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

PRINTED: 08/28/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  16G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/10/2017
NAME OF PROVIDER OR SUPPLIER  VILLAGE NORTHWEST UNLIMITED		STREET ADDRESS, CITY, STATE, ZIP CODE  330 VILLAGE CIRCLE SHELDON, IA 51201	
(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)
W 000 INITIAL COMMENTS		W 000	
<p>The investigation of #69612-C resulted in a deficiency cited at W153.</p> <p>W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record reviews, facility staff failed to immediately report allegations of client abuse and/or mistreatment to the administrator or designee. As a result, allegations of abuse and/or mistreatment were not reported to the appropriate state agency. This affected 1 of 1 client (Client #1) identified as a result of investigation #69612-C. Finding follows:</p> <p>When interviewed on 8/9/17 at 2:20 p.m. Resident Skills Trainer A reported she witnessed RST C kiss Client #1 on the lips and stick out her tongue and lick Client #1's cheek. RST A stated Client #1 was blind and laughed and thought it funny when RST C did this. Client #1 liked to give hugs and was very affectionate. RST A stated she considered RST C's actions to be inappropriate touching. She further stated she did not report the incident because the House Manager and RST C were friends and nothing would get done. She stated the House Manager knew this happened and did not do anything about it. RST A reported she discussed her</p>			
W 153		<p>For Systemic Education 9/30/17</p> <p>The ICF/ID and Program Services Director has developed an educational tool that all ICF/ID staff will participate in. The tool will be a training exercise that aids with identification of abuse and emphasizes the need for immediate reporting per VNU Policy. The ICF/ID and Program Services Director will be responsible for on-going compliance.</p> <p>To address the immediate compliance, the ICF/ID Program Services Director met with each of the staff members involved and provided re-education of our policy and the requirements to immediately report to their supervisor.</p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Sandy W. Whetzel</i>		TITLE  CEO	(X6) DATE  9-1-17

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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<p>W 153 Continued From page 1</p> <p>concerns with Former RST B who also felt the behavior of RST C to be inappropriate. She confirmed she did not report this as abuse/neglect to the facility. She also stated she did not have a specific date and time this occurred.</p> <p>When interviewed on 8/8/17 at 4:00 p.m. RST B reported she witnessed RST C kiss Client #1 on the lips and lick her face 3-4 times. She also reported seeing RST C hold hands with Client #1. She felt the relationship was inappropriate. She confirmed she did not report the allegations of abuse to her supervisors or the facility.</p> <p>Record review revealed no report of alleged abuse and/or mistreatment of Client #1.</p> <p>Record review of the facility's abuse and neglect policy, last revised 5/27/17, stated: Any person witnessing a possible act of abuse is mandated by law and Village policy to report it "immediately" means as soon as possible, but not to exceed 24 hours after discovery of the incident.</p> <p>When interviewed on 8/10/17 at 8:00 a.m. the House Manager stated she never witnessed any kissing on the lips or licking the face of Client #1 by any staff. She further stated she never heard of any such behavior and would have reported this immediately as per facility policy.</p>		W 153	