RK 4/19/17 GAC 4/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING ~~OK FILE~~ _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

(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 At the time of investigation 66557-I a deficiency was cited at W153.	W 000		
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 interview and record review, the facility failed to ensure staff immediately reported allegations of abuse to the administrator or designee and the Department of Inspections and Appeals per state law and facility policy. This affected 2 of 2 clients identified during the investigation (Client #1, Client #2). Finding follows: Record review on 3/13/17 revealed Type 1 Investigation Reports identified Client #1 and Client #2 as alleged victims of possible physical abuse. According to the documents, on 2/15/17 RTW (Resident Treatment Worker) A informed a facility supervisor of the following allegations of abuse. a. RTW A reported, in December, 2016 (date unknown), he observed staff hit Client #1 with his/her helmet, hit the client in the chest region and kicked the client in the leg. RTW A also reported on 12/21/16 he observed staff physically hold Client #1 on the sofa and spit in the client's	W 153	See attached POC 4/3/17	

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 153	Continued From page 1 face. The Woodward Resource Center ID Sheet identified Client #1 had diagnosis of personality change due to brain injury, aggressive type and bipolar disorder. The primary diagnosis included moderate intellectual disability. b. RTW A reported on 11/12/16, he observed staff transfer Client #2 using a "bear hug" and throw the client in bed The Woodward Resource Center ID Sheet identified the resident's diagnoses included cognitive and psychotic disorder and primary diagnosis as severe intellectual disability. The reports documented Woodward Resource Center (WRC) staff reported the allegations to DIA on 2/15/17. While the facility investigations concluded all allegations could not be substantiated, staff failed to make a timely report to WRC supervisory staff. Record review revealed a policy and procedures titled Incident Management, last reviewed on 5/26/15, and included staff reporting requirements. Staff were directed to report all incidents immediately to assure individual safety and protection. The policy also documented failure to report would be in violation of the policy. When interviewed on 3/15/17 at 9:30 a.m. the Director of Quality Management stated if staff truly had concerns about possible abuse, they should have been reported to a supervisor within two hours. She confirmed involved staff had training and prior knowledge of the Incident Management Policy.	W 153		

4/19/17 CAC 4/19/17

Woodward Resource Center
Plan of Correction for DIA Investigation #66557-I

W-153 – 483.420(d)(2): The facility must ensure that all allegation so 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.

On February 15, 2017, DIA interviewed RTW A as the alleged perpetrator of client abuse. During the DIA interview, RTW A made two new allegation that RTW B mistreated Client 1 and Client 2. The alleged incident with Client1 occurred two months prior (i.e., two weeks before Christmas). The alleged incident involving Client 2 occurred on November 12, 2016, about three months earlier.

On February 15th, 2017, the DIA surveyor informed WRC that RTW A had new abuse allegations to report. RTW A reported the new allegation to WRC supervisory staff. Upon receiving these new allegations on February 15, 2017, WRC initiated an internal investigation and reported the allegations to DIA.

WRC's thorough internal investigation concluded that physical abuse was unsubstantiated involving RTW B.

RTW A's new allegations that were made on February 15th, 2017, appear to be retaliation against RTW B. RTW A suspected that RTW B turned RTW A in for abuse. RTW A was on administrative leave when he/she made these new allegations implicating RTW B. At this time, RTW A was under investigation for two, separate cases involving possible verbal and sexual abuse of a client and possible mental psychological and verbal abuse of two clients. Mental psychological and verbal abuse was substantiated as a result of WRC's internal investigation of these cases.

On February 15th, 2017, following the reports of potential incidents, WRC took immediate action to address the incidents to ensure the safety of Client 1 and Client 2. RTW B was relieved out of the house pending investigation. WRC initiated a thorough investigation. WRC, on the same day, reported the incident to DIA. Information regarding a potential delay in reporting was identified through the investigation and reviewed at WRC Incident Review Committee on February 24th, 2017.

Individual response

WRC fully reviewed the incidents and found that trained employee, RTW A, failed to perform in a manner consistent with competency-based training. RTW A had been trained on incident reporting requirements on October 12th, 2016. WRC will continue to provide competency-based training and monitor employees to enable them to perform their duties effectively, efficiently, and competently. RTW A was put on administrative leave on January 7, 2016 and resigned on March 5th, 2017 while on administrative leave prior to WRC terminating his/her employment.

All available 103 Franklin staff were re-trained on the WRC Incident Management Policy types of abuse, including reporting requirements.

Responsible: Team 2 Treatment Program Administrator
Date Completed: 4/3/17

Systemic Response:
WRC will continue to provide competency-based training to employees to enable them to perform their duties effectively, efficiently and competently. WRC will monitor employees to enable them to perform their duties effectively, efficiently, and competently.

The WRC Incident Management Policy is trained to staff during new employee orientation and thereafter on an annual basis. This includes training on reporting requirements.

All available WRC employees (all job classifications) have been re-trained on the types of abuse listed in the WRC Incident Management Policy and reporting immediately if a possible reportable incident occurs.

Responsible: Assistant Superintendent
Date Completed: 4/3/17