RE 2/22/17 CAC 2/21/17

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

PRINTED: 02/15/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G003	A. BUILDING _____ B. WING _____	C 02/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD RESOURCE CENTER	711 SOUTH VINE STREET GLENWOOD, IA 51534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following complaint survey was completed 1/11/17 - 2/3/17 and included the following investigations: 65074-C, 65079-I, 65215-C, and 65216-I. Condition-level deficiencies were cited at W266 and W318. These findings led to the following determinations of Immediate Jeopardy (IJ): On 1/12/17 at approximately 4:40 p.m., IJ was determined based on the facility's failure to ensure appropriate staff interaction with clients. Staff utilized unauthorized techniques to address inappropriate client behavior. Additionally, staff failed to report incidents of inappropriate behavior management by peers. The facility developed a plan to remove theIJ, which included staff training of behavior interventions and behavior support programs, in addition to increased supervision in the home. The IJ was removed on 1/12/17 at approximately 8:00 p.m. On 1/19/17 at approximately 11:00 a.m., the facility was notified IJ was determined based on the facility's failure to ensure timely medical treatment and pain managment for clients with significant injuries. The facility developed a plan to remove the IJ, which included retraining of medical staff on assessment of injuries, facility protocols for x-ray and emergent care, and standards of care for pain management. The IJ was removed on 1/20/17 at approximately 12:45 p.m. Standard-level deficiencies were cited at W125,	W 000	See attached POC 2/24/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 W153, W288, and W322.	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS 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. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to consistently ensure the rights of all clients regarding health, safety and respect for each person's health care needs. The facility failed to act promptly to ensure medical treatment sought and adequate pain management for significant injury. This affected 1 of 2 sample clients (Client #1) identified during the complaint survey of #65074-C, 65079-I, 65215-C, and 65216-I. Finding follows: Record review on 1/16/17 revealed an Incident Report, dated 1/13/17 at 6:45 a.m., completed by Resident Treatment Worker (RTW) A. The report detailed staff assisted Client #1 with a brief change. When rolling towards and resting against staff, the staff's knee gave out and Client #1 slid off the bed. Staff had a hold of Client #1 and prevented his/her head and body from reaching the floor; Client #1's knees hit the floor and his/her body landed on staff's knee. RTW A had their arms under the client and lifted/rolled the client back to the bed, when he noticed the client's thumb bled. RTW A did not know how Client #1 hurt his/her thumb, but thought it may	W 125		

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W 125	Continued From page 2	W 125		

have possibly gotten caught on the bed brake lever. Staff examined the thumb and immediately called for other staff to call nurse.

The report further documented the fall and head injury assessment that occurred. Registered Nurse (RN) A documented upon arrival at approximately 6:59 a.m. she observed a dime sized scrape, no broken skin, to the client's left knee and a pink mark, approximately 0.7 centimeters (cm) by 0.4 cm on his/her right knee; no bruises or edema were noted to either knee. The RN further documented, "...rt (right) hand rt thumb on visual exam appears to be very much out of alignment, bruised and swollen, nail bed is raised up off nail bed nail seems to be split near base of nail and bleeding slightly. Nail bed bluish tinged strong radial pulse..." The report further noted the ARNP asked that the thumb be stabilized as much as possible and she would order an x-ray. The ARNP arrived at 7:31 a.m. to see Client #1 and instructed administration of Tylenol. The report documented, "... 7:35 a.m. hold off administering h(his/her) routine meds to be sure (he/she) can keep (his/her) PRN Tylenol down in case of stomach upset as (Client #1) is [moaning and] yelling out..." RN A documented instruction from the ARNP to put a "stat" order on the x-ray to include Client #1's right thumb, wrist and hand. A gentle splint was applied per instruction from the ARNP and his/her right hand elevated on a pillow as they awaited x-ray to rule out fracture.

Additional record review revealed Client #1's clinical notes. Review revealed the following:

a. 1/13/17 at 9:17 a.m., RN B documented nursing assessment: "near fall this am (morning)

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W 125	Continued From page 3 during routine cares, knees scraped floor, small abrasion, right thumb w/(with) swelling, bruising, injury to nail, and unnatural appearing alignment per (RN A)... x-ray order in place, awaiting mobile x (x-ray) arrival, thumb splinted, Tylenol given also, (Physician A) aware." b. 1/13/17 at 10:45 a.m., Licensed Practical Nurse (LPN) A documented nursing assessment: "(Client #1) has been making vocal sounds [on a regular basis]...Right thumb swollen and red and bruise in color. Limited ROM (range of motion) to extremity of thumb. Nail is pushing outward with edema under nail bed and bleeding around nail. Area cleansed and ice applied with ace wrap applied. [Mobile x-ray] was here with [x-ray] completed... Trauma to right thumb... To be seen by OD (on duty physician)." c. 1/13/17 at 11:10 a.m., RN B documented nursing assessment: "right thumb, distal section w/ significant swelling, bleeding from the thumb nail site, blue in color" Assessment: "trauma to right thumb... seen by Physician A [at] GRC's (Glenwood Resource Center) clinical wing... x-ray report available now, multiple fractures reported, ER (emergency room) evaluation pending..." d. 1/13/17 at 12:00 p.m., LPN A documented nursing assessment: "To JEMH (Jennie Edmundson Methodist Hospital) by state van with a departure time of 12:30 p.m..." e. 1/13/17 at 4:19 p.m., RN C documented ER communication: "...client is being admitted... Client will be taken to surgery sometime dx (dignoses) fracture..." f. 1/13/17 at 8:00 p.m., RN C documented JEMH	W 125		

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communication: "...Client had ORIF (open reduction internal fixation) of the Right thumb and has a splint and 1/2 cast along with ace wrap..."

Additional record review revealed a resource center grievance, dated 1/13/17. The grievance, completed by RTW A and RTW B, described on 1/13/17 Client #1 had an incident report regarding his/her right thumb. The incident occurred at 6:45 a.m. Client #1 received Tylenol at 7:30 a.m. Nurses came to the house right away to assess and took vitals. The ARNP was called and came to the house at approximately 7:40 a.m. The ARNP ordered x-rays. RTW B documented, "This [writer] overheard a nurses conversation on the phone stating Mobile-X (x-ray) wasn't called until after 8:00 a.m. Mobile-X didn't arrive until approx. 9:30 a.m. Still have not heard any results of x-ray [at] 11:00 a.m." The report continued, "Nurse said (Physician A) wanted to see (Client #1) [at] clinic. Staff requested [Physician A] come to house but that didn't happen. This grievance is being [filed] on behalf of (Client #1) for the fact that he had to suffer for 5+ hours before getting seen and sent to hospital."

Treatment Program Manager (TPM) A received the grievance for review on 1/18/17. TPM A documented, "(Client #1) sustained a serious injury to (his/her) [right] thumb on 1/13/17 [at] 6:45 a.m. (He/She) was sent to hospital after waiting several hours. Injury required surgical intervention..."

Treatment Program Administrator (TPA) A signed the grievance 1/20/17, and noted, "...The injury was noted to occur on 1/13/17 at 6:45 a.m. (Client #1) left for treatment after being seen by the doctor at the medical clinic and send to the

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W 125	Continued From page 5 ER at noon. I met with the brother/guardian... to discuss the incident." TPA A further noted, "The family was also concerned about the delay in services." The Human Rights Committee (HRC) received the grievance on 1/23/17. A summary of their findings was issued 2/3/17, and included: "...There were concerns regarding the judgment surrounding the delay in sending client to hospital. First nursing assessment stated 'rt thumb on visual exam appears to be very much out of alignment'; then issue becomes less clear where staff indicate that they requested (Physician A) come out to the house, but a time for the request is not listed... Also Mobile-X was unable to be at campus until 2 hours after request. Although Mobile-X contract states that results for a STAT call is 4 hours, it may be wise to examine time frames for making decisions regarding where or who performs X-ray... Looking into policies, there may be room for improvements and updating. The Radiological Protocol seemed to reference old processes with a small portion dedicated to GRC current practice. The other trainings being unknown as there are NO GRC policies on pain management, emergent fractures, physical assessments with impediment..." When interviewed on 1/24/17 at 12:30 p.m. RTW B stated she came from the hallway when the injury first occurred and RTW A asked for help. RTW B stated she saw Client #1's injury and it immediately began swelling and turning purple, the nail bed was popped up and it bled. She stated it appeared to be a bad injury and it was "very obvious it was broken." RTW B stated she called Licensed Practical Nurse (LPN) A and he	W 125		

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came to the home immediately. Registered Nurse (RN) A then arrived to assess. RTW B stated she took Client #1's vitals: Client #1 had a higher blood pressure (BP), but he/she has a little high BP; his/her heartrate was "a little elevated." RTW B stated she thought Client #1's thumb was broken, as did RTW A and LPN A. Advanced Registered Nurse Practitioner (ARNP) A came to the home shortly after 7:00 a.m. RN A had made a makeshift bandage/splint for Client #1's thumb. ARNP A did not remove the bandage to assess Client #1's injury, she just said they would get x-rays. When asked to clarify, RTW B stated it did not appear ARNP assessed Client #1's injury. RTW B reported Client #1 in pain the entire time he waited to go to ER. She stated they waited to see Physician A after the mobile x-rays were taken. She stated they told every supervisor and every nurse that Client #1 needed to immediately to the ER and it did not happen. RTW B accompanied Client #1 to the emergency room. She stated they left campus around 12:10 p.m. and arrived at 12:40 p.m. When they arrived to the hospital, she stated they asked "what took so long to get (him/her) here?" She stated Client #1 was clearly in pain and let out "gut wrenching" cries. She stated he/she had been in pain since 7:00 a.m. and had received Tylenol, but he/she needed more. She requested pain medication for Client #1 while in triage at the ER, and they gave him/her Lortab. They took Client #1 back to take x-rays, again. Client #1 was still in pain, and was given morphine. RTW B stated Client #1 should have gone right out to the ER. RTW B stated she filed a grievance on Client #1's behalf. She stated she was frustrated they asked nursing to have Physician A come to the home. The nurse told them the physician was not coming to the home, they needed to take Client #1 to clinic.

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W 125	Continued From page 7 RTW B stated Client #1 was clearly in pain the whole time he/she waited. She stated she told every supervisor and every nurse that Client #1 needed to go to ER, but no one listened. According to facility policy, "Individual Rights," dated 10/18/16, clients should receive "care in a manner maintaining their dignity and respecting their individuality and be treated with consideration, respect and full recognition of their dignity and individuality."	W 125		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to consistently ensure allegations of potential client abuse/mistreatment were identified and reported immediately to the administrator. This pertained to 1 of 2 clients (Client #2) identified during complaint investigation #65074-C, 65079-I, 65215-C, and 65216-I. Finding follows: Record review on 1/11/17 revealed an incident report, dated 1/10/17, completed by Resident Treatment Supervisor (RTS) A at 2:45 p.m. The RTS documented Client #2 grabbed and pulled a Psych Assistants (PA) hair with both hands. The	W 153		

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W 153	Continued From page 8 staff assigned to Client #2, Resident Treatment Worker (RTW) C intervened along with RTS A. Additional staff present were RTW D and PA B. According to the report, staff held the client's hands close to the staff's head and waited for the client to let go. While the group continued to wait, RTW E walked toward the group and stated, "I can help with this." Immediately he took his forefinger and thumb and placed them on the client's nose. His fingers were placed in front of the client's mouth. He stated, "If (he/she) can't breathe, (he/she) will let go." The RTS intervened and explained that he could not do that and removed him from the situation and the house. When interviewed on 1/11/17 at 1:35 p.m. RTW E admitted he saw Client #2 pulling PA A's hair. He walked to the group from the front and put his thumb and first finger on the clients' nose. He pinched the clients' nose. He said his hands were not tightly on the clients nose. He explained he did this to distract the client. He confirmed he had done this about a week prior when Client #2 had RTW F's hair. He said that time he held the clients' nose about 10 seconds. As soon as the client released, RTW E released. He denied being shown this technique and just did it himself the two times. Interview with RTW D on 1/12/17 at 2:15 p.m. via phone, confirmed she was present at the incident on 1/10/17. She explained the situation as RTW E stated he thought he could help. She stated RTW E put hands on nose and over the clients mouth. The supervisor told him he could not do that and he let go. Also, RTW E said "it worked last time." She reported RTW C also stated that it only took 20 seconds last time and (he/she) let go. RTW D had not seen this technique used in	W 153		

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W 153	Continued From page 9 the past. During an interview with PA A, she explained Client #2 pulled her hair on 1/10/17. She held the clients' hands close to her own head and conveyed to the staff helping that the client was not hurting her. She stated she saw RTW E walk up and put his hands and fingers over clients nose and lips. RTW E commented about if (he/she) can't breathe (he/she) will let go. She noted he pinched the nose for a couple seconds and was told to stop and he did. When interviewed on 1/12/17 at 1:05 p.m. RTS A confirmed she assisted with the incident. She held the client's hands to PA A's head and also blocked the client from head butting her. She observed RTW E walk towards them saying he could help with this. He put his palm of his hand over Client #2's mouth and his thumb and first finger on the client's nose and commented that if (he/she) can't breathe (he/she) will let go. Immediately the RTS told him he could not do that and he let go. She then had him leave the area and informed him he needed to go to the supervisor's office and she notified management. When interviewed on 1/12/17 at 2:40 p.m. RTW F explained Client #2 pulled her hair the week prior-approximately 1/3/17. She stated RTW E was present during the hair pulling incident, however she did not see where any staff's hands were. She was bent forward and could not see what was going on. She did hear a rumor that day or the next that they plugged the client's nose to get him/her to release her hair. She could not remember who told her this information. She denied informing any supervisors or management about this information.	W 153		

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W 153	Continued From page 10 Record review on 1/12/17 revealed an 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 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..." On 1/12/17 at approximately 4:40 p.m., Immediate Jeopardy was determined based on the facility's failure to ensure appropriate staff interaction with clients. Staff utilized unauthorized techniques to address inappropriate client behavior. Additionally, staff failed to report incidents of inappropriate behavior management by peers. The facility developed a plan to remove the IJ, which included staff training of behavior interventions and behavior support programs, in addition to increased supervision in the home. The IJ was removed on 1/12/17 at approximately 8:00 p.m.	W 153		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met.	W 266		

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W 266	Continued From page 11 This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to maintain minimum compliance with the Condition of Participation (CoP) - Client Behavior and Facility Practices. The facility failed to ensure staff consistently utilized approved techniques to manage inappropriate client behavior. These findings led to a determination of immediate jeopardy on 1/12/17 at approximately 4:40 p.m.,based on the facility's failure to ensure appropriate staff intervention with clients. Staff utilized unauthorized techniques to address inappropriate client behavior. Additionally, staff failed to report incidents of inappropriate behavior management by peers. The facility developed a plan to remove the IJ, which included staff training of behavior interventions and behavior support programs, in addition to increased supervision in the home. The IJ was removed on 1/12/17 at approximately 8:00 p.m. Cross-reference W288: Based on interviews and record review, the facility failed to ensure staff consistently and correctly utilized approved interventions to address inappropriate client behavior. Staff utilized unapproved techniques to address inappropriate client behavior not addressed in the individual program plan.	W 266		
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.	W 288		

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W 288	Continued From page 12 This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff consistently and correctly utilized approved interventions to address inappropriate client behavior. Staff utilized unapproved techniques to address inappropriate client behavior not addressed in the individual program plan. This affected 1 of 1 client (Client #2) identified during the investigation of 65074-C and 65079-I. Finding follows: Record review on 1/11/17 revealed an incident report, dated 1/10/17, completed by Resident Treatment Supervisor (RTS) A at 2:45 p.m. The RTS documented Client #2 grabbed and pulled a Psych Assistant's (PA) hair with both hands. The staff assigned to Client #2, Resident Treatment Worker (RTW) C intervened along with RTS A. Additional staff present were RTW D and PA B. According to the report, staff held the client's hands close to the staff's head and waited for the client to let go. While the group continued to wait, RTW E walked toward the group and stated, "I can help with this." Immediately he took his forefinger and thumb and placed them on the client's nose. His fingers were placed in front of the client's mouth. He stated, "If (he/she) can't breathe, (he/she) will let go." The RTS intervened and explained that he could not do that and removed him from the situation and the house. When interviewed on 1/11/17 at 1:35 p.m. RTW E admitted he saw Client #2 pulling PA A's hair. He walked to the group from the front and put his thumb and first finger on the client's nose. He	W 288		

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W 288	Continued From page 13 pinched the client's nose. He said his hands were not tightly on the client's nose. He explained he did this to distract the client. RTS A told him, "Don't do that." and he let go. Within a minute Client #2 released his hands from, PA A's hair. He confirmed he had done this about a week prior when Client #2 had RTW F's hair. He said that time he held the client's nose about 10 seconds. As soon as the client released, RTW E released. He denied being shown this technique and just did it himself the two times. RTW E confirmed training on Mandt techniques and explained when clients pull hair, staff should hold their hand to the head until they tire out. Interview with RTW D on 1/12/17 at 2:15 p.m. via phone, confirmed she was present at the incident on 1/10/17. She explained the situation as RTW E stated he thought he could help. She stated RTW E put hands on nose and over the client's mouth. The supervisor told him he could not do that and he let go. Also, RTW E said "it worked last time." She reported RTW C also stated that it only took 20 seconds last time and (he/she) let go. RTW D had not seen this technique used in the past. During an interview with PA A, she explained Client #2 pulled her hair on 1/10/17. She held the client's hands close to her own head and conveyed to the staff helping that the client was not hurting her. She stated she saw RTW E walk up and put his hands and fingers over Client #2's nose and lips. RTW E commented about if (he/she) can't breathe (he/she) will let go. She noted he pinched the nose for a couple seconds and was told to stop and he did. When interviewed on 1/12/17 at 1:05 p.m. RTS A	W 288		

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W 288	Continued From page 14 confirmed she assisted with the incident. She held the client's hands to PA A's head and also blocked the client from head butting her. She observed RTW E walk towards them saying he could help with this. He put the palm of his hand over Client #2's mouth and his thumb and first finger on the client's nose and commented that if (he/she) can't breathe (he/she) will let go. Immediately the RTS told him he could not do that and he let go. She then had him leave the area and informed him he needed to go to the supervisor's office and she notified management. When interviewed on 1/12/17 at 2:40 p.m. RTW F explained Client #2 pulled her hair the week prior-approximately 1/3/17. She stated RTW E was present during the hair pulling incident, however she did not see where any staff's hands were. She was bent forward and could not see what was going on. She did hear a rumor that day or the next that they plugged the client's nose to get him/her to release her hair. She could not remember who told her this information. She denied informing any supervisors or management about this information. Record review revealed Client #2's behavior support plan, started 12/5/16, included target behaviors of: aggression, property destruction, self-injurious behavior (SIB), stripping, inappropriate social behavior, and inappropriate sexual behavior. The BSP did not include hair pulling. When staff saw target behaviors, the BSP instructed staff to: give one verbal prompt to stop using a firm voice, back away if aggression directed at staff. If you cannot back away when aggression is displayed towards staff, if aggression is directed at a peer, or for any other target behaviors, use GRC approved techniques	W 288		

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W 288	Continued From page 15 to interrupt the behavior. On 1/12/17 at approximately 4:40 p.m., Immediate Jeopardy was determined based on the facility's failure to ensure appropriate staff interventions with clients. Staff utilized unauthorized techniques to address inappropriate client behavior. Additional, staff failed to report the IJ, which included staff training on behavior interventions and behavior support programs, in addition to increased supervision in the home. The IJ was removed on 1/12/17 at approximately 8:00 p.m.	W 288		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to be in minimal compliance with the Condition of Participation (COP) - Health Care Services. The facility failed to ensure all clients were consistently provided appropriate health care services in accordance with their needs; including failure to adequately assess an injury and provide Client #1 pain medication to alleviate the severe pain from a fractured thumb. Findings follow: A determination of Immediate Jeopardy (IJ) was made based on the facility's failure to ensure adequate assessment of significant injuries, timely medical attention, and appropriate paint	W 318		

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W 318	Continued From page 16 management for clients with significant injuries. The facility was notified of the IJ on 1/19/17 at approximately 11:00 a.m. The facility developed a plan to remove the IJ, which included retraining of medical staff on assessment of injuries, facility protocols for x-ray and emergent care, and standards of care for pain management. The IJ was removed on 1/20/17 at approximately 12:45 p.m. Cross-reference W322: Based on interviews, and record reviews, the facility failed to ensure clients consistently received appropriate medical care to address acute health concerns. Staff failed to to adequately assess client injury, ensure timely follow up, and provide adequate pain management.	W 318		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure clients consistently received appropriate medical care to address acute health concerns. Staff failed to adequately assess client injury, ensure timely follow up, and provide adequate pain management. This affected 1 of 1 client (Clients #1) identified as a result of investigation #62515-C and 62516-I. Findings follow: Record review on 1/16/17 revealed an Incident Report, dated 1/13/17 at 6:45 a.m., completed by	W 322		

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W 322	Continued From page 17 Resident Treatment Worker (RTW) A. The report detailed staff assisted Client #1 with a brief change. When rolling towards and resting against staff, the staff's knee gave out and Client #1 slid off the bed. Staff had a hold of Client #1 and prevented his/her head and body from reaching the floor; Client #1's knees hit the floor and his/her body landed on staff's knee. RTW A had their arms under the client and lifted/rolled the client back to the bed, when he noticed the client's thumb bled. RTW A did not know how Client #1 hurt his/her thumb, but thought it may have possibly gotten caught on the bed brake lever. Staff examined the thumb and immediately called for other staff to call nurse. The report further documented the fall and head injury assessment that occurred. Registered Nurse (RN) A documented upon arrival at approximately 6:59 a.m. she observed a dime sized scrape, no broken skin, to the client's left knee and a pink mark, approximately 0.7 centimeters (cm) by 0.4 cm on his/her right knee; no bruises or edema were noted to either knee. The RN further documented, "...rt (right) hand rt thumb on visual examination appears very much out of alignment, bruised and swollen, nail bed is raised up off nail bed nail seems to split near base of nail and bleeding slightly. Nail bed bluish tinged strong radial pulse..." The report further noted the Advanced Registered Nurse Practitioner (ARNP) asked that the thumb be stabilized as much as possible and she would order an x-ray. The ARNP arrived at 7:31 a.m. to see Client #1 and instructed administration of Tylenol. The report documented, "...7:35 a.m. hold off administering (his/her) routine meds to be sure (he/she) can keep (his/her) PRN Tylenol down in case of stomach upset as (Client #1) is	W 322		

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W 322	Continued From page 18 [moaning and] yelling out..." RN A documented instruction from the ARNP to put a "stat" order on the x-ray to include Client #1's right thumb, wrist and hand. A gentle splint was applied per instruction from the ARNP and his/her right hand elevated on a pillow as they awaited x-ray to rule out fracture. Additional record review revealed Client #1's clinical notes. Review revealed the following timeline regarding Client #1's injury: a. 1/13/17 at 9:17 a.m., RN B documented nursing assessment: "near fall this am (morning) during routine cares, knees scraped floor, small abrasion, right thumb w/(with) swelling, bruising, injury to nail, and unnatural appearing alignment per (RN A)... x-ray order in place, awaiting mobile x (x-ray) arrival, thumb splinted, Tylenol given also, (Physician A) aware." b. 1/13/17 at 10:45 a.m., Licensed Practical Nurse (LPN) A documented nursing assessment: "(Client #1) has been making vocal sounds [on a regular basis]... Right thumb swollen and red and bruise in color. Limited ROM (range of motion) to extremity of thumb. Nail is pushing outward with edema under nail bed and bleeding around nail. Area cleansed and ice applied with ace wrap applied. [Mobile x-ray] was here with [x-ray] completed... Trauma to right thumb... To be seen by OD (on duty physician)." c. 1/13/17 at 11:10 a.m., RN B documented nursing assessment: "right thumb, distal section with significant swelling, bleeding from the thumb nail site, blue in color" Assessment: "trauma to right thumb... seen by Physician A [at] GRC's (Glenwood Resource Center) clinical wing... x-ray	W 322		

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W 322	Continued From page 19 report available now, multiple fractures reported, ER (emergency room) evaluation pending..." d. 1/13/17 at 12:00 p.m., LPN A documented nursing assessment: "To JEMH (Jennie Edmundson Methodist Hospital) by state van with a departure time of 12:30 p.m..." e. 1/13/17 at 4:19 p.m., RN C documented ER communication: "...client is being admitted... Client will be taken to surgery sometime dx (diagnosis) fracture..." f. 1/13/17 at 8:00 p.m., RN C documented JEMH communication: "...Client had ORIF (open reduction internal fixation) of the Right thumb and has a splint and 1/2 cast along with ace wrap..." When interviewed on 1/18/17 at 1:15 p.m., Resident Treatment Worker (RTW) A confirmed Client #1 fell out of bed while he provided cares. He explained he rolled the client towards him while changing his/her brief, and leaned the client against him. RTW A's knee gave out and the client fell, partially on RTW A and partially on the floor. RTW A lifted Client #1 back to his/her bed and put up the bed rail. He looked at the client's knees and they appeared fine, but noticed his/her hand had "a significant injury." He described Client #1's right thumb as "purple and disfigured, turning blue to purple." RTW A stated Client #1 did not begin moaning right away, but began about 10 -15 minutes later and continued to cry out. RTW A stated he placed cool packs on the injury and called for a co-worker to call the nurse right away. RTW A recalled the nurse arrived within five minutes to assess the injury, and stated medical treatment was needed. The nurse called for mobile x-rays and they took two hours	W 322		

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W 322	Continued From page 20 to get there. RTW A stated the nurse could tell it was broken and did not understand why Client #1 wasn't taken to the emergency room. RTW A stated it took two more hours to see Physician A, and they finally just took him/her to Physician A's office. As soon as Physician A saw Client #1, he immediately sent him/her to the emergency room. RTW A stated Client #1 showed significant pain within 15 minutes of the injury and the nurses wanted to send him/her to the emergency room, but they required physician approval. When interviewed on 1/24/17 at 12:30 p.m. RTW B stated she came from the hallway when the injury first occurred and RTW A asked for help. RTW B stated she saw Client #1's injury and it immediately began swelling and turning purple, the nail bed was popped up and it bled. She stated it appeared as a bad injury and it was "very obvious it was broken." RTW B stated she called Licensed Practical Nurse (LPN) A and he came to the home immediately. Registered Nurse (RN) A then arrived to assess. RTW B stated she took Client #1's vitals: Client #1 had a higher blood pressure (BP), but he/she has a little high BP; his/her heartrate was "a little elevated." RTW B stated she thought Client #1's thumb was broken, as did RTW A and LPN A. The ARNP came to the home shortly after 7:00 a.m. RN A had made a makeshift bandage/splint for Client #1's thumb. The ARNP did not remove the bandage to assess Client #1's injury, she just said they would get x-rays. When asked to clarify, RTW B stated it did not appear the ARNP assessed Client #1's injury. RTW B reported Client #1 in pain the entire time he waited to go to ER. She stated they waited to see Physician A after the mobile x-rays were taken. She stated they told every supervisor and every nurse that Client #1 needed	W 322		

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W 322	Continued From page 21 to immediately to the ER and it did not happen. RTW B accompanied Client #1 to the emergency room. She stated they left campus around 12:10 p.m. and arrived at 12:40 p.m. When they arrived to the hospital, she stated they asked "what took so long to get (him/her) here?" She stated Client #1 was clearly in pain and let out "gut wrenching" cries. She stated he/she had been in pain since 7:00 a.m. and had received Tylenol, but he/she needed more. She requested pain medication for Client #1 while in triage at the ER, and they gave him/her Lortab. They took Client #1 back to take x-rays, again. Client #1 was still in pain, and was given morphine. When interviewed on 1/25/17 at 9:30 a.m. LPN A recalled he received a call from RTW A and went to the house. RTW A and RTW B were at Client #1's bedside and it was apparent he/she had an injury. RTW A told him what happened. At that point the thumb appeared swollen and the thumb nail appeared "pushed up." LPN A attempted to immobilize the thumb. He reported Client #1 appeared to "be in a little bit of pain." He thought they would be getting him/her something for the pain. RN A arrived to the home, and he figured Client #1 would be "sent out." He explained Client #1's thumb appeared to be fractured. He talked with RN A and she stated she had not yet spoken with the on-call physician. He stated he asked if they were "okay" and she said yes, so he left and thought they would send Client #1 out. He stated he returned to the home around 8:45 - 9:00 a.m. and saw Client #1 still there. He stated Client #1 had a splint on the injury and appeared to be in discomfort. LPN A reported he cut away some of the dressing and checked the circulation. He stated the injury appeared red and swollen. He believed x-ray arrived before 10:00 a.m. He	W 322		

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W 322	Continued From page 22 contacted the clinic (on campus) right after x-ray left and told RN B the thumb appeared swollen. She reported the x-ray came back with a fracture. She told him they wanted to see Client #1 in the clinic. LPN A reported Physician A never refused to come out to the home to see Client #1, they just bypassed him and sent the client to the clinic. LPN A reported he was not in the home when the ARNP came to assess, but he was with Client #1 when Physician A assessed him/her. Physician A realized Client #1's thumb was fractured. He cleaned his/her injury and prepared to send him/her out to the emergency room. LPN A reported Client #1 in pain "more often than not," but did not show pain the entire time. He stated Client #1 would act like the injury hurt, and cry out in pain. LPN A stated he felt they did an "okay job," except for Client #1's pain and he felt he/she should have been sent out right away. He stated it was a very painful injury Client #1 sustained, with the injury to the nail bed and the severe fracture. When interviewed on 1/19/17 at 12:30 Registered Nurse A (RN A) stated LPN A called her to the house around 6:45 a.m. and she arrived at 6:50 a.m. LPN A told her he thought Client #1 had a fractured finger. RN A reported she assessed the injury and noted the thumb to be bruised, and out of alignment. She reported Client #1 yelled and it was apparent he/she was in pain. Staff working in the home, who knew the client, reported he/she was in pain and she knew it to be true. RN A reported she felt the client should have gone to the ER right away. RN A called Physician A and was told the ARNP was on-call. She called the on-call physician, the ARNP, and told her Client #1's thumb was probably fractured. The ARNP asked RN A to stabilize the thumb, which she did	W 322		

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W 322	Continued From page 23 using a tongue depressor, gauze, and tape. She reported the thumb bled from the nail, through the gauze. RN A asked the ARNP if she wanted an x-ray and told her she would order it "stat." Around 7:30 a.m., the ARNP arrived at the house to assess the injury. RN A offered to remove the bandage/splint for ARNP A to assess Client#1's thumb, but she said "No." Client #1 received Tylenol around 7:40 a.m. for pain. When interviewed on 1/18/17 at 2:45 p.m. ARNP A stated she went out to the house to see Client #1. He/she sat in a wheelchair. She reported the injury was bandaged, so she did not see that it was an open fracture. She stated she asked the nurse to get x-rays of the client's right hand fingers/thumb. ARNP A reported the nurse informed her of an open area with some bleeding, but no deformity. When asked if Client #1 was in pain, ARNP A reported the client was "a little loud," but she did not find it out of normal. ARNP A confirmed she never observed Client #1's injury with the bandage off. When interviewed on 1/18/17 at 2:30 p.m. Physician A stated ARNP A went to the home to see Client #1, prior to 8:00 a.m. ARNP A then came to a meeting and notified Physician A she ordered x-rays. He asked to be notified when Mobile-X arrived to complete the x-rays. Physician A reported he received an email from the Health Care Coordinator informing him Client #1's thumb was swollen. He asked if it was a soft tissue injury. ARNP A was unclear whether it was torn skin, laceration, or open wound, she just ordered x-ray, so Physician A requested they bring Client #1 to clinic to look at it. Within 5-10 minutes they called to report Client #1 had a fracture. Client #1 arrived to the clinic and he	W 322		

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W 322	Continued From page 24	W 322		

assessed. Physician A reported the thumb was swollen. There was no laceration or torn skin. The nail was displaced. He reported no open fracture and no soft tissue injury. Physician A reported Client #1 showed no signs of pain and appeared calm at this point, and he thought the Tylenol was working.

When interviewed on 1/24/17 at 2:15 p.m. the Director of Nursing (DON) stated nurses use two different pain scales to assess client pain. She said they need clinical evidence the client is in pain in order to document this.

Record review on 1/17/17 revealed Adult Nonverbal Pain Scale (ANVPS). The scale provided the following areas: face, activity, guarding, physiologic I (vital signs), and physiologic II, and required scoring from 0-2. The cumulative score then provided the level of pain from "no pain" to "worst imaginable." The document directed, "Score of 0-2 indicates no pain, 3-6 moderate pain, and 7-10 severe pain."

Record review on 1/17/17 revealed nurses assessments for Client #1 from 1/13/17. The assessments documented the following:

a. At 8:12 a.m., assessment completed by RN A documented: BP 132/ 88 and a pulse rate of 90, respirations 18. RN A utilized "faces (Adult Nonverbal Pain Scale)" pain assessment tool, and rated Client #1's pain at 5 [out of 10]. The assessment also revealed a pain scale (faces) of a level 5. RN A documented, RTW B reported while giving personal cares to Client #1, he rolled the client toward him and the side of the bed and the client began to fall. RTW B reported he did break most of the fall and only Client #1's knees

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G003	A. BUILDING _____ B. WING _____	C 02/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD RESOURCE CENTER	711 SOUTH VINE STREET GLENWOOD, IA 51534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 25 touched the floor. The assessment further noted, "left knee has dime sized scrape no broken skin, and no edema noted, Rt (right) knee has only a pink mark approx. 0.7cm (centimeters) by 0.4cm no bruises or edema at either knee cap no other injury noted except rt hand rt thumb on visual assessment appears to be very much out of alignment, bruised and swollen, nail bed is raised up off nail bed nail seems to be split near base of nail and bleeding slightly. Nail bed bluish tinged strong radial pulse. Nail bed cleansed gently with saline was and On call (ARNP A) called at 7:05 am She asked that the thumb be stabilized as much as possible and she will order a x-ray (ARNP A) here on unit at 7:31 a.m. to see (Client #1) CMA (certified medication aide) instructed to administer PRN (as needed) Tylenol... (Client #1) is moaning and yelling out. (ARNP A) instructed (RN A) to put a 'stat' order for x-ray to include (his/her) Right thumb, wrist and hand this was done at 7:46 a.m. Gentle splint was applied as instructed by (ARNP A)." b. At 10:45 a.m. assessment completed by LPN A documented: pulse rate of 90 and respirations 18. Subjective documented: "Staff reports bleeding from dressing." Objective documented: "(Client #1) has been making vocal sounds at regular bases [sic]... Right thumb swollen and ruse and bruise in color... Limited ROM to extremity of thumb. Nail is pushing outward with edema under nail bed and bleeding around nail... Mobil X Ray [sic] was here with (x-ray) completed." c. At 11:10 a.m. assessment completed by RN B documented: BP 138/82, pulse 82, respirations 18. Assessment did not include a pain rating, but noted, "significant pain this morning, has been crying out continually, even after Tylenol per staff,	W 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 322	Continued From page 26 seems to have settled down in past 30 minutes or so." Objective documented: "right thumb, distal section w/significant swelling, bleeding from thumb nail site, blue in color." Assessment documented: "trauma to right thumb" Plan documented: " seen by (Physician A)... x-ray report available now, multiple fractures reported, ER evaluation pending..." d. At 12:00 p.m. assessment completed by LPN A documented no vitals. The assessment rated Client #1's pain at 8, using ANVPS and noted, "Tylenol was given at 7:30 pm and was ineffective [sic]" Plan documented: "To (Jennie Edmundson Methodist Hospital) ER by state van with a departure time of 12:30 p.m. Further record review revealed Emergency Department documentation for Client #1 from JEMH on 1/13/17 revealed the following: a. Client #1 presented with right hand pain, swelling and injury. b. Onset seven hours prior. c. The degree of pain was noted as moderate. d. Vital signs noted on 1/13/17 at 1:38 p.m.: pulse 90 beats per minute (bpm), respirations 16 breaths (br)/minute (min), and BP 148/99. e. Musculoskeletal assessment noted: "Distal upper extremity, Hand, Fingers/toes: Right, first, tenderness, swelling, abrasion, erythema, deformity 1st right digit, deformity, fingernail lifted..." f. Radiology results on 1/13/17 at 12:52 p.m.	W 322		

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W 322	Continued From page 27 revealed, "Moderately displaced and comminuted (break or splinter of the bone into more than two fragments) first distal phalanx fracture. Extension of fracture into the articular surface. Oblique mildly displaced fracture of the first proximal phalanx extending from the proximal metaphysis to the distal metaphysis. No dislocation. Moderate soft tissue swelling." g. Nursing note, dated 1/13/17 2:00 p.m., documented, : thumb intact - fingernail raised and not intact to skin [underneath]. nail dark in color... after IM (intramuscular) morphine given patient had less moaning and didn't seem s as intense/restless." h. At 2:27 p.m. JEMH Physician recommended surgical intervention. Client #1 was admitted. i. The Operate/Surgical Reports documented the following findings: "Right thumb proximal phalanx shift fracture that is mildly displaced... There is a highly comminuted distal phalanx fracture. j. Social Worker/Case Manager daily summary noted, "Pt (patient) crying out in pain. The client's hand had been wrapped. Additional review of Client #1's record revealed the following: a. Client #1's Individual Support Plan (ISP), dated 8/30/16, noted: "(Client #1) does not use words, but does communicate through sounds and expressions. b. Client #1's comprehensive functional assessment (CFA), reviewed 7/26/16, documented Client #1 able to express	W 322		

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W 322	Continued From page 28 displeasure (i.e. crying). When interviewed on 1/18/17 at 3:30 p.m., Treatment Program Manager (TPM) A reported Client #1 can and will make noise when he/she is in pain. She explained it is apparent when something is not ok with Client #1. Record review on 1/24/17 revealed an email from Investigator A to the Director of Quality Management, sent 1/24/17. The email noted concerns regarding the investigation into Client #1's injury. Concerns included: a. "... The record would reflect a considerable period of time elapsed from the time that a witnessed incident occurred resulting in a fracture to the client's right thumb to the time the client received necessary emergency care (surgery) to address the fracture. The record indicates the incident occurred near 6:45 AM, nursing staff were notified quickly, and the doctor on call as notified of a potential for fracture around 7:00 AM. The on call doctor did not physically examine the injury as it had already been stabilized and wrapped at her direction. X-rays were ordered, however, they were not completed until after 10:00 AM, and the client did not leave for emergency treatment until after 12:00 PM..." b. "... There was also concern raised regarding pain management for the client. The trauma and subsequent pain were identified by 7:00 AM and Tylenol was given as of 7:40 AM. At approximately 10:45 AM, nursing had contact with the physician and it was made clear that the client was in pain and that the dressing had 'bled through.' The doctor reported at that point, he did observe the client and observed no signs or	W 322		

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W 322	Continued From page 29 symptoms of pain, so he offered no additional pain management. The Psych. Asst. who was present during that examination reported the client did seem to be more comfortable as the original splint dressing had been replaced by an ACE wrap which appeared to support the injury better at the time... (RTW B) reports the client continued to make vocalizations indicating pain during the trip to the hospital and she requested pain relief for the client there which (he/she) received around 1:30 PM. She reports the client continued to show signs and symptoms of pain without relief from the pain medication and requested something further. The record reflects the client was given Morphine at 3:00 PM..." The above findings lead to a determination of Immediate Jeopardy (IJ), based on the facility's failure to ensure adequate assessment of significant injuries, timely medical attention, and appropriate paint management for clients with significant injuries. The facility was notified of the IJ on 1/19/17 at approximately 11:00 a.m. The facility developed a plan to remove the IJ, which included retraining of medical staff on assessment of injuries, facility protocols for x-ray and emergent care, and standards of care for pain management. The IJ was removed on 1/20/17 at approximately 12:45 p.m.	W 322		

LK 2/22/17 CAC 2/21/17

Glenwood State Resource Center
Plan of Correction for Investigations #65074-C, 65079-I, 65215-C, and 65216-I

W 125 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS 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:

- The Advanced Registered Nurse Practitioner has been retrained in generally accepted standards of practice in the area of physical assessments including how to assess an injury without impediment.
- The Advanced Registered Nurse Practitioner has been retrained in Glenwood Resource Center (GRC) procedures for pain management.
- The Advanced Registered Nurse Practitioner has been retrained in generally accepted standards of practice for pain management including the clinical identification of pain.
- The Advanced Registered Nurse Practitioner has been retrained on procedures for emergent care including emergency care of possible fractures
- The Advanced Registered Nurse Practitioner has been retrained on procedures for obtaining x-rays.

Responsible: Medical Director
Date Completed: January 25, 2017

- Instructions and protocols will be written that provide supervisory staff in client care areas direction for how to raise questions or concerns regarding medical or nursing care to the appropriate medical or nursing provider.
- A description of the roles, responsibilities, and scope of practice for the Advanced Registered Nursing Practitioner and the Physician's Assistance will be written.
- The instructions, protocols, and description listed above will be trained to the medical staff, nursing staff, assistant superintendent for program services, treatment program administrators, treatment program managers, resident treatment supervisors, and other supervisors or clinicians that are associated with client care and treatment.

Responsible: Superintendent
Date Completed: February 24, 2017

Systemic Response:

- The GRC Medical Director will establish procedures for pain assessment and management.
- Medical providers have been retrained in generally accepted standards of practice in the area of physical assessments including how to assess an injury without impediment.
- Medical providers were trained in GRC procedures for pain management.
- Medical providers have been retrained in expectations and standards of practice for pain management including the clinical identification of pain.

- Medical providers have been retrained on procedures for emergent care including emergency care of possible fractures.
- Medical providers have been retrained on procedures for obtaining x-rays.

Responsible: Medical Director
Date Completed: January 25, 2017

- Nursing staff were retrained in GRC procedures for pain management.
- Nursing staff have been retrained in generally accepted standards of practice for pain management including the clinical identification of pain.
- Nursing staff have been retrained on procedures for emergent care including emergency care of possible fractures.
- Nursing staff have been retrained nurses on procedures for obtaining x-rays.

Responsible: Administrator of Nursing
Completed: Nursing staff that were available and at work were retrained by January 23, 2017. Those on leave are retrained when they return to work.

- The Human Rights policy and the Individual Rights policy were up-dated and combined
- All staff were trained on changes to the combined policy.
- The combined policy is retrained to staff during new employee orientation and on an annual basis thereafter.
- An expert outside entity was contracted with to visit the facility, complete a detailed review of GRC's operation, and complete a root cause analysis of issues at Glenwood Resource Center, including, but not limited to client protection and safety. The expert outside entity visited GRC from February 8 through February 11, 2017.

Responsible: Acting Superintendent
Date Completed: Staff that were available for work were trained by February 7, 2017. Staff on leave are trained when they return to work.

W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS 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:
- On January 10, 2017 Glenwood Resource Center supervisor was at House 253, observed the incident and immediately stopped RTW E's behavior. RTW E was suspended, the incident was thoroughly investigated, and RTW E was terminated from employment as a direct result of the investigation.
- Beginning January 12, 2017 staff in House 253 were retrained on proper reporting and that the staff must immediately report any suspected instances of client mistreatment including, but not limited

to, rumors, hearsay, off hand comments or any other indication of any kind that mistreatment may have taken place or might take place.

- Starting January 20, 2017, supervisors began interviewing staff in House 253 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 February 6, 2017 the interviews were changed to small focus group discussions that included the same topics.

Responsible: Assistant Superintendent of Program Services
Date Completed: Training began January 12, 2017 and is on-going

Systemic Response:

- Supervisors retrained all staff available for work and on duty on the following:
    - Beginning January 12, 2017 staff were retrained that they must immediately report any suspected instances of client mistreatment including, but not limited to, rumors, hearsay, off hand comments or any other indication of any kind that mistreatment may have taken place or might take place.
- Beginning January 20, 2017, each shift, supervisors are required to interview two resident treatment workers 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 February 6, 2017 the interviews were changed to small focus group discussions that included the same topics.
- The Incident Management Policy is trained to staff during new employee orientation and on an annual basis. The Incident Management Policy dated 11/2/20017 was reviewed on 1/6/2017 with no revisions determined to be necessary.

Responsible: Assistant Superintendent for Program Services
Date Completed: Training of staff that were working and available began on January 12, 2017. All staff available to work were trained by January 25, 2017. Staff on leave are trained when they return to work.

W 266 483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met.

Individual Response:

- On January 10, 2017 Glenwood Resource Center supervisor was at House 253 observed the incident and immediately stopped RTW E's behavior. RTW E was suspended, the incident was thoroughly investigated, and RTW E was terminated from employment as a direct result of the investigation.
- Beginning on January 12, 2017 all staff assigned to work in House 253 were retrained on each BSP for each individual in the home. The training emphasized that only authorized interventions/restraints may be used when they are required.

Responsible: Assistant Superintendent of Program Services
Date Completed: Training began on January 12, 2017. Staff that were available and at work were trained by January 19, 2017. Staff that were on leave were trained when they returned to work.

Systemic Response:

- Beginning January 13, 2017 a new expectation was implemented that a supervisor (Administrator on Duty, Treatment Program Manager, or Resident Treatment Supervisor) is to be called to the site when a physical restraint is used to observe and guide interactions with the client to ensure compliance with policy. Supervisors have been directed to debrief each employee involved, immediately following the incident, to ensure proper procedures were used.
- Beginning January 12, 2017 supervisors retrained all staff available for work and on duty on the following:
    - The requirement to have the supervisor report to the site when a physical restraint is used,
    - The requirement to debrief with staff immediately following the incident to ensure proper procedures were followed, and
    - That all staff must immediately report any suspected instances of client mistreatment including, but not limited to, rumors, hearsay, off hand comments or any other indication of any kind that mistreatment may have taken place or might take place.
- Resident Treatment Workers available for work have been retrained on Behavior Support Plans for the clients with whom they work.
- Resident Treatment Workers were retrained on prohibited practices.
- Beginning January 20, 2017, each shift supervisors are required to interview two resident treatment workers 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 February 6, 2017 the interviews were changed to small focus group discussions that included the same topics.

Responsible: Assistant Superintendent for Program Services
Date Completed: Staff training began on January 12, 2017. By January 25, 2017 all staff available to work were trained by January 25, 2017. Staff on leave are trained when they return to work.

W 288 483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.

Individual Response:

- On January 10, 2017 Glenwood Resource Center supervisor was at House 253 observed the incident and immediately stopped RTW E's behavior. RTW E was suspended, the incident was thoroughly investigated, and RTW E was terminated from employment as a direct result of the investigation.
- Beginning on January 12, 2017 all staff assigned to work in House 253 were retrained on each BSP for each individual in the home. The training emphasized that only authorized interventions/restraints may be used when they are required.

Responsible: Assistant Superintendent of Program Services
Date Completed: Training began on January 12, 2017. Staff that were available and at work were trained by January 19, 2017. Staff that were on leave were trained when they returned to work.

Systemic Response:

- Beginning January 13, 2017 a new expectation was implemented that a supervisor (Administrator on Duty, Treatment Program Manager, or Resident Treatment Supervisor) is to be called to the site when a physical restraint is used to observe and guide interactions with the client to ensure compliance with policy. Supervisors have been directed to debrief each employee involved, immediately following the incident, to ensure proper procedures were used.
- Beginning January 12, 2017 supervisors retrained all staff available for work and on duty on the following:
    - The requirement to have the supervisor report to the site when a physical restraint is used,
    - The requirement to debrief with staff immediately following the incident to ensure proper procedures were followed, and
    - That all staff must immediately report any suspected instances of client mistreatment including, but not limited to, rumors, hearsay, off hand comments or any other indication of any kind that mistreatment may have taken place or might take place.
- Resident Treatment Workers available for work have been retrained on Behavior Support Plans for the clients with whom they work.
- Resident Treatment Workers were retrained on prohibited practices.
- Beginning January 20, 2017, each shift, supervisors were required to interview two resident treatment workers 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 February 6, 2017 the interviews were changed to small focus group discussions that included the same topics.

Responsible: Assistant Superintendent for Program Services

Date Completed: Staff training began on January 12, 2017. By January 25, 2017 all staff available to work were trained by January 25, 2017. Staff on leave are trained when they return to work.

W 318 483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.

Individual Response:

- The Advanced Registered Nurse Practitioner has been retrained in generally accepted standards of practice in the area of physical assessments including how to assess an injury without impediment.
- The Advanced Registered Nurse Practitioner has been retrained in Glenwood Resource Center (GRC) procedures for pain management.
- The Advanced Registered Nurse Practitioner has been retrained in generally accepted standards of practice for pain management including the clinical identification of pain.
- The Advanced Registered Nurse Practitioner has been retrained on procedures for emergent care including emergency care of possible fractures
- The Advanced Registered Nurse Practitioner has been retrained on procedures for obtaining x-rays.

Responsible: Medical Director
Date Completed: January 25, 2017

- Instructions and protocols will be written that provide supervisory staff in client care areas direction for how to raise questions or concerns regarding medical or nursing care to the appropriate medical or nursing provider.
- A description of the roles, responsibilities, and scope of practice for the Advanced Registered Nursing Practitioner and the Physician's Assistance will be written.
- The instructions, protocols, and description listed above will be trained to the medical staff, nursing staff, assistant superintendent for program services, treatment program administrators, treatment program managers, resident treatment supervisors, and other supervisors or clinicians that are associated with client care and treatment.

Responsible: Superintendent
Date Completed: February 24, 2017

- The Advanced Registered Nurse Practitioner has been retrained in generally accepted standards of practice in the area of physical assessments including how to assess an injury without impediment.
- The Advanced Registered Nurse Practitioner has been retrained in Glenwood Resource Center (GRC) procedures for pain management.
- The Advanced Registered Nurse Practitioner has been retrained in generally accepted standards of practice for pain management including the clinical identification of pain.
- The Advanced Registered Nurse Practitioner has been retrained on procedures for emergent care including emergency care of possible fractures
- The Advanced Registered Nurse Practitioner has been retrained on procedures for obtaining x-rays.

Responsible: Medical Director
Date Completed: January 25, 2017

Systemic Response:

- The GRC Medical Director will establish procedures for pain assessment and management.
- Medical providers have been retrained in generally accepted standards of practice in the area of physical assessments including how to assess an injury without impediment.
- Medical providers were trained in GRC procedures for pain management.
- Medical providers have been retrained in expectations and standards of practice for pain management including the clinical identification of pain.
- Medical providers have been retrained on procedures for emergent care including emergency care of possible fractures.
- Medical providers have been retrained on procedures for obtaining x-rays.

Responsible: Medical Director
Date Completed: January 25, 2017

Systemic Response:

- The GRC Medical Director will establish procedures for pain assessment and management.
- Medical providers have been retrained in generally accepted standards of practice in the area of physical assessments including how to assess an injury without impediment.
- Medical providers were trained in GRC procedures for pain management.
- Medical providers have been retrained in expectations and standards of practice for pain management including the clinical identification of pain.
- Medical providers have been retrained on procedures for emergent care including emergency care of possible fractures.
- Medical providers have been retrained on procedures for obtaining x-rays.

Responsible: Medical Director
Date Completed: January 25, 2017

- Nursing staff were retrained in GRC procedures for pain management.
- Nursing staff have been retrained in generally accepted standards of practice for pain management including the clinical identification of pain.
- Nursing staff have been retrained on procedures for emergent care including emergency care of possible fractures.
- Nursing staff have been retrained nurses on procedures for obtaining x-rays.

Responsible: Administrator of Nursing
Completed: Nursing staff that were available and at work were retrained by January 23, 2017. Those on leave are retrained when they return to work.

- The Human Rights policy and the Individual Rights policy were up-dated and combined
- All staff were trained on changes to the combined policy.
- The combined policy is retrained to staff during new employee orientation and on an annual basis thereafter.
- An expert outside entity was contracted with to visit the facility, complete a detailed review of GRC's operation, and complete a root cause analysis of issues at Glenwood Resource Center, including, but not limited to client protection and safety. The expert outside entity visited GRC from February 8 through February 11, 2017 to complete the work.

Responsible: Acting Superintendent
Date Completed: Staff that were available for work were trained by February 7, 2017. Staff on leave are trained when they return to work.

W 322 4483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.

Individual Response: