Cac 5/16/17 Haller 5/16/17

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 04/20/2017

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 A recertification survey was conducted on 4/3/17 - 4/20/17 On 4/6/17 at approximately 3:20 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure appropriate action taken regarding suspicious injuries of unknown origin. This included, but was not limited to: failure to throughly investigate suspicious injuries of unknown origin and failure to report to the appropriate state agency. The facility developed a plan to remove the IJ, which included training of Treatment Program Managers on steps to complete during the investigative process and completion of documentation. The facility also made the necessary reports where appropriate and completed investigations of suspicious injuries of unknown origin which had been identified during the survey. The Immediate Jeopardy was removed 4/20/17. Deficiencies were written at W104, W148, W153, W154, W156, W159, W189, W214, W249, W440, and W445. A condition level deficiency was written at W122. In addition, investigation #67247-I was conducted and resulted in a deficiency cited at W189. Investigation #67473-I was completed and resulted in a deficiency cited at W249. Investigations #67472-I, 67665-I, and #67555-I were conducted during the survey and resulted in a deficiency cited at W153. Investigations #67101-I and #67390 were also conducted during the survey and resulted in no deficiencies.	W 000	See attachment POC 6/5/17	
W 104	483.410(a)(1) GOVERNING BODY	W 104		

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 104	Continued From page 1 The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the governing body failed to provide adequate direction and oversight to ensure consistent implementation of policy and procedure to ensure the health and safety of clients. The facility failed to consistently implement policies and procedures regarding incident management, including investigation of suspicious injuries of unknown origin and reporting allegations of abuse. Additionally, the facility failed to ensure adequate implementation of fire drill/evacuation policy and procedure. This potentially affected all clients residing at Glenwood Resource Center. Findings follow: 1. See W154 for specific information regarding the facility's failure to complete thorough investigations into suspicious injuries of unknown origin. Record review on 4/3/17 revealed Glenwood Resource Center Policy Number: 07-38, effective 11/2/07, regarding Incident Management. Page 13 of the policy regarding Type 2 Incident Reviews documented, "All incidents that are not investigated as Type 1 shall be reviewed by supervisory/administrative staff that have successfully completed competency-based training for incident reviews to evaluate the cause of the incident, the impact on the individual, and the need for corrective actions." The policy further directed, "... The QIDP (Qualified	W 104		

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W 104	Continued From page 2 Intellectual Disability Professional) shall review all incident reports after the supervisory/administrative staff review has been completed to review for: Completeness of the report, whether appropriate corrective action was identified, and whether a required clinical and Interdisciplinary Team review was completed." On 4/6/17 at 3:00 p.m. Treatment Program Administrator (TPM) A stated the TPMs were responsible for completing the Type 2 investigations on all Injuries of unknown origin. She further stated the TPM's should complete a thorough investigation interviewing as many people as possible and on all shifts too attempt determine the cause of the unknown injury. 2. Record review of facility fire drill reports revealed the facility failed to consistently ensure client presence in the homes during evacuation drills. Furthermore, the facility failed to consistently document client participation in drills. For additional information see W440 and W445. Record review revealed the facility's policy regarding evacuations, revised 9/1/16. The policy instructed fire drills to be held once every 90 days on each shift in each residential home and in each non-residential building during occupied hours. The policy further instructed a full evacuation drill to occur once each year on each shift at each residential home and non-residential building. The TPM should receive notification of completion of a fire drill and complete a debriefing, including a list of all clients participating in the drill. The policy indicated all reports would be reviewed to determine regulatory agency compliance and report any	W 104		

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W 104	Continued From page 3 instances of noncompliance. When interviewed on 4/5/17 at 10:40 a.m., the Director of Administrative Services explained a random schedule for evacuation drills was established and completed, regardless of client presence. The Director of Administrative Services confirmed clients should be in the home during completion of evacuation drills. When interviewed on 4/11/17 at 11:00 a.m., Superintendent A agreed clients should be present for all evacuation drills, including actual evacuation drills. Superintendent A noted the purpose of drills to be for clients and staff, not for alarms.	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to comply with the Condition of Participation: Client Protections. This was evidenced by facility failure to: a) conduct thorough investigations of incidents of unknown origin/suspicious injuries/possible abuse, b) follow the incident management policy and investigate injuries of unknown origin, c) ensure staff immediately reported allegations of abuse. This potentially affected all clients residing at Glenwood Resource Center. Cross-reference W104: Based on interviews and record reviews, the governing body failed to	W 122		

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W 122	Continued From page 4 provide adequate direction and oversight to ensure consistent implementation of policy and procedure to ensure the health and safety of clients. The facility failed to consistently implement policies and procedures regarding incident management, including investigation of suspicious injuries of unknown origin and reporting allegations of abuse. Facility staff failed to complete thorough investigations into injuries of unknown origin and therefore could not confirm or deny injuries were potentially the result of abuse, neglect, or mistreatment. Cross-reference W148: Based on interviews and record reviews, the facility failed to promptly notify guardians of significant incidents, including, but not limited to: injuries of unknown origin, suspicious injuries, and changes in client conditions. Cross-reference W153: Based on interviews and record reviews, the facility failed to ensure staff immediately reported allegations of potential abuse, neglect, and/or mistreatment or suspicious injuries according to facility policy and procedures (Incident Management Policy). Due to the lack of thoroughness during the investigative process the facility could not identify the cause of suspicious injuries, therefore could not determine if the injuries were potentially a result of abuse, neglect, or mistreatment. Cross-reference W154: Based on interviews and record review, the facility failed to conduct thorough investigation into suspicious injuries of unknown origin. Cross-reference W156: Based on interviews and record reviews the facility failed to report results	W 122		

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W 122	Continued From page 5 of incident investigations according to the facility Incident Management Policy. The facility failed to complete a thorough investigation of all incidents of unknown origin until identified during the annual survey. Due to the lack of thoroughness in the investigative process, the facility was unable to report results to the administrator and appropriate agencies within five working days of the incidents. On 4/6/17 at approximately 3:20 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure appropriate action taken regarding suspicious injuries of unknown origin. This included, but was not limited to: failure to thoroughly investigate suspicious injuries of unknown origin and failure to failure to report to the appropriate state agency. The facility developed a plan to remove the IJ, which included training of Treatment Program Managers on steps to complete during the investigative process and completion of documentation. The facility also made the necessary reports where appropriate and completed investigations of suspicious injuries of unknown origin which had been identified during the survey. The Immediate Jeopardy was removed 4/20/17.	W 122		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by:	W 148		

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W 148	Continued From page 6 Based on interviews and record reviews, the facility failed to promptly notify guardians of significant incidents, including, but not limited to: injuries of unknown origin, suspicious injuries, and changes in client conditions. The facility failed to follow the Incident Management Policy in regard to guardian notification. This pertained to 2 sample clients (Clients #8 and #14) and 7 clients added to the sample (Clients #23, #24,#27, #28, #29, #30, #31). Findings follow: Record review revealed the following: a. Client #27's Type 2 Incident Review (IR), dated 2/24/17. The IR revealed on 2/24/17 at 2:45 p.m. Resident Treatment Worker (RTW) C assisted Client #27 with changing his/her shirt and identified a bruise of unknown origin on the top of his/her right breast the size of a half dollar. b. Client #8's Type 2 IR, dated 3/6/17. The IR revealed on 3/6/17 RTW D assisted Client #8 in undressing for his/her shower. Staff identified a red mark on the inner left thigh 3 centimeter long approximately where the elastic line of his/her pull up was located. The injury was documented as an injury of unknown origin. c. Client #28's Type 2 IR, dated 3/26/17 at 9:41 p.m. The IR revealed on 3/26/17 at 9:41 p.m. when RTW E assisted Client #28 with cares they noticed two bruises on his/her left upper thigh and three small bruises on his/her right upper thigh of unknown origin. d. Client #29's Type 2 IR, dated 3/3/17 at 1:17 a.m. The IR revealed staff noticed dried blood on	W 148		

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W 148	Continued From page 7 Client #29's upper, inner thigh by groin area, similar to that of menstruation. Staff cleaned the area and reported to the nurse who determined, due to the client having total hysterectomy, the dried blood could not have been from menstruation. Further nursing assessment revealed a small scratch near the clitoris. e. Client #14's Type 2 IR, dated 2/26/17 at 1:15 p.m. The IR revealed RTW G laid Client #14 down and noticed a small thin scratch around his/her pelvic area of unknown origin. The scratch was around 3 inches long and red in color. f. Client #30's Type 2 IR, dated 2/26/17 at 1:35 a.m. The IR revealed, on 2/26/17 at 1:35 a.m. RTW H assisted Client #30 with personal cares and noticed two small scrapes on his/her left upper buttocks. g. Client #23's Type 2 IR, dated 3/8/17 at 8:15 am. The IR revealed a RTW noted two bruises on the client's upper leg of unknown origin. h. Client #24's Type 2 IR, dated 3/9/17. The IR revealed, staff noticed a blue bruise with a red/purple on center on the client's right thigh of unknown origin. i. Client #31's Type 2 IR, dated 3/12/17. The IR revealed, during routine care, a RTW discovered two large scratches on the client's right buttocks and a medium scratch and abrasion on the left buttocks of unknown origin. Record reviews revealed the IRs failed to include documentation of guardian notification. When interviewed on 4/17/17 at 9:00 a.m. Client	W 148		

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W 148	Continued From page 8 #29's guardian stated she was not notified of the client's injury until the week of 4/3/17. She further stated the facility acknowledged the failure to communicate the injury to her and apologized for the lack of communication. Record review on 4/3/17 revealed Glenwood Resource Center's policy regarding the incident reporting process, effective 11/2/07. Page 11 of the policy regarding Incident Reporting Process stated: The parent, guardian, legal representative, or family shall be notified of incidents requiring a Type 1 investigation within 24 hours of the report. All other incidents shall be reported in a timely manner. When interviewed on 4/13/17 at 11:00 a.m. Superintendent A confirmed guardians should have been notified of the identified injuries of unknown origin.	W 148		
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 reviews, the facility failed to ensure staff immediately reported allegations of potential abuse, neglect, or mistreatment, as well as suspicious injuries of unknown origin to the administrator and appropriate state agency in accordance with facility policy and procedures (Incident	W 153		

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W 153	Continued From page 9 Management Policy). The facility's failure to complete thorough investigations into incidents of unknown origin further lead to a failure to report incidents of unknown origin suspicious in nature to the state agency. This pertained to 2 sample clients (Clients #8 and #14) and 8 clients added to the sample (Clients #23, #24,#27, #28, #29, #30, #33 and #34). Findings follow: Record review on 4/3/17 revealed the facility failed to complete thorough investigations into the following incidents of unknown origin to determine they were or were not suspicious in nature (See W154 for additional information. Record review revealed the following incidents of unknown origin: a. Client #29's Type 2 Incident Report (IR), dated 3/3/17 at 1:17 a.m. The IR revealed staff noticed dried blood on Client #29's upper, inner thigh by groin area, similar to that of menstruation. Area was cleaned and staff reported to the nurse who determined, due to the client having total hysterectomy, the dried blood could not have been from menstruation. Further nursing assessment revealed a small scratch near the clitoris. b. Client #14's Type 2 IR, dated 2/26/17 at 1:15 p.m. The IR revealed on 2/26/17 at 1:15 p.m. Resident Treatment Worker (RTW) G laid Client #14 down and noticed a small thin scratch around his/her pelvic area of unknown origin. The scratch was around 3 inches long and red in color. c. Client #27's Type 2 Incident Review (IR), dated 2/24/17. The IR revealed on 2/24/17 at 2:45 p.m.	W 153		

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W 153	Continued From page 10 Resident Treatment Worker (RTW) C assisted Client #27 with changing his/her shirt and noticed a bruise of unknown origin on the top of his/her right breast the size of a half dollar. d. Client #8's Type 2 IR, dated 3/6/17. The IR revealed on 3/6/17 RTW D assisted Client #8 in undressing for his/her shower. Staff found a red mark on the inner left thigh three centimeters long, approximately where the elastic line of his/her pull up was located. The injury was documented as an injury of unknown origin. e. Client #28's Type 2 IR, dated 3/26/17 at 9:41 p.m. The IR revealed on 3/26/17 at 9:41 p.m. when RTW E assisted Client #28 with cares they noticed two bruises on his/her left upper thigh and three small bruises on his/her right upper thigh of unknown origin. f. Client #30's Type 2 IR, dated 2/26/17 at 1:35 a.m. The IR revealed RTW H assisted Client #30 with personal cares and noticed two small scrapes on his/her left upper buttocks. g. Client #23's Type 2 IR dated 3/8/17 at 8:15 a.m. The IR revealed a RTW noted 2 bruises on the client's upper leg of unknown origin. h. Client #24's Type 2 IR dated 3/9/17. According to the IR, staff noticed a blue bruise with a red/purple on center on the client's right thigh of unknown origin. Further record review revealed the facility's incident management policy, effective 11/2/07, defined "Suspicious Injury" as An injury where the initial explanation of the injury appears inconsistent with the injury sustained.; or other	W 153		

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W 153	Continued From page 11 injuries that may be questionable as to how they happened, which might include, but are not limited to, unexplained black eyes, bruises around the neck or on the inner thighs, or any patterned injuries regardless of the area of the body. On 4/6/17 at 3:00 p.m. Treatment Program Administrator (TPM) A stated the TPMs were responsible for completing the Type 2 investigations on all Injuries of unknown origin. She further stated the TPM's should complete a thorough investigation interviewing as many people as possible and on all shifts too attempt determine the cause of the unknown injury. 2. a. Record review on 4/12/17 revealed an incident report for Client #33 completed by RTW M on that date. RTW M reported on 4/10/17 at approximately 5:30 p.m. she observed RTW N take a spoon and smear food on Client #33's face. RTW M told RTW N to "knock it off" and wiped Client #33's face off. She then held the client's hand and told him/her it would be ok. b. Continued record review revealed an incident report for Client #34 regarding the same incident, completed by RTW M. She reported observing RTW N also take a spoon and smear food over Client #34's face on 4/10/17 at approximately 5:30 p.m. RTW M reported she told RTW N to "knock it off," wiped the client's face off, then patted the client's hand and told him/her it would be ok. According to the incident reports, these incidents were reported to RTS B on 4/12/17 at 1:45 p.m. When interviewed on 4/12/17 at 6:08 p.m., RTW	W 153		

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W 153	Continued From page 12	W 153		

M reported on 4/10/17 during dinner she observed RTW N smear food across the faces of Client #33 and Client #34. RTW M stated the interactions between RTW N and Client #33 and Client #34 made her uncomfortable. It was her first day in the home, and she was afraid she was overreacting. RTW M indicated she should have reported the incidents right away.

When interviewed on 4/12/17 at 5:13 p.m., RTS B stated during conversation with a new RTW it was mentioned some things bothered RTW M while working in House 254, specifically working with RTW N. RTS A reported this to TPM K at House 254. At approximately 1:45 p.m., RTS B and TPM K spoke with RTW M. She reported she was bothered by RTW N at dinner on 4/10/17. She explained he took a spoonful of food and wiped it over the mouth of Client #34. She told him to stop and cleaned the client up. RTW M reported RTW N then did the same to Client #33. RTW M reported she thought about reporting the incidents to TPM K, but did not. RTS B confirmed RTW M should have reported her concerns immediately.

The facility reported the incidents with Client #33 and Client #34 occurred on 4/10/17 (Monday), and the facility reported these to Department of Inspections and Appeals (DIA) on 4/12/17.

Record review on 4/3/17 revealed the facility's policy regarding incident management, 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,

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W 153	Continued From page 13 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." On 4/6/17 at approximately 3:20 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure appropriate action taken regarding suspicious injuries of unknown origin. This included, but was not limited to: failure to thoroughly investigate suspicious injuries of unknown origin and failure to report to the appropriate state agency. The facility developed a plan to remove the IJ, which included training of Treatment Program Managers on steps to complete during the investigative process and completion of documentation. The facility also made the necessary reports where appropriate and completed investigations of suspicious injuries of unknown origin which had been identified during the survey. The Immediate Jeopardy was removed 4/20/17.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to conduct thorough investigation into suspicious injuries of unknown origin. This pertained to 2 sample clients (Clients #8 and #14) and 7 clients added to the sample (Clients #23, #24,#27, #28, #29, #30, #31). Findings follow: 1. Record review on 4/3/17 revealed the	W 154		

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W 154	Continued From page 14 following: a. Client #27's Type 2 Incident Review (IR), dated 2/24/17. The IR revealed on 2/24/17 at 2:45 p.m. Resident Treatment Worker (RTW) C assisted Client #27 with changing his/her shirt. They noticed a bruise of unknown origin on the top of his/her right breast the size of a half dollar. When interviewed on 4/6/17 at 8:30 a.m. Treatment Program Manager (TPM) D confirmed he failed to complete a thorough Type 2 investigation into the incident on 2/24/17 with Client #27. TPM D stated he interviewed two staff, one on a.m. shift and one on p.m. shift, but failed to interview any staff on the overnight shift. He further stated he thought the injury likely occurred from bumping a table; however, he wasn't certain how the injury occurred. b. Client #8's Type 2 IR, dated 3/6/17. The IR revealed on 3/6/17 RTW D assisted Client #8 in undressing for his/her shower. Staff found a red mark on the inner left thigh three centimeters (cm) long approximately where the elastic line of his/her pull up was located. The injury was documented as an injury of unknown origin. When interviewed on 4/6/17 at 8:30 a.m. TPM D confirmed he failed to complete a thorough Type 2 investigation into the incident reported on 3/6/17 with Client #8. He stated Client #8 was on 1 to 1 supervision on the overnight shift, due to getting up during the night and documented falls. TPM D stated he failed to interview the staff who worked with Client #8 on the night shift as well as all other shifts. c. Client #28's Type 2 IR dated 3/26/17 at 9:41	W 154		

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W 154	Continued From page 15 p.m. The IR revealed on 3/26/17 at 9:41 p.m., when RTW E assisted Client #28 with cares, they noticed two bruises on his/her left upper thigh and three small bruises on his/her right upper thigh of unknown origin. When interviewed on 4/6/17 at 8:30 a.m. TPM D confirmed he failed to complete a thorough Type 2 investigation into the incident of unknown origin. TPM D stated he talked to Client #28, but did not document the conversation. TPM D stated he failed to interview any other shifts and made an assumption to how the injuries occurred; however, the injuries remained unknown. d. Client #29's Type 2 IR dated 3/3/17 at 1:17 a.m. The IR revealed staff noticed dried blood on Client #29's upper, inner thigh by groin area, similar to that of menstruation. Area was cleaned and staff reported to the nurse who determined, due to the client having total hysterectomy, the dried blood could not have been from menstruation. Further nursing assessment revealed a small scratch near the clitoris. When interviewed on 4/10/17 at 12:00 p.m. TPM E stated she failed to document a nurse's statement indicating she caused the injury during insertion of a rectal tube and Client #29 being agitated during cares. However, during an interview on 4/10/17 at 2:00 p.m. Nurse A contradicted the statement. Nurse A stated she was aware of the injury and discussed possible reasons for the injury, including inserting the rectal tube. She stated did not see any injury and was not aware that an injury occurred until later the following day. TPM E failed to interview other staff on all shifts	W 154		

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W 154	Continued From page 16 to determine the cause of the injury of unknown origin. TPM E confirmed she did not complete a thorough Type 2 investigation into the incident on 3/3/17 with Client #29. e. Client #14's Type 2 IR, dated 2/26/17 at 1:15 p.m. The IR revealed on 2/26/17 at 1:15 p.m. RTW G laid Client #14 down and noticed a small thin scratch around his/her pelvic area of unknown origin. The scratch was around 3 inches long and red in color. When interviewed on 4/10/17 at 12:05 p.m. TPM E confirmed she failed to complete a thorough Type 2 investigation into the incident with Client #14 on 2/26/17. TPM E stated the scratch was near where the brief would touch the skin, and most likely caused the injury. She further stated she did not talk to or interview any other staff working on any of the other shifts therefore the injury remained unknown. f. Client #30's Type 2 IR, dated 2/26/17 at 1:35 a.m. The IR revealed RTW H assisted Client #30 with personal cares and noticed two small scrapes on his/her left upper buttocks. When interviewed on 4/10/17 at 12:10 p.m. TPM E confirmed she failed to complete a thorough Type 2 investigation into the incident of unknown origin dated 2/26/17 at 1:35 a.m. She stated she did not interview any other staff to obtain information and concluded, by herself, the injury was caused by the Velcro on his/her brief. g. Client #23's Type 2 IR dated 3/8/17 at 8:15 a.m. The IR revealed a RTW noted 2 bruises on the client's upper leg of unknown origin. TPM A stated she talked to the a.m./p.m. staff, checked	W 154		

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W 154	Continued From page 17 the environment and observed how the client maneuvered and sat in the home. She confirmed she failed to document all of her actions and thus did not complete a thorough investigation according to the document. h. Client #24's Type 2 IR, dated 3/9/17. According to the IR, staff noticed a blue bruise with a red/purple on center on the client's right thigh. The origin of the bruise was unknown. When interviewed on 4/6/17 at 9:30 a.m. TPM A confirmed she failed to document a thorough investigation into Client #24's bruise of unknown origin on his/her thigh. TPM A stated she talked to the a.m. and p.m. staff and checked the environment, but failed to document the information. Further interview with RTW B on 4/11/17 revealed she did not think the TPM discussed the incident with her even though she was the one who reported the bruise and was a regular staff in the house. i. Client #31's Type 2 IR, dated 3/12/17. The IR revealed, during routine care, a RTW discovered 2 large scratches on the client's right buttocks and a medium scratch and abrasion on the left buttocks of unknown origin. In the analysis and recommendation section, Resident Treatment Supervisor (RTS) A documented two staff interviewed without listing the specific time and date. RTS A concluded, after talking to staff and nurse, it appeared the client had irritated an area and scratched at it, making the scratch marks on his/her skin. TPM G concluded the client most likely scratched him/herself, due to a history of several IRs within the past several months for scratching himself/herself in the same area. No specific recommendations for prevention of	W 154		

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W 154	Continued From page 18 repeated incidents were made by TPM G. When interviewed on 4/10/17 at 11:00 a.m. TPM G stated she did not complete any further interviews regarding Client #31's scratches; therefore, did not complete a thorough investigation. She understood interviews were only completed with third shift staff, but not on other shifts because the scratches generally occurred while the client was in bed. TPM G stated staff tried to keep the client's fingernails trimmed but did not make any further recommendations regarding prevention of injury. Record review on 4/3/17 revealed Glenwood Resource Center Policy Number: 07-38, effective 11/2/07, regarding Incident Management. Page 13 of the policy regarding Type 2 Incident Reviews documented, "All incidents that are not investigated as Type 1 shall be reviewed by supervisory/administrative staff that have successfully completed competency-based training for incident reviews to evaluate the cause of the incident, the impact on the individual, and the need for corrective actions." The policy further directed, "... The QIDP (Qualified Intellectual Disability Professional) shall review all incident reports after the supervisory/administrative staff review has been completed to review for: Completeness of the report, whether appropriate corrective action was identified, and whether a required clinical and Interdisciplinary Team review was completed." On 4/6/17 at 3:00 p.m. Treatment Program Administrator (TPM) A stated the TPMs were responsible for completing the Type 2 investigations on all Injuries of unknown origin. She further stated the TPM's should complete a	W 154		

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W 154	Continued From page 19 thorough investigation interviewing as many people as possible and on all shifts too attempt determine the cause of the unknown injury. On 4/6/17 at approximately 3:20 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure thorough investigations were completed on suspicious injuries of unknown origin. The facility developed a plan to remove the IJ, which included training of Treatment Program Managers on steps to complete during the investigative process and completion of documentation. The facility also completed investigations of suspicious injuries of unknown origin which had been identified during the survey.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to report results of incident investigations according to the facility Incident Management Policy. The facility failed to complete a thorough investigation of all incidents of unknown origin until identified during the annual survey. Due to the lack of thoroughness in the investigative process, the facility was unable to report results to the administrator and appropriate agencies within five working days of the incidents. This pertained to 2 sample clients (Clients #8 and #14) and 7 clients added to the sample (Clients #23, #24,#27, #28, #29, #30,	W 156		

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W 156	Continued From page 20 #31). Findings follow: 1. Record review on 4/3/17 revealed the following: a. Client #27's Type 2 Incident Review (IR), dated 2/24/17. The IR revealed on 2/24/17 at 2:45 p.m. Resident Treatment Worker (RTW) C assisted Client #27 with changing his/her shirt. They noticed a bruise of unknown origin on the top of his/her right breast the size of a half dollar. When interviewed on 4/6/17 at 8:30 a.m. Treatment Program Manager (TPM) D confirmed he failed to complete a thorough Type 2 investigation into the incident on 2/24/17 with Client #27. TPM D stated he interviewed two staff, one on a.m. shift and one on p.m. shift, but failed to interview any staff on the overnight shift. He further stated he thought the injury likely occurred from bumping a table; however, he wasn't certain how the injury occurred. b. Client #8's Type 2 IR, dated 3/6/17. The IR revealed on 3/6/17 RTW D assisted Client #8 in undressing for his/her shower. Staff found a red mark on the inner left thigh three centimeters (cm) long approximately where the elastic line of his/her pull up was located. The injury was documented as an injury of unknown origin. When interviewed on 4/6/17 at 8:30 a.m. TPM D confirmed he failed to complete a thorough Type 2 investigation into the incident reported on 3/6/17 with Client #8. He stated Client #8 was on 1 to 1 supervision on the overnight shift, due to getting up during the night and documented falls. TPM D stated he failed to interview the staff who worked with Client #8 on the night shift as well as all other	W 156		

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W 156	Continued From page 21 shifts. c. Client #28's Type 2 IR dated 3/26/17 at 9:41 p.m. The IR revealed on 3/26/17 at 9:41 p.m., when RTW E assisted Client #28 with cares, they noticed two bruises on his/her left upper thigh and three small bruises on his/her right upper thigh of unknown origin. When interviewed on 4/6/17 at 8:30 a.m. TPM D confirmed he failed to complete a thorough Type 2 investigation into the incident of unknown origin. TPM D stated he talked to Client #28, but did not document the conversation. TPM D stated he failed to interview any other shifts and made an assumption to how the injuries occurred; however, the injuries remained unknown. d. Client #29's Type 2 IR dated 3/3/17 at 1:17 a.m. The IR revealed staff noticed dried blood on Client #29's upper, inner thigh by groin area, similar to that of menstruation. Area was cleaned and staff reported to the nurse who determined, due to the client having total hysterectomy, the dried blood could not have been from menstruation. Further nursing assessment revealed a small scratch near the clitoris. When interviewed on 4/10/17 at 12:00 p.m. TPM E stated she failed to document a nurse's statement she caused the injury during insertion of a rectal tube and Client #29 being agitated during cares. However, during an interview on 4/10/17 at 2:00 p.m. Nurse A contradicted the statement. Nurse A stated she was aware of the injury and discussed possible reasons for the injury, including inserting the rectal tube. She stated did not see any injury and was not aware that an injury occurred until later the following	W 156		

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W 156	Continued From page 22 day. TPM E did not interview other staff on all shifts to determine the cause of the injury of unknown origin. TPM E confirmed she did not complete a thorough Type 2 investigation into the incident on 3/3/17 with Client #29. e. Client #14's Type 2 IR, dated 2/26/17 at 1:15 p.m. The IR revealed on 2/26/17 at 1:15 p.m. RTW G laid Client #14 down and noticed a small thin scratch around his/her pelvic area of unknown origin. The scratch was around 3 inches long and red in color. When interviewed on 4/10/17 at 12:05 p.m. TPM E confirmed she failed to complete a thorough Type 2 investigation into the incident with Client #14 on 2/26/17. TPM E stated the scratch was near where the brief would touch the skin, and most likely caused the injury. She further stated she did not talk to or interview any other staff working on any of the other shifts therefore the injury remained unknown. f. Client #30's Type 2 IR, dated 2/26/17 at 1:35 a.m. The IR revealed RTW H assisted Client #30 with personal cares and noticed two small scrapes on his/her left upper buttocks. When interviewed on 4/10/17 at 12:10 p.m. TPM E confirmed she failed to complete a thorough Type 2 investigation into the incident of unknown origin dated 2/26/17 at 1:35 a.m. She stated she did not interview any other staff to obtain information and concluded, by herself, the injury was caused by the Velcro on his/her brief. g. Client #23's Type 2 IR dated 3/8/17 at 8:15	W 156		

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W 156	Continued From page 23 a.m. The IR revealed a RTW noted 2 bruises on the client's upper leg of unknown origin. TPM A stated she talked to the a.m./p.m. staff, checked the environment and observed how the client maneuvered and sat in the home. She confirmed she failed to document all of her actions and thus did not complete a thorough investigation according to the document. h. Client #24's Type 2 IR, dated 3/9/17. According to the IR, staff noticed a blue bruise with a red/purple on center on the client's right thigh. The origin of the bruise was unknown. When interviewed on 4/6/17 at 9:30 a.m. TPM A confirmed she failed to document a thorough investigation into Client #24's bruise of unknown origin on his/her thigh. TPM A stated she talked to the a.m. and p.m. staff and checked the environment, but failed to document the information. Further interview with RTW B on 4/11/17 revealed she did not think the TPM discussed the incident with her even though she was the one who reported the bruise and was a regular staff in the house. i. Client #31's Type 2 IR, dated 3/12/17. The IR revealed, during routine care, a RTW discovered 2 large scratches on the client's right buttocks and a medium scratch and abrasion on the left buttocks of unknown origin. In the analysis and recommendation section, Resident Treatment Supervisor (RTS) A documented two staff interviewed without listing the specific time and date. RTS A concluded, after talking to staff and nurse, it appeared the client had irritated an area and scratched at it, making the scratch marks on his/her skin. TPM G concluded the client most likely scratched him/herself, due to a history of	W 156		

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W 156	Continued From page 24 several IRs within the past several months for scratching himself/herself in the same area. No specific recommendations for prevention of repeated incidents were made by TPM G. When interviewed on 4/10/17 at 11:00 a.m. TPM G stated she did not complete any further interviews regarding Client #31's scratches; therefore, did not complete a thorough investigation. She understood interviews were only completed with third shift staff, but not on other shifts because the scratches generally occurred while the client was in bed. TPM G stated staff tried to keep the client's fingernails trimmed but did not make any further recommendations regarding prevention of injury. Record review on 4/3/17 revealed the facility's policy regarding incident management, effective 11/2/07. Page 13 of the policy regarding Type 2 Incident Reviews documented, "All incidents that are not investigated as Type 1 shall be reviewed by supervisory/administrative staff and that have successfully completed competency-based training for incident reviews to evaluate the cause of the incident, the impact on the individual, and the need for corrective actions." Additionally, the Qualified Intellectual Disability Professional shall review all incident reports after the supervisory/administrative staff review has been completed to review for: "Completeness of the report, whether appropriate corrective action was identified, and whether a required clinical and Interdisciplinary Team review was completed." The policy also documented all incident reviews should be completed within five working days of the reporting of the incident. On 4/6/17 at 3:00 p.m. Treatment Program	W 156		

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W 156	Continued From page 25 Administrator A stated the TPMs were responsible for completing the Type 2 investigations on all Injuries of unknown origin. She further stated the TPM's should complete a thorough investigation interviewing as many people as possible and on all shifts too attempt determine the cause of the unknown injury.	W 156		
W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the Qualified Intellectual Disabilities Professional (QIDP) failed to effectively monitor and coordinate services in order to meet client needs. This affected 1 of 2 clients who lived at the infirmary (Client #25). Finding follows: Intermittent observations throughout the survey revealed Client #25 resided at the infirmary. Record review revealed the following: a. Daily Medical/Administration Staff Meeting, dated 6/3/16, indicated Client #25's Interdisciplinary Team (IDT) needed to schedule a meeting "to discuss moving (him/her) into a living unit." b. Referral for Client #25 to move to Area Two completed by Treatment Program Manager (TPM) C, dated 6/7/16. The request indicated: "(Client #25) receives (his/her) nutrition/medication/fluids via G-Tube. (He/She) requires nursing presence 24 hours a day due to (his/her) scheduled nutritional/fluid. (He/She)	W 159		

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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
W 159	Continued From page 26 currently is stable psychiatrically and medically. (His/Her) medical condition has been good for over 2 years. This can be attributed to the consistent structured feeding/fluid intake schedule. Attempts in the past to make changes to (his/her) regimen have resulted in medical complications including bowel obstructions and aspirations. (Client #25) would need to be in a home where food/drink and the preparation of such is limited. Psychiatrically (Client #25) is stable. (He/She) does cycle at times and this would involve yelling, SIB (Self-Injurious Behavior) and possible aggression. (Client #25) can become very paranoid in that (he/she) thinks others are trying to take (his/her) belongings or are bothering (him/her). (Client #25) does attend a job assignment at recycling in the mornings and afternoons." c. Client #25's Individual Support Plan (ISP), dated 2/28/17, indicated Client #25 considered the infirmary his/her home and his/her stay at the infirmary was "required at this time due to all meds/nutrition/fluids being administered via g-tube and requires nurse presence." The ISP also indicated Client #25 did well at the infirmary where less people received regular food. d. Client #25's meeting minutes, dated 9/9/16, evaluated Client #25 for a potential move out of the infirmary and into an Area Two home. Identified issues included Client #25 ate at night, often slept during the day, refused or participated in few activities, attended little work, and his/her low rate of aggression to being left alone or unchallenged. e. Client #25's follow-up meeting, dated 9/12/16, indicated an action plan to move Client #25 out of	W 159		

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W 159	Continued From page 27	W 159		

the infirmary. The plan included Client #25 worked with regular staff, ensured he/she had specific contact time with his/her peers scheduled every day for at least two hours, clarified the need to be encouraging and supportive with Client #25's participation and to strategically attempt to redirect refusals, and focused more on descriptive documentation. After two weeks, TPA B distributed a summary of the documentation so the group evaluated Client #25's status and response.

f. Client #25's IDT meeting, dated 10/25/16, summarized Client #25's activity and behavior from 9/12/16 to 9/29/16. The summary indicated Client #25's obstacles which prevented him/her to participate in more activities during the two week baseline. The summary also indicated: "the current IDT at this point can offer information as requested and continue to provide (him/her) with supports (he/she) has in place." Supports continued while the team waited for the leadership decision in regards to Client #25's move from infirmary.

When interviewed on 4/11/17 at 3:50 p.m. TPA A reported Client #25 needed a home with increased nursing. There are only two homes, in Area Two with increased nursing. Client #25 displayed aggression and she was concerned about the safety of other clients, especially medically fragile clients which typically resided in those two homes.

When interviewed on 4/11/17 at 4:50 p.m. Physician Assistant (PA) A identified Client #25 moved into the infirmary in 12/2010. According to PA A, Client #25 had gone almost a year without any hospitalizations and he/she was medically

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W 159	Continued From page 28 stable. She stated Client #25's feedings were decreased to accommodate his/her activities during the day. The PA confirmed it was not medically necessary for Client #25 to stay in the infirmary. When interviewed on 4/13/17 at 9:30 a.m. Treatment Program Administrator (TPA) B reported Client #25 was referred to Area Two. He stated they had a series of on-going discussions about the referral. The discussions consisted of Client #25's feedings, work attendance, and activities. TPA B stated they ran a baseline on Client #25's work attendance late last fall. He also stated the effort made to reconcile issues failed to get pushed along. TPA B indicated TPM C continued to feel Client #25 was happy and his/her needs were met. TPA B believed Client #25 continued to be evaluated and the referral was not denied. TPA B confirmed the team failed to have a final discussion to determine where Client #25 should live. When interviewed on 4/13/17 at 9:55 a.m. Superintendent A confirmed the team failed to finalize and complete a transition plan for Client #25 to move out of the infirmary. She stated she would facilitate a meeting to determine a plan and have Client #25 moved into a home within 30 days.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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W 189	Continued From page 29 This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to provide adequate training to ensure staff handled emergency situations effectively and competently. Staff failed to provide adequate support to ensure client safety when a client experienced a fall. This affected 1 of 1 client (Client #11) identified as a result of facility self-reported incident #67247-I. Finding follows: Record review on 4/3/17 revealed Client #11's Incident Report, completed 3/10/17 at 7:12 a.m. by Resident Treatment Worker (RTW) O. The report documented Client #11 "fell slowly to the floor and landed on (his/her) buttocks." The injury/incident type identified "fall" with the type of fall listed as "slip or trip." The RTW documented the client complained of left hip pain. RTW O contacted Licensed Practical Nurse (LPN) A. The LPN, Registered Nurse (RN) A and Doctor (Dr.) A assessed Client #11 and noted tenderness of the left hip. Dr. A referred the client to the emergency room for x-rays and treatment. According to Client #11's face sheet, the client was 73 years old with the following diagnosis: profound intellectual disability, intermittent explosive disorder, bipolar disorder, seizures, degenerative arthritis, osteoporosis, dysphagia and history of compression vertebral fractures. Further record review revealed Client #11's Individual Support Plan (ISP) completed on 9/19/16. The plan included a Comprehensive Care Plan with the goal "will not experience fractures related to osteoporosis or falls." The risks identified included falls, osteoporosis and	W 189		

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W 189	Continued From page 30 fractures. The plan listed triggers, such as inability to use an extremity. The supports section documented, "Nursing will perform physical assessments at least quarterly or when the triggers/signs and symptoms are noted/reported." When interviewed on 4/4/17 at 8:30 a.m. RTW O explained she showered other clients in the bathroom where client #11 sat on the toilet. In the past Client #11 would transfer to the shower chair independently. She was close to the client; however, as he/she transferred to the chair the client fell on the floor. She and Psychology Assistant (PSY A) lifted the client onto the shower chair. RTW O showered the client and after the shower the client did not want to put any weight on the left leg. She called LPN A who assessed the client. RTW A confirmed the floor may have been wet since she had given numerous showers that a.m. She admitted she received training to call a nurse prior to moving a client that had fallen if the client was not trying to get up. She explained the client sat on the floor not showing signs of pain, however did not move to get up on their own. Interview with the PSY A on 4/4/17 at 11:20 a.m. confirmed she assisted RTW O to lift Client #11 to the shower chair. She was standing in the hall at the time, saw the client sitting on the floor and asked the RTW if she needed help. When RTW O asked for help the Psych Assistant helped lift the client. She denied the client showing any signs of pain, however she admitted receiving training to call the nurse to assess prior to moving the client. She said the floor was "icky" and she just wanted to move the client instead of leave the client on the floor.	W 189		

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W 189	Continued From page 31 When interviewed on 4/5/17 at 10:10 a.m. LPN A explained her assessment of the client. The client did not want to put any weight on the left leg. She denied grimacing or moaning of the client. She made sure the client received a pain medication, notified the RN A and Dr. A Interview with Dr. A on 4/12/17 at 9:30 a.m. revealed he assessed Client #11 and noted the client expressed some discomfort when he flexed the left leg. He explained the mobile x-ray was delayed so he transferred the client to the emergency room. The client was diagnosed with a hip fracture and hospitalized for three days. No surgery was required. When requested, the facility provided portions of "Heartsaver First Aid" training, which included measures to be taken with a possible head, neck, or spinal injury. These measures included: securing the scene, sending for help, and having the person remain as still as possible. Additional training documentation provided included a medical emergency drill checklist. The list included, but was not limited to: 1. Notify the nurse via emergency radio system 2. Do not move individual until evaluated by nurse/physician. On 5/1/17 at 5:04 p.m., Superintendent A confirmed staff training simply stated if someone falls, motor vehicle accident, or sports injury has occurred do the following: make sure the scene is safe, have the person remain where they are, call for advanced help (nursing, physician, 911). When interviewed on 4/5/17 at 10:40 a.m. Director of Educational Services confirmed RTW O completed the Heart Saver Training which	W 189		

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W 189	Continued From page 32 included the instruction for staff to call a nurse prior to moving a client who had fallen on the floor and was not trying to get up independently.	W 189		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to appropriately utilize the Comprehensive Functional Assessment (CFA) to completely and thoroughly identify the specific developmental needs of clients. This affected 4 of 22 sample clients (Client #4, Client #14, Client #15 and Client #22). Findings follow: Record review revealed the following: a. Client #4's CFA completed 9/15/16. Skill area statements, such as Domestic, Communication, Community/Social Skills and Health Care, throughout the CFA were assessed Not Applicable (NA). b. Client #14's CFA completed 11/22/16. Throughout the CFA, skill areas such as, Domestic, Elimination, and Community/Social skills areas were assessed as NA. c. Client #15's CFA completed 7/8/16. Activities of Daily Living, Elimination, Communication and Community Skill areas were consistently assessed as NA.	W 214		

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W 214	Continued From page 33 d. Client #22's CFA, completed 4/25/16. Throughout the assessment, various sections were identified as NA. Additional record review revealed the CFA instructions page. According to the instructions, if a person being assessed needed any type of prompt (verbal, gestural, etc.) the skill should be marked as a need. The instructions further noted, "NA" or "Not Applicable" indicated the statement cannot apply to the person. In addition the instructions clarified NA should "never be based on lack of opportunities". Use of NA in the noted CFAs indicated staff failed to provide the opportunity for clients to demonstrate the skill, thus staff failed to accurately identify client abilities and skill deficits. When interviewed on 4/12/17 at approximately 9:10 a.m., Treatment Program Manager (TPM) B agreed the CFA was not accurately completed and confirmed areas identified as "Not Applicable" on the CFA should have been identified as a "Need."	W 214		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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W 249	Continued From page 34 This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, facility staff failed to consistently implement client Individual Support Plans (ISPs) as written. This affected 4 of 22 sample clients (Client#2, #12, #13,#15, #20) and two clients added to the sample (Client #32 and #35). Findings follow: 1. Record review on 4/17/17 revealed the following: a. Glenwood Resource Center Incident Report completed by Resident Treatment Supervisor (RTS) C on 4/12/17 at 9:30 p.m. The report documented Client #12 "was found in a bathroom masturbating" Client #35. The two clients were separated and Client #12 placed on 1 to 1 supervision. Client #35 moved to the other side of the house. According to Client #12 and #35's nursing assessments completed on 4/12/17 at 10:35 p.m. by RN B, neither client received any injuries. b. Client #12's Behavior Support Plan (BSP) indicated "close" supervision required for a.m. and p.m. shifts., defined as: 15 minute accountability for a.m. and p.m. shifts, "if (Client #12) suddenly leaves the area, staff will immediately request assistance from other staff as needed to ensure that close supervision is maintained... If the staff is unable to immediately gain additional support, they must take immediate steps (e.g. call supervisor) to ensure that close supervision is resumed as soon as possible," Exceptions included: (Client #12) "may be alone in (client's) bedroom OR restroom... Staff must first check to ensure these areas are empty before allowing (Client #12) to be alone in these	W 249		

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W 249	Continued From page 35 rooms... (Client #12) may choose to wait for the restroom to empty; otherwise staff will accompany (him/her) into the restroom... when (Client #12) is alone in (his/her) bedroom or the restroom, staff must maintain eyesight of the door to ensure that close supervision is resumed either when (Client #12) exits or another person enters the area." c. Client #12's accountability sheet for 4/12/17 indicated RTW Q accountable for Client #12 from 7:00 p.m. 9:30 p.m. When interviewed on 4/17/17 at 2:50 p.m. RTW P explained she was accountable for a 1 to 1 on the right side of the house. She walked with the client she was assigned to into the restroom. She observed Client #12 with a hand on Client #35's penis. RTW P shouted for another staff and yelled Client #12 "was masturbating (Client #35) in the bathroom." Another staff arrived and notified the administrator on call. RTW P explained Client #12's supervision was close and he/she could not be in the bathrooms without staff checking first. If a client was in the bathroom, staff stayed in the bathroom or one of the clients used another bathroom. RTW P explained Client #35's supervision was general when at home. She stated RTW Q had accountability for Client #12 and Client #37, who was general supervision. RTW P explained RTW Q also had accountability for Client #36, who required close supervision and assistance with walking, while the Certified Medication Aide administered medications. According to RTW P, RTW Q had been in the other bathroom with Client #36 and assisted him/her to bed as this event took place in the bathroom.	W 249		

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W 249	Continued From page 36 When interviewed on 4/18/17 at 2:10 p.m. RTW Q confirmed she had accountability for Client #12 and Client #37 on 4/12/17 during the p.m. shift. She stated Client #12 required close supervision according to the BSP. She confirmed Client #37's supervision was general. She explained she also had accountability for Client #36 while medication was administered. Client #36's supervision was close and required assistance with walking and personal cares. On 4/12/17 she walked with Client #36 and told other staff she was assisting him/her with personal cares. After she assisted Client #36 with personal cares she assisted him/her to bed. She assumed the other staff would watch her other 2 clients. She observed Client #12 in his/her bedroom before she assisted Client #36 to the bathroom. While in the bathroom with Client #36, RTW Q could not see Client #12. RTW Q assisted Client #36 to bed and heard RTW P say what had happened in the bathroom. She confirmed she had accountability for Client #12 at the time. She denied signing accountability to another staff while she assisted Client #36 with personal cares and bedtime. She acknowledged she received training regarding all clients' supervision. When interviewed on 4/12/17 at 10:45 p.m., Superintendent A reported Client #12 found in the restroom with Client #35. She explained Client #12 was found masturbating Client #35. Superintendent A explained Client #12 required visual line of sight supervision and staff were required to check the restroom prior to allowing Client #12 to be alone. Superintendent A reported staff failed to provide the visual supervision and failed to check the restroom prior to Client #12 entering.	W 249		

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W 249	Continued From page 37 2. Observation on 4/10/17 at approximately 12:10 p.m. revealed Client #32's fingernails were not trimmed and had rough/jagged edges. Record review on 4/11/17 revealed Client #32's Accident and Incident Report dated 3/22/17, indicated staff noticed a reddened scratch about a half an inch long on Client #32's left hip while changing his/her brief. A note from TPM F read, "(Client #32) often has (his/her) pants and has very long fingernails. Staff have tried multiple times to trim (his/her) fingernails with not success. Staff will monitor (Client #32) and make sure (he/she) is not scratching (himself/herself)." Further record review revealed Client #32's Individual Support Plan (ISP) dated 10/5/16. The ISP noted nail trimming as a concern, as not to cut them too closely. The ISP also indicated Client #32's nails needed to be trimmed because Client #32 may scratch himself/herself. When interviewed on 4/11/17 at 4:45 p.m., TPM F confirmed Client #32 frequently scratched himself/herself. He could not produce any documentation that staff cut Client #32's fingernails on a regular basis. 3. Observations on 4/3/17 at House 473 during the evening meal revealed Client #20 ate goulash, salad, whole garlic toast, and kiwi fruit cut in halves. Staff encouraged Client #20 to take small bites and drinks throughout the meal but failed to assist Client #20 cut his/her kiwi into bite size pieces. Additional observations on 4/3/17 at House 473	W 249		

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W 249	Continued From page 38 during lunch revealed Client #20 consumed taco salad, a whole apple, and ice cream. Staff encouraged Client #20 to take small bites, and take drinks but failed to assist Client #20 cut his/her apple into bite size pieces. Record review on 4/11/17 revealed Client #20's Physical Nutritional Management Plan (PNMP), revised 3/7/17. The PNMP noted Client #20's foods were to be bite size consistency except he/she could have whole bread and toast. Continued record review revealed Client #20's ISP, dated 5/26/16, indicated, Client #20's foods should be cut into bite sized consistency due to Client #20 taking large of bites and overstuffing his/her mouth. The ISP noted Client #20 could have whole bread and toast. When interviewed on 4/11/17 at 6:30 p.m., Treatment Program Manager (TPM) I confirmed Client #20 should have all foods, except toast and bread, cut into bite size pieces. 4. Observations on 4/3/17 at House 133 during the evening meal revealed Client #2 ate large bites of pureed food, rapidly and repeatedly without taking drinks. Once during the meal, RTW I verbally prompted Client #2 to drink. Observations on 4/4/17 at House 133 during breakfast revealed RTW J spooned pureed cereal and bread into one section of a deep divided plate. She failed to separate the food out on the plate. Client #2 ate three oversized bites of cereal and continued to eat eight more bites before RTW J prompted him/her to take a drink. Client #2 drank from a 2 handle spouted cup and ate 11 more bites before prompted to take	W 249		

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W 249	Continued From page 39 another drink. Further observations on 4/10/17 during lunch revealed Client #2 overloaded his/her spoon. Food dropped onto Client #2's chin and clothing protector when he/she took two rapid bites of food. RTW J told Client #2 she would help him/her and proceeded to feed him/her. RTW J fed Client #2 and intermittently offered him/her drinks from a 2 handled cup. After Client #2 drank the milk in the 2 handled cup, RTW J offered him/her thickened juice in a cup without handles. Client #2 drank several repeated long drinks from the cup. Record review on 4/3/17 revealed Client #2's Physical Nutritional Management Plan (PNMP) dated 3/14/17. The PNMP identified Client #2's high risk for choking, aspiration and pneumonia. The PNMP noted he/she used a 2 handle spout cup, a 4" white handled coated infant spoon, a red divided plate and a Dycem. The PNMP indicated Client #2 needed to "consume food at a slow rate" and staff should spread food out onto the divided plate to encourage smaller bites. In addition Client #2 needed to have liquids throughout the meal and staff should offer him/her drinks frequently to slow his/her intake. When interviewed on 4/10/17 at 1:45 p.m. TPM F confirmed staff should use an extra spoon to knock excess food off Client #2's spoon if he/she overloaded his/her spoon to ensure safe bite size. He further confirmed staff should follow Client #2's PNMP, spread the food around on the plate, prompt Client #2 to take frequent drinks, and use a 2 handle spout cup. 5. Observations at House 133 on 4/3/17 during	W 249		

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	16G003	A. BUILDING _____ B. WING _____	C 04/20/2017

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W 249	Continued From page 40 the evening meal, on 4/4/17 during breakfast, and on 4/10/17 during lunch revealed staff consistently failed to prompt/encourage Client #2 to place his/her clothing protector in the hamper. Record review on 4/10/17 revealed Client #2's Individual Implementation Program (IIP) for self-help skills, included placing laundry in a hamper. The IIP objective noted during grooming time, Client #2 should grasp a towel and place it in the dirty laundry hamper. The Opportunities to Generalize section noted Client #2 "may practice this skill with other items at any time during (his/her) scheduled day activities where using a gross motor skill may be needed to complete a task." When interviewed on 4/10/17 at 2:30 p.m., TPM F confirmed staff should have encouraged Client #2 to put his/her clothing protector in the hamper at meals. 6. Observation on 4/5/17 during lunch revealed Client #15's PNMP card laid on the table while RTW K fed him/her. At the end of the meal, Client #15 pulled his/her clothing protector off and RTW K placed the clothing protector in a dishpan. RTW K wheeled Client #15 to the kitchen and set the dishpan on the counter. RTW K failed to encourage Client #15 to hold his/her PNMP card and place the clothing protector in the hamper. Observations on 4/5/17 from 4:55 p.m. - 5:30 p.m. revealed Client #15 sat at the table while RTW L fed him/her. RTW L failed to encourage Client #15 to hold his/her PNMP card. At 5:25 p.m., RTW L pushed Client #15 to the kitchen, set a dishpan of dirty dishes on the counter, wheeled Client #15 to the dining room and RTW	W 249		

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W 249	Continued From page 41 L placed Client #15's clothing protector in the dirty laundry hamper. Record review on 4/11/17 revealed Client #15's Occupational Therapy report dated 9/9/16. The report noted Client #15 should be encouraged to hold his/her PNMP card and/or place his/her clothing protector in the hamper after meals. When interviewed on 4/11/17 at 9:35 a.m. TPM J confirmed staff should encourage Client #15 to hold his/her PNMP and place his/her clothing protector in the hamper as "part of (his/her) routine". 7. Observations on 4/4/17 at 5:10 p.m. in House 462 revealed staff wheeled Client #13 to the dining room in his/her wheelchair. Staff provided hand-over-hand assistance in handwashing, obtaining dishes and scooping food onto his/her plate prior to feeding the client. Further observations on 4/5/17 at 7:30 a.m. revealed staff provided Client #13 hand-over-hand assistance in obtaining place setting and food items prior to going to the dining room table. Staff provided full assistance in scooping food onto his/her plate and prompted the client to assist with holding the feeding utensil. After several refusals to eat while holding the spoon, staff fed Client #13 the remainder of his/her meal. Record review revealed Client #13's IPP for communication addressing use of a LittleMac Communicator at mealtimes to tell staff he/she would be ready to eat. According to the IIP, staff should turn on the Communicator and have the device placed on a surface for easy access.	W 249		

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W 249	Continued From page 42 After gaining Client #13's attention, staff should show him/her how to activate the Communicator and ask him/her "Are you ready to eat?" Staff should provide a second verbal cue, "Touch the spoon on the button if you are ready to eat." Staff should also provide hand at elbow assistance as needed to activate the Communicator. After Client #13 activated the Communicator, staff should give him/her a bite of food and repeat for a total of 3 times. When interviewed on 4/12/17 at 8:45 a.m. PSY A A stated she recently moved Client #13's communication switch to the counter and staff should prompt the client to use the switch prior to the start of the meal. She stated staff asked her to look at the switch because it sounded "foggy" and needed the battery changed. After changing the battery PSY A A attempted to operate the switch but the device failed to activate. When interviewed on 4/12/17 at 8:45 a.m. TPM H confirmed the communication switch should be used at all mealtimes and the client should have additional opportunities to use the switch.	W 249		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure client participation in evacuation drills on each shift of personnel at least quarterly. The facility failed to consistently document client presence in the home at the time of drill and/or client participation. This affected 7	W 440		

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W 440	Continued From page 43 of 17 Homes (Houses 239, 241, 242, 248, 470, 473, 250, and 253). Findings included: Record review revealed the following: 1. Fire Drill Reports for House 239: a. Drill completed 8/19/16 at 8:50 a.m. failed to document any client participation in the drill. b. Drill completed 8/19/16 at 7:00 p.m. failed to document any client participation in the drill. c. Drill completed 10/24/16 at 11:50 p.m. failed to document any client participation in the drill. d. Drill completed 11/8/16 at 1:00 p.m. documented no clients on the unit at the time of drill completion. e. Drill completed 11/10/16 at 3:10 p.m. failed to document any client participation in the drill. f. Drill completed 2/2/17 at 8:30 a.m. failed to document any client participation in the drill and noted no client were in the zone at the time. 2. Fire Drill Reports for House 241: a. Drill completed 8/23/16 at 9:02 p.m. failed to document any client participation in the drill. b. Drill completed 2/13/17 at 1:10 p.m. failed to document any client participation in the drill, and noted no clients were located in the zone area at the time of the drill. 3. Fire Drill Reports for House 242: a. Drill completed 2/13/17 at 1:18 p.m. failed to document any client participation in the drill, and noted no clients were in the zone at the time of the drill.	W 440		

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W 440	Continued From page 44 4. Fire Drill Reports for House 248: a. Drill completed 5/20/16 at 7:45 p.m. failed to document any client participation in the drill. 5. Fire Drill Reports for House 470: a. Drill completed 8/19/16 8:30 a.m. failed to document any client participation in the drill. b. Drill completed 11/8/16 at 12:48 p.m. failed to document any client participation in the drill. c. Drill completed 11/10/16 at 5:00 p.m. failed to document any client participation in the drill. 6. Fire Drill Reports for House 473: a. Drill completed 7/18/16 at 10:10 p.m. failed to document any client participation. 7. Fire Drill Reports for House 250 : a. Drill completed 8/19/16 at 11:15 p.m. failed to document any client participation. Treatment Program Manager (TPM) D documented, "Apparently there were no issues although I have no idea who participated." b. Drill completed 11/11/16 at 1:00 a.m. failed to document any client participation in the drill. c. Drill completed 2/6/17 at 11:45 p.m. failed to document any client participation in the drill. 8. Fire Drill Reports for House 253: a. Drill completed 10/31/16 at 1:40 p.m. documented no one, staff or clients, present in the home at the time of the drill. Further record review revealed Glenwood	W 440		

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W 440	Continued From page 45 Resource Center's policy for evacuations, revised 9/1/16. The policy directed: "The TPM will complete a debriefing of each fire drill ... The debriefing shall include: list of all clients participating in drill." When interviewed on 4/11/16 at 11:00 a.m., Superintendent A confirmed clients should be present in the homes for drills. Superintendent A noted drills were for staff and clients, not for alarms.	W 440		
W 445	483.470(i)(2)(i) EVACUATION DRILLS The facility must actually evacuate clients during at least one drill each year on each shift. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure all clients participated in an actual evacuation drill at least annually on each shift of personnel. The facility failed to consistently document client participation in actual evacuation drills completed. This affected 3 of 17 homes (Houses 248, 250, and 465). Findings included: Record review revealed the following: 1. Fire Drill Report for House 248 documented a full evacuation drill completed 6/13/16 at 5:30 p.m. The form failed to document client participation in the drill. 2. Fire Drill Report for House 248 documented a full evacuation drill completed 6/22/16 at 10:55 p.m. The form failed to document client	W 445		

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W 445	Continued From page 46 participation in the drill. 3. Fire Drill Report for House 250 documented a full evacuation drill completed 8/4/16 at 3:30 p.m. The form documented only four clients participated. No additional full evacuation drills for the p.m. shift could be located. 4. Fire Drill Report for House 465 documented a full evacuation drill completed 5/27/16 at 12:30 a.m. The form documented three clients refused to participate in the drill. The form failed to document clients that did participate. Further record review revealed Glenwood Resource Center's policy for evacuations, revised 9/1/16. The policy instructed: once each year, one drill for each shift at each residential home must include a full evacuation. The policy further directed: "The TPM will complete a debriefing of each fire drill ... The debriefing shall include: list of all clients participating in drill." When interviewed on 4/11/17 at 11:00 a.m. Superintendent A confirmed all clients should participate in an actual evacuation drill on each shift at least annually. Superintendent A agreed all clients should be present during completion of an actual evacuation drill.	W 445		

CAC 5/16/17 05/15/17

Plan of Correction for Glenwood Resource Center (GRC)
Annual Survey 4/3/17- 4/20/17
Statement of Deficiencies

V Hatcher 5/16/17

W104 – Governing Body

1. Incident Management (see W154 for more information)

Individual Response:

Administrative staff trained all Resident Treatment Supervisors (RTSs) and Treatment Program Managers (TPMs) on the expectation that all staff, that are likely to contribute to identifying the cause of an injury of unknown origin, must be interviewed unless the cause of the injury is identified before all staff interviews are completed. RTSs and TPMs were trained that:

- When investigating injuries of unknown origin the investigators must interview:
  - The staff that completed the incident report;
  - All staff that were assigned accountability for the client on that shift ; and
  - All staff that had accountability for the client prior to the shift within a time period indicative of when the injury most likely occurred or until the time the injury was documented as not being present.

- The results of staff interviews done by the Resident Treatment Supervisor will be summarized on the Type 2 incident review form under II. C. 2. and the results of interviews of staff done by the Treatment Program Manager will be under IV. 6.

- Investigators must thoroughly review the environment to identify any hazards that may have contributed to the injury and ensure appropriate follow-up is completed.

- The investigator will interview each of the identified staff and complete the investigation within five working days of the report of the incident.

Responsible: Assistant Superintendent - TPS
Date Completed: 4/20/17

Systemic Response:

The Treatment Program Administrators will review all investigations of injuries of unknown origin to ensure the thoroughness of the investigation within five working days of completion of the report.

Responsible: Assistant Superintendent - TPS
Date Completed: 4/10/17

2. Fire Evacuation Drills (see W440 and W445 for more information)

Individual Response:

The Director of Environmental Services and the Assistant Superintendent - TTS were re-trained on the Evacuation Drill policy and the requirement that clients must be present when drills are conducted and that client participation is to be documented on the drill report.

Responsible: Superintendent
Date Completed: 4/18/17

Systemic Response:

Policy was reviewed for compliance with regulations and was revised to include further administrative review of debriefings and compliance with regulations.

Fire drill reports will be monitored to ensure compliance to the requirements.

Responsible: Assistant Superintendent - TSS
Date Completed: 4/18/17

W122 – Client Protections

The plan of correction for W122 is described in the plan of correction for W104, W148, W153, W154, and W156 for the individual and systemic corrective actions with assignments for persons responsible and completion dates.

W 148 – Communication with Clients, Parents and Guardians

Individual Response:

GRC social workers, Treatment Program Managers, Resident Treatment Supervisors, Administrator on Duty, and Medical Providers, that work with clients #8, #14, #23, #24, #27, #28, #29, #30 and #31 will be re-trained on the requirements to notify parents and guardians of their family member/ward injuries of unknown origin, suspicious injuries, and change in client's condition and to document the parent/guardian notification in the client file.

Responsible: Assistant Superintendent - TPS
Date Completed: 5/31/17

Systemic Response:

For quality assurance, periodic reviews of client records (i.e., parent/guardian contact notations) will be completed to verify that parents/guardians were notified of family member/ward injuries of unknown origin, suspicious injuries, and change in client's condition.

Responsible: Social Work Supervisor
Date Completed: 5/31/17 & ongoing

W153 – Staff Treatment of Clients

1. Thorough investigation of injuries of unknown origin

Individual Response:

Administrative staff trained all Resident Treatment Supervisors (RTSs) and Treatment Program Managers (TPMs) on the expectation that all staff, that are likely to contribute to identifying the cause of an injury of unknown origin, must be interviewed unless the cause of the injury is identified before all staff interviews are completed. RTSs and TPMs were trained that:

- When investigating injuries of unknown origin the investigators must interview:
  - The staff that completed the incident report;
  - All staff that were assigned accountability for the client on that shift ; and
  - All staff that had accountability for the client prior to the shift within a time period indicative of when the injury most likely occurred or until the time the injury was documented as not being present.

- The results of staff interviews done by the Resident Treatment Supervisor will be summarized on the Type 2 incident review form under II. C. 2. and the results of interviews of staff done by the Treatment Program Manager will be under IV. 6.

- Investigators must thoroughly review the environment to identify any hazards that may have contributed to the injury and ensure appropriate follow-up is completed.

- The investigator will interview each of the identified staff and complete the investigation within five working days of the report of the incident.

Responsible: Assistant Superintendent - TPS
Date Completed: 4/20/17

One injury identified during the survey as suspicious was referred as a Type 1 investigation, reported to DIA, and GRC's investigation was completed by 04/04/17.

Responsible: Director of Quality Assurance
Date Completed: 4/4/17

Systemic Response:

The Treatment Program Administrators will review all investigations of injuries of unknown origin to ensure the thoroughness of the investigation within five working days of completion of the report.

Responsible: Assistant Superintendent-TPS
Date Completed: 4/10/17

The Quality Assurance Director will review injuries of unknown origin and determine if they are suspicious. Suspicious injuries will be reported to DIA and an internal Type 1 investigation will be completed.

Responsible: Director of Quality Assurance
Date Completed: 4/20/17

2. Immediate Reporting Allegations of Abuse, Neglect, or Mistreatment

Individual Response:

GRC confirmed that RTW M was trained in appropriate and timely reporting of alleged abuse. GRC confirmed that RTW M did not report allegations of abuse by RTW N involving Clients #30 and #31 timely. The RTW M and RTW N and were terminated from employment.

Responsible: Superintendent
Date Completed: 5/5/17

System Response:

GRC will continue to train all staff in the requirement to report alleged abuse immediately to supervisors. GRC will take appropriate personnel action, up to and including termination, when it is discovered that staff have not timely report allegations of abuse, neglect, or mistreatment of clients.

Responsible: Superintendent
Date Completed: Ongoing

W154 – Staff Treatment of Clients

Individual Response:

The Treatment Program Administrators, Treatment Program Managers and Resident Treatment Supervisors of clients #8, #14, #23, #24, #27, # 28, #29, #30 and #31 were retrained on conducting a thorough and complete investigation of Type II incidents in an effort to identify the cause of injuries of unknown origin, the impact of the incident on the individual and any need for corrective actions.

Treatment Program Administrators reviewed the Type 2 investigations for clients #8, #14, #23, #24, #27, # 28, #29, #30, and #31.

Responsible: Assistant Superintendent - TPS
Date Completed: 4/10/17

One suspicious injury identified during the survey was referred as a Type 1 investigation, it was reported to DIA, and GRC's investigation was completed by 4/4/17.

Responsible: Director of Quality Assurance
Date Completed: 4/4/17

Systemic Response:

The Treatment Program Administrators will review all investigations of injuries of unknown origin to ensure the thoroughness of the investigation within five working days of completion of the report.

Responsible: Assistant Superintendent - TPS
Date Completed: 4/10/17

The Quality Assurance Director will determine which injuries of unknown origin are suspicious, report suspicious injuries to DIA, and initiate a Type 1 investigation of suspicious injuries.

Responsible: Director of Quality Assurance
Date Completed: 4/20/17

W156 – Staff Treatment of Clients

Individual Response:

The Treatment Program Administrators, Treatment Program Managers and Resident Treatment Supervisors of clients #8, #14, #23, #24, #27, # 28, #29, #30, and #31 were retrained on conducting a thorough and complete investigation of Type II incidents in an effort to identify the cause of the incident, the impact of the incident on the individual and any need for corrective actions.

Treatment Program Administrators are responsible to review each Type 2 investigations and to conclude the investigation with a comprehensive review of the findings.

Responsible: Assistant Superintendent - TPS
Date Completed: 4/10/17

One suspicious injury identified during the survey was referred as a Type 1 investigation, it was reported to DIA, and GRC's investigation was completed by 4/4/17.

Responsible: Director of Quality Assurance
Date Completed: 4/4/17

Systemic Response:

The Treatment Program Administrators will review all investigations of injuries of unknown origin to ensure the thoroughness of the investigation within five working days of completion of the report.

Responsible: Assistant Superintendent - TPS
Date Completed: 4/10/17

The Quality Assurance Director will determine which injuries of unknown origin are suspicious, report suspicious injuries to DIA, and initiate a Type 1 investigation of suspicious injuries.

Responsible: Director of Quality Assurance
Date Completed: 4/20/17

W159 – Active Treatment Integrated, Coordinated, and Monitored by a Qualified Intellectual Disability Professional (QIDP)

Individual Response

The survey identified one client of 220 clients was affected. The Interdisciplinary Team, including the QIDP, met and identified a plan to support Client #25's transition to a home on the Glenwood Resource Center campus. The plan addresses client #25's identified support needs

and includes a process of formal meetings and reporting on the client's progress. Supports will be adjusted as needs are identified. The guardian was informed of and approved the plan for transition. The transition is in process and Client #25 began to spend the majority of his waking hours at his/her new home on 5/8/17. The plan is to fully transition to the home by early June 2017.

Responsible: Assistant Superintendent - TPS
Date Completed: 6/5/17

Systemic Response

QIDPs will be trained on the expectation that individuals are transitioned back to a residential living unit once their medical needs are sufficiently addressed at the infirmary to ensure that client supports are provided in the home.

Responsible: Treatment Program Administrators
Date Completed: 5/31/17

W189 – Staff Training Program

Individual Response

Staff in Client #11's home will be trained on the GRS Fall Protocol that was developed on 5/10/17.

Responsible: Treatment Program Manager
Date Completed: 6/2/17

Systemic Response

A fall protocol was developed and adopted on 5/10/17 that clarifies that, if a client falls and is not able to get off of the floor without assistance or indicates pain, staff will seek a nurse assessment before moving the client, unless the client's location is not safe. Staff will be trained on the new protocol.

Responsible: Assistant Superintendent-TPS
Date Completed: 6/2/17

W214 – Individual Program Plan

Individual Response

The Comprehensive Functional Assessments (CFAs) of Clients #4, #14, #15, and #22 are being reviewed to ensure that CFAs completely and accurately identify client abilities and functional support needs. Individual support plans will be revised, as needed.

Responsible: Assistant Superintendent - TPS
Date Completed: 6/2/17

Systemic Response

Treatment Program Managers were retrained to ensure that the CFAs completely and thoroughly identify the clients' needs, specifically, to ensure that when clients who are able to perform a part of a task, with the support of staff, the CFA documents the task as a need and not as "not applicable."

Responsible: Assistant Superintendent - TPS
Date Completed: 5/12/17

Comprehensive Functional Assessments are being reviewed to identify errors, as described above, and will be revised to clearly and accurately identify client need.

Responsible: Assistant Superintendent - TPS
Date Completed: 6/2/17

W249 – Program Implementation

Individual Response

Client #12 lives in a single bedroom with no roommate. At this time Client #12 has 1:1 supervision. Client #12's BSP and level of supervision is being revised and will be retrained to staff working with Client #12.

Client #35 was moved to the opposite side of house 360 on 4/12/17and will remain there.

RTW Q will be re-trained on the GRC Accountability Policy.

Responsible: Treatment Program Administrator
Date Completed: 5/26/17

Systemic Response

BSP program monitors will continue to be completed to ensure programs are implemented consistent with the client's plans.

Responsible: Director of Psychology
Date Completed: 6/2/17

Individual Response

Nail trimming on a weekly basis will be added to Client #32s Daily Activity Record (DAR) for staff to document.

Responsible: Treatment Program Administrator
Date Completed: 6/2/17

Systemic Response

GRC IDTs will continue to monitor incident reports and take appropriate actions to prevent repeat incidents of like nature.

Responsible: Treatment Program Administrators
Date Completed: 6/2/17

Individual Response

Staff working with Clients #20, #2, #15, and #13, including RTW I, RTW J, RTW K, and RTW L will be re-trained on their respective Physical Nutritional Management Plans (PNMPs).

Responsible: Treatment Program Administrators
Date Completed: 6/2/17

Systemic Response

PNMP program monitors will continue to be completed to ensure programs are implemented consistent with the client's plans.

Individual Response

Staff at house 133 will be re-trained on Client #2's SH:4 IIP.

Staff at house 462 will be re-trained on Client #13's COMM:6 IIP.

Responsible: Treatment Program Administrators
Date Completed: 6/2/17

Systemic Response

IIP program monitors will continue to be completed to ensure programs are implemented consistent with the client's plans.

Responsible: Treatment Program Administrators
Date Completed: 6/2/17

W440 – Evacuation Drills

Individual Response:

The Director of Environmental Services and the Assistant Superintendent - TSS were re-trained on the Evacuation Drill policy and that clients must be present when drills are conducted and that client participation be documented on the drill report.

Responsible: Superintendent
Date Completed: 4/18/17

Systemic Response:

The Evacuation Drill Policy was reviewed for compliance with regulations and was revised to include further administrative review of debriefings, compliance with regulations, and was trained to leadership team.

Responsible: Assistant Superintendent - TSS
Date Completed: 4/18/17

W445 – Evacuation Drills

Individual Response:

The Director of Environmental Services and the Assistant Superintendent - TSS were re-trained on the Evacuation Drill policy and the requirement that clients must be present when drills are conducted and that client participation is to be documented on the drill report.

Responsible: Superintendent
Date Completed: 4/18/17

Systemic Response:

The Evacuation Drill Policy was reviewed for compliance with regulations and was revised to include further administrative review of debriefings, compliance with regulations, and was trained to leadership team.

Responsible: Assistant Superintendent - TTS
Date Completed: 4/18/17