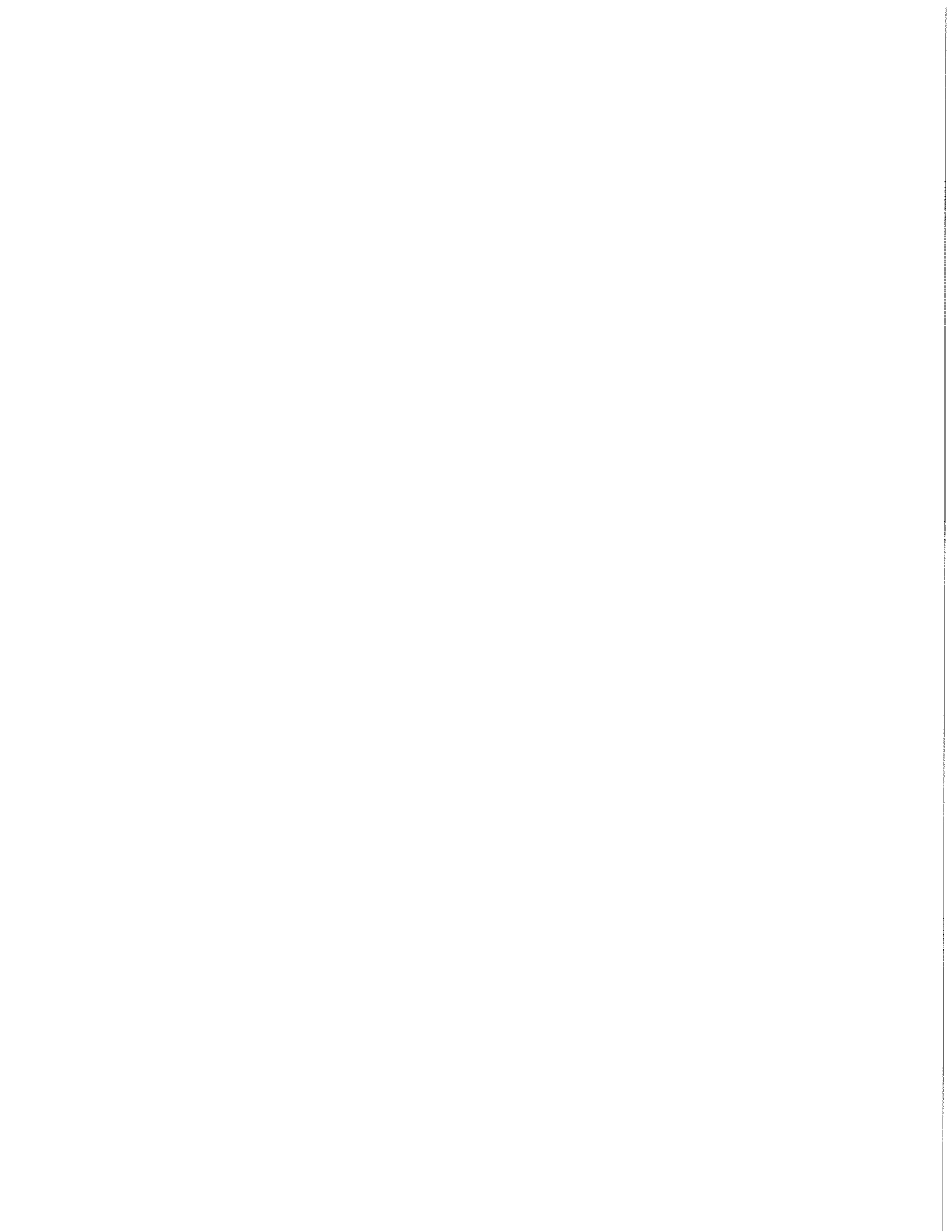




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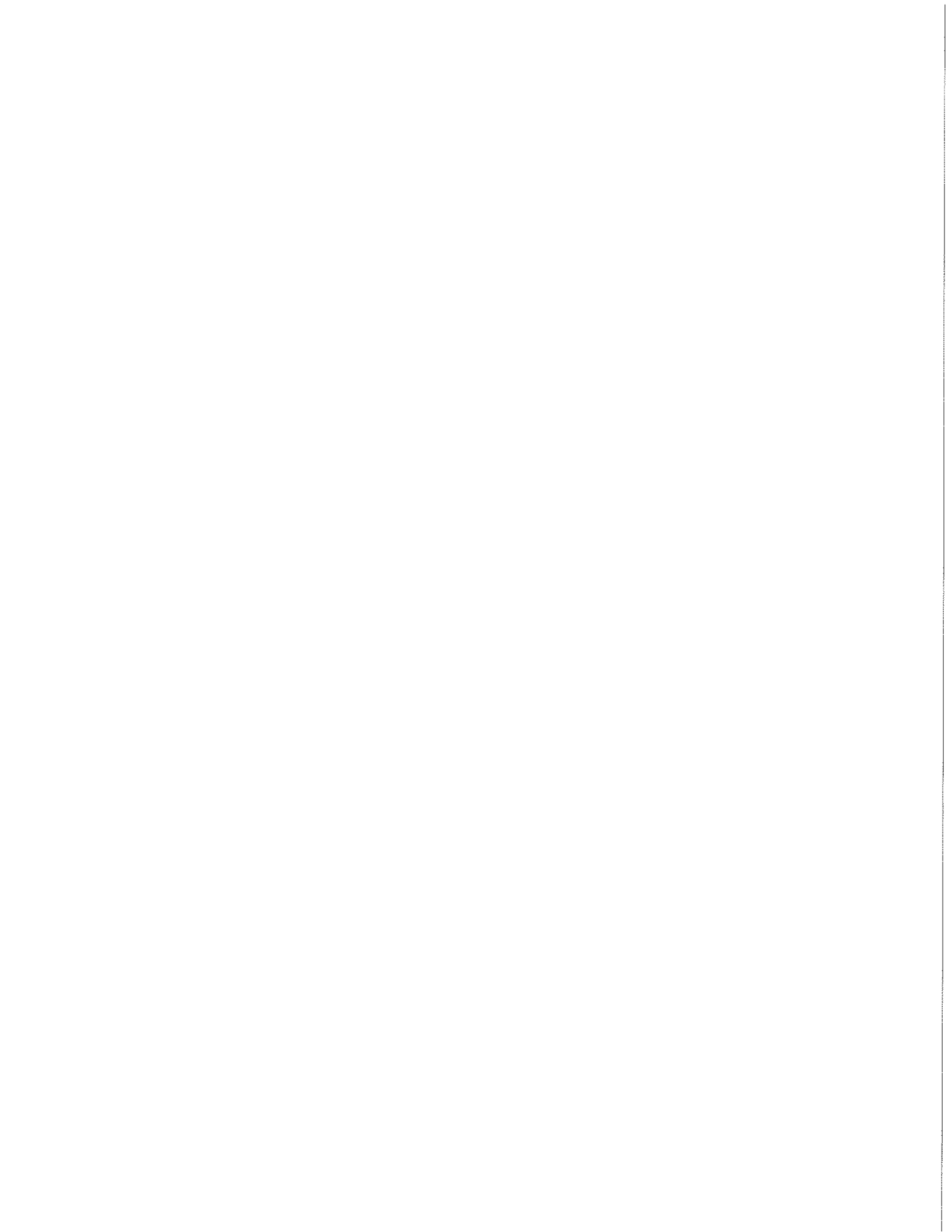
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| W 153  | <p>Continued From page 52</p> <p>another client who received one to one supervision and could not have been in the area and did not see the incident happen. FRTW A also believed RTW A told another staff that they were supposed to be with their other clients. FRTW A stated the staff concluded a non-verbal client hurt him/her. According to FRTW A, the staff discussed their alibis and falsified the incident. FRTW A believed this would happen again and did not want to be asked to falsify an incident. FRTW A confirmed he failed to report the incident because he was afraid someone would come after him. FRTW A reported RTW A asked him if he was a snitch during his first shifts with RTW A. FRTW A told RTW A he had never been in a position to snitch. RTW A explained to FRTW A that he was not to turn in senior staff or FRTW A would get fired. RTW A stated they would be able to find out who turned the senior staff in and there would be retaliation as a result. FRTW A felt it best to leave and send out the information as soon as possible.</p> <p>6. Record review revealed the following:</p> <p>a. FRTW A's Exit Information Questionnaire, dated 9/22/16, noted, "...Resident's various diagnoses and histories were discussed in front of other residents and non-involved staff..."</p> <p>b. Facility Type 1 Incident Investigation Report, dated 10/17/16. The report indicated, "On 10/17/16 an incident was reported to QM indicating that new information had been received that alleges (Client #2) was present when (RTW A) made remarks in front of the client related to the client's diagnosis, stating, "This is (Client #2), (he/she) is schizophrenic, how are those voices, (Client #2)?" The alleged date of the incident was</p> | W 153  |   |   |



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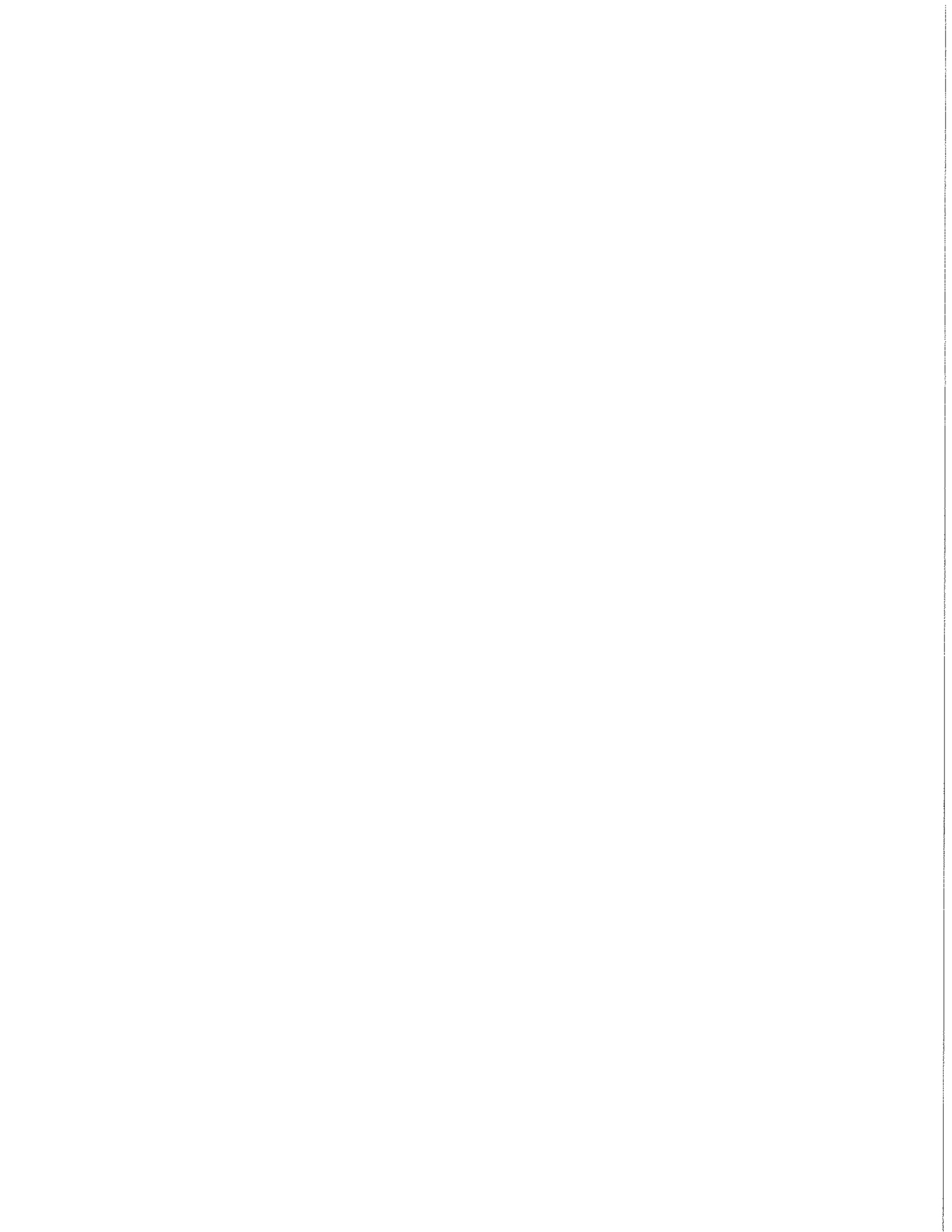
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| W 153   | <p>Continued From page 53</p> <p>8/19/16 on PM shift but it has yet to be confirmed. Other persons were alleged to have been present at the time of the incident."</p> <p>When interviewed on 11/17/16 at 2:27 p.m. FRTW A reported RTW A gave him a rundown of everyone in the house. RTW A talked about their problems in the living room with other people around. According to FRTW A, RTW A was not following Health Insurance Portability and Accountability Act of 1996 (HIPAA). FRTW A recalled Client #2 diagnosed with Schizophrenia. Client #2 was asked if he/she heard voices. FRTW A stated staff jokingly talked to Client #2 about voices and Client #2 would shut down and go back to his/her bedroom.</p> <p>7. When interviewed on 11/14/16 at 4:40 p.m. RTW Y recalled an incident occurred at House 470 on p.m. shift. RTW Y stated RTW Z made a special snack, cake with whipped cream. When Client #22 went to the kitchen to get cake, RTW Z "airplaned" a spoon with whipped cream toward Client #22, acting like he was going to put it in his/her mouth. Instead, RTW Z smeared the whipped cream on Client #22's face. The client became upset, and yelled at RTW Z. RTW Z told Client #22 he/she needed to apologize before he/she got cake. Client #22 refused to apologize to RTW Z, put his/her dishes away, and went to bed. RTW Y stated Client #22 did not get snack that night. She stated she reported the incident to her supervisor about a week later.</p> <p>Record review revealed the facility's Type 1 investigation report. According to the report, the incident allegedly occurred 10/6/16 and was reported to the supervisor on 10/12/16 at 2:40 p.m.</p> | W 153   |   |                      |   |



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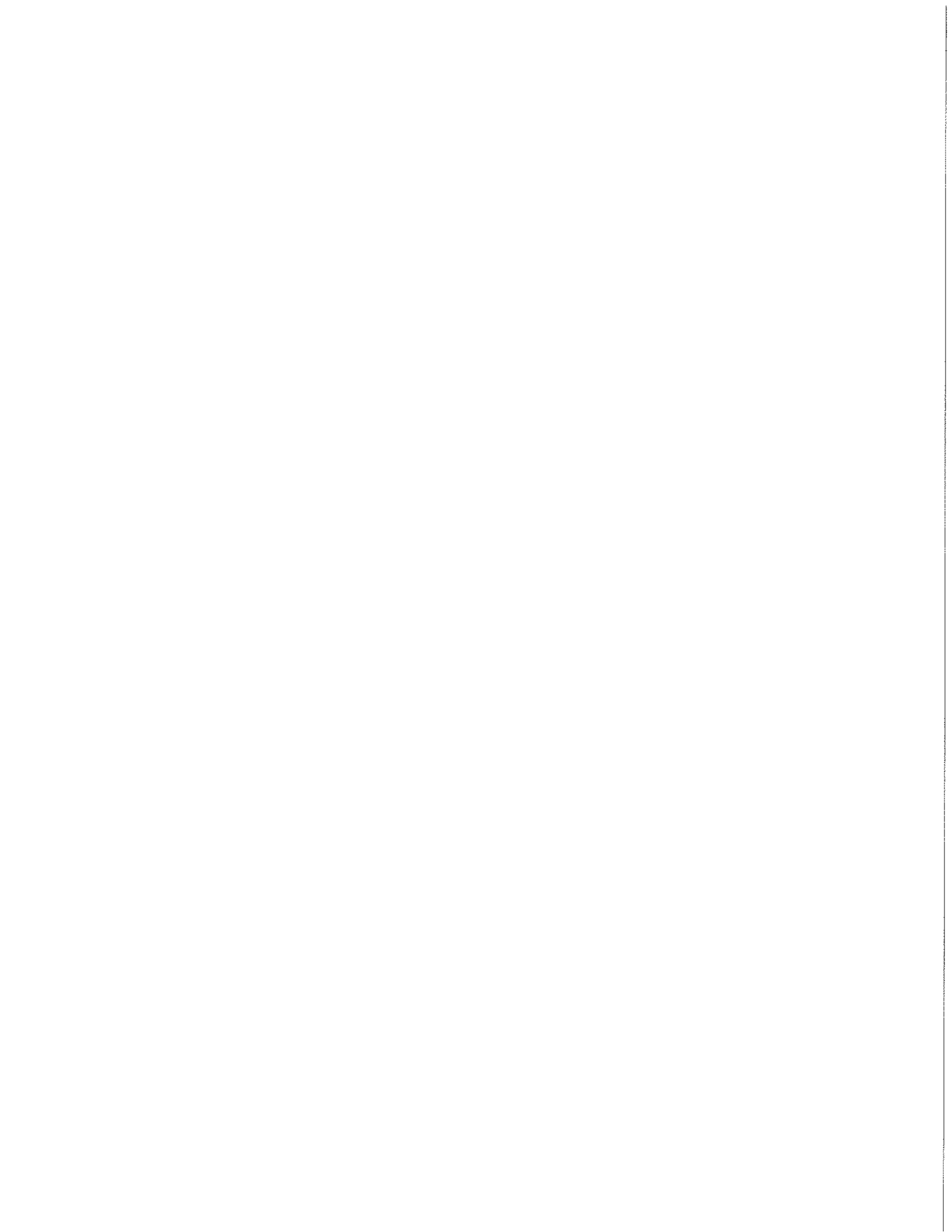
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| W 153   | <p>Continued From page 54</p> <p>8. When interviewed on 11/14/16 at 4:40 p.m., RTW Y recalled an incident that occurred at House 470 during the p.m. shift. RTW Y stated Client #21 earned his/her reinforcer for appropriate behavior, which was a drink flavor packet. As Client #21 searched through his/her options, RTW Z dumped the basket on the floor and told the client to pick it up. Client #21 laughed and picked the packets up, and RTW Z helped. RTW Y felt the interaction to be inappropriate. She stated she reported it a week later to a supervisor.</p> <p>Record review revealed the facility's Type 1 investigation report. According to the report, the incident allegedly occurred 10/6/16 and was reported to the supervisor on 10/12/16 at 2:40 p.m.</p> <p>9. Record review on 11/2/16 revealed facility Type 1 Incident Investigation Report, completed 8/18/16. The report indicated an incident was reported to RTS D on 8/8/16 at 3:27 p.m. The incident included "on 8/6/16, possible abuse/neglect occurred when providing care to (Client #25), by two regular support staff of the unit."</p> <p>When interviewed on 11/2/16 at 12:58 p.m. Food and Nutrition Services (FNS) Worker A reported she previously worked as a RTW. FNS Worker A recalled on 8/6/16 and 8/7/16 RTW CC and RTW DD split responsibility of Client #25. RTW CC took the first part of the shift and RTW DD took the second part of the shift. According to FNS Worker A, on both days RTW CC sat knee to knee with Client #25 and pushed him/her down when he/she tried to get up. RTW CC walked</p> | W 153   |   |                      |   |



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| W 153  | <p>Continued From page 55</p> <p>Client #1 a few times, but complained about him/her. FNS Worker A reported RTW DD also sat in front of Client #1, on an office chair, and restricted him/her from getting up. FNS Worker A witnessed Client #25 push RTW CC and RTW DD away while she walked through the living room. FNS Worker A recalled RTW CC and RTW DD pushed Client #25 at his/her gait belt area or grabbed onto Client #25's gait belt and pulled him/her down to a sitting position. At times, RTW DD sat with her back towards Client #25. On one of the two nights, FNS Worker A assisted another client down the hall when she heard RTW DD raise her voice and say, "Don't touch me you perv." According to FNS Worker A, RTW DD was on the phone and Client #25 pulled her hair. FNS Worker A stated she also heard Client #25 grunting and trying to get up. FNS Worker A told a nurse, RTW CC and RTW DD would not let Client #25 get up, but the nurse instructed FNS Worker A Client #25 needed to sit when he/she received his/her medications. FNS Worker A also reported RTW CC or RTW DD used Snapchat, took pictures of Client #25 and called him/her a name. FNS Worker A voiced her concern when the overnight staff arrived, but RTW CC and RTW DD stated Client #25 was having trouble walking throughout the shift. According to FNS Worker A, Client #25 should be walked whenever he/she attempted to get up, unless he/she received medication. FNS Worker A stated Client #25 should walk the hallway 25 times a shift. FNS Worker A confirmed she waited until 8/8/16 to report the incident to her supervisor. She believed RTW CC and RTW DD would have known if she reported to the RTS on duty on 8/6/16 and 8/7/16.</p> <p>10. Record review on 10/31/16 revealed the</p> | W 153  |   |                      |   |

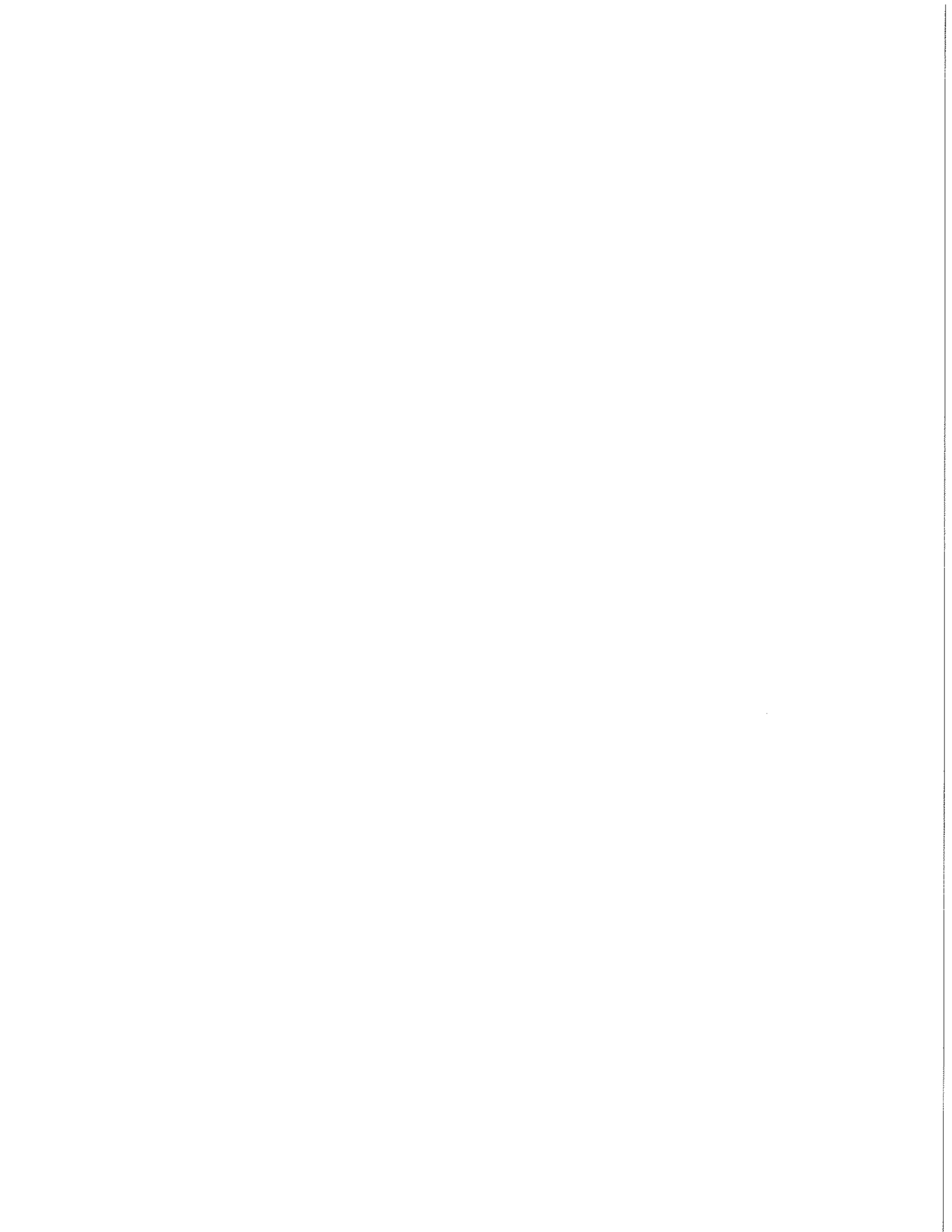




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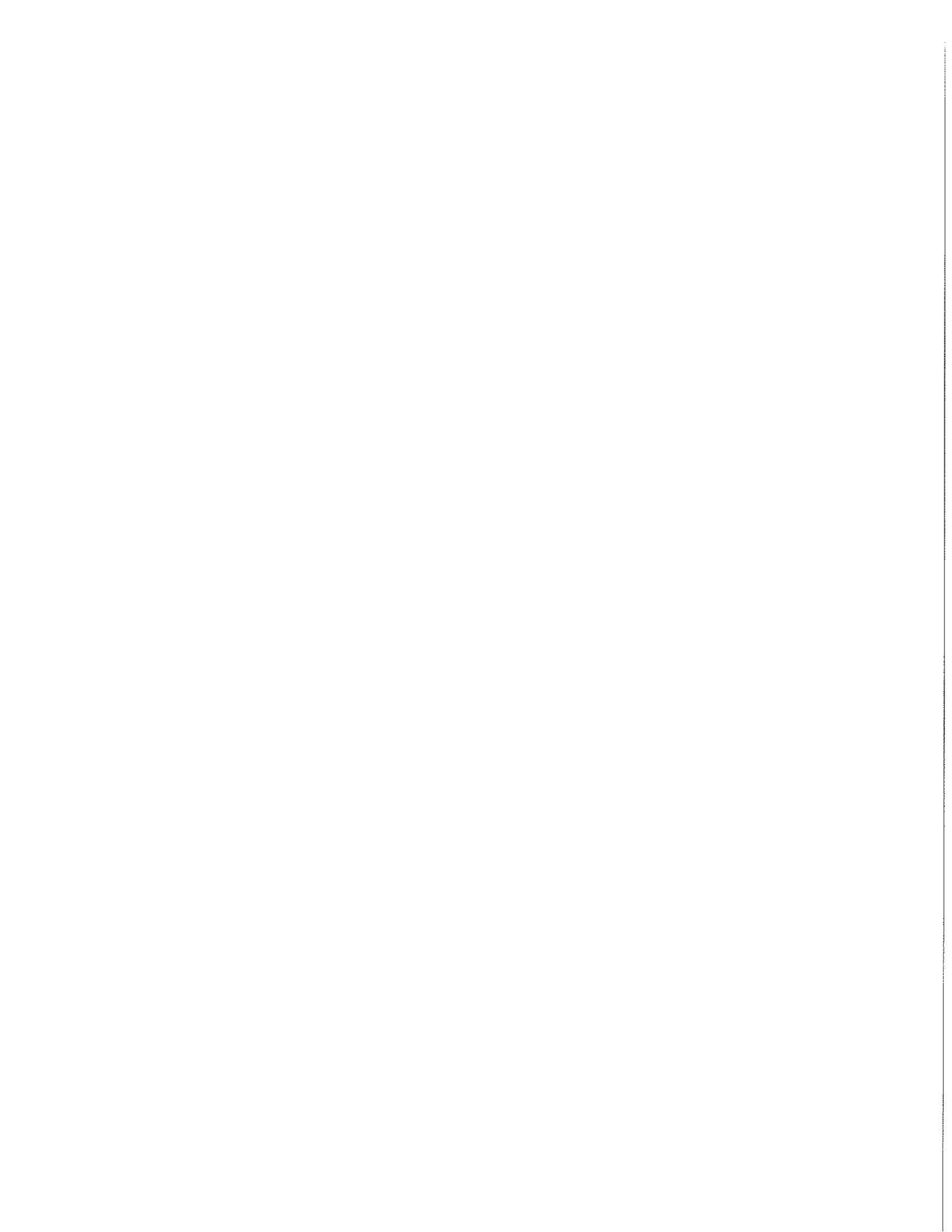
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| W 153   | <p>Continued From page 56 following:</p> <p>a. Type 1 Incident Investigation Report completed 8/18/16. The report indicated an incident for Client #26 was reported to RTS D on 8/8/16 at 5:13 p.m. The incident included "on 8/6/16, possible abuse/neglect occurred due to not providing person cares and repositioning by one regular RTW of this house."</p> <p>b. Type 1 Incident Investigation Report completed 8/18/16. The report indicated an incident for Client #27 was reported to RTS D on 8/8/16 at 5:18 p.m. The incident included "on 8/6/16, possible abuse/neglect occurred due to not providing person cares and repositioning by one regular RTW of this house."</p> <p>C. Type 1 Incident Investigation Report completed 8/18/16. The report indicated an incident for Client #28 was reported to RTS D on 8/8/16 at 5:22 p.m. The incident included "on 8/6/16, possible abuse/neglect occurred due to not providing person cares and repositioning by one regular RTW of this house."</p> <p>When interviewed on 10/31/16 at 2:20 p.m. FNS Worker A reported on 8/6/16 and 8/7/16 from 2:00 p.m. to approximately 5:00 p.m., Client #26, Client #27, and Client #28 were not repositioned according to their plans. FNS Worker A stated RTW CC was assigned to Client #26, Client #27, and Client #28. FNS Worker A recalled RTW CC sat in the same spot while FNS Worker A repositioned and provided personal care to her group of clients. According to FNS Worker A, Client #26, Client #27, and Client #28 should have been repositioned every 2 hours. FNS Worker A stated they may have to go over the 2</p> | W 153   |   |                      |   |



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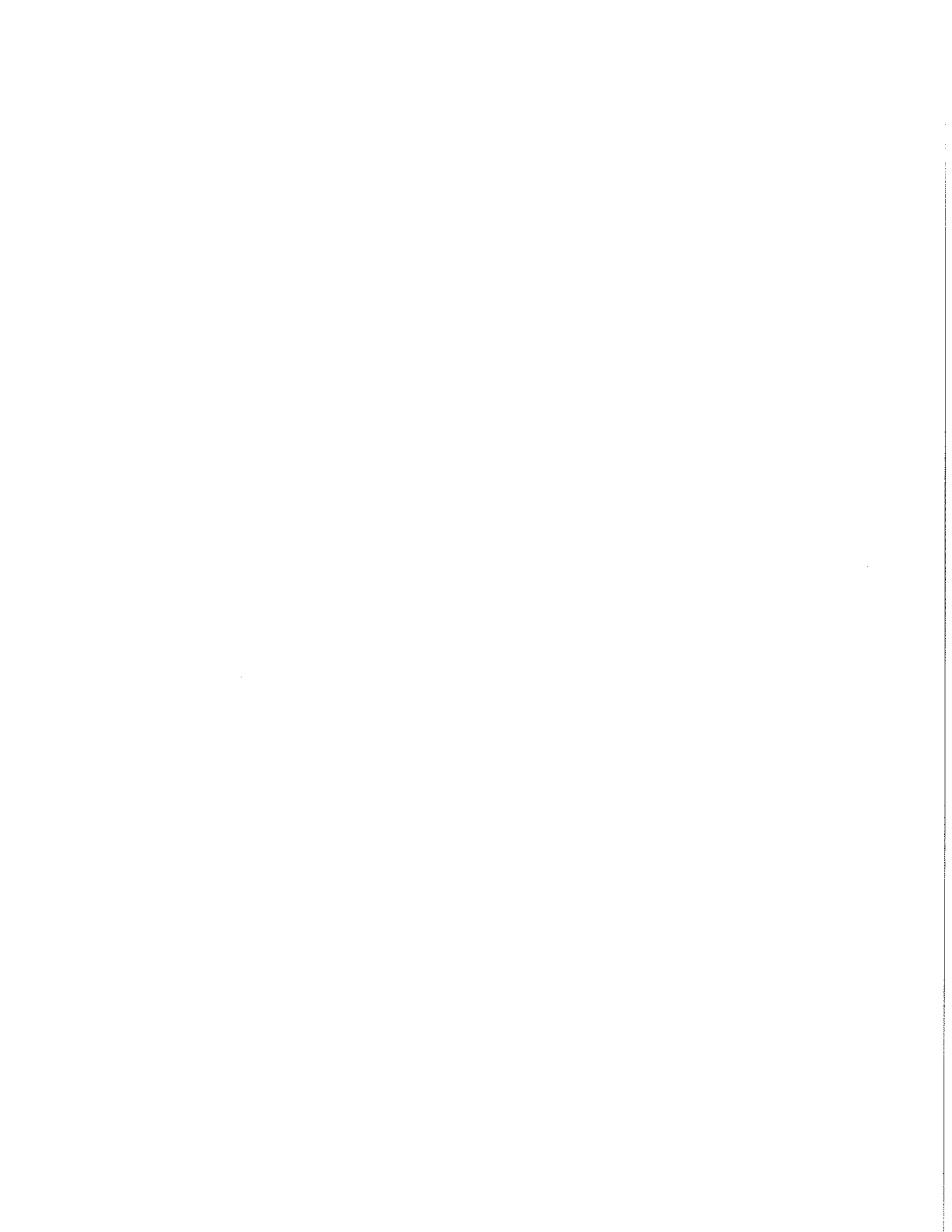
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| W 153   | <p>Continued From page 57</p> <p>hours if staff are assisting other clients. FNS Worker A believed the time to reposition a client took 15 to 30 minutes depending on the clients needs. On 8/6/16, FNS Worker A assumed RTW CC repositioned the clients and thought maybe RTW CC was fast. On 8/7/16, FNS Worker A looked at Client #26, Client #27, and Client #28's accountability sheet. FNS Worker A stated RTW CC documented the clients were in their wheelchairs when FNS Worker A observed them in bed. After FNS Worker A looked at the document, she believed on 8/6/16 RTW CC also repositioned the clients on paper but not in person. FNS Worker A reported on 8/7/16, at approximately 5:00 p.m., FNS Worker A walked into Client #26's bedroom. FNS Worker A stated RTW CC observed her, went into Client #26's bedroom and stated she was going to give Client #26 a bath. FNS Worker A reported after RTW CC gave Client #26 a shower, RTW CC repositioned Client #27 and Client #28 before she went to break. FNS Worker A remembered on 8/6/16, RTW CC gave Client #26 a fast shower and repositioned Client #27 and Client #28 before she left for break.</p> <p>When interviewed on 3:14 p.m. RTS D confirmed FNS Worker A failed to report the incidents of potential abuse/neglect for Client #25, Client #26, Client #27, and Client #28. She stated FNS Worker A reported the incidents to RTS D on 8/8/16. RTS D informed FNS Worker A she knew better and she was just as guilty as RTW CC and RTW DD.</p> <p>Record review revealed the facility's incident management policy, effective 11/2/07. The policy instructed, "All staff... have a responsibility to assure individual safety and protection from harm</p> | W 153   |   |                      |   |



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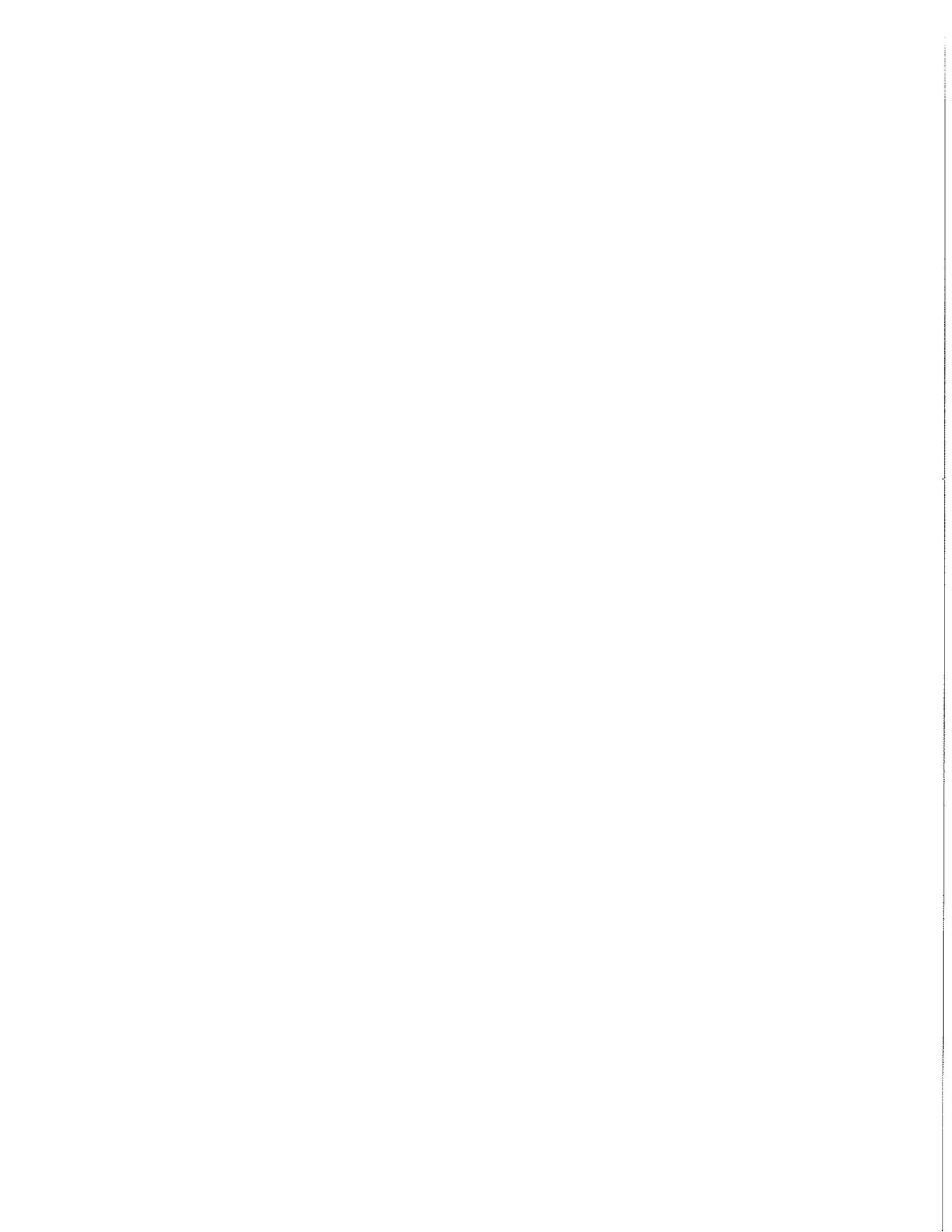
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| W 153   | Continued From page 58<br>and therefore shall report all incidents immediately." The policy included staff reporting requirements, which directed, "Staff shall immediately verbally report all incidents, including those that may be reported to the staff by a volunteer or contractor, to the staff's direct line supervisor or supervisor on duty." The requirements further directed, "The staff that suspects, has knowledge of, or receives a report of abuse shall report the allegation to DIA (Iowa Department of Inspections and Appeals) within 24 hours of knowledge of the incident..."<br><br>On 11/15/16 at approximately 9:30 a.m. Immediate Jeopardy (IJ) was determined based on the facility's failure to protect clients from abuse and mistreatment. The facility was notified at approximately 10:00 a.m. The facility developed and implemented a plan to remove the IJ. The plan included increased supervision in the homes on evenings and weekends and retraining of staff. The plan also included oversight follow-up and observations by Department of Human Services (DHS) Division of Mental Health and Disability Services, to be completed at least twice monthly. The IJ was removed on 12/6/16 at 1:00 p.m. | W 153   |   |                      |   |
| W 193   | 483.430(e)(3) STAFF TRAINING PROGRAM<br><br>Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.<br><br>This STANDARD is not met as evidenced by:<br>Based on interviews and record review, facility staff failed to exhibit adequate skills to correctly and consistently provide supports as specified in  | W 193   |   |                      |   |



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| W 193  | Continued From page 59<br>individual program plans. This affected 3 of 28 sample clients (Clients #1, #4, and #24).<br><br>Findings follow:<br><br>1. Record review revealed the following:<br><br>a. Type 1 Incident Investigation Report, dated 9/26/16, noted, "Staff notified this RTS of an unknown injury to (Client #1) on (his/her) neck, shoulders, and back. Upon further follow up to house 248 (Client #1) was asked to show us the area noted. (He/she) had multiple scratches, scrapes, and bruises to (his/her) neck, back, and shoulders. When asking (Client #1) what happened, (he/she) stated, 'The PM's held me down and shot me.'<br><br>b. Client #1's Behavior Support Plan (BSP), dated 8/4/16, noted Client #1's target behaviors as aggression, self-injurious behaviors (SIB), property destruction, and noncompliance. Precursor behavior for Client #1 was identified as verbal aggression. According to Client #1's plan, when Client #1 displayed verbal aggression, staff should, "...Assist (him/her) in identifying an appropriate alternative behavior consistent with the social skills protocol. If (Client #1) exhibits an appropriate response, reinforce that behavior by providing verbal praise. When (Client #1) does not exhibit an appropriate response and continues to engage in verbal aggression; briefly restate the appropriate behavior identified and do not provide further attention. Redirect (Client #1) back to the activity in progress when (he/she) is calm ..." The plan defined noncompliance as "refusal to complete assigned household chores, self-care tasks, or vocational tasks, after 2 verbal prompts have been delivered spaced 5 minutes | W 193  |   |                      |   |

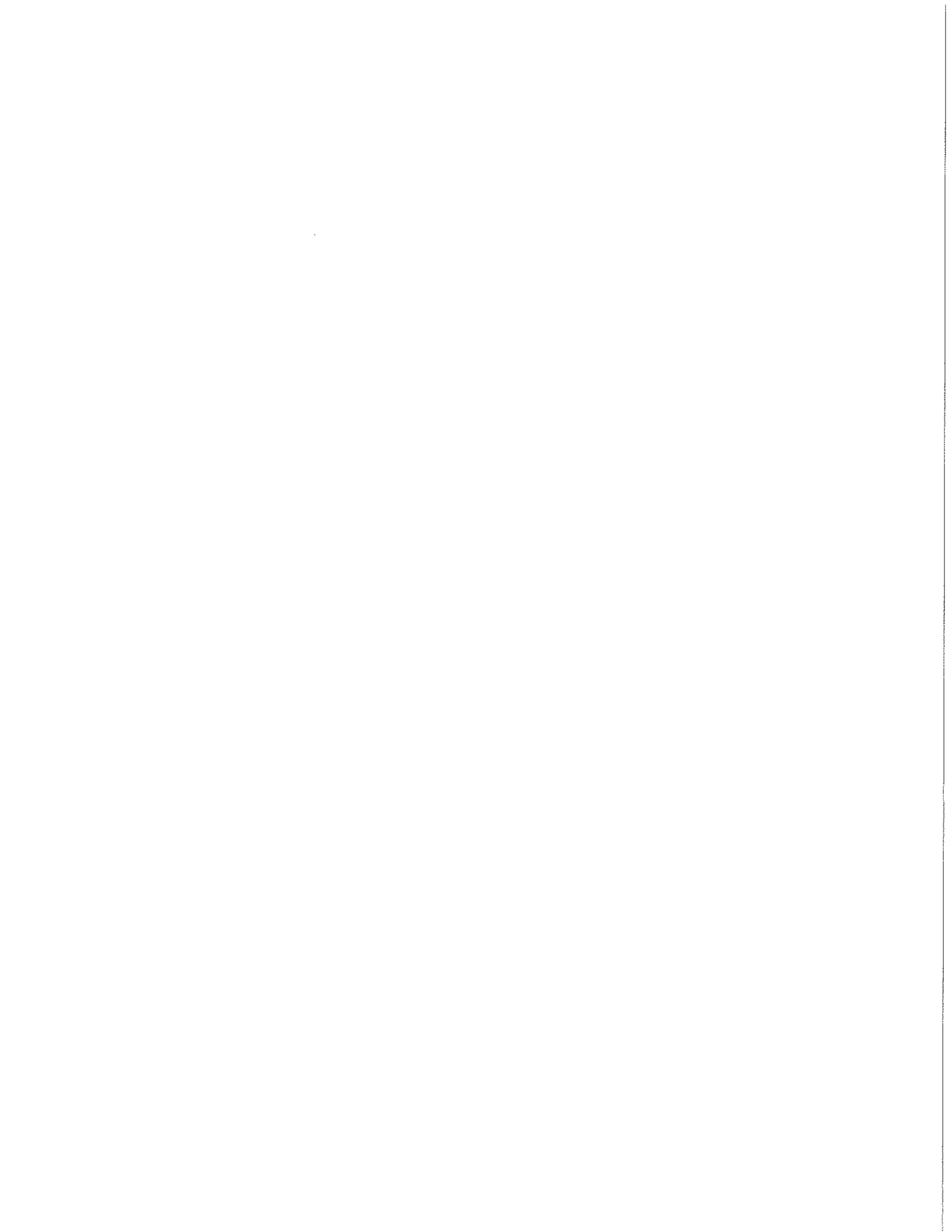




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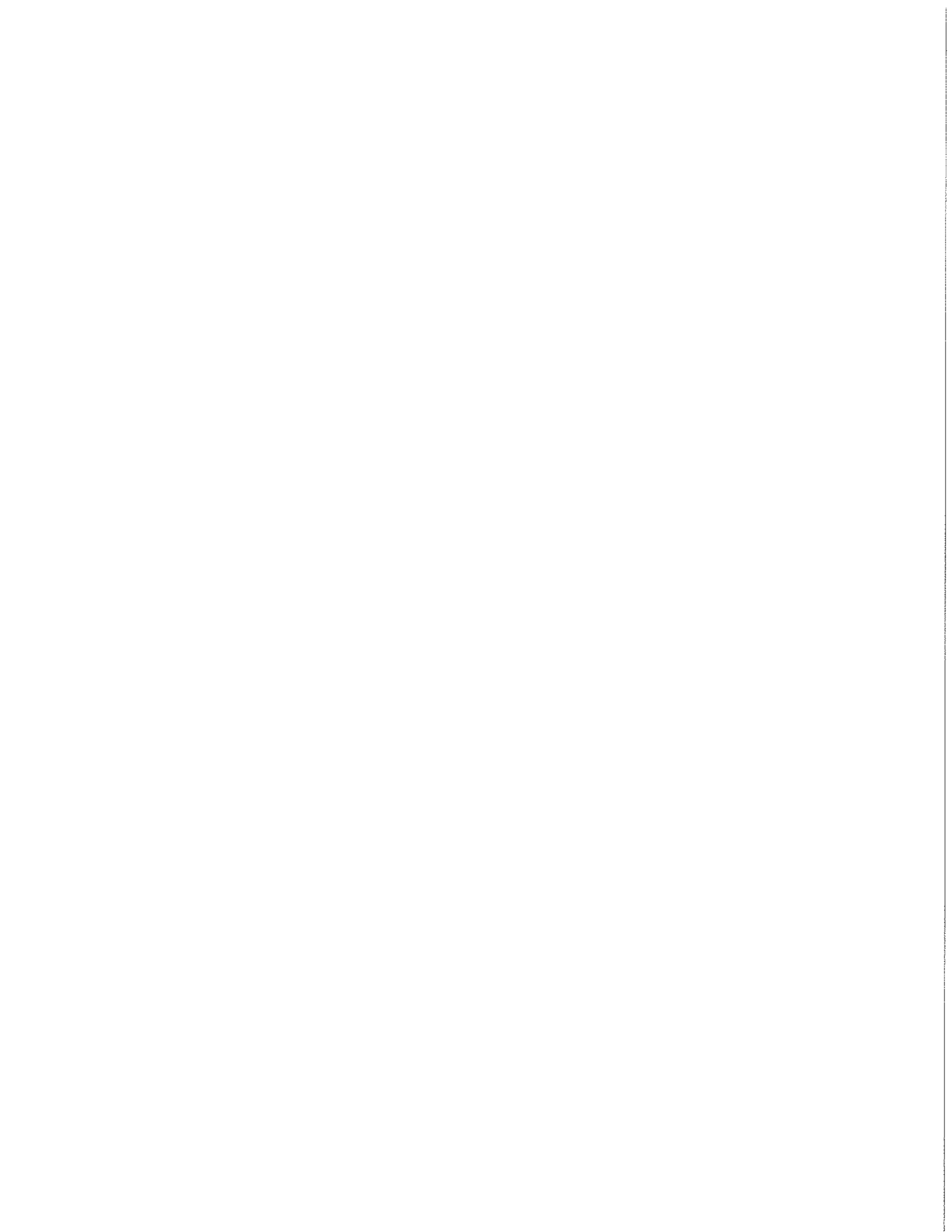
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| W 193   | <p>Continued From page 60</p> <p>apart." According to Client #1's plan, when he/she displayed noncompliance staff should, "...provide (him/her) with one prompt to complete the task. If noncompliance continues following the prompt, continue providing prompts at 5 minute intervals..." The plan also indicated for all targeted behaviors staff should, "...give as little attention as possible. Use GRC approved procedures to block or redirect behaviors that pose a risk of injury. Redirect (him/her) back to scheduled activities when (he/she) is calm (no target behaviors or precursors)..."</p> <p>When interviewed on 11/21/16 at 1:13 p.m., RTW B reported on 9/23/16 he assisted Client #1 with cleaning the bathroom. Client #1 yelled and threw the mop bucket. According to RTW B, RTW A walked into the bathroom and grabbed Client #1 by the arms. RTW A told Client #1 the other clients were sleeping. RTW B left the bathroom because he did not want to be around the interaction between Client #1 and RTW A. RTW B heard Client #1 yelling, but Client #1 yelled when he/she was asked to mop. RTW B stated after RTW A left, he went back into the bathroom and Client #1 was mopping. RTW B stated he believed Client #1's bruising came from RTW A and did not know where else the bruising would have come from.</p> <p>2. Record review on 11/14/16 revealed the facility's type 1 investigation report, completed 11/1/16. The report outlined an allegation of physical abuse against Client #24. A community member reported observing RTW AA strike Client #24 in the back of the head after he/she picked up something from the ground and put it in his/her mouth.</p> | W 193  |   |   |



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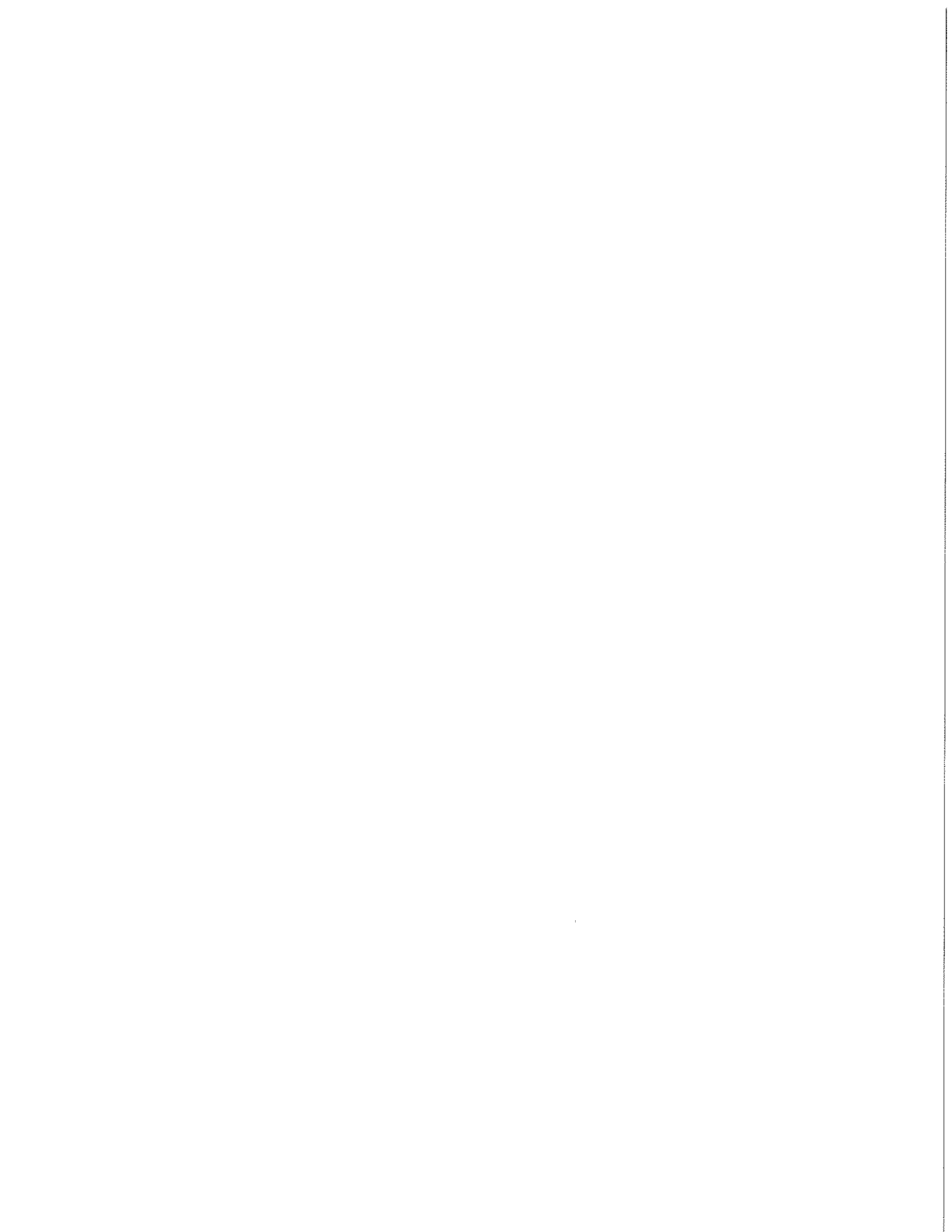
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| W 193   | <p>Continued From page 61</p> <p>Additional record review revealed Client #24's BSP, started 4/18/16, included the target behaviors of pica, defined as swallowing or drinking something not intended for human consumption; pica attempts, defined as attempting to swallow or drink something that is not intended for human consumption. For Client #24 this meant moving inedible items toward his/her mouth or putting such an item in his/her mouth but not swallowing it. Examples included cigarette butts. Interventions listed to prevent target behaviors included, but were not limited to: offering Client #24 a piece of gum before leaving the house, asking the client to carry items to ensure his/her hands were not empty, ensuring Client #24 walked beside or in front of staff when outside, visually scanning the area for cigarette butts and other items when the client went from one location to another, and redirecting Client #24 away from areas with cigarette butts when possible. Client #24's BSP indicated the client required close supervision, defined as walking in front of or beside staff and staff remaining at a distance that allowed them to intervene within five seconds.</p> <p>When interviewed on 11/15/16 at 11:20 a.m., RTW AA recalled she, RTW BB, and Activities Specialist (AS) A took Client #24 and four of his/her peers to the Dollar General store. RTW AA explained Client #24 required close supervision due to pica behavior. After completing their shopping, RTW AA volunteered to take all five clients, including Client #24 out to the van. She stated as they waited at the front of the store to check out, the clients were pointing at items, grabbing other items, and she worried about another clients history of inappropriately touching others. As RTW AA took all five clients</p> | W 193  |   |   |



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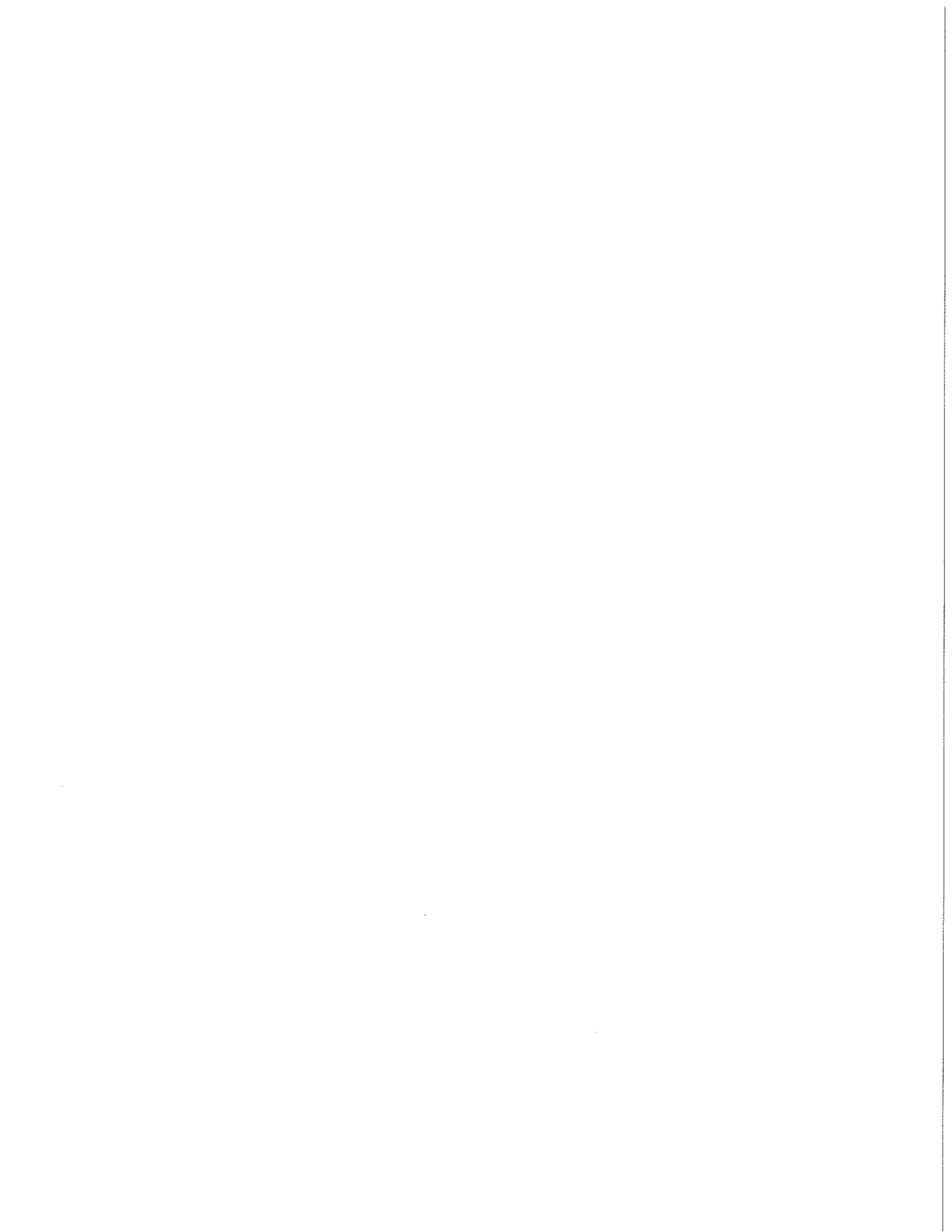
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| W 193   | <p>Continued From page 62</p> <p>out to the van, Client #24 began to walk ahead, and she asked him/her to stop. As Client #24 approached the van, she saw him/her bend over. She recalled she yelled, "(Client #24)! No!", then stopped and held his/her face to try to get the items out, as he/she had eaten a cigarette butt from the ground. She stated she was able to remove some of the cigarette butt, and asked the client why he/she had done that. RTW AA stated she had difficulty getting into the van and kicked cigarette butts under the van to remove them from Client #24's sight.</p> <p>When interviewed on 11/15/16 at 10:20 a.m. RTW BB stated she also went on the outing to the Dollar General Store. RTW BB explained Client #24 required close supervision due to pica behavior, and explained the client would eat cigarette butts. RTW BB stated Client #24's BSP directed he/she should have gum when out in the community. RTW BB stated she was unsure if the client had gum during the outing.</p> <p>When interviewed on 11/14/16 at 1:00 p.m., Activities Specialist (AS) A confirmed she went on the outing to the Dollar General Store. ASA stated Client #24 should have gum before outings, due to pica behavior. She explained his/her staff were responsible for ensuring Client #24 had gum. She could not recall if Client #24 had gum during the outing.</p> <p>3. Record review revealed the following:</p> <p>a. Type 1 Incident Investigation report, dated 10/10/16, noted, "At 11:30 AM on 10/10/16, (Client #4) reported to (Food and Nutrition Services (FNS) Supervisor) that (FNS Driver A) had seen (him/her) engaged in horseplay with</p> | W 193  |   |                      |



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| W 193   | <p>Continued From page 63</p> <p>someone on (his/her) route which involved using the middle finger gesture and cursing and (FNS Driver A) said, 'Do you want me to turn you in for cussing like you did to me?'" The facility separated FNS Driver A from Client #4.</p> <p>b. Client #4's BSP, dated 7/19/16, noted Client #4's precursors included disruptive behavior, defined as "yelling, screaming, teasing peers, flipping others off, arguing, hitting walls, slamming doors and cussing that does not cease within 30 seconds of a second verbal prompt." According to Client #4's plan, when Client #4 displayed disruptive behavior, staff should "Provide one prompt to 'stop.'" If (Client #4) continues displaying disruptive behavior provide (him/her) with an additional prompt and remind (him/her) of (his/her) response cost. If disruptive behavior does not cease within 30 seconds following the second prompt, mark the data sheet, (Client #4 will not attend off-unit activities for the remainder of the day and the next day (see response cost). Minimize all other attention. Redirect (Client #4) back to the scheduled activity when disruptive behavior stops..."</p> <p>When interviewed on 11/14/16 at 2:10 p.m., FNS Driver A reported on 10/10/16 he worked with Client #4. FNS Driver A explained Client #4 was supposed to help with delivering and picking up the food trays in the houses. According to FNS Driver A, Client #4 wanted to do what Client #4 wanted to do. FNS Driver A stated he didn't try to be mean to Client #4, but his voice might have been more stern after asking Client #4 to do something four or five times. Client #4 liked to tease and took teasing too far at times. FNS Driver A recalled on 10/10/16, he and Client #4 were at House 462, when Client #4 walked out of</p> | W 193   |   |                      |   |

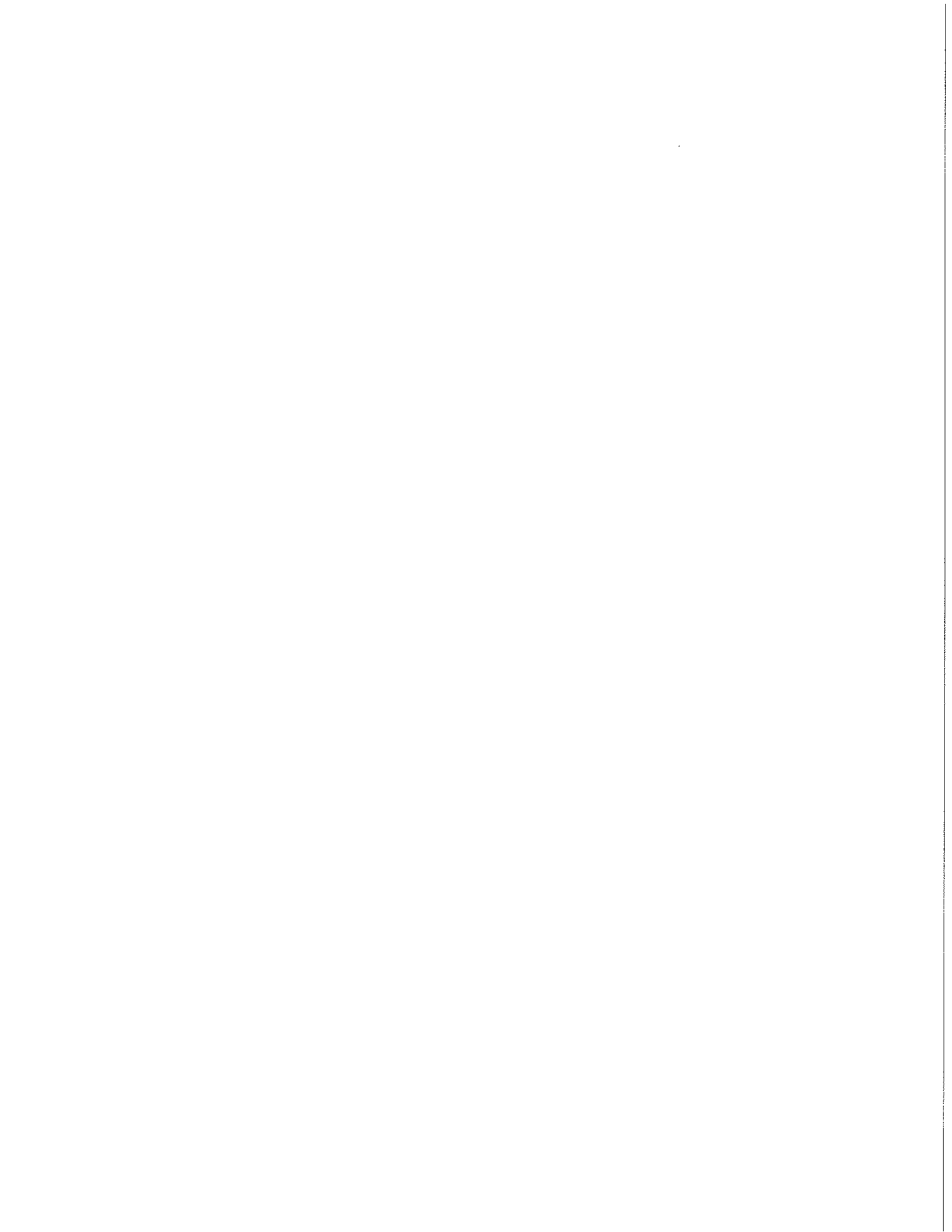




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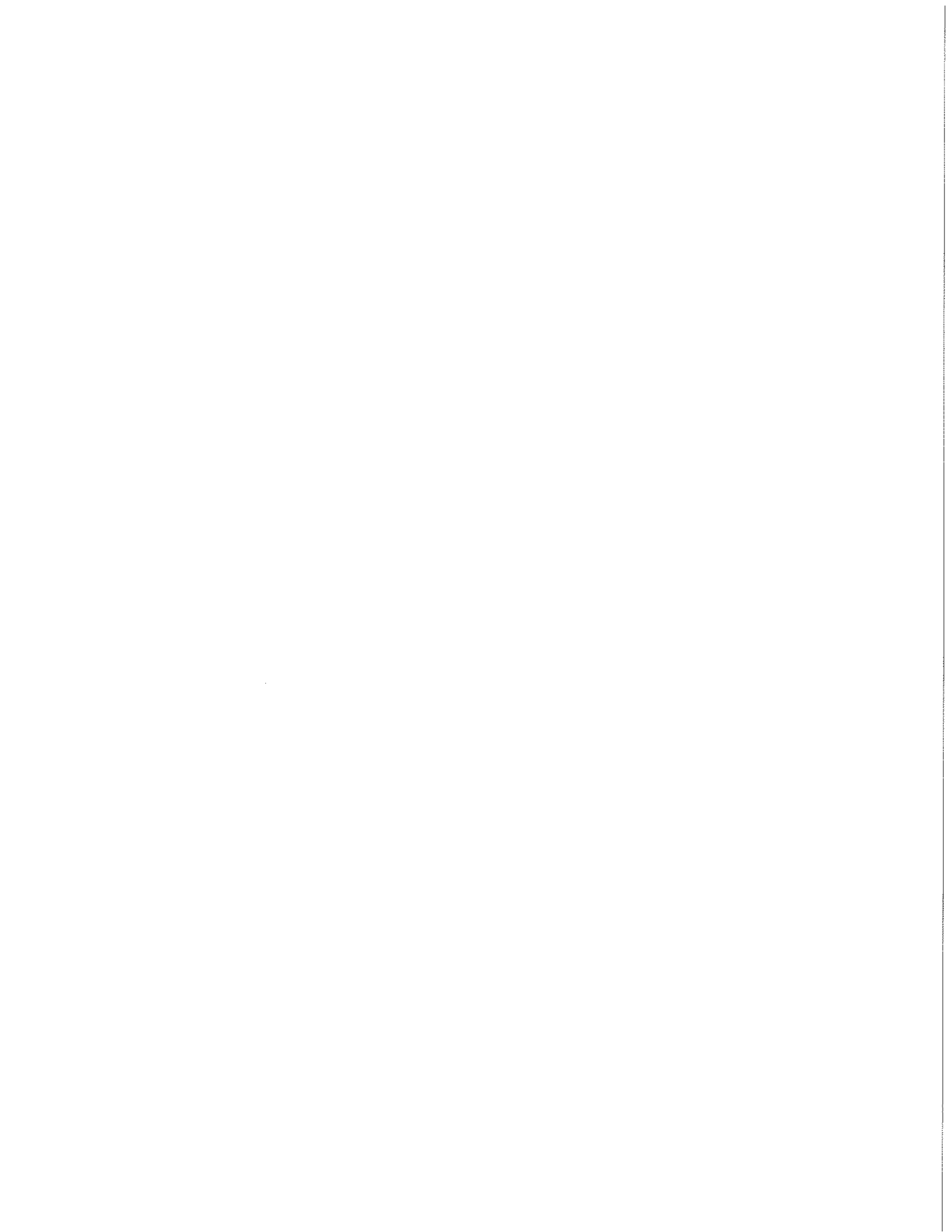
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| W 193   | <p>Continued From page 64</p> <p>the house cussing. Client #4 then stuck both middle fingers toward House 462. FNS Driver A could not tell if Client #4 tried to be playful. FNS Driver A told Client #4 he/she could not cuss and that he would not report him/her for cussing. According to FNS Driver A, approximately 3 weeks prior to this incident, Client #4 reported FNS Driver A for cussing at him/her. FNS Driver A stated on 10/10/16 he tried to teach Client #4 what society wants. Client #4 told FNS Driver A he/she was just kidding. FNS Driver A thought since they were in the van, it was a teaching moment.</p> <p>When interviewed on 12/6/16 at 4:28 p.m., Client #4 reported every time he/she worked with FNS Driver A, he swore at Client #4. Client #4 stated when he/she tried to talk to FNS Driver A, he said to get back to work and it wasn't time to slack off. Client #4 stated he/she turned FNS Driver A in for cussing. According to Client #4, at house 462, he/she horse played with staff and told them to bring it on and flipped them off. FNS Driver A told Client #4 that he/she did not get paid for slacking off and asked if he/she wanted to be turned in.</p> <p>When interviewed on 11/21/16 at 2:06 p.m., the FNS Director stated she reported the incident with FNS Driver A and Client #4. She reported Client #4 used his/her middle finger and FNS Driver A threatened Client #4. FNS Director stated FNS Driver A told Client #4 he could turn Client #4 in, like Client #4 turned FNS Driver A in. FNS Driver A stated he saw the threat as a learning opportunity. According to FNS Director, prior to the incident on 10/10/16, Client #4 reported FNS Driver A for cussing at him/her. She believed FNS Driver A retaliated against Client #4 by making the threat. FNS Director</p> | W 193   |   |                      |   |



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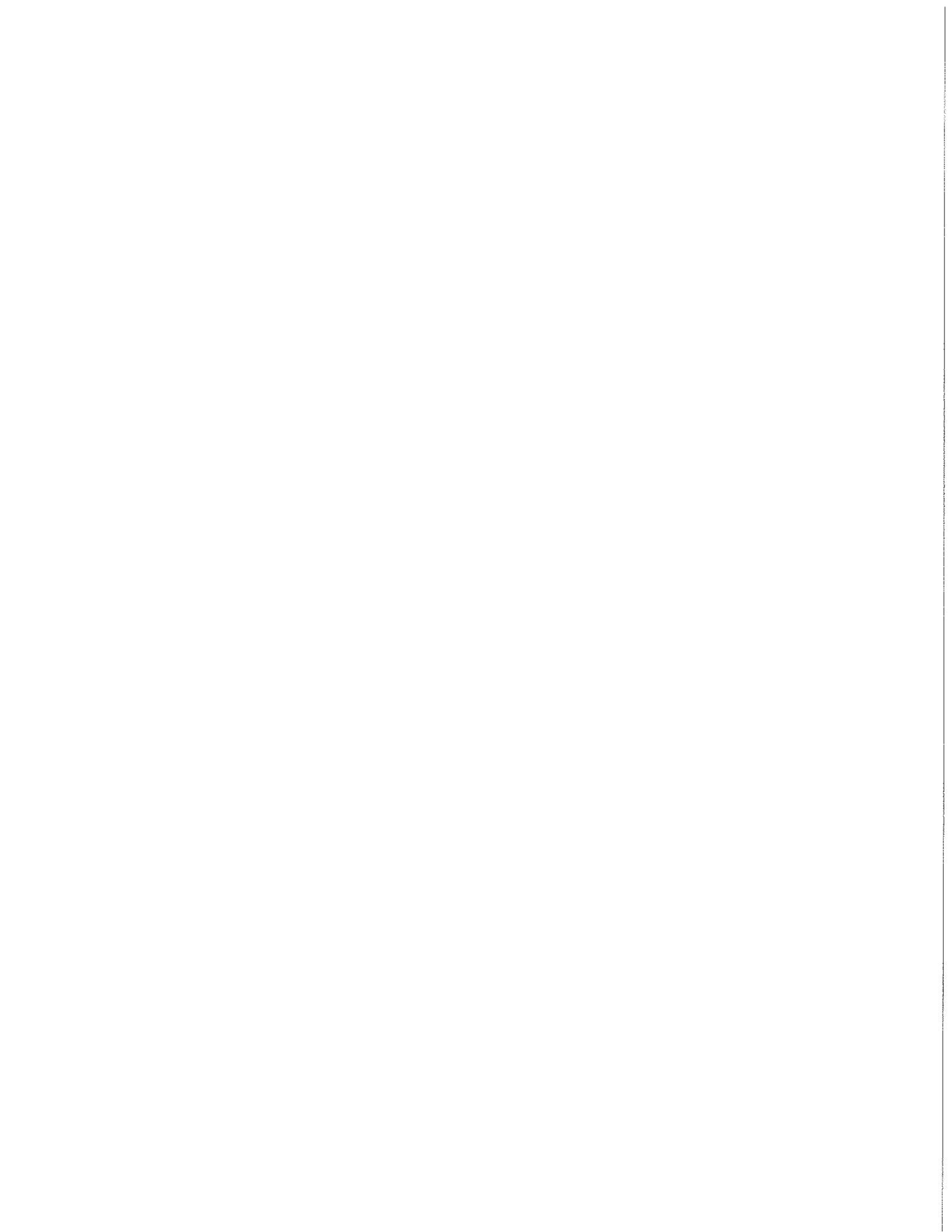
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| W 193<br><br>W 268  | Continued From page 65<br>confirmed FNS Driver A failed to follow Client #4's behavior support plan.<br>483.450(a)(1)(i) CONDUCT TOWARD CLIENT<br><br>These policies and procedures must promote the growth, development and independence of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on interviews and record review, the facility staff failed to ensure consistent implementation of policy and procedure to manage appropriate staff and client interactions. The facility failed to provide an environment to promote growth, development, and independence. This affected 18 of 28 sample clients (Clients #1, #2, #3, #4, #5, #6, #7, #8, #15, #16, #17, #18, #19, #20, #22, #23, #24, #25) and potentially affected 227 of 227 clients residing at Glenwood Resource Center (GRC).<br><br>Findings follow:<br><br>1. When interviewed on 11/15/16 at 2:00 p.m. Resident Treatment Worker (RTW) K recalled she worked overtime at House 253 on 11/6/16 from 10:00 a.m. - 2:00 p.m. RTW K recalled as she sat with her assigned client during snack, the conversation among the staff in the area turned sexual in nature. The conversation occurred between RTW H and RTW J in front of Clients #15, #16, #17, #18, #19, and #20. RTW K recalled RTW H asked RTW J if he would like to engage in anal intercourse with his wife, RTW I. As this conversation continued, RTW H spoke of how he would like to engage in anal intercourse with RTW K. As snack ended, Client #15 and | W 193<br><br>W 268  |   |                      |   |



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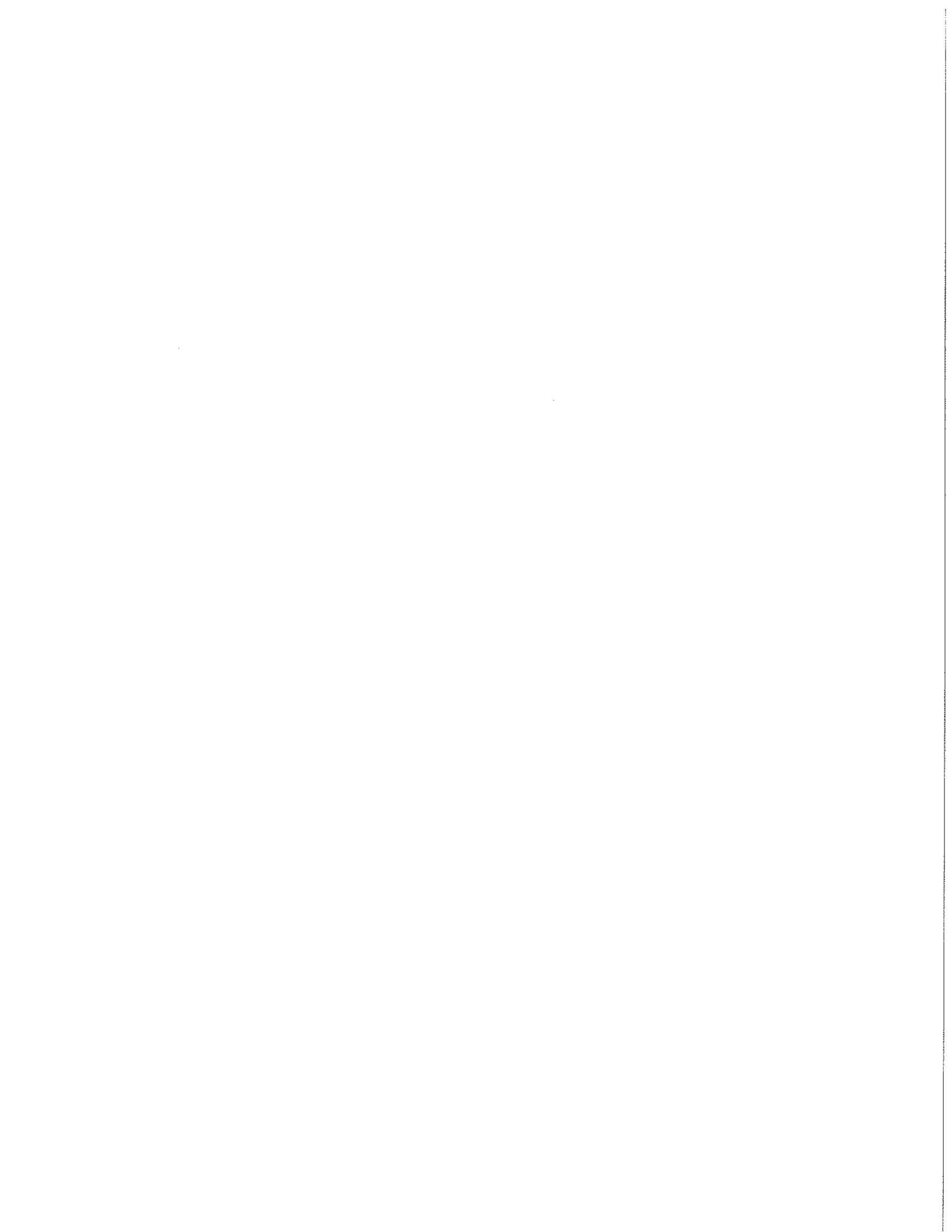
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| W 268  | Continued From page 66<br>Client #16 were told to sit on the couch. Client #15 stood from the couch, and RTW H hit him/her on the head with a butter knife. Client #15 sat back down on the couch with tears in his/her eyes, held his/her head, curled up in the fetal position and began rocking. Client #16 then stood from the couch and was hit on the head with a spoon or butter knife by RTW J. RTW K reported the hit to the head could be heard. Client #16 grabbed his/her head and sat back down. RTW K recalled this occurred amongst the on-going inappropriate conversation regarding anal intercourse and male genitals. Client #15 again stood from the couch, and was hit on the head by RTW H. Client #16 stood and was also hit on the head, though RTW K could not see who hit Client #16. RTW K reported she saw Client #15 hit, heard both clients hit, and heard their reactions. She reported both clients held their heads, rocked, and cowered. In the midst of these activities, RTW K reported an additional conversation occurred between RTW I and RTW J regarding laundry and how it was a "woman's job." RTW N also participated in this conversation and encouraged Client # 17 and Client #18 to push the laundry basket towards RTW I. RTW I responded to the clients, "If you do it, I'll kick your ass." RTW K recalled RTW H and RTW J then began to ask Client #19, "Does Grandma make you horny?," referring to RTW H's wife, RTW I. RTW H and RTW J repeatedly asked Client #19 this, until he/she said "Grandma makes me horny." RTW K recalled, at that point, RTW J asked Client #20 if RTW U liked to engage in oral sex or anal intercourse with other men. Client #20 refused to answer the question. RTW J stood closer to Client #20 and RTW U stood directly behind the client, where he could not be seen. RTW J, again, asked Client #20 if | W 268  |   |                      |   |



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| W 268   | <p>Continued From page 67</p> <p>RTW U liked to engage in oral sex or anal intercourse with other men. Client #20 continued to refuse, and RTW J continued to tell him/her to answer. Client #20 shook his/her head no, became very upset, and began to cry as staff continued to pressure him/her to answer the question about RTW U. RTW K reported RTW I then asked her to go take a break with her. RTW K and RTW I went outside to break and RTW K asked if RTW I liked her job. RTW K reported RTW I replied they liked the weekends because they could do whatever they wanted without supervisors. At that point it was time for lunch. Client #20 refused to put his/her clothing protector on. RTW U told the client he/she needed to put it on, and the client continued to refuse. RTW U told Client #20 he/she could not eat if he/she did not put the clothing protector on. Client #20, again, refused and RTW U said, "You better do it." Client #20 put the clothing protector on. Finally, towards the end of lunch, RTW H called RTW K to the living room. As she entered, she noticed RTW H sitting next to Client #19 with his leg laying over the client and Client #19 red-faced and sobbing. RTW K asked RTW H what was wrong, and he replied he told Client #19 that Grandma (RTW I) was never coming back. RTW K recalled Client #19 sobbed, hugged RTW H's leg, and rocked.</p> <p>Further interview with RTW K revealed she did not report these incidents immediately because she was scared. RTW K reported she feared retaliation and did not feel safe.</p> <p>2. When interviewed on 11/21/16 at 5 p.m. RTW L stated on 11/10/16 she was pulled to work at House 253 from 2:00 p.m. - 6:00 p.m. While in House 253 that day, she witnessed RTW M hit</p> | W 268  |   |   |

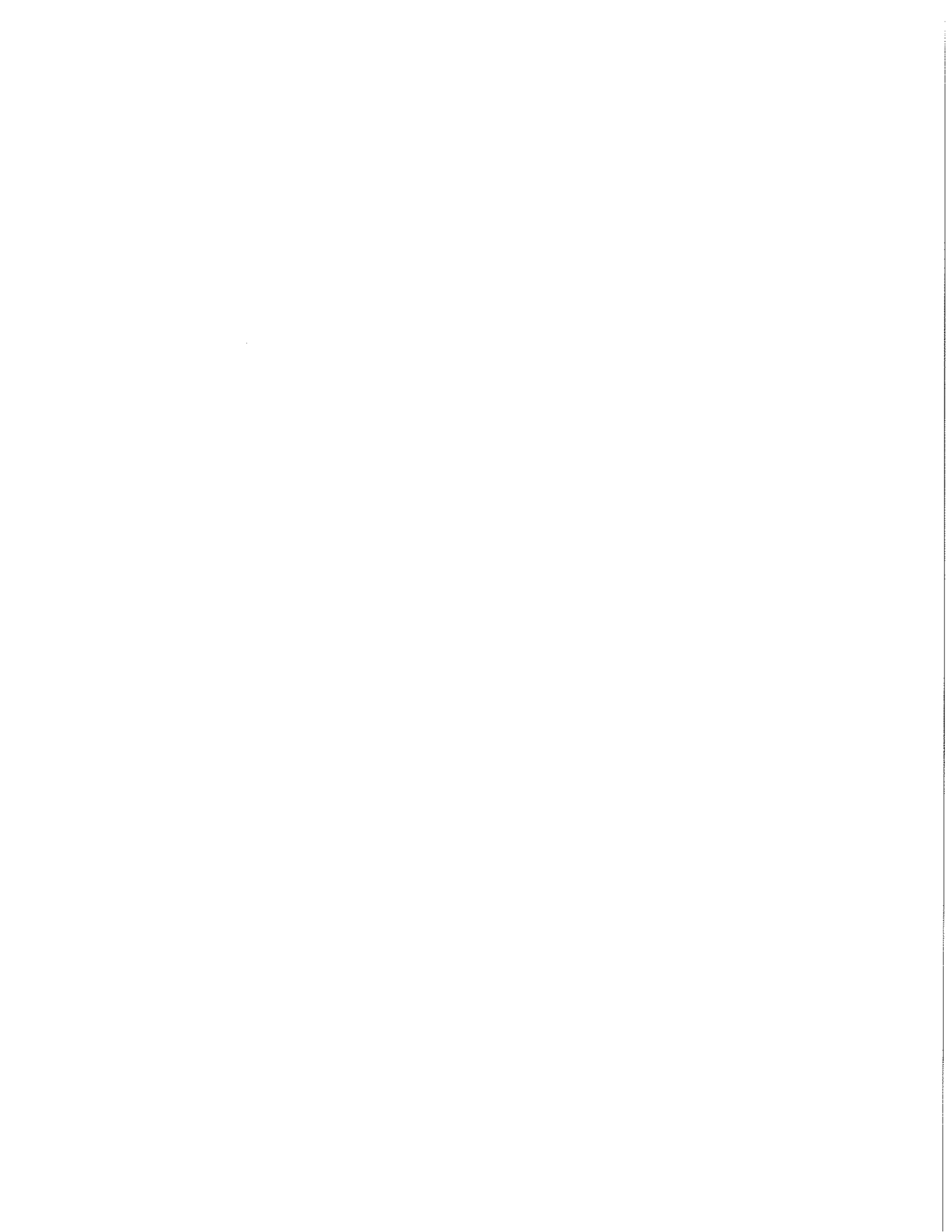




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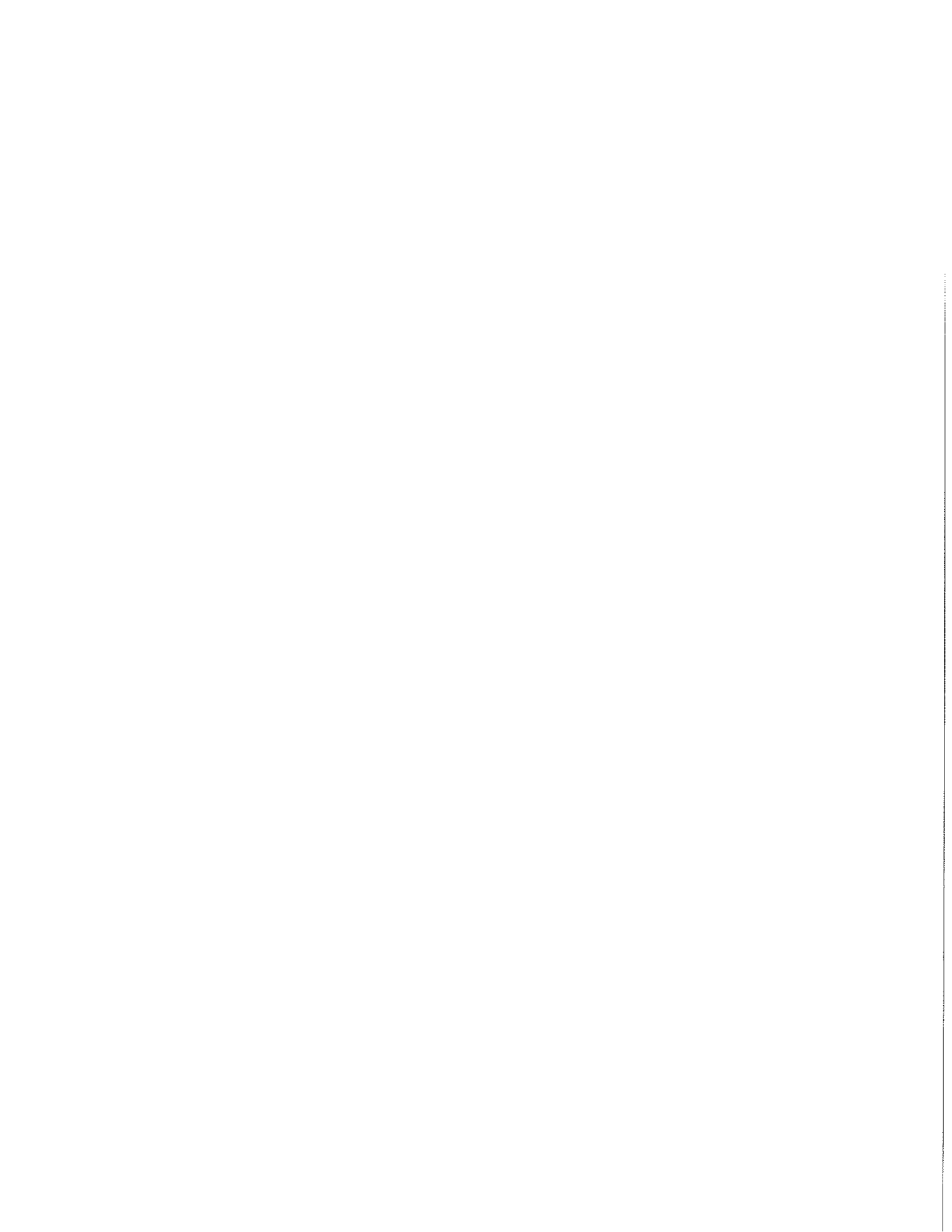
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| W 268   | <p>Continued From page 68</p> <p>Client #15 on the head with a butter knife while RTW H held him/her down on the couch. She stated she used her cell phone to record the incident.</p> <p>Observation during interview with RTW L revealed she shared a video clearly showing RTW M striking Client #15 on the head with an object and saying "Are we good?" The video also clearly showed RTW H holding Client #15 by the neck on the couch to prevent the client from getting up.</p> <p>When interviewed on 11/21/16 at 11:45 a.m. RTW M confirmed she and RTW H were the two staff in the video. She confirmed she hit Client #15 with a butter knife and stated, "Are we good?" She stated she had seen others use the butter knife in this same manner, including RTW I who used this technique on Client #15 multiple times and referred to it as the "Reset Button." RTW M stated she did not report any of the multiple incidents when RTW H and RTW I used a butter knife to hit clients or got physical with the clients. RTW M stated she was intimidated and scared of RTW H. RTW M stated RTW H had made comments about people who turn people in. She stated there was a rule in the house and they made staff feel uncomfortable and not want to report anything.</p> <p>When interviewed on 11/21/16 at 10:00 a.m., The Director of Quality Management (DQM) stated all clients at the facility should be treated with dignity and respect and at no point should staff ever use threats physical abuse, physically abuse, intimidate, or swear and talk about inappropriate sexual acts around the clients. She further stated RTW H, I, J and L were all suspended from</p> | W 268   |   |                      |   |



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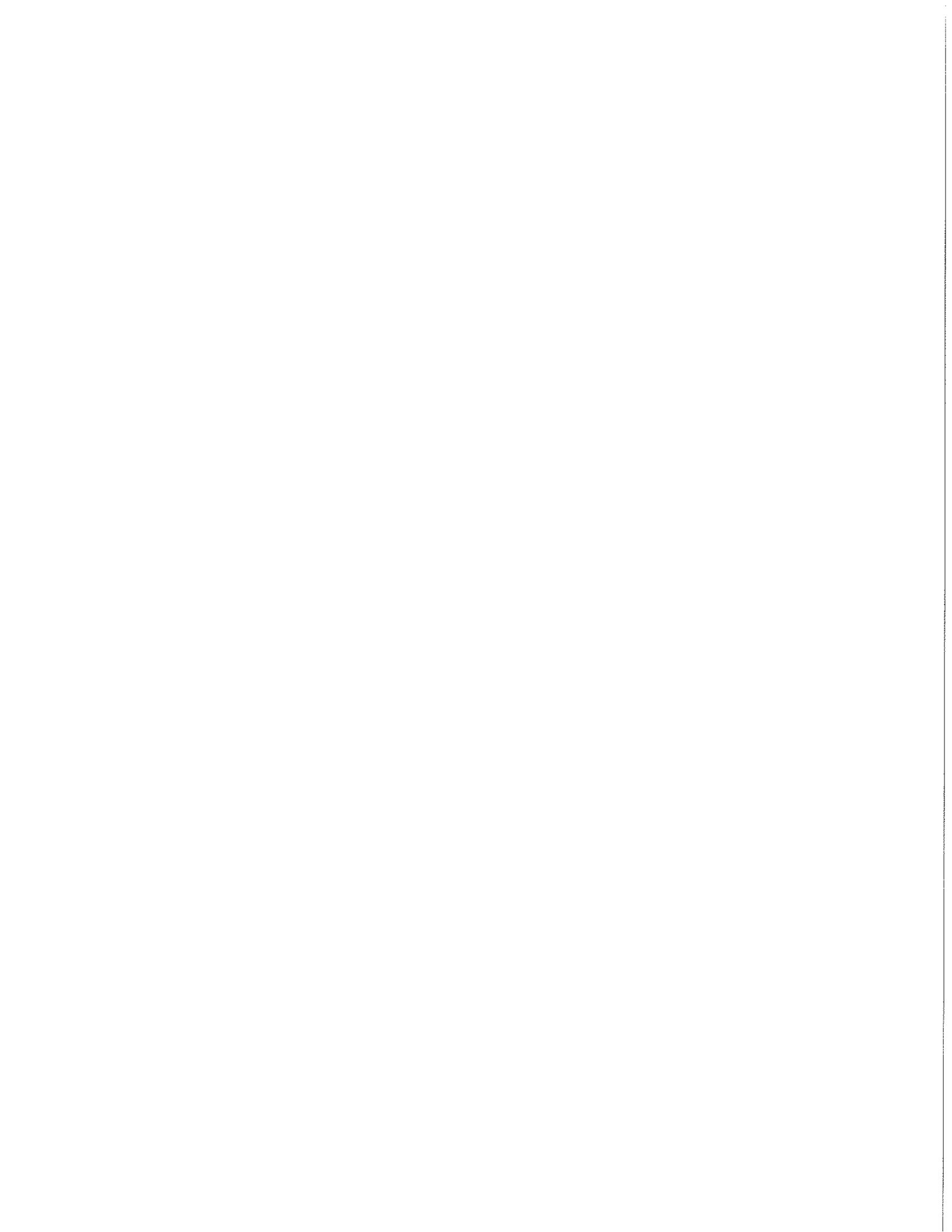
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| W 268   | <p>Continued From page 69</p> <p>employment for substantiated psychological, verbal and mental abuse. She confirmed the facility failed to keep the clients free from physical and psychological abuse</p> <p>3. When interviewed on 11/21/16 at 5:00 p.m. RTW L stated she observed Client #15 rocking in a recliner, refusing to stop when redirected. RTW H walked across the room, grabbed Client #15 by his/her legs, and pulled him/her from the recliner to the floor. RTW H told Client #15 he/she would have to sit on the floor if he/she didn't stop. RTW H left the immediate area and returned to the client for whom he had accountability. RTW L stated a few minutes later Client #15 began to rock hard in the recliner again. RTW H came across the room, stood behind Client #15, and hit him/her in the back of the head with his fist three times.</p> <p>4. When interviewed on 11/28/16 at 11 a.m. RTW N stated on 11/6/16 he witnessed RTW I use a butter knife and hit Client #15 and Client #16 while working at House 253. RTW N further stated when she hit the clients with a butter knife she would say, "Knock it off!" RTW N then stated he had a bad day a few months back and slapped Client #15 in the back of the head.</p> <p>5. When interviewed on 11/22/16 at 3:15 p.m. Client #17 stated he/she witnessed RTW I use a butter knife to hit Client #15. He/she stated she used the knife to calm Client #15 down. Client #17 stated RTW I would say, "Are we Done?" Client #17 stated he/she witnessed this multiple times.</p> <p>6. When interviewed on 11/21/16 at 7:00 p.m. Client #18 stated he/she witnessed RTW H, RTW</p> | W 268  |   |   |



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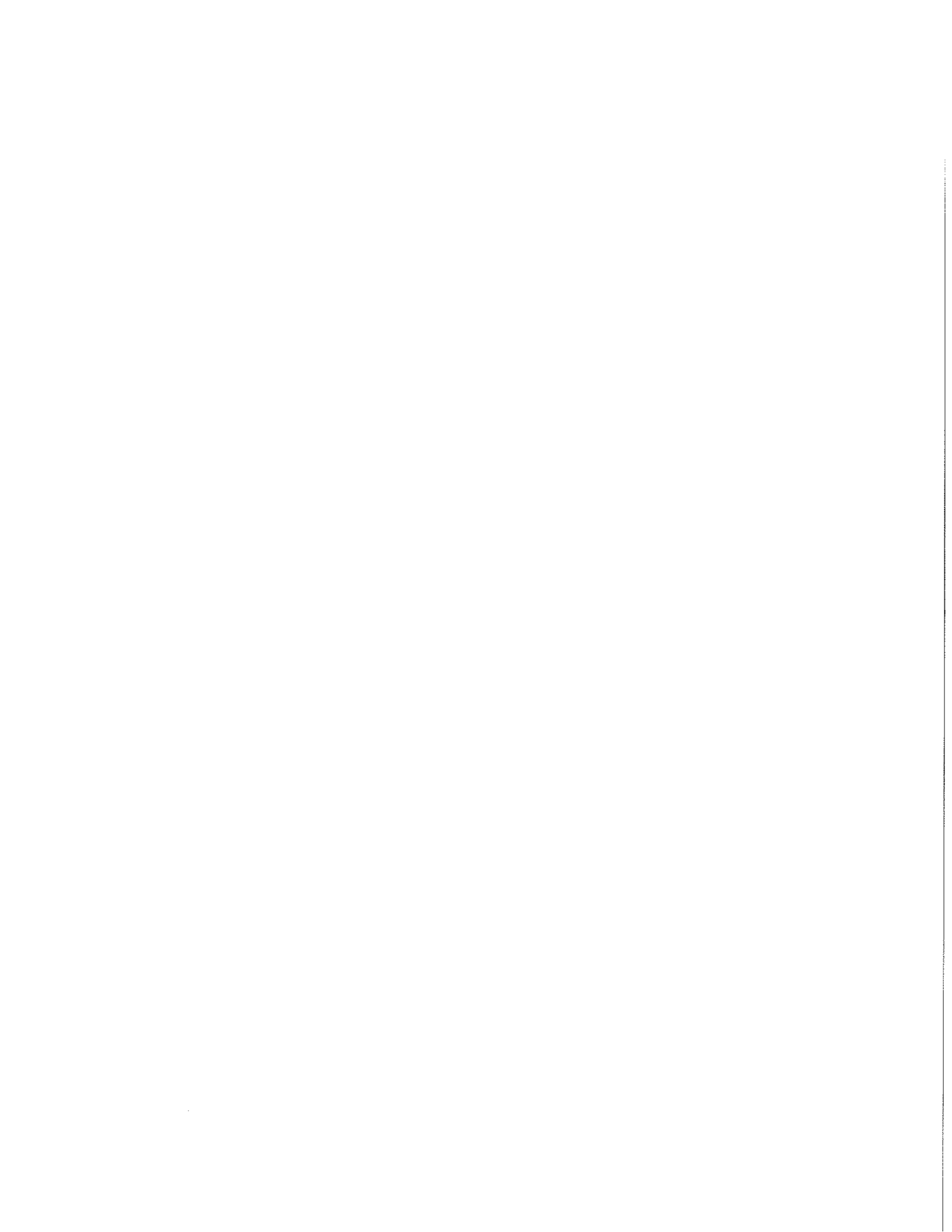
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>16G003</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                         |   | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/10/2017</b> |
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| W 268   | <p>Continued From page 70</p> <p>I, RTW J and RTW M all use a butter knife to hit Client #15. He/she further stated, "I wish they would not do that." When asked again who they hit with a butter knife Client #18 stated Client #15. When asked if he/she had ever witnessed a staff put anyone's head on the counter he/she stated "Yes," and explained RTW J did this to Client #15. When asked if anyone else ever used a butter knife or forcefully put anyone's head on the counter Client #18 stated, "No."</p> <p>7. Record review on 12/12/16 revealed a facility investigation initiated 11/23/16 alleged RTW J grabbed Client #23 by the back of the neck and pushed his/her face into the counter. RTW J held the client's face to the counter for approximately 30 seconds and commented, "Don't do that again." Client # 23 had taken a bag of chips from the cupboard and stood by the counter holding them.</p> <p>When interviewed on 12/13/16 at 2:15 p.m. RTW L stated RTW's J voice tone "would have made me mad."</p> <p>8. Record review revealed Type 1 Incident Investigation Report, dated 9/26/16. The report indicated, "Staff notified this RTS of an unknown injury to (Client #1) on (his/her) neck, shoulders, and back. Upon further follow up to house 248 (Client #1) was asked to show us the area noted. (He/she) had multiple scratches, scrapes, and bruises to (his/her) neck, back, and shoulders. When asking (Client #1) what happened, (he/she) stated, "The PM's held me down and shot me."</p> <p>When interviewed on 11/7/16 at 12:36 p.m. Client #1 reported he/she did not know how the bruises happened. He stated the cops were called and</p> | W 268  |   |   |



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| W 268  | <p>Continued From page 71</p> <p>the cop said to talk to RTW A. Client #1 then recalled RTW A did it in the bathroom (caused the bruises), but could not recall what happened.</p> <p>When interviewed on 11/7/16 at 12:47 p.m. RTW B reported he was appalled by Client #1's bruises. He stated he did not know how Client #1 received the bruises. According to RTW B, he did not notice Client #1's bruises when he assisted Client #1 with his/her shower on 9/22/16 and 9/23/16. RTW B reported he did not know of anyone, nor had he witnessed anyone place their hands on Client #1.</p> <p>During additional interview on 11/21/16 at 1:13 p.m. RTW B reported on 9/23/16 he assisted Client #1 with cleaning the bathroom. Client #1 yelled and threw the mop bucket. According to RTW B, RTW A walked into the bathroom and grabbed Client #1 by the arms. RTW A told Client #1 the other clients were sleeping. RTW B left the bathroom because he did not want to be around the interaction. RTW A heard Client #1 yell, but Client #1 often yelled when asked to mop. RTW B stated after RTW A left he went back into the bathroom and Client #1 mopped. RTW B confirmed he failed to report the incident because RTW A threatened new staff including RTW B. RTW B stated RTW A told him if he said anything or did anything they would get him fired. According to RTW B, RTW A bragged about getting a previous staff fired and RTW B has a lot on the line. RTW B stated he believed Client #1's bruising came from RTW A and did not know where else the bruising would have come from.</p> <p>When interviewed on 11/15/16 at 2:34 p.m. RTW Q reported she worked with RTW A on one occasion at House 248. RTW A came across as</p> | W 268  |   |                      |   |

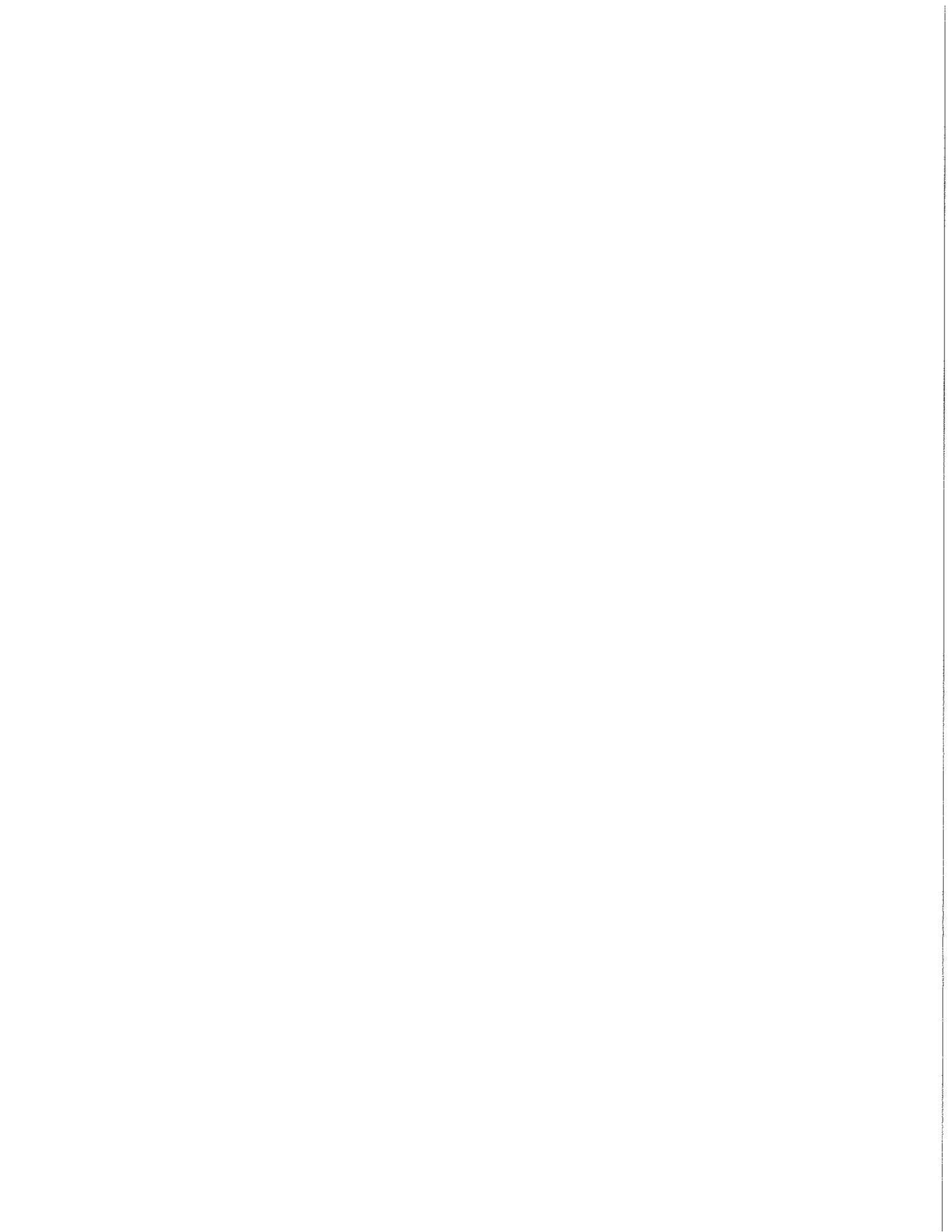




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| W 268   | <p>Continued From page 72</p> <p>the boss and acted like he ran the place. RTW Q worked at House 248 after RTW A was removed from the house. She assisted Client #1 in the shower and saw his/her bruises. RTW Q stated Client #1 told her RTW A caused the bruises. RTW A assured Client #1 that she would make sure he/she was safe. RTW Q recalled Client #1 repeated RTW A's name over and over again.</p> <p>9. Record review revealed the following:</p> <p>a. Client #3's Incident Report, dated 8/22/16, documented while Client #3 sat in the day room another peer hit him/her in the face and his/her eyes were reddened.</p> <p>b. Former Resident Treatment Worker (FRTW) A's Exit Information Questionnaire, dated 9/22/16, noted, "...I was providing one-on-one supervision in a residential wing of my house when I overheard yelling coming from a different part of the house. I wasn't able to see or hear exactly what was going on, but voices were raised, seemingly upset. I remained with my charge, but later on I overheard several of my coworkers (again, from another room) talking about how one of them had been wrestling or something with a resident, and that the resident had received a minor injury as a result. They discussed how, even though they had been present, they each had a plausible alibi, and therefore couldn't have been around when the injury occurred, and one of them was told to write up an incident report explaining how a nonverbal resident had attacked the injured resident, resulting in the injury. I couldn't tell exactly who was and wasn't involved, and in what capacity. I neither saw the incident, the injury, nor the incident report. What I did know was, if what I seemed to have overheard</p> | W 268   |   |                      |   |



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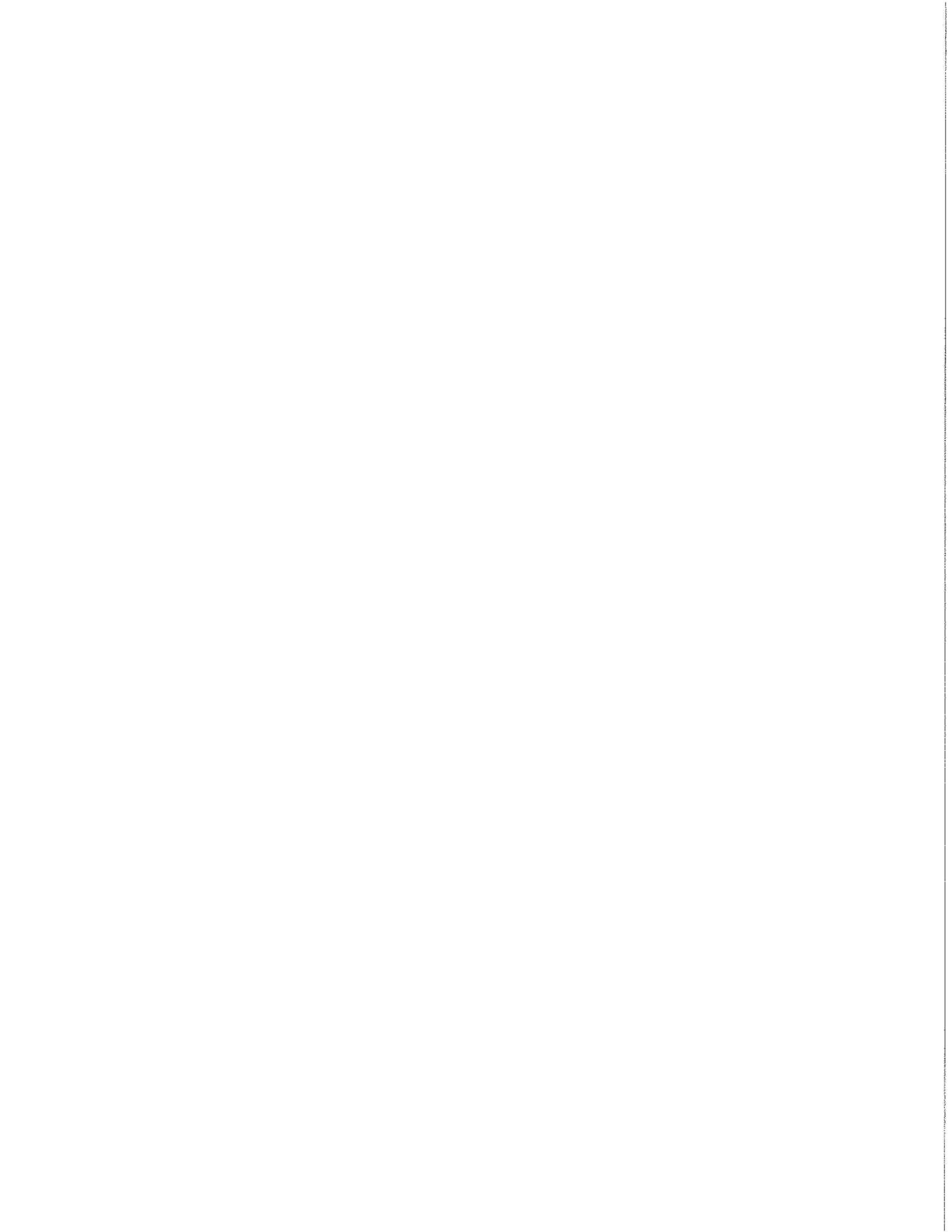
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| W 268 | <p>Continued From page 73</p> <p>was actually what happened, it would only be a matter of time before someone would ask me to falsify an incident report to cover up the borderline abusive behavior of my coworkers..."</p> <p>c. Record review revealed facility Type 1 Incident Investigation Report dated 10/13/16. The report indicated, "On 10/13/16 at 5:00 PM QM (Department) was informed of new information that indicates an incident report filed for the client on 8/22/16 at 9:15 PM by (RTW C) was not factual and that the injury noted to the client's eye which was attributed to a peer to peer aggression incident, was instead the result of staff actions which resulted in an injury." According to the report, no immediate protections were implemented at the time of the incident as no allegation of potential abuse was made until 10/13/16. The facility suspended RTW C on 10/13/16. RTW A and RTW D were suspended prior to 10/13/16 due to another investigation. The facility determined the incident to be substantiated.</p> <p>When interviewed on 11/17/16 at 2:27 p.m. FRTW A reported one big event forced him to resign. He stated the evening prior to his resignation, RTW A sat in the day room with a client who needed one on one supervision. According to FRTW A, he heard what sounded like wrestling in the dining room. FRTW A described chairs being moved and Client #3 repeatedly saying, "Stop! Leave me alone." When the wrestling stopped FRTW A heard Client #3 say, "Why did you do that? Look at my arm!" FRTW A stated two or three staff discussed the incident in the dining room. FRTW A believed RTW A explained he had accountability for another client who received one to one</p> | W 268 |  |  |
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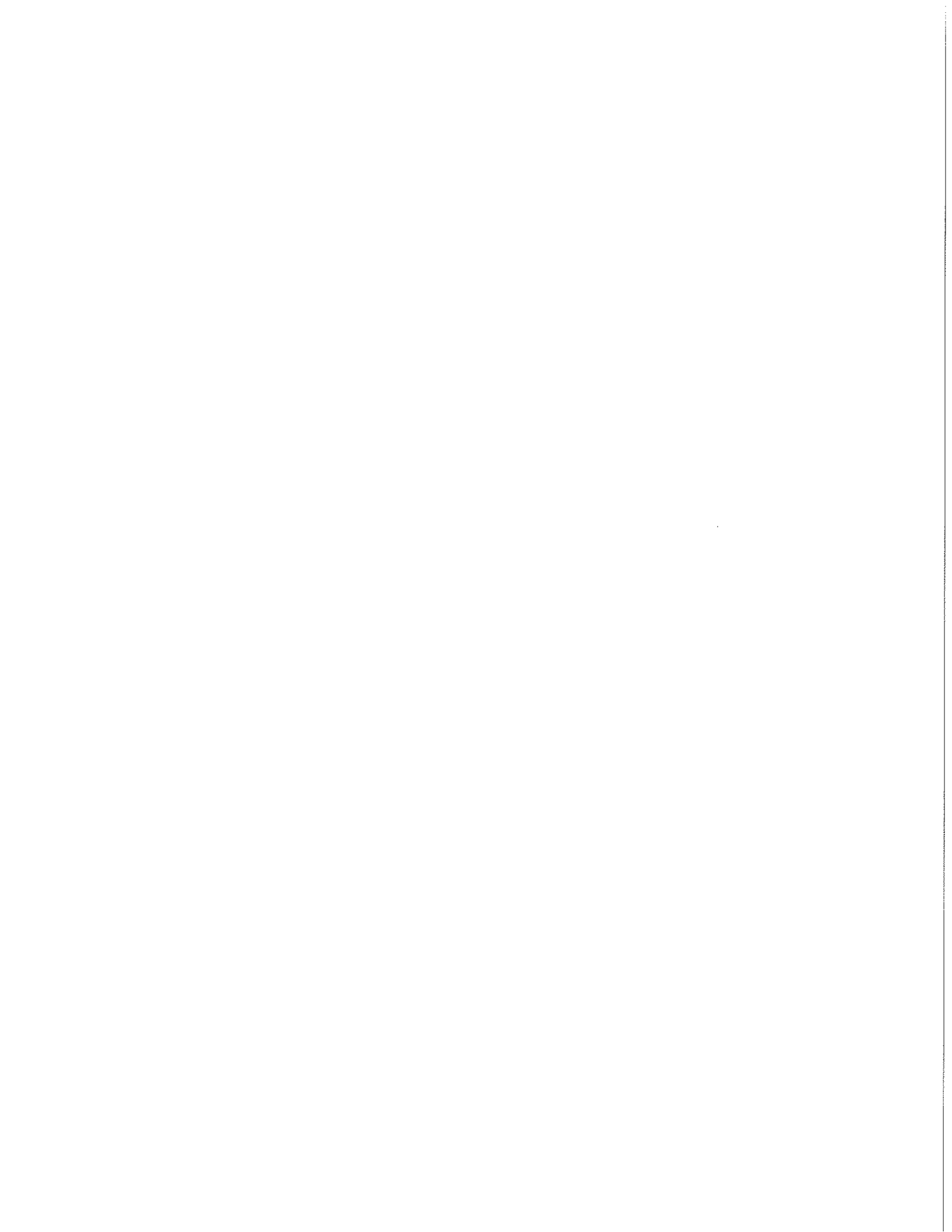
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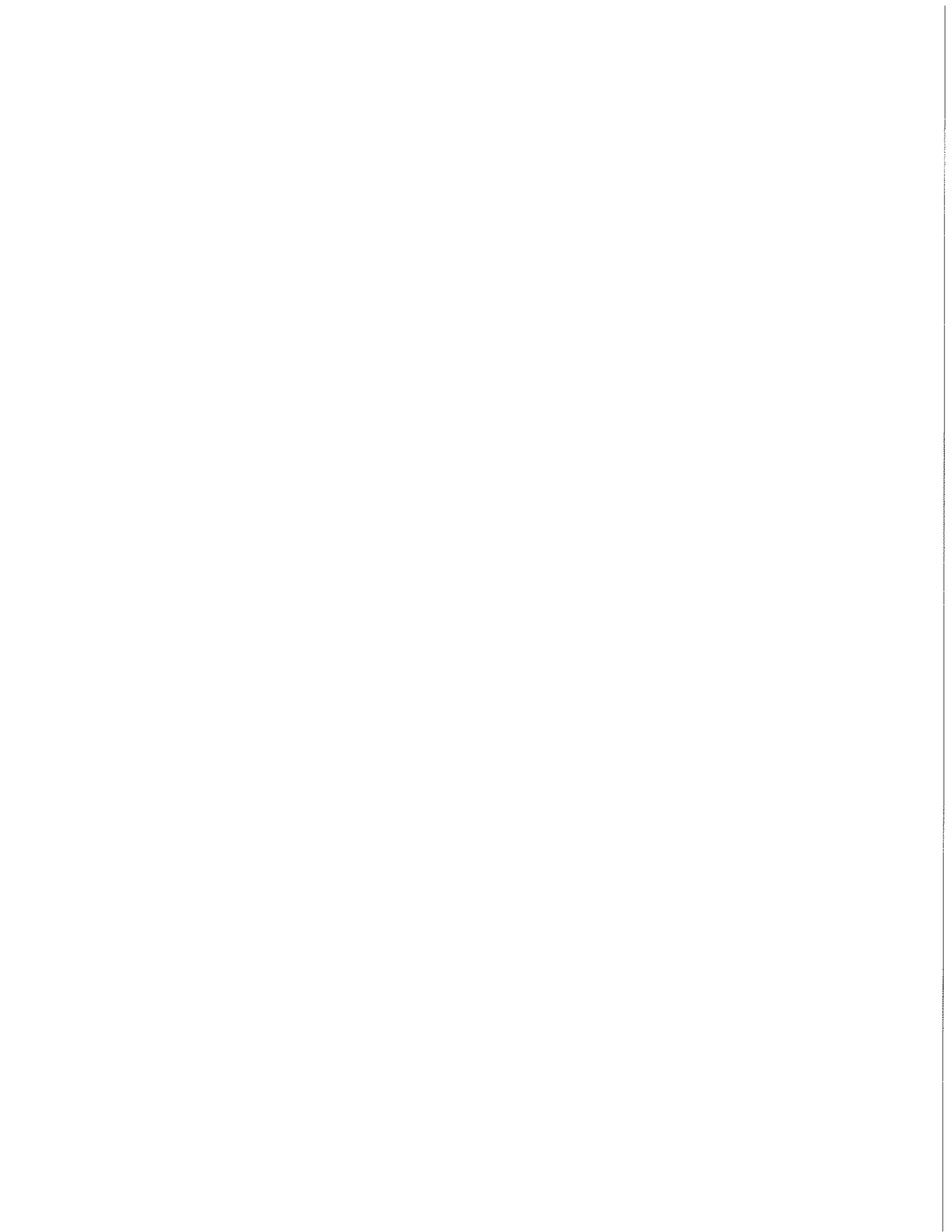
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| W 268 | <p>Continued From page 74</p> <p>supervision, could not have been in the area and did not see the incident happen. FRTW A also believed RTW A told another staff that they were supposed to be with their other clients. FRTW A stated the staff concluded a non-verbal client hurt him/her. According to FRTW A, the staff discussed their alibis and falsified the incident. FRTW A believed this would happen again and did not want to be asked to falsify an incident. FRTW A confirmed he failed to report the incident because he was afraid someone would come after him. FRTW A reported RTW A asked FRTW A if he was a snitch during his first shifts with RTW A. FRTW A told RTW A he had never been in a position to snitch. RTW A explained to FRTW A that he was not to turn in senior staff or FRTW A would get fired. RTW A stated they would be able to find out who turned the senior staff in and there would be retaliation as a result. FRTW A felt it best to leave and send out the information as soon as possible.</p> <p>When interviewed on 11/15/16 at 3:30 p.m. Client #3 reported RTW C and RTW D picked on clients. He/she stated they nitpicked and told them they could not have any snacks. According to Client #3, RTW C and RTW D swear at the clients until they get worked up. Client #3 stated after the clients were worked up, RTW C and RTW D told them they could not go on an outing because they were on restrictions. Client #3 reported when he/she was getting a pop out of the cupboard, RTW C said "What are you doing you f***ing retard?" Client #3 stated RTW D walked in and said the same thing.</p> <p>10. Record review revealed Facility Type 1 Incident Investigation Report, dated 8/16/16. "(Client #6) and another peer were involved in (a)</p> | W 268 |  |  |
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| W 268   | <p>Continued From page 75</p> <p>physical altercation that resulted in (Client #6) being scratched on (his/her) chin. (His/her) ears were scratched. (He/she) also had some redness on his cheek. (Client #6) and (his/her) peer fought until they were separated by staff." Through the course of another investigation an allegation was made against RTW D.</p> <p>During facility interview on 10/10/16 at 3:19 p.m., Client #6 reported "...he/she threw two balls at (Client #4) one a small orange ball and then the other a squishy sensory ball. At first (Client #6) reported (he/she) decided to throw the balls on (his/her) own. Then (Client #6) stated (RTW D) told (him/her) to throw a ball at (Client #4). (Client #6) reported (he/she) decided to throw the first ball the orange one. Then (RTW D) told (him/her) to throw the second ball at (Client #4). (Client #6) asked (RTW D) if (he/she) throws the ball at (Client #4) will (he/she) get marked on (his/her) data and (RTW D) explained no ... (Client #6) said (RTW D) told (him/her) to throw the ball at (Client #6) to teach (him/her) a lesson not to tease the other 248 individuals." The allegation was substantiated by the facility.</p> <p>When interviewed on 12/6/16 at 4:28 p.m. Client #4 reported listening to music and RTW D told Client #8 and Client #6 to throw things at him/her.</p> <p>11. Record review revealed Facility Type 1 Incident Investigation Report, dated 9/26/16. The report indicated, "(Client #5) reported to me at the cafeteria that staff members tease (Client #1). (He/she) said that when (he/she) is screaming and yelling they don't stop. (He/she) said they threaten to take (his/her) CD's and also hide them from (him/her) when (he/she) is upset. (Client #8) heard (Client #5) telling me and (he/she) said</p> | W 268   |   |                      |   |

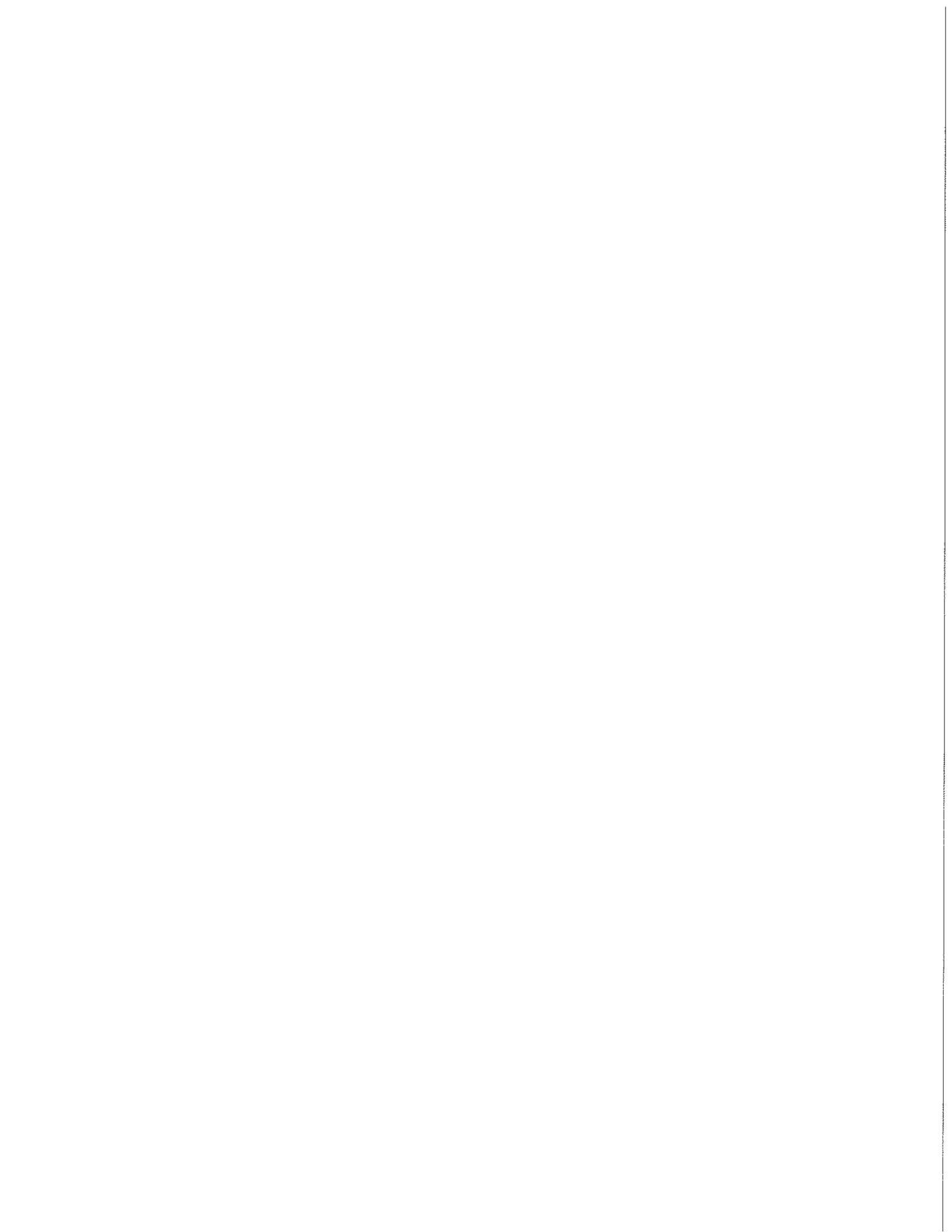




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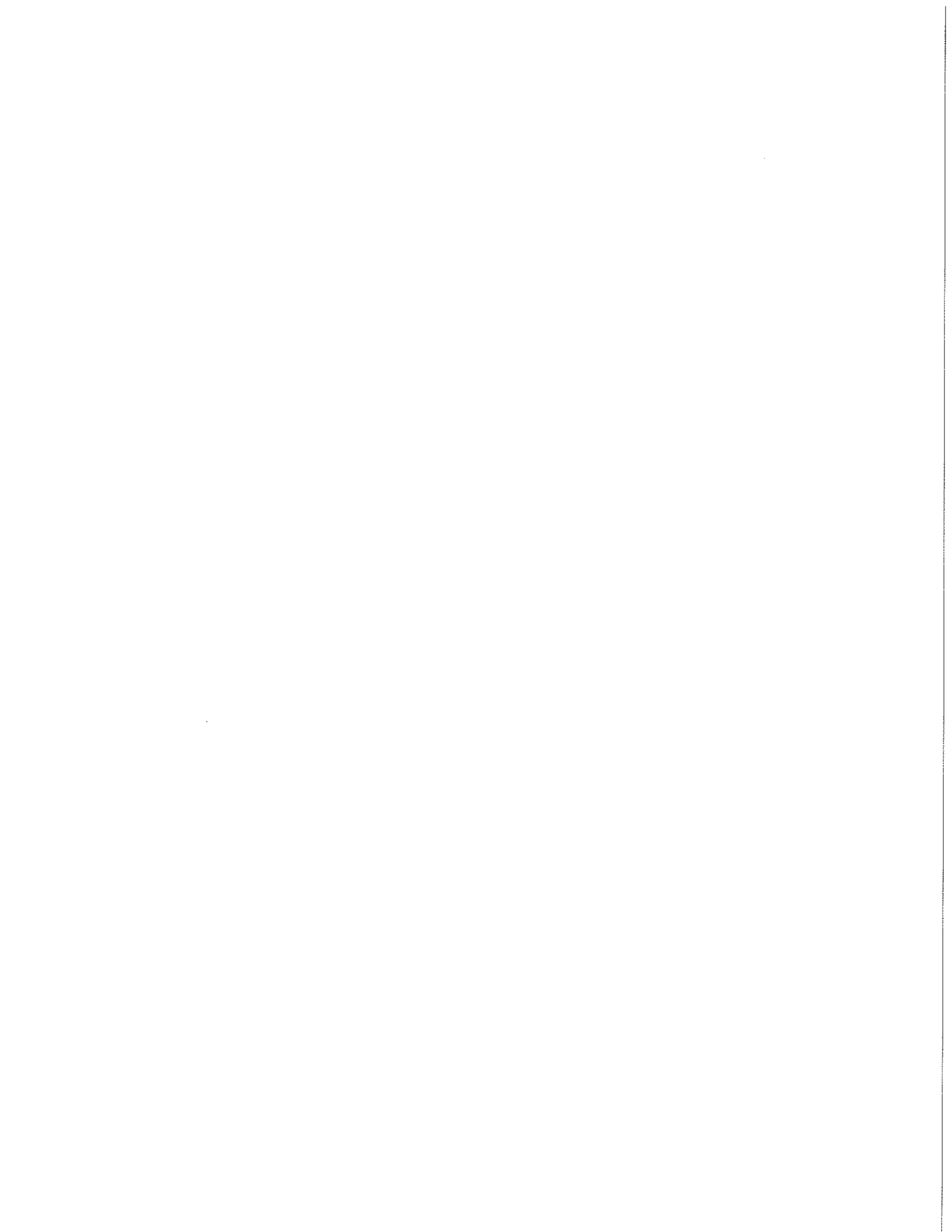
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| W 268   | <p>Continued From page 76</p> <p>that PM's do mess with (him/her). (Client #5) said it's (RTW A, RTW B, and RTW D). (Client #8) said that it's (RTW A and RTW D). (RTW D) not (RTW B)." The facility determined the allegation to be substantiated.</p> <p>When interviewed on 11/15/15 at 4:15 p.m. Client #5 reported he/she witnessed RTW D's issues with Client #1. Client #5 stated RTW D provoked Client #1 to have issues more than RTW A and RTW B. Client #5 woke up one day because of Client #1 yelling. Client #5 stated he/she stood in his/her doorway and watched RTW D provoke Client #1 and saw Client #1 throwing things. According to Client #5, RTW D put Client #1 into a restraint. Client #4 stated the RTS and the TPM were not there. Client #5 reported RTW A and RTW B joked around, but they were not the main aggressors towards Client #1. RTW D messed with certain clients once the RTS and TPM left. Client #4 stated RTW D also messed with Client #3. Client #3 asked RTW D to stop, but RTW D thought it was funny. RTW A and RTW B did that sometimes, but not to get someone to become angry. When you tell RTW A and RTW B to stop they stop, but RTW D went on and on.</p> <p>When interviewed on 11/15/16 at 3:30 p.m. Client #3 reported RTW C and RTW D picked on clients. He/she stated they nitpicked and told them they could not have any snacks. According to Client #3, RTW C and RTW D swore at the clients until they got worked up. Client #3 stated after the clients are worked up, RTW C and RTW D told them they could not go on an outing because they were on restrictions. Client #3 reported RTW C and RTW D picked on Client #1 a lot.</p> | W 268   |   |                      |   |



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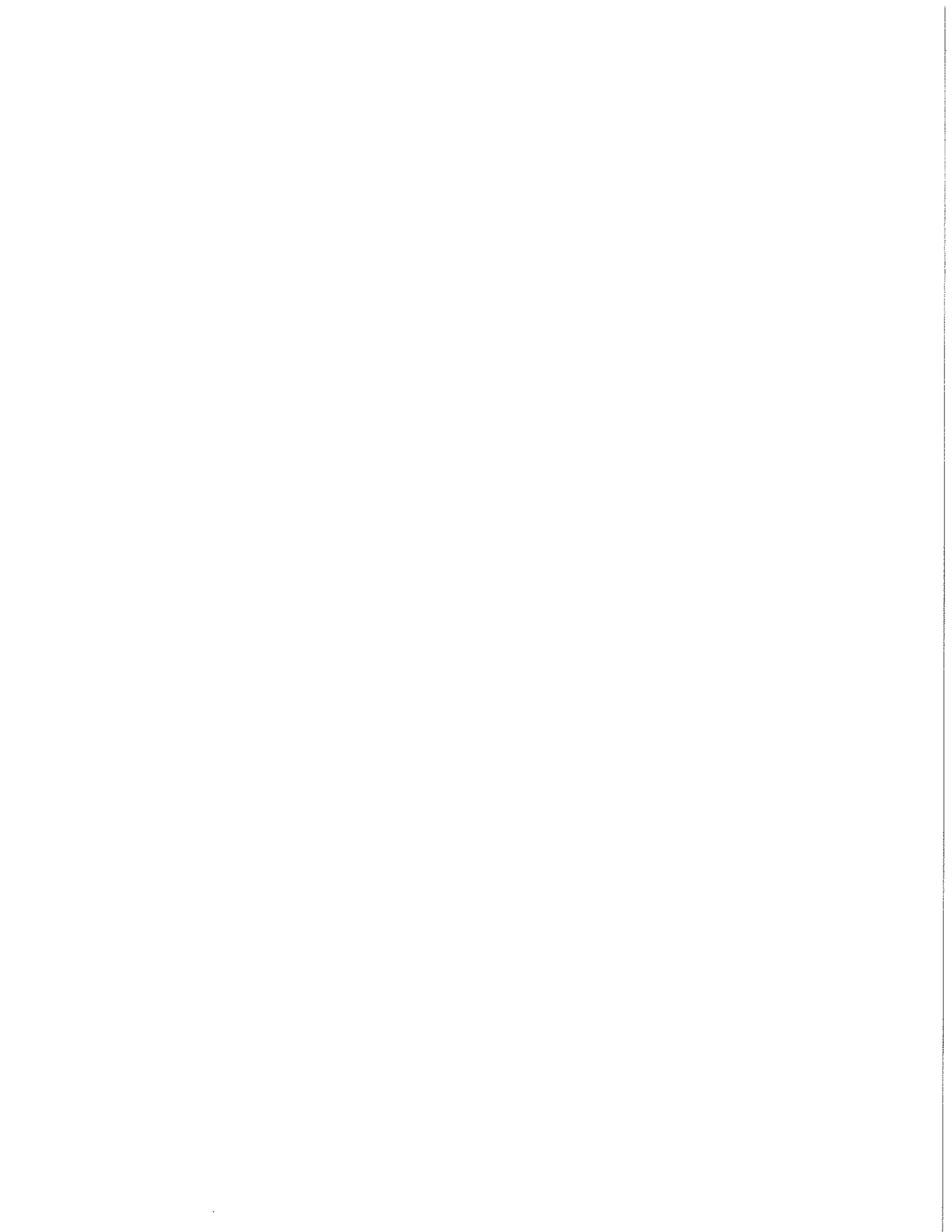
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| W 268   | Continued From page 77<br><br>When interviewed on 11/15/16 at 3:40 p.m. Client #7 reported morning shifts were fine, but evening shifts were chaotic. Client #7 stated RTW A threatened and cussed at clients. Client #7 also stated RTW A and RTW D teased Client #1. RTW D told Client #1, "Look, look (Client #8) has your 80's CD." RTW D had the CD. According to Client #7, RTW D tried to make Client #1 angry. Client #1 tipped furniture. RTW D ran into Client #1's bedroom and hid the CD. Client #1 asked where the CD was and RTW D said he did not know. Client #7 stated Client #1 threw a fit then RTW D gave Client #1 his/her CD back. RTW A came in laughing and Client #1 became angry and broke things. Staff egged it on and on. Client #1 threw things at staff. He/she threw the laundry hamper and broke it. RTW A got physical with Client #1 and hurt him/her; described as staff used a pressure point on the neck to make Client #1 stop. RTW D observed this and did something but Client #7 could not remember what. Client #7 stated they mostly picked on other clients. Client #7 reported they used profanity. He stated they told inappropriate jokes with sexual content, RTW A used the "F word" and the "B word" when Client #7 was around, and RTW D talked about sexual inappropriate things, such as women's vaginas. Client #7 believed he/she reported it to investigations. Client #7 did not want them to return to work because he/she did not like them getting clients upset.<br><br>12. Record review revealed the following:<br><br>a. FRTW A's Exit Information Questionnaire, dated 9/22/16, noted, "...Resident's various diagnoses and histories were discussed in front of other residents and non-involved staff..." | W 268   |   |                      |   |



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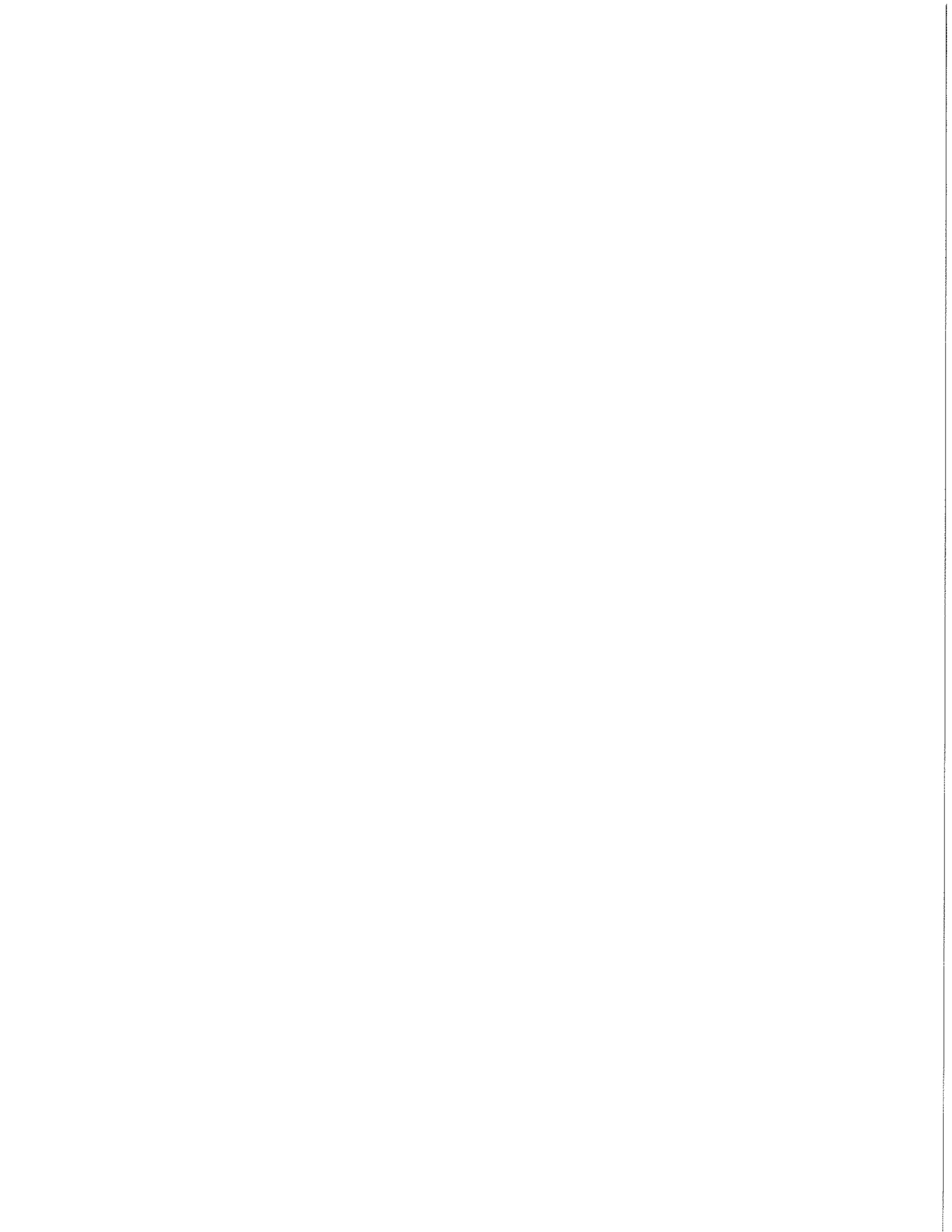
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| W 268   | <p>Continued From page 78</p> <p>b. Facility Type 1 Incident Investigation Report, dated 10/17/16. The report indicated, "On 10/17/16 an incident was reported to QM indicating that new information had been received that alleges (Client #2) was present when (RTW A) made remarks in front of the client related to the client's diagnosis, stating, "This is (Client #2), (he/she) is schizophrenic, how are those voices, (Client #2)?" The alleged date of the incident was 8/19/16 on PM shift but it has yet to be confirmed. Other persons were alleged to have been present at the time of the incident."</p> <p>When interviewed on 11/17/16 at 2:27 p.m. FRTW A reported RTW A gave him a rundown of everyone in the house. RTW A talked about their problems in the living room with other people around. Record review revealed the following:</p> <p>13. When interviewed on 11/14/16 at 4:40 p.m. RTW Y recalled an incident that occurred at House 470 on p.m. shift. RTW Y stated RTW Z made a special snack, cake with whipped cream. When Client #22 went to the kitchen to get cake, RTW Z "airplaned" a spoon with whipped cream toward Client #22, acting like he was going to put it in his/her mouth. Instead, RTW Z smeared the whipped cream on Client #22's face. The client became upset, and yelled at RTW Z. RTW Z told Client #22 he/she needed to apologize before he/she got cake. Client #22 refused to apologize to RTW Z, put his/her dishes away, and went to bed. RTW Y stated Client #22 did not get snack that night. She stated she reported the incident to her supervisor about a week later.</p> <p>Record review revealed the facility's Type 1 investigation report. According to the report, the</p> | W 268   |   |                      |   |



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| W 268   | <p>Continued From page 79</p> <p>incident allegedly occurred 10/6/16 and was reported to the supervisor on 10/12/16 at 2:40 p.m.</p> <p>14. Record review on 11/14/16 revealed the facility's Type 1 investigation report, completed 11/1/16. The report described on 10/25/16 a community member reported to Glenwood Resource Center (GRC) that they witnessed a GRC staff member strike a GRC client in the back of the head while outside the van in the parking lot of the Dollar General Store after the client picked something up from the ground and put it in his/her mouth. The client was identified as Client #24. The facility substantiated physical abuse against the staff.</p> <p>When interviewed on 11/18/16 at 8:37 a.m., Community Member A reported she observed five GRC clients and three GRC staff in the Dollar General Store. She saw RTW AA leave the store with most of the clients. She reported she left the store right after RTW AA and the clients and witnessed RTW AA hit the back of a client's head. She believed the client picked something up from the ground and put it in his/her mouth prior.</p> <p>When interviewed on 11/18/16 at 3:40 p.m., Community Member B reported she witnessed a GRC staff come out of the Dollar General Store with approximately 4 clients. One of the clients picked something up off of the ground and put it in his/her mouth. One of the staff then tried to get something out of the client's mouth. She reported the staff grabbed the client by the shirt hard, and pulled him/her toward her. Staff then smacked the client on the back of the head.</p> <p>When interviewed on 11/18/16 at 3:50 p.m.,</p> | W 268   |   |                      |   |

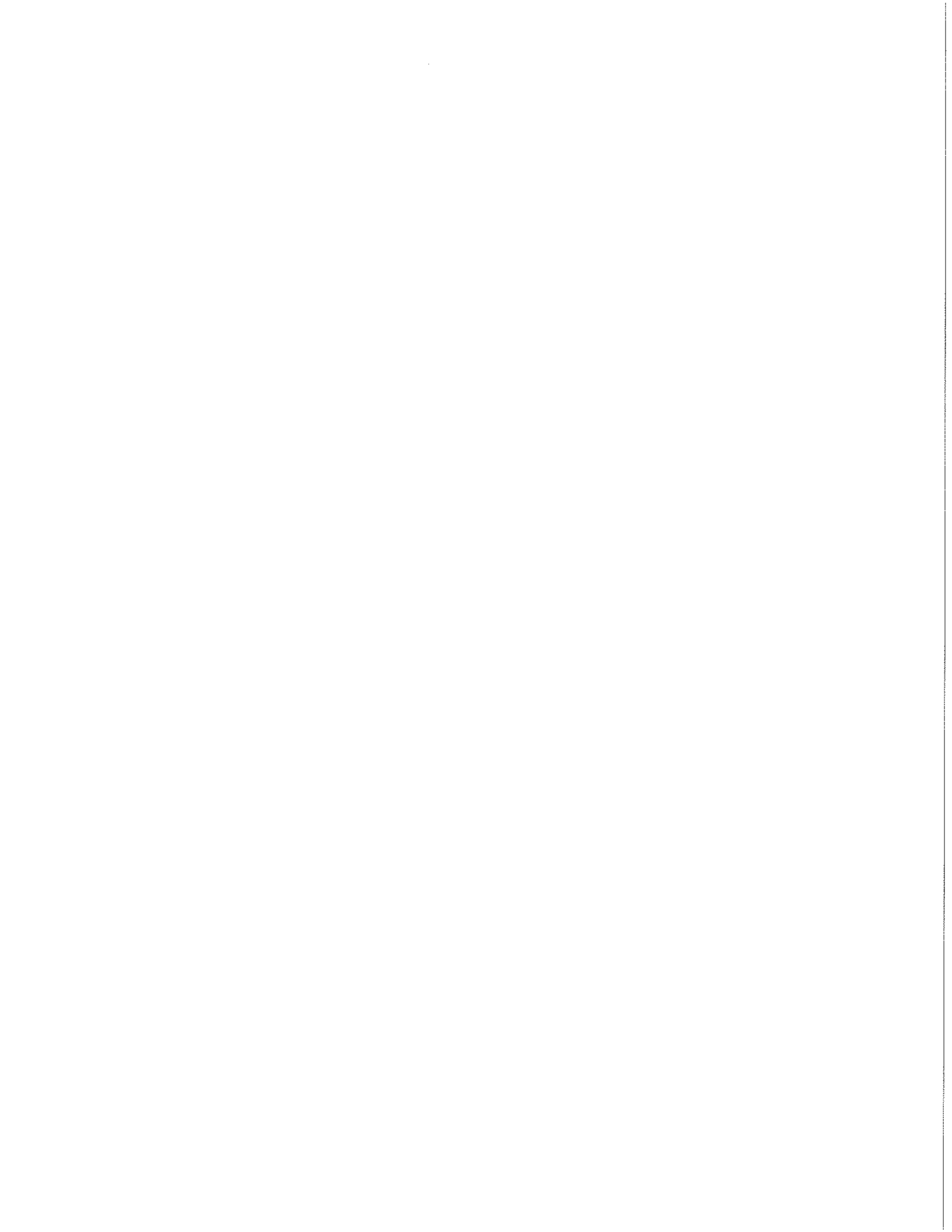




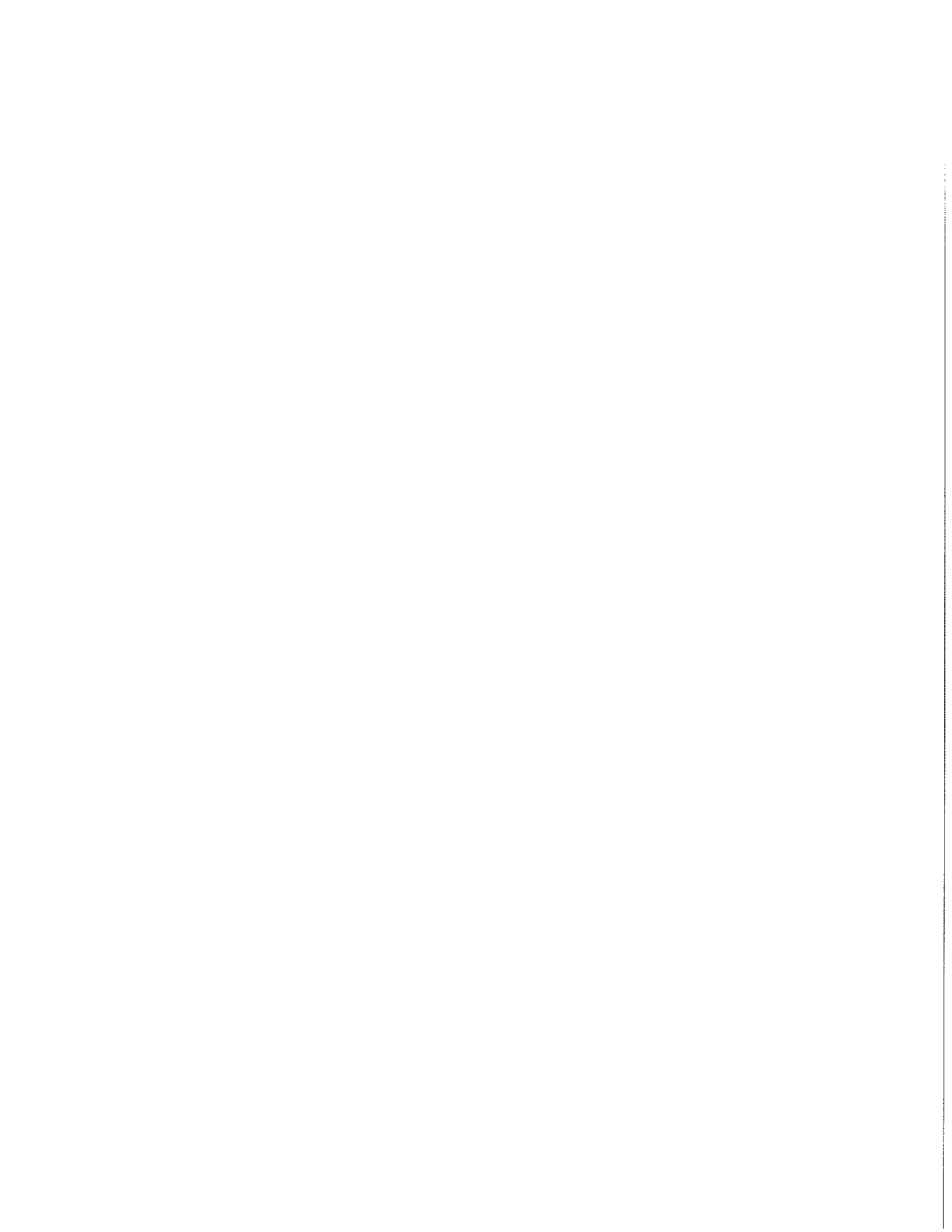
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| W 268   | <p>Continued From page 80</p> <p>Community Member C reported he witnessed a staff member grab the shirt of a client and hit the client in the back of the head. He reported the staff hit the client because he/she put something in his/her mouth.</p> <p>15. When interviewed on 11/2/16 at 12:58 p.m. Food and Nutrition Services (FNS) Worker A reported she previously worked as a RTW. FNS Worker A recalled on 8/6/16 and 8/7/16 RTW CC and RTW DD split responsibility with Client #25. RTW CC took the first part of the shift and RTW DD took the second part of the shift. According to FNS Worker A, on both days RTW CC sat knee to knee to Client #25 and pushed him/her down when he/she tried to get up. RTW CC walked Client #1 a few times, but complained about him/her. FNS Worker A reported RTW DD also sat in front of Client #1, on an office chair, and restricted him/her from getting up. FNS Worker A witnessed Client #25 push RTW CC and RTW DD away while she walked through the living room. FNS Worker A recalled RTW CC and RTW DD pushed Client #25 at his/her gait belt area or grabbed onto Client #25's gait belt and pulled him/her down to a sitting position. At times, RTW DD sat with her back towards Client #25. On one of the two nights, FNS Worker A assisted another client down the hall when she heard RTW DD raise her voice and say, "Don't touch me you perv." According to FNS Worker A, RTW DD was on the phone and Client #25 pulled her hair. FNS Worker A stated she also heard Client #25 grunting and trying to get up. FNS Worker A told a nurse, RTW CC and RTW DD would not let Client #25 get up, but the nurse instructed FNS Worker A Client #25 needed to sit when he/she received his/her medications. FNS Worker A also reported RTW CC or RTW DD</p> | W 268   |   |                      |   |



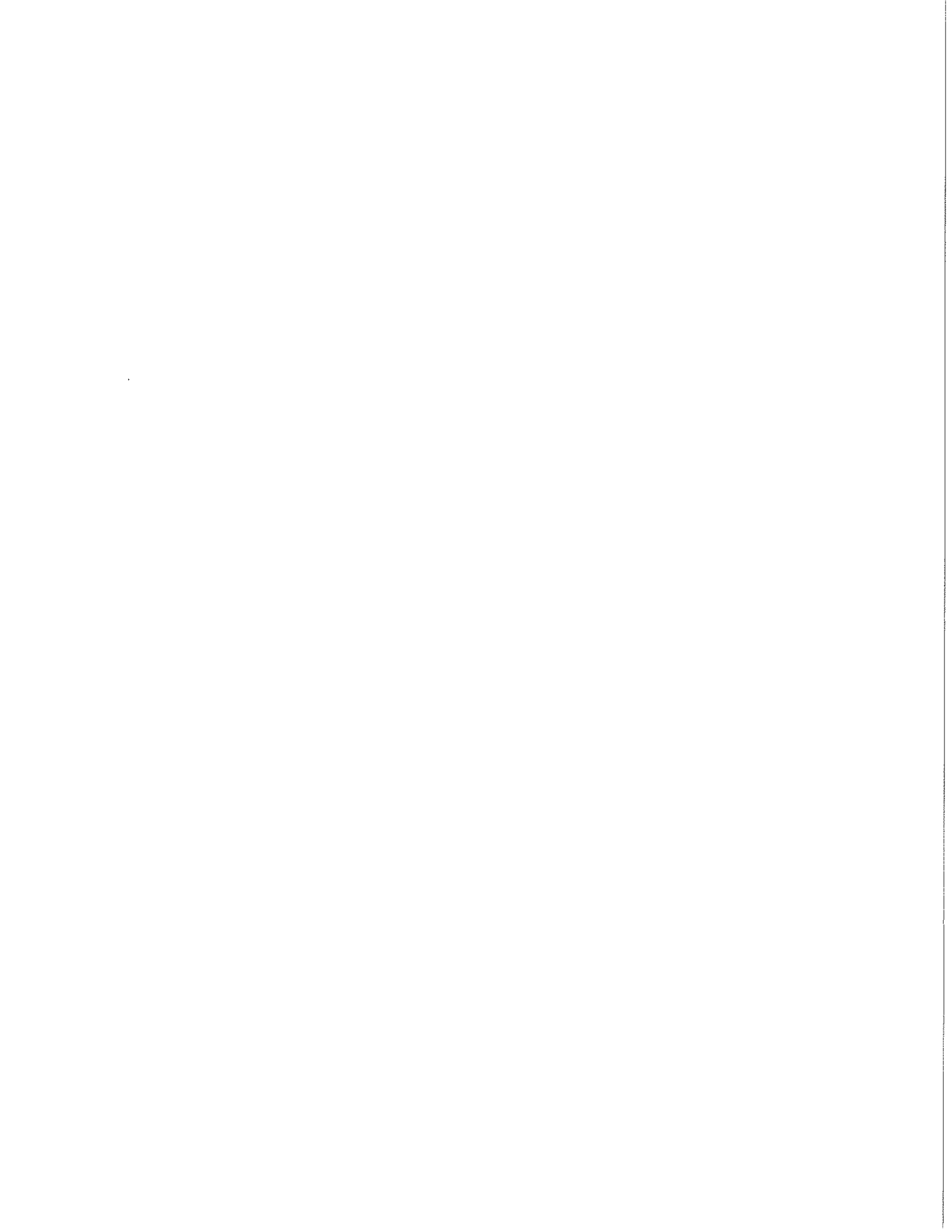
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| W 268  | <p>Continued From page 81</p> <p>were doing Snapchat, took pictures of Client #25 and called him/her a name. FNS Worker A voiced her concern when the overnight staff arrived, but RTW CC and RTW DD stated Client #25 was having trouble walking throughout the shift. According to FNS Worker A, Client #25 should be walked whenever he/she attempted to get up, unless he/she received medication. FNS Worker A stated Client #25 should walk the hallway 25 times a shift. FNS Worker A confirmed she waited until 8/8/16 to report the incident to her supervisor. She believed RTW CC and RTW DD would have known if she reported to the RTS on duty on 8/6/16 and 8/7/16.</p> <p>Record review on 11/3/16 revealed the following:</p> <p>a. Client #25's Individual Support Plan, dated 1/12/16, indicated Client #25 must "be able to walk around the house as much as (he/she) wants."</p> <p>b. Client #25's Mobility Program indicated "(Client #25)will ambulate for 25 minutes on the AM shift and 25 minutes on the PM shift..." Justification for Client #25's program included, "Maintaining (Client #25's) ability to walk will help to maintain (his/her) independence while promoting musculoskeletal, cardiovascular, gastrointestinal, and pulmonary health. (Client #25) is considered overweight and oftentimes needs much encouragement to be active and maintain positive health. This skill will promote a healthy, active lifestyle allowing for maintenance of functional mobility skills and independence with ADLs leading to improved transition into the community."</p> <p>When interviewed on 11/2/16 at 3:14 p.m. RTS D</p> | W 268  |   |                      |   |



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| W 268   | Continued From page 82<br>confirmed staff failed to follow Client #25's plan. RTS stated staff should not restrict Client #25 from getting up to walk. She stated she believed FNS Worker A because she had recently had to talk to RTW CC about her work performance.<br><br>Record review revealed Employee Handbook dated November 2014, General Standards of Conduct and Work Rules, directed, "... employees shall avoid boisterous or inappropriate discussions and behavior... employees are expected to maintain appropriate control of themselves, even under provocation. The use of abusive, profane, argumentative, offensive, or threatening language or attempts to inflict bodily harm or mental anguish will not be tolerated... Employees shall not engage in illegal or disorderly conduct including, but not limited to, roughhousing, pushing, throwing objects, immoral or indecent conduct, or participate in any activity, misconduct or behavior in the workplace and/or while on duty, which may have a negative effect on the Department's reputation and/or community standing... Employees shall not make false, misleading or malicious statements concerning themselves, other employees, clients, and supervisors, or falsify forms or work documents, or intentionally enter false information into automated systems, or intentionally give false or misleading information, or omit information significant to the Department... Employees shall treat other employees, guests, visitors, and Department clients with dignity and respect... Employees shall not mistreat, abuse, coerce, neglect or exploit employees, visitors or clients, whether verbally, physically, sexually or financially. When physical contact is a part of an employee's duties, each contact will be | W 268   |   |                      |   |



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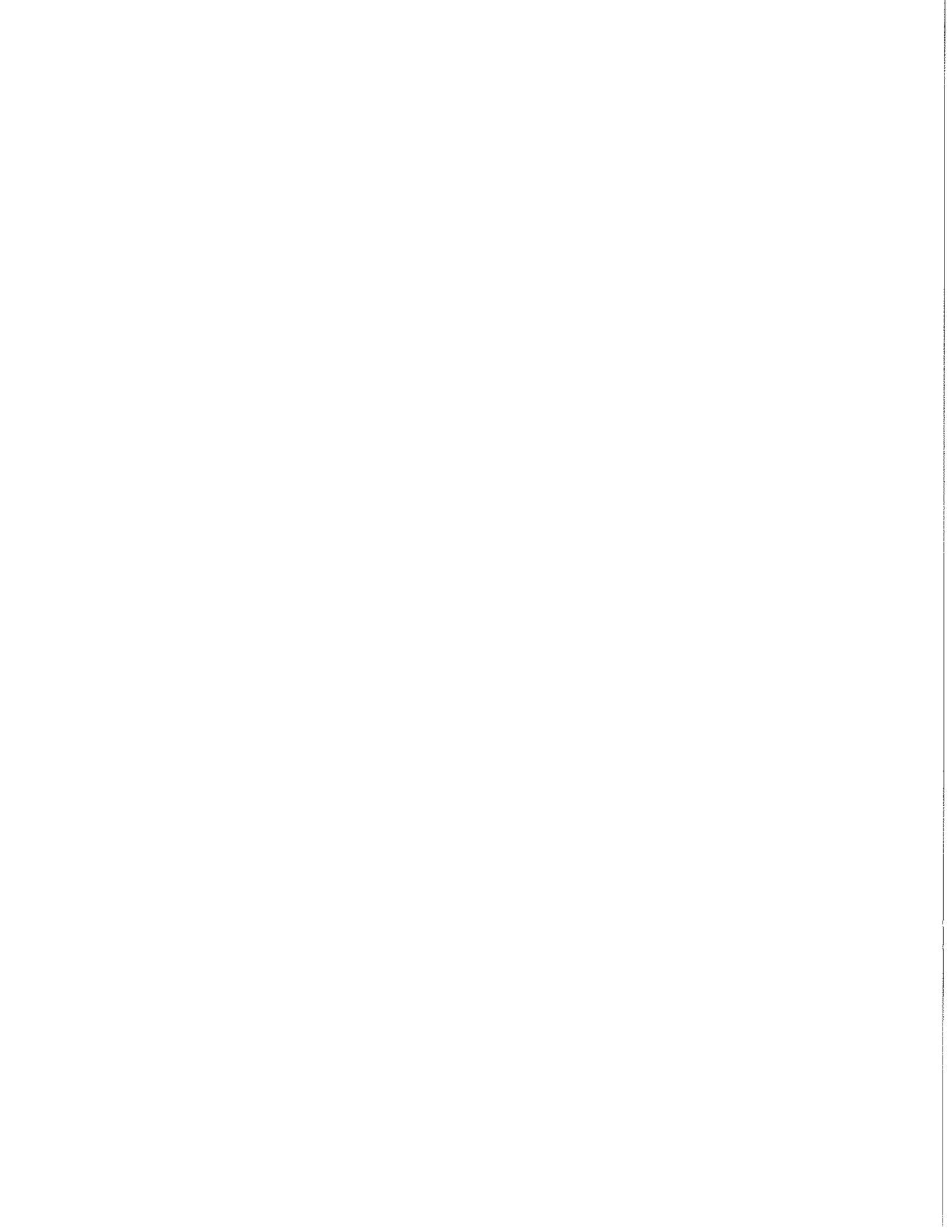
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| W 268 | Continued From page 83<br>performed in a professional manner... Abuse of an employee's position or authority by requesting, forcing or engaging clients, other employees or visitors in consensual or nonconsensual sexual relations or sexually-related activities including sexually suggestive remarks is considered serious misconduct and shall result in disciplinary action up to and including discharge from employment and/or legal action against the employee..." The handbook further guided the following under confidentiality: "... Employees shall not violate confidentiality of protected health information. Protected health information is defined as 'information that contains a person's medical information, including treatment and payment information, either past, present, or future..." | W 268 |  |  |
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JK  
1/27/17  
JK

CAC  
1/27/17

GRC Plan of Correction for DIA incident Investigation #'s: 62570-I, 62572-I, 63292-I, 63881-M, 64234-I, 64240-I, 64252-M, 64253-I, 64279-I, 64397-I, 64438-C, 64457-I, 64459-I, 64464-I, 64465-I, 64557-M, 64559-I, 64578-M, 64579-M, 64593-C, 64603-M, 64924-I, 64989-I, 65017-I

**Tag W102, Governing Body and Management**, found at 483.410: The facility must ensure that specific governing body and management requirements are met.

**Systemic Response**

**Governing Body and Management Actions Taken:**

- November 16, 2016, central office Mental Health and Disability Services (MHDS) staff, including the Administrator of MHDS, began making twice a month calls to review the status of the monitoring actions. MHDS staff, including the Administrator of MHDS also personally visits the facility two times per month to review the effectiveness of monitoring activities.
- November 16, 2016, the number of supervisors on the weekday evening shifts and weekend day and evening shifts was increased to a minimum of 7. Supervisors include Resident Treatment Supervisors (RTS) and Treatment Program Managers (TPM).
- November 17, 2016, the Superintendent began meeting with individual line supervisors one-on-one to discuss issues and expectations of treatment and immediate reporting of abuse or mistreatment, and the need to ensure individual reporters are safe and not intimidated from reporting. The Superintendent also discusses any issues or concerns regarding the status and effectiveness of monitoring and reporting suspected abuse and ensuring a safe environment for reporting.
- November 18, 2016, supervisors were required to record the time period and specific house that they monitored.
- November 28, 2016, the Superintendent directed that an email be sent to all staff that affirmed:
  - The facility has a zero tolerance for abuse and neglect,
  - All facility staff are mandatory reporters of suspected abuse or neglect and are required to report suspected instances immediately,
  - Affirmed that all staff that report suspected abuse or neglect will be free from retaliation, and
  - All facility staff are to be provided a violence free work place.
- December 2, 2016, supervisors were required to document findings of their monitoring visits. During monitoring visits, if supervisors find situations that need immediate attention, they take corrective action immediately onsite. Documentation is submitted to their supervisors, Treatment Program Administrators (TPAs). The findings are also shared with the Superintendent and the Assistant Superintendent for Program Services. These reports are reviewed daily and the TPAs ensure that any identified issues are addressed.

- December 6, 2016, supervisors were re-trained on what constitutes abuse and mistreatment, requirements to report suspected abuse or mistreatment, and signs and symptoms of mistreatment.
- Beginning December 6, 2016, MHDS staff also review the facility's Quality Council notes focusing on incident reports to determine if the facility is identifying concerning trends or other issues that should be addressed to ensure the protection and safety of individuals being served.
- December 19, 2016, nearly all staff had completed competency-based re-training on abuse reporting. The only staff that had not completed training by that date were staff who were on extended leave or suspended, pending investigation. Once staff returned to work they completed the competency-based re-training.
- December 23, 2016, staff were issued cards to be placed in the sleeves of their facility identification that summarized the re-training they had received.
- January 17, 2017, the Division Administrator of Mental Health and Disability Services of the Department of Human Services became the point of accountability and responsibility for GRC and personally directed the development and implementation of the corrective action plan. GRC and the Administrator of MHDS will personally direct the local executive leadership in taking action that assures clients are protected and safe.

Beginning January 23, 2017, each shift, supervisors will also be required to interview two resident treatment workers (RTWs) to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Supervisors will provide coaching and guidance on the spot as indicated by staff responses.

Information from these interviews will be reported daily to the TPAs who will ensure appropriate action has been taken related to the RTWs response. Information from interviews will be compiled and included as part of a weekly residential house report. The weekly house report will provide documentation regarding progress toward correcting deficiencies and issues that remain to be addressed.

TPAs are expected to personally monitor each of the houses under their supervision each shift they work. If TPAs find situations that need immediate attention, they take needed corrective action immediately on site. The findings of their monitoring is documented and reported to the Assistant Superintendent of Program Services.

Other top and middle management staff have been assigned to do unannounced monitoring of each residential house once per week. This includes the Superintendent, Assistant Superintendent of Program Services, Director of Quality Management, Director of Psychology, Day Services Director, Treatment Support Services Director, Director of Nursing, Speech Therapy Services Director, Management Information Services Director, 2<sup>nd</sup> Shift Administrator, Business Manager and the Director of Information Services who document their monitoring visits and report any findings weekly. If top and middle management staff find situations that need immediate attention, they take those immediate steps on site. The Superintendent and Assistant Superintendent review top and middle management staff monitoring findings weekly and ensure appropriate action has been taken to address any negative findings.

Beginning January 23, 2017, top and middle managers will be required to interview four resident treatment workers (RTWs) per week to determine that the staff interviewed:

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- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Beginning January 23, 2017, each house in the facility will be reevaluated weekly to ensure compliance of client protection and safety. In addition to RTW interviews described earlier, the evaluation will include a review of incident reports, key staff indicators and key client indicators. These reports will help pinpoint areas that need to be addressed in each individual house and document client protections and safety.

Before February 23, 2017, the Department of Human Services will secure the external experts to review and evaluate the facility regarding assuring and the provisions of client protection and safety.

Before February 23, 2017, the facility will have completed a root cause analysis by an expert in the field that is approved by DIA. The results of the root cause analysis will be used to make needed adjustments in the corrective action plan and other actions the facility is taking to ensure client protection and safety.

**Responsible: Administrator of MHDS**

**Date Completed: 1/13/17**

**Tag W104, Governing Body**, found at 483.41 (a)(1): The governing body must exercise general policy, budget and operating direction over the facility.

**Individual response**

As the result of intensive investigation of incidents that occurred, RTWs H, I, M, A, and B had their

employment terminated or resigned in lieu of termination. RTW K received personnel action and re-training related to not providing the correct level of supervision as required by the treatment plan and failure to report potential abuse or neglect immediately to a supervisor. RTW L received appropriate personnel action and re-training.

**Responsible: Superintendent**

**Date Completed: 1/13/17**

### **Systemic Response**

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Before February 23, 2017, the facility will have completed a root cause analysis by an expert in the field that is approved by DIA. The results of the root cause analysis will be used to make needed adjustments in the corrective action plan and other actions the facility is taking to ensure client protection and safety.

The Incident Management Policy is trained to staff during new employee orientation and on an annual basis. The Incident Management Policy dated 11/2/07 was reviewed 1/6/17 with no revisions determined to be necessary.

The Individual Rights Policy is trained to staff during new employee orientation and on an annual basis. Before February 10, 2017, the Individual Rights Policy dated 10/18/06 will be reviewed, revised, and trained as needed.

The Human Rights Policy is trained to staff during new employee orientation and on an annual basis. The Human Rights Policy dated 11/25/08 was revised 5/1/16 and trained as needed. Before February 10, 2017, the Human Rights Policy revised 5/1/16 will be reviewed, revised, and trained as needed.

**Responsible: Administrator of MHDS**

**Date Completed: 1/13/17**

**Tag W122, Client Protections**, found at 483.420: The facility must ensure that specific client protection requirements are met.

### **Systemic Response**

Governing Body and Management Actions Taken:

- November 16, 2016, central office Mental Health and Disability Services (MHDS) staff, including the Administrator of MHDS, began making twice a month calls to review the status of the monitoring actions. MHDS staff, including the Administrator of MHDS also personally visits the facility two times per month to review the effectiveness of monitoring activities.
- November 16, 2016, the number of supervisors on the weekday evening shifts and weekend day and evening shifts was increased to a minimum of 7. Supervisors include Resident Treatment Supervisors (RTS) and Treatment Program Managers (TPM).
- November 17, 2016, the Superintendent began meeting with individual line supervisors one-on-one to discuss issues and expectations of treatment and immediate reporting of abuse or mistreatment, and the need to ensure individual reporters are safe and not intimidated from reporting. The Superintendent also discusses any issues or concerns regarding the status and effectiveness of monitoring and reporting suspected abuse and ensuring a safe environment for reporting.
- November 18, 2016, supervisors were required to record the time period and specific house that they monitored.
- November 28, 2016, the Superintendent directed that an email be sent to all staff that affirmed:
  - The facility has a zero tolerance for abuse and neglect,
  - All facility staff are mandatory reporters of suspected abuse or neglect and are required to report suspected instances immediately,
  - Affirmed that all staff that report suspected abuse or neglect will be free from retaliation, and
  - All facility staff are to be provided a violence free work place.
- December 2, 2016, supervisors were required to document findings of their monitoring visits. During monitoring visits, if supervisors find situations that need immediate attention, they take corrective action immediately onsite. Documentation is submitted to their supervisors, Treatment Program Administrators (TPAs). The findings are also shared with the

Superintendent and the Assistant Superintendent for Program Services. These reports are reviewed daily and the TPAs ensure that any identified issues are addressed.

- December 6, 2016, supervisors were re-trained on what constitutes abuse and mistreatment, requirements to report suspected abuse or mistreatment, and signs and symptoms of mistreatment.
- Beginning December 6, 2016, MHDS staff also review the facility's Quality Council notes focusing on incident reports to determine if the facility is identifying concerning trends or other issues that should be addressed to ensure the protection and safety of individuals being served.
- December 19, 2016, nearly all staff had completed competency-based re-training on abuse reporting. The only staff that had not completed training by that date were staff who were on extended leave or suspended, pending investigation. Once staff returned to work they completed the competency-based re-training.
- December 23, 2016, staff were issued cards to be placed in the sleeves of their facility identification that summarized the re-training they had received.
- January 17, 2017, the Division Administrator of Mental Health and Disability Services of the Department of Human Services became the point of accountability and responsibility for GRC and personally directed the development and implementation of the corrective action plan. GRC and the Administrator of MHDS will personally direct the local executive leadership in taking action that assures clients are protected and safe.

Beginning January 23, 2017, each shift, supervisors will also be required to interview two resident treatment workers (RTWs) to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Supervisors will provide coaching and guidance on the spot as indicated by staff responses.

Information from these interviews will be reported daily to the TPAs who will ensure appropriate action has been taken related to the RTWs response. Information from interviews will be compiled and included as part of a weekly residential house report. The weekly house report will provide documentation regarding progress toward correcting deficiencies and issues that remain to be addressed.

TPAs are expected to personally monitor each of the houses under their supervision each shift they work. If TPAs find situations that need immediate attention, they take needed corrective action



immediately on site. The findings of their monitoring is documented and reported to the Assistant Superintendent of Program Services.

Other top and middle management staff have been assigned to do unannounced monitoring of each residential house once per week. This includes the Superintendent, Assistant Superintendent of Program Services, Director of Quality Management, Director of Psychology, Day Services Director, Treatment Support Services Director, Director of Nursing, Speech Therapy Services Director, Management Information Services Director, 2<sup>nd</sup> Shift Administrator, Business Manager and the Director of Information Services who document their monitoring visits and report any findings weekly. If top and middle management staff find situations that need immediate attention, they take those immediate steps on site. The Superintendent and Assistant Superintendent review top and middle management staff monitoring findings weekly and ensure appropriate action has been taken to address any negative findings.

Beginning January 23, 2017, top and middle managers will be required to interview four resident treatment workers (RTWs) per week to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Beginning January 23, 2017, each house in the facility will be reevaluated weekly to ensure compliance of client protection and safety. In addition to RTW interviews described earlier, the evaluation will include a review of incident reports, key staff indicators and key client indicators. These reports will help pinpoint areas that need to be addressed in each individual house and document client protections and safety.

Before February 23, 2017, the Department of Human Services will secure the external experts to review and evaluate the facility regarding assuring and the provisions of client protection and safety.

Before February 23, 2017, the facility will have completed a root cause analysis by an expert in the field that is approved by DIA. The results of the root cause analysis will be used to make needed adjustments in the corrective action plan and other actions the facility is taking to ensure client protection and safety.

**Responsible: Administrator of MHDS**  
**Date Completed: 1/13/17**

**Tag W125, Protection of Clients Rights**, found at 483.420 (a)(3): The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as

clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.

**Individual response**

As the result of thorough investigation of incidents that occurred, RTWs H, J, U, M, N, A, B, C, D, and DD had their employment terminated or resigned in lieu of termination. RTW L and K received appropriate personnel action and re-training.

The Behavior Support Plans for Clients #1, #2, #3, #4, #5, #7, and #8 were re-trained to staff working at house 248. The FNS Worker will be trained on Client #4's Behavior Support Plan.

The Behavior Support Plans for Clients #15, #16, #20, and #23 were re-trained to staff working at house 253. RTWs K and L will be re-trained on Clients #15, 16, 20, and 23 Behavior Support Plans prior to working in house 253.

The Behavior Support Plans for Client #24 were re-trained to staff working at house 360.

The Behavior Support Plans for Client #25 were re-trained to staff working at house 468, including RTW CC.

The Behavior Support Plan for Client #22 was retrained to staff working at house 470.

**Responsible: Treatment Program Administrators**

**Date Completed: 1/13/17**

The Mobility Program for Client #25 will be re-trained to staff working at house 468, including RTW CC.

**Responsible: Treatment Program Administrator**

**Date Completed: 1/13/17**

**Systemic Response**

Behavior Support Plans are routinely monitored by Psychologists and Psychology Assistants through completion of Program Implementation Monitor forms. Mobility programs are routinely monitored by physical therapists through completion of Program Implementation Monitor forms.

**Responsible: Superintendent**

**Date Completed: 1/13/17**

Governing Body and Management Actions Taken:

- November 16, 2016, central office Mental Health and Disability Services (MHDS) staff, including the Administrator of MHDS, began making twice a month calls to review the status of the monitoring actions. MHDS staff, including the Administrator of MHDS also personally visits the facility two times per month to review the effectiveness of monitoring activities.

- November 16, 2016, the number of supervisors on the weekday evening shifts and weekend day and evening shifts was increased to a minimum of 7. Supervisors include Resident Treatment Supervisors (RTS) and Treatment Program Managers (TPM).
- November 17, 2016, the Superintendent began meeting with individual line supervisors one-on-one to discuss issues and expectations of treatment and immediate reporting of abuse or mistreatment, and the need to ensure individual reporters are safe and not intimidated from reporting. The Superintendent also discusses any issues or concerns regarding the status and effectiveness of monitoring and reporting suspected abuse and ensuring a safe environment for reporting.
- November 18, 2016, supervisors were required to record the time period and specific house that they monitored.
- November 28, 2016, the Superintendent directed that an email be sent to all staff that affirmed:
  - The facility has a zero tolerance for abuse and neglect,
  - All facility staff are mandatory reporters of suspected abuse or neglect and are required to report suspected instances immediately,
  - Affirmed that all staff that report suspected abuse or neglect will be free from retaliation, and
  - All facility staff are to be provided a violence free work place.
- December 2, 2016, supervisors were required to document findings of their monitoring visits. During monitoring visits, if supervisors find situations that need immediate attention, they take corrective action immediately onsite. Documentation is submitted to their supervisors, Treatment Program Administrators (TPAs). The findings are also shared with the Superintendent and the Assistant Superintendent for Program Services. These reports are reviewed daily and the TPAs ensure that any identified issues are addressed.
- December 6, 2016, supervisors were re-trained on what constitutes abuse and mistreatment, requirements to report suspected abuse or mistreatment, and signs and symptoms of mistreatment.
- Beginning December 6, 2016, MHDS staff also review the facility's Quality Council notes focusing on incident reports to determine if the facility is identifying concerning trends or other issues that should be addressed to ensure the protection and safety of individuals being served.
- December 19, 2016, nearly all staff had completed competency-based re-training on abuse reporting. The only staff that had not completed training by that date were staff who were on extended leave or suspended, pending investigation. Once staff returned to work they completed the competency-based re-training.
- December 23, 2016, staff were issued cards to be placed in the sleeves of their facility identification that summarized the re-training they had received.

- January 17, 2017, the Division Administrator of Mental Health and Disability Services of the Department of Human Services became the point of accountability and responsibility for GRC and personally directed the development and implementation of the corrective action plan. GRC and the Administrator of MHDS will personally direct the local executive leadership in taking action that assures clients are protected and safe.

Beginning January 23, 2017, each shift, supervisors will also be required to interview two resident treatment workers (RTWs) to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Supervisors will provide coaching and guidance on the spot as indicated by staff responses.

Information from these interviews will be reported daily to the TPAs who will ensure appropriate action has been taken related to the RTWs response. Information from interviews will be compiled and included as part of a weekly residential house report. The weekly house report will provide documentation regarding progress toward correcting deficiencies and issues that remain to be addressed.

TPAs are expected to personally monitor each of the houses under their supervision each shift they work. If TPAs find situations that need immediate attention, they take needed corrective action immediately on site. The findings of their monitoring is documented and reported to the Assistant Superintendent of Program Services.

Other top and middle management staff have been assigned to do unannounced monitoring of each residential house once per week. This includes the Superintendent, Assistant Superintendent of Program Services, Director of Quality Management, Director of Psychology, Day Services Director, Treatment Support Services Director, Director of Nursing, Speech Therapy Services Director, Management Information Services Director, 2<sup>nd</sup> Shift Administrator, Business Manager and the Director of Information Services who document their monitoring visits and report any findings weekly. If top and middle management staff find situations that need immediate attention, they take those immediate steps on site. The Superintendent and Assistant Superintendent review top and middle management staff monitoring findings weekly and ensure appropriate action has been taken to address any negative findings.

Beginning January 23, 2017, top and middle managers will be required to interview four resident treatment workers (RTWs) per week to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Beginning January 23, 2017, each house in the facility will be reevaluated weekly to ensure compliance of client protection and safety. In addition to RTW interviews described earlier, the evaluation will include a review of incident reports, key staff indicators and key client indicators. These reports will help pinpoint areas that need to be addressed in each individual house and document client protections and safety.

Before February 23, 2017, the Department of Human Services will secure the external experts to review and evaluate the facility regarding assuring and the provisions of client protection and safety.

Before February 23, 2017, the facility will have completed a root cause analysis by an expert in the field that is approved by DIA. The results of the root cause analysis will be used to make needed adjustments in the corrective action plan and other actions the facility is taking to ensure client protection and safety.

The Individual Rights Policy is trained to staff during new employee orientation and on an annual basis. Before February 10, 2017, the Individual Rights Policy dated 10/18/06 will be reviewed, revised, and trained as needed.

The Human Rights Policy is trained to staff during new employee orientation and on an annual basis. The Human Rights Policy dated 11/25/08 was revised 5/1/16 and trained as needed. Before February 10, 2017, the Human Rights Policy revised 5/1/16 will be reviewed, revised, and trained as needed.

**Responsible: Administrator of MHDS**  
**Date Completed: 1/13/17**

**Tag W127, Protection of Clients Rights**, found at 483.420 (a)(5): The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.

**Individual response**

As the result of intensive investigation of incidents that occurred, RTWs J, H, I, N, U, M, A, B, C, AA, BB, DD, and D had their employment terminated or resigned in lieu of termination. RTWs K, L, Y, Z, CC, FNS Worker A received appropriate personnel action and re-training.

The Behavior Support Plans for Clients #1, #3, #4, 6, and #7 were re-trained to staff working at house

248.

The Behavior Support Plans for Clients #15, #16, #17, #18, #20, and #23 were re-trained to staff working at house 253.

The Behavior Support Plan for Client # 22 was re-trained to staff working at house 470. RTW Z will be re-trained on Client #22's Behavior Support Plan prior to returning to work at house 470.

The Behavior Support Plan for Client #24 was re-trained to all staff working at house 360.

The Behavior Support Plan for Client #25 was re-trained to staff working at house 468, including RTW CC.

**Responsible: Treatment Program Administrator**

**Date Completed: 1/13/17**

### **Systemic Response**

Governing Body and Management Actions Taken:

- November 16, 2016, central office Mental Health and Disability Services (MHDS) staff, including the Administrator of MHDS, began making twice a month calls to review the status of the monitoring actions. MHDS staff, including the Administrator of MHDS also personally visits the facility two times per month to review the effectiveness of monitoring activities.
- November 16, 2016, the number of supervisors on the weekday evening shifts and weekend day and evening shifts was increased to a minimum of 7. Supervisors include Resident Treatment Supervisors (RTS) and Treatment Program Managers (TPM).
- November 17, 2016, the Superintendent began meeting with individual line supervisors one-on-one to discuss issues and expectations of treatment and immediate reporting of abuse or mistreatment, and the need to ensure individual reporters are safe and not intimidated from reporting. The Superintendent also discusses any issues or concerns regarding the status and effectiveness of monitoring and reporting suspected abuse and ensuring a safe environment for reporting.
- November 18, 2016, supervisors were required to record the time period and specific house that they monitored.
- November 28, 2016, the Superintendent directed that an email be sent to all staff that affirmed:
  - The facility has a zero tolerance for abuse and neglect,
  - All facility staff are mandatory reporters of suspected abuse or neglect and are required to report suspected instances immediately,
  - Affirmed that all staff that report suspected abuse or neglect will be free from retaliation, and
  - All facility staff are to be provided a violence free work place.

- December 2, 2016, supervisors were required to document findings of their monitoring visits. During monitoring visits, if supervisors find situations that need immediate attention, they take corrective action immediately onsite. Documentation is submitted to their supervisors, Treatment Program Administrators (TPAs). The findings are also shared with the Superintendent and the Assistant Superintendent for Program Services. These reports are reviewed daily and the TPAs ensure that any identified issues are addressed.
- December 6, 2016, supervisors were re-trained on what constitutes abuse and mistreatment, requirements to report suspected abuse or mistreatment, and signs and symptoms of mistreatment.
- Beginning December 6, 2016, MHDS staff also review the facility's Quality Council notes focusing on incident reports to determine if the facility is identifying concerning trends or other issues that should be addressed to ensure the protection and safety of individuals being served.
- December 19, 2016, nearly all staff had completed competency-based re-training on abuse reporting. The only staff that had not completed training by that date were staff who were on extended leave or suspended, pending investigation. Once staff returned to work they completed the competency-based re-training.
- December 23, 2016, staff were issued cards to be placed in the sleeves of their facility identification that summarized the re-training they had received.
- January 17, 2017, the Division Administrator of Mental Health and Disability Services of the Department of Human Services became the point of accountability and responsibility for GRC and personally directed the development and implementation of the corrective action plan. GRC and the Administrator of MHDS will personally direct the local executive leadership in taking action that assures clients are protected and safe.

Beginning January 23, 2017, each shift, supervisors will also be required to interview two resident treatment workers (RTWs) to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Supervisors will provide coaching and guidance on the spot as indicated by staff responses.

Information from these interviews will be reported daily to the TPAs who will ensure appropriate action has been taken related to the RTWs response. Information from interviews will be compiled and included as part of a weekly residential house report. The weekly house report will provide

documentation regarding progress toward correcting deficiencies and issues that remain to be addressed.

TPAs are expected to personally monitor each of the houses under their supervision each shift they work. If TPAs find situations that need immediate attention, they take needed corrective action immediately on site. The findings of their monitoring is documented and reported to the Assistant Superintendent of Program Services.

Other top and middle management staff have been assigned to do unannounced monitoring of each residential house once per week. This includes the Superintendent, Assistant Superintendent of Program Services, Director of Quality Management, Director of Psychology, Day Services Director, Treatment Support Services Director, Director of Nursing, Speech Therapy Services Director, Management Information Services Director, 2<sup>nd</sup> Shift Administrator, Business Manager and the Director of Information Services who document their monitoring visits and report any findings weekly. If top and middle management staff find situations that need immediate attention, they take those immediate steps on site. The Superintendent and Assistant Superintendent review top and middle management staff monitoring findings weekly and ensure appropriate action has been taken to address any negative findings.

Beginning January 23, 2017, top and middle managers will be required to interview four resident treatment workers (RTWs) per week to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Beginning January 23, 2017, each house in the facility will be reevaluated weekly to ensure compliance of client protection and safety. In addition to RTW interviews described earlier, the evaluation will include a review of incident reports, key staff indicators and key client indicators. These reports will help pinpoint areas that need to be addressed in each individual house and document client protections and safety.

Before February 23, 2017, the Department of Human Services will secure the external experts to review and evaluate the facility regarding assuring and the provisions of client protection and safety.

Before February 23, 2017, the facility will have completed a root cause analysis by an expert in the field that is approved by DIA. The results of the root cause analysis will be used to make needed adjustments in the corrective action plan and other actions the facility is taking to ensure client protection and safety.



The Incident Management Policy is trained to staff during new employee orientation and on an annual basis. The Incident Management Policy dated 11/2/07 was reviewed 1/6/17 with no revisions determined to be necessary.

The Individual Rights Policy is trained to staff during new employee orientation and on an annual basis. Before February 10, 2017, the Individual Rights Policy dated 10/18/06 will be reviewed, revised, and trained as needed.

**Responsible: Administrator of MHDS**  
**Date Completed: 1/13/17**

**Tag W149, Staff Treatment of Clients**, found at 483.420 (d)(1): The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

### **Systemic Response**

Governing Body and Management Actions Taken:

- November 16, 2016, central office Mental Health and Disability Services (MHDS) staff, including the Administrator of MHDS, began making twice a month calls to review the status of the monitoring actions. MHDS staff, including the Administrator of MHDS also personally visits the facility two times per month to review the effectiveness of monitoring activities.
- November 16, 2016, the number of supervisors on the weekday evening shifts and weekend day and evening shifts was increased to a minimum of 7. Supervisors include Resident Treatment Supervisors (RTS) and Treatment Program Managers (TPM).
- November 17, 2016, the Superintendent began meeting with individual line supervisors one-on-one to discuss issues and expectations of treatment and immediate reporting of abuse or mistreatment, and the need to ensure individual reporters are safe and not intimidated from reporting. The Superintendent also discusses any issues or concerns regarding the status and effectiveness of monitoring and reporting suspected abuse and ensuring a safe environment for reporting.
- November 18, 2016, supervisors were required to record the time period and specific house that they monitored.
- November 28, 2016, the Superintendent directed that an email be sent to all staff that affirmed:
  - The facility has a zero tolerance for abuse and neglect,
  - All facility staff are mandatory reporters of suspected abuse or neglect and are required to report suspected instances immediately,
  - Affirmed that all staff that report suspected abuse or neglect will be free from retaliation, and
  - All facility staff are to be provided a violence free work place.

- December 2, 2016, supervisors were required to document findings of their monitoring visits. During monitoring visits, if supervisors find situations that need immediate attention, they take corrective action immediately onsite. Documentation is submitted to their supervisors, Treatment Program Administrators (TPAs). The findings are also shared with the Superintendent and the Assistant Superintendent for Program Services. These reports are reviewed daily and the TPAs ensure that any identified issues are addressed.
- December 6, 2016, supervisors were re-trained on what constitutes abuse and mistreatment, requirements to report suspected abuse or mistreatment, and signs and symptoms of mistreatment.
- Beginning December 6, 2016, MHDS staff also review the facility's Quality Council notes focusing on incident reports to determine if the facility is identifying concerning trends or other issues that should be addressed to ensure the protection and safety of individuals being served.
- December 19, 2016, nearly all staff had completed competency-based re-training on abuse reporting. The only staff that had not completed training by that date were staff who were on extended leave or suspended, pending investigation. Once staff returned to work they completed the competency-based re-training.
- December 23, 2016, staff were issued cards to be placed in the sleeves of their facility identification that summarized the re-training they had received.
- January 17, 2017, the Division Administrator of Mental Health and Disability Services of the Department of Human Services became the point of accountability and responsibility for GRC and personally directed the development and implementation of the corrective action plan. GRC and the Administrator of MHDS will personally direct the local executive leadership in taking action that assures clients are protected and safe.

Beginning January 23, 2017, each shift, supervisors will also be required to interview two resident treatment workers (RTWs) to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Supervisors will provide coaching and guidance on the spot as indicated by staff responses.

Information from these interviews will be reported daily to the TPAs who will ensure appropriate action has been taken related to the RTWs response. Information from interviews will be compiled and included as part of a weekly residential house report. The weekly house report will provide

documentation regarding progress toward correcting deficiencies and issues that remain to be addressed.

TPAs are expected to personally monitor each of the houses under their supervision each shift they work. If TPAs find situations that need immediate attention, they take needed corrective action immediately on site. The findings of their monitoring is documented and reported to the Assistant Superintendent of Program Services.

Other top and middle management staff have been assigned to do unannounced monitoring of each residential house once per week. This includes the Superintendent, Assistant Superintendent of Program Services, Director of Quality Management, Director of Psychology, Day Services Director, Treatment Support Services Director, Director of Nursing, Speech Therapy Services Director, Management Information Services Director, 2<sup>nd</sup> Shift Administrator, Business Manager and the Director of Information Services who document their monitoring visits and report any findings weekly. If top and middle management staff find situations that need immediate attention, they take those immediate steps on site. The Superintendent and Assistant Superintendent review top and middle management staff monitoring findings weekly and ensure appropriate action has been taken to address any negative findings.

Beginning January 23, 2017, top and middle managers will be required to interview four resident treatment workers (RTWs) per week to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Beginning January 23, 2017, each house in the facility will be reevaluated weekly to ensure compliance of client protection and safety. In addition to RTW interviews described earlier, the evaluation will include a review of incident reports, key staff indicators and key client indicators. These reports will help pinpoint areas that need to be addressed in each individual house and document client protections and safety.

Before February 23, 2017, the Department of Human Services will secure the external experts to review and evaluate the facility regarding assuring and the provisions of client protection and safety.

Before February 23, 2017, the facility will have completed a root cause analysis by an expert in the field that is approved by DIA. The results of the root cause analysis will be used to make needed adjustments in the corrective action plan and other actions the facility is taking to ensure client protection and safety.

The Incident Management Policy is trained to staff during new employee orientation and on an annual basis. The Incident Management Policy dated 11/2/07 was reviewed 1/6/17 with no revisions determined to be necessary.

The Individual Rights Policy is trained to staff during new employee orientation and on an annual basis. Before February 10, 2017, the Individual Rights Policy dated 10/18/06 will be reviewed, revised, and trained as needed.

The Human Rights Policy is trained to staff during new employee orientation and on an annual basis. The Human Rights Policy dated 11/25/08 was revised 5/1/16 and trained as needed. Before February 10, 2017, the Human Rights Policy revised 5/1/16 will be reviewed, revised, and trained as needed.

**Responsible: Administrator of MHDS**

**Date Completed: 1/13/17**

**Tag W153, Staff Treatment of Clients**, found at 483.420 (d)(2): The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

**Individual response**

As the result of thorough investigation of incidents that occurred, RTWs H, J, I, N, U, M, B, A, DD and D had their employment terminated or resigned in lieu of termination. RTWs K, L, Y, Z, CC, and FNS Worker A received appropriate personnel action and re-training.

RTWs K, L, Y, Z, CC and FNS Worker A were re-trained on the Abuse Reporting requirements.

**Responsible: Superintendent**

**Date Completed: 1/13/17**

**Systemic Response**

Governing Body and Management Actions Taken:

- November 16, 2016, central office Mental Health and Disability Services (MHDS) staff, including the Administrator of MHDS, began making twice a month calls to review the status of the monitoring actions. MHDS staff, including the Administrator of MHDS also personally visits the facility two times per month to review the effectiveness of monitoring activities.
- November 16, 2016, the number of supervisors on the weekday evening shifts and weekend day and evening shifts was increased to a minimum of 7. Supervisors include Resident Treatment Supervisors (RTS) and Treatment Program Managers (TPM).
- November 17, 2016, the Superintendent began meeting with individual line supervisors one-on-one to discuss issues and expectations of treatment and immediate reporting of abuse or mistreatment, and the need to ensure individual reporters are safe and not intimidated from reporting. The Superintendent also discusses any issues or concerns regarding the status and effectiveness of monitoring and reporting suspected abuse and ensuring a safe environment for reporting.
- November 18, 2016, supervisors were required to record the time period and specific house

that they monitored.

- November 28, 2016, the Superintendent directed that an email be sent to all staff that affirmed:
  - The facility has a zero tolerance for abuse and neglect,
  - All facility staff are mandatory reporters of suspected abuse or neglect and are required to report suspected instances immediately,
  - Affirmed that all staff that report suspected abuse or neglect will be free from retaliation, and
  - All facility staff are to be provided a violence free work place.
- December 2, 2016, supervisors were required to document findings of their monitoring visits. During monitoring visits, if supervisors find situations that need immediate attention, they take corrective action immediately onsite. Documentation is submitted to their supervisors, Treatment Program Administrators (TPAs). The findings are also shared with the Superintendent and the Assistant Superintendent for Program Services. These reports are reviewed daily and the TPAs ensure that any identified issues are addressed.
- December 6, 2016, supervisors were re-trained on what constitutes abuse and mistreatment, requirements to report suspected abuse or mistreatment, and signs and symptoms of mistreatment.
- Beginning December 6, 2016, MHDS staff also review the facility's Quality Council notes focusing on incident reports to determine if the facility is identifying concerning trends or other issues that should be addressed to ensure the protection and safety of individuals being served.
- December 19, 2016, nearly all staff had completed competency-based re-training on abuse reporting. The only staff that had not completed training by that date were staff who were on extended leave or suspended, pending investigation. Once staff returned to work they completed the competency-based re-training.
- December 23, 2016, staff were issued cards to be placed in the sleeves of their facility identification that summarized the re-training they had received.
- January 17, 2017, the Division Administrator of Mental Health and Disability Services of the Department of Human Services became the point of accountability and responsibility for GRC and personally directed the development and implementation of the corrective action plan. GRC and the Administrator of MHDS will personally direct the local executive leadership in taking action that assures clients are protected and safe.

Beginning January 23, 2017, each shift, supervisors will also be required to interview two resident treatment workers (RTWs) to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Supervisors will provide coaching and guidance on the spot as indicated by staff responses.

Information from these interviews will be reported daily to the TPAs who will ensure appropriate action has been taken related to the RTWs response. Information from interviews will be compiled and included as part of a weekly residential house report. The weekly house report will provide documentation regarding progress toward correcting deficiencies and issues that remain to be

addressed.

TPAs are expected to personally monitor each of the houses under their supervision each shift they work. If TPAs find situations that need immediate attention, they take needed corrective action immediately on site. The findings of their monitoring is documented and reported to the Assistant Superintendent of Program Services.

Other top and middle management staff have been assigned to do unannounced monitoring of each residential house once per week. This includes the Superintendent, Assistant Superintendent of Program Services, Director of Quality Management, Director of Psychology, Day Services Director, Treatment Support Services Director, Director of Nursing, Speech Therapy Services Director, Management Information Services Director, 2<sup>nd</sup> Shift Administrator, Business Manager and the Director of Information Services who document their monitoring visits and report any findings weekly. If top and middle management staff find situations that need immediate attention, they take those immediate steps on site. The Superintendent and Assistant Superintendent review top and middle management staff monitoring findings weekly and ensure appropriate action has been taken to address any negative findings.

Beginning January 23, 2017, top and middle managers will be required to interview four resident treatment workers (RTWs) per week to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Beginning January 23, 2017, each house in the facility will be reevaluated weekly to ensure compliance of client protection and safety. In addition to RTW interviews described earlier, the evaluation will include a review of incident reports, key staff indicators and key client indicators. These reports will help pinpoint areas that need to be addressed in each individual house and document client protections and safety.

Before February 23, 2017, the Department of Human Services will secure the external experts to review and evaluate the facility regarding assuring and the provisions of client protection and safety.

Before February 23, 2017, the facility will have completed a root cause analysis by an expert in the field that is approved by DIA. The results of the root cause analysis will be used to make needed adjustments in the corrective action plan and other actions the facility is taking to ensure client protection and safety.

The Incident Management Policy is trained to staff during new employee orientation and on an annual basis. The Incident Management Policy dated 11/2/07 was reviewed 1/6/17 with no revisions determined to be necessary.

**Responsible: Administrator of MHDS**

**Date Completed: 1/13/17**

**Tag W193, Staff Training Program**, found at 483.430 (e)(3): Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

**Individual response**

As the result of a thorough investigation of incidents that occurred, RTWs B, A, AA and BB had their employment terminated or resigned in lieu of termination.

**Responsible: Superintendent**

**Date Completed: 1/13/17**

FNS Driver A received personnel action and will receive re-training related to appropriate interactions and proper implementation of Client #4's Behavior Support Plan.

**Responsible: Superintendent**

**Date Completed: 2/2/17**

The Behavior Support Plans for Clients #1 and #4 will be re-trained to staff working at house 248, including FNS Driver A.

The Behavior Support Plan for Client #24 will be re-trained to staff working at house 360.

**Responsible: Treatment Program Administrators**

**Date Completed: 2/2/17**

**Systemic response**

RTWs will be re-trained on Behavior Support Plans for the clients they are assigned to support. Behavior Support Plans are routinely monitored by Psychologists and Psychology Assistants through completion of Program Implementation Monitor forms.

**Responsible: Treatment Program Administrators**

**Date Completed: 2/10/17**

**Tag W268, Conduct Toward Client**, found at 483.450 (a)(1)(i): These policies and procedures must promote the growth, development and independence of the client.

**Individual response**

As the result of intensive investigation of incidents that occurred, RTWs H, J, I, U, M, N, A, and B had their employment terminated or resigned in lieu of termination. RTW K and L received appropriate personnel action and re-training.

**Responsible: Superintendent**

**Date Completed: 1/13/17**

Staff receive training annually on Mandt, Incident Management, Dignity and Respect and Human Rights. RTWs K, L, and Q will be re-trained on the Incident Management, Dignity and Respect and Human Rights.

**Responsible: Treatment Program Administrator**  
**Date Completed: 1/13/17**

### **Systemic Response**

#### **Governing Body and Management Actions Taken:**

- November 16, 2016, central office Mental Health and Disability Services (MHDS) staff, including the Administrator of MHDS, began making twice a month calls to review the status of the monitoring actions. MHDS staff, including the Administrator of MHDS also personally visits the facility two times per month to review the effectiveness of monitoring activities.
- November 16, 2016, the number of supervisors on the weekday evening shifts and weekend day and evening shifts was increased to a minimum of 7. Supervisors include Resident Treatment Supervisors (RTS) and Treatment Program Managers (TPM).
- November 17, 2016, the Superintendent began meeting with individual line supervisors one-on-one to discuss issues and expectations of treatment and immediate reporting of abuse or mistreatment, and the need to ensure individual reporters are safe and not intimidated from reporting. The Superintendent also discusses any issues or concerns regarding the status and effectiveness of monitoring and reporting suspected abuse and ensuring a safe environment for reporting.
- November 18, 2016, supervisors were required to record the time period and specific house that they monitored.
- November 28, 2016, the Superintendent directed that an email be sent to all staff that affirmed:
  - The facility has a zero tolerance for abuse and neglect,
  - All facility staff are mandatory reporters of suspected abuse or neglect and are required to report suspected instances immediately,
  - Affirmed that all staff that report suspected abuse or neglect will be free from retaliation, and
  - All facility staff are to be provided a violence free work place.
- December 2, 2016, supervisors were required to document findings of their monitoring visits. During monitoring visits, if supervisors find situations that need immediate attention, they take corrective action immediately onsite. Documentation is submitted to their supervisors, Treatment Program Administrators (TPAs). The findings are also shared with the Superintendent and the Assistant Superintendent for Program Services. These reports are reviewed daily and the TPAs ensure that any identified issues are addressed.
- December 6, 2016, supervisors were re-trained on what constitutes abuse and mistreatment, requirements to report suspected abuse or mistreatment, and signs and symptoms of mistreatment.



- Beginning December 6, 2016, MHDS staff also review the facility's Quality Council notes focusing on incident reports to determine if the facility is identifying concerning trends or other issues that should be addressed to ensure the protection and safety of individuals being served.
- December 19, 2016, nearly all staff had completed competency-based re-training on abuse reporting. The only staff that had not completed training by that date were staff who were on extended leave or suspended, pending investigation. Once staff returned to work they completed the competency-based re-training.
- December 23, 2016, staff were issued cards to be placed in the sleeves of their facility identification that summarized the re-training they had received.
- January 17, 2017, the Division Administrator of Mental Health and Disability Services of the Department of Human Services became the point of accountability and responsibility for GRC and personally directed the development and implementation of the corrective action plan. GRC and the Administrator of MHDS will personally direct the local executive leadership in taking action that assures clients are protected and safe.

Beginning January 23, 2017, each shift, supervisors will also be required to interview two resident treatment workers (RTWs) to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Supervisors will provide coaching and guidance on the spot as indicated by staff responses.

Information from these interviews will be reported daily to the TPAs who will ensure appropriate action has been taken related to the RTWs response. Information from interviews will be compiled and included as part of a weekly residential house report. The weekly house report will provide documentation regarding progress toward correcting deficiencies and issues that remain to be addressed.

TPAs are expected to personally monitor each of the houses under their supervision each shift they work. If TPAs find situations that need immediate attention, they take needed corrective action immediately on site. The findings of their monitoring is documented and reported to the Assistant Superintendent of Program Services.

Other top and middle management staff have been assigned to do unannounced monitoring of each residential house once per week. This includes the Superintendent, Assistant Superintendent of Program Services, Director of Quality Management, Director of Psychology, Day Services Director,

Treatment Support Services Director, Director of Nursing, Speech Therapy Services Director, Management Information Services Director, 2<sup>nd</sup> Shift Administrator, Business Manager and the Director of Information Services who document their monitoring visits and report any findings weekly. If top and middle management staff find situations that need immediate attention, they take those immediate steps on site. The Superintendent and Assistant Superintendent review top and middle management staff monitoring findings weekly and ensure appropriate action has been taken to address any negative findings.

Beginning January 23, 2017, top and middle managers will be required to interview four resident treatment workers (RTWs) per week to determine that the staff interviewed:

- Have the knowledge to accurately recognize and appropriately and immediately report suspected abuse or mistreatment,
- Feel safe in reporting suspected instances of abuse or mistreatment,
- Have knowledge about how to respond to Behavior Support Plans,
- Have knowledge about personal care schedules, and
- Have knowledge about the appropriate level of supervision.

Beginning January 23, 2017, each house in the facility will be reevaluated weekly to ensure compliance of client protection and safety. In addition to RTW interviews described earlier, the evaluation will include a review of incident reports, key staff indicators and key client indicators. These reports will help pinpoint areas that need to be addressed in each individual house and document client protections and safety.

Before February 23, 2017, the Department of Human Services will secure the external experts to review and evaluate the facility regarding assuring and the provisions of client protection and safety.

Before February 23, 2017, the facility will have completed a root cause analysis by an expert in the field that is approved by DIA. The results of the root cause analysis will be used to make needed adjustments in the corrective action plan and other actions the facility is taking to ensure client protection and safety.

**Responsible: Administrator of MHDS**

**Date Completed: 1/13/17**