5/30/18 OK 5/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G017	A. BUILDING _____ B. WING _____	C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE HOMES	5945 MORNINGSIDE AVENUE SIOUX CITY, IA 51106

(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 Investigations #74216-M, #75128-M and #74088-A were conducted on 3/7/18 to 4/19/18 and resulted in deficiencies written at W127, W153, W154, W155, and W249. The Investigations also resulted in a condition level deficiency written at W122. On 4/13/18 at approximately 10:35 a.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure client safety from potential abuse, by failing to report, thoroughly investigate, and prevent reoccurrence of potential abuse. The facility developed a plan to remove the IJ, which included training regarding identification of abuse, reporting, implementation of safeguards, and investigation. The facility also reported and completed identified potential abuse investigations.	W 000	See attached POC 5/15/18	
W 122	CLIENT PROTECTIONS CFR(s): 483.420 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. The facility failed to: a) consistently provide a positive environment free from client mistreatment, b) immediately report alleged abuse, c) thoroughly investigate potential abuse allegations, and d) prevent further abuse while investigating an allegation of abuse. This potentially affected all clients residing at Courage Homes.	W 122		

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 122	Continued From page 1 Cross-reference W127: Based on interviews and record reviews, the facility failed to adequately identify abuse. As a result, the facility failed to take adequate and appropriate measures to ensure the safety of clients, including identification of abuse, investigation of alleged abuse, and implementation of safeguards to ensure the safety of all clients residing in the facility. Cross-reference W153: Based on interview and record review, the facility failed to ensure staff immediately reported allegations of potential according to facility policy and procedures (Child and Dependent Adult Abuse Policy). See W153. Cross-reference W154: Based on interviews and record review, the facility failed to conduct thorough investigations into alleged abuse. Cross-reference W155: Based on interviews and record reviews the facility failed to take appropriate measures prevent further abuse while investigating an allegation of abuse. Due to the lack of thoroughness in the investigative process, the facility failed to keep clients safe. On 4/13/18 at approximately 10:35 a.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure client safety from potential abuse, by failing to report, thoroughly investigate, and prevent reoccurrence of potential abuse. The facility developed a plan to remove the IJ, which included training regarding identification of abuse, reporting, implementation of safeguards, and investigation. The facility also reported and completed identified potential abuse investigations.	W 122		

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W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to adequately identify abuse. As a result, the facility failed to take adequate and appropriate measures to ensure the safety of clients, including identification of abuse, investigation of alleged abuse, and implementation of safeguards to ensure the safety of all clients residing in the facility. This potentially affected all clients residing at Courage Homes. Findings follow: See W153, W154, and W155 for additional information. 1. Record review revealed Residential Living Assistant (RLA) A's employee chronology. An entry by the Program Coordinator (PC) dated 2/2/18 documented, "(RLA A) told me earlier this week that if you slap (Client #7's) hands, (he/she) stops picking. I asked her to define slapping (and) she said just play, not hard, she then swatted me softly. I told her (at) no time may we "playfully swat or hit" anyone. I explained that it can be misinterpreted (and) the person may think hitting is OK. She said she understood." Additional record review revealed no facility investigation could be located. When interviewed on 3/21/18 at 3:00 p.m., RLA A	W 127		

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W 127	Continued From page 3 reported an incident with Client #2. She stated Client #2 had a sore on his/her buttocks and she assisted with his/her dressing change. Client #2 turned towards her and RLA A's right hand rested on Client #2's right forearm. Client #2 tried to bite RLA A's hand and as a "knee jerk reaction," she hit Client #2 on the hand. According to RLA A, she did not intend to hurt him/her. As RLA A hit Client #2, she stated, "no, don't do that." Client #2 replied, "Don't do that." RLA A told Client #2 he/she was right and she was sorry. RLA A stated she distracted Client #2 enough for the nurse to apply the new dressing. According to RLA A, she continually asked Client #2 if he/she was OK and he/she replied he/she was fine. RLA A stated Client #2 did not have any injuries. RLA A could not remember who else was in the room, but there was a nurse and another staff. When interviewed on 3/20/18 at 9:45 a.m., RLA B reported on 1/24/18, RLA B and RLA A assisted the nurse with Client #2's treatment. Client #2 rolled on his/her left side and he/she tried to bite RLA A. RLA A told RLA B she swatted Client #2 because he/she tried to bite. RLA B did not see or hear RLA A swat at Client #2. RLA B stated RLA A was close to Client #2's head and RLA B was at his/her hips. RLA B informed RLA A to document the behavior, but she did not. According to RLA B, RLA A talked to the PC the next day about swatting Client #2. RLA B stated RLA A also told the PIA (Physical Intervention Alternative) trainers about the incident. RLA B explained when Client #2 tried to bite or aggress they block him/her. RLA B did not report the incident, but stated she would report right away if she witnessed it. RLA B also stated they have busy days and sometimes forget or run out of time.	W 127		

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W 127	Continued From page 4 When interviewed on 3/20/18 at 10:20 a.m., the PC reported RLA A had problems with redirection. The PC could not remember the date, but prior to 2/6/18, she talked to RLA A about swatting clients. According to the PC, Client #7 picked at his/her skin. RLA A stated if she swatted or smacked Client #7's hand he/she might stop picking. The PC did not think RLA A smacked Client #7's hand. The PC reported RLA A informed the PC how she playfully slapped Client #2 because he/she tried to bite her. The PC stated Client #2 had regularly scheduled dressing changes on a sore on his/her coccyx. Client #2, at times, was not cooperative with the dressing changes; he/she grabbed and pinched. The PC stated humor helped with Client #2. Talking or thinking about other things helped redirect Client #2. When interviewed by the PC, RLA B did not know RLA A slapped Client #2. According to the PC, if RLA B witnessed RLA A slap Client #2, she would report it. The PC was unsure if RLA B reported RLA A's admission to slapping Client #2. The PC could not recall who administered Client #2's treatment the day RLA A slapped him/her, nor did she remember interviewing the nurse. The PC stated RLA A demonstrated how she brushed her hand against Client #2's arm. In the PC's opinion, she felt RLA A's action was not abusive and she felt she handled it appropriately. The PC did not interview or talk to Client #2 about the incident until after a potential abuse incident occurred with Client #1, when she asked Client #2 if anyone hit him/her. 2. Record review revealed Client #1's Injury Report dated 2/6/18, indicated, "(Licensed Practical Nurse (LPN) A) was walking into the living room when she heard (Resident Living Assistant (RLA) A) smack (Client #1's) hand.	W 127		

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W 127	Continued From page 5 When asked what that noise was and what (happened), she admitted she smacked (Client #1's) hand. (LPN A) stated she didn't see what hand she smacked." When interviewed on 3/20/18 at 8:50 a.m., LPN A reported on 2/6/18 at approximately 6:30 a.m. to 7:00 a.m., she walked from the medication room to use the restroom. As she approached the dining room and living room area, she heard a smack or slap noise. LPN A remembered Client #1 and RLA A were the only two in the living room at that time. LPN A asked RLA A what the noise was. RLA A stated she slapped him/her because he/she kept taking off his/her oxygen. LPN A told RLA A, she could not do that. RLA A did not respond. LPN A reported the incident to First Shift Supervisor. LPN A took Client #1 into the dining room for either his/her feeding or a breathing treatment. She completed a skin assessment for injuries. LPN A found a scratch on the back of his/her hand, but no red area. LPN A described the scratch as possibly a day old and almost sealed. The scratch was not bleeding. When interviewed on 3/21/18 at 3:00 p.m., RLA A reported on 2/6/18 she stood in the living room and watched clients. She stated she turned to document on where clients were and what they were doing. RLA A remembered a couple clients in the living room, but she could not remember who they were. She stated the client's accountability sheets would contain that information. RLA A stood less than an arm's length away from Client #1. He/she faced the opposite direction as her, but she could see him/her out of the corner of her eye. Client #1 reached for his/her tubing with the backside of	W 127		

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W 127	Continued From page 6 his/her hand against his/her face. According to RLA A, she moved her hand over to block and redirect Client #1's hand down. RLA A stated she hit the back of his/her hand just right to make a clap sound. She did not mean to hit him/her. She stated her right hand made contact with his/her right hand. LPN A asked what the noise was and RLA A responded she swatted Client #1. LPN A stated she wished she did not say that. The PC sent her home. Record review revealed facility child and dependent adult abuse policy dated 7/16/15, indicated, "Mid-Step Services will make every effort to ensure the safety of the consumers and employees ... If an employee of Mid-Step Services witnesses an incident, has a suspicion, or reasonably believes a consumer has suffered abuse, the employee is required to take immediate steps to ensure that the suspected abuse is stopped, then report directly to the administrator, supervisor, on-duty administrator, and the appropriate regulatory agency (Department of Human Services or Department of Inspections and Appeals)." When interviewed on 4/19/18 at 11:15 a.m., the Administrator acknowledged the facility failed to address potential abuse immediately and prevent reoccurrence.	W 127		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through	W 153		

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W 153	Continued From page 7 established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff immediately reported allegations of abuse to the Department of Inspections and Appeals (DIA). This affected 2 of 6 sample clients (Client #2 and Client #3) reviewed during investigations #74216-M, #75128-M and #74088-A. Findings follow: Refer to W127, W154, and W155 for additional information. 1. Record review revealed Residential Living Assistant (RLA) A's employee chronology. An entry by the Program Coordinator (PC) dated 2/2/18 indicated, "(RLA A) told me earlier this week that if you slap (Client #7's) hands, (he/she) stops picking. I asked her to define slapping (and) she said just play, not hard, she then swatted me softly. I told her (at) no time may we "playfully swat or hit" anyone. I explained that it can be misinterpreted (and) the person may think hitting is OK. She said she understood." Additional record review revealed no facility investigation could be located. When interviewed on 3/21/18 at 3:00 p.m., RLA A reported an incident with Client #2. She stated Client #2 had a sore on his/her buttocks and she assisted with his/her dressing change. Client #2 turned towards her and RLA A's right hand rested on Client #2's right forearm. Client #2 tried to bite RLA A's hand and as a "knee jerk reaction," she hit Client #2 on the hand. According to RLA A, she did not intend to hurt him/her. As RLA A hit	W 153		

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W 153	Continued From page 8 Client #2, she stated, "no, don't do that." Client #2 replied, "Don't do that." RLA A told Client #2 he/she was right and she was sorry. RLA A stated she distracted Client #2 enough for the nurse to apply the new dressing. According to RLA A, she continually asked Client #2 if he/she was OK and he/she replied he/she was fine. RLA A stated Client #2 did not have any injuries. RLA A could not remember who else was in the room, but there was a nurse and another staff. When interviewed on 3/19/18 at 9:30 p.m., First Shift Supervisor A reported on 2/6/18, the PC informed her about an incident with Client #2. RLA A stated she swatted Client #2's hand after he/she tried to bite her. First Shift Supervisor A was unaware of the date of the incident. When interviewed on 3/20/18 at 9:45 a.m., RLA B reported on 1/24/18, RLA B and RLA A assisted the nurse with Client #2's treatment. Client #2 rolled on his/her left side and he/she tried to bite RLA A. RLA A told RLA B she swatted Client #2 because he/she tried to bite. RLA B did not see or hear RLA A swat at Client #2. RLA B stated RLA A was close to Client #2's head and RLA B was at his/her hips. RLA B informed RLA A to document the behavior, but she did not. According to RLA B, RLA A talked to the PC the next day about swatting Client #2. RLA B stated RLA A also told the PIA (Physical Intervention Alternative) trainers about the incident. RLA B explained when Client #2 tried to bite or aggress they block him/her. RLA B did not report the incident, but stated she would report right away if she witnessed it. RLA B also stated they have busy days and sometimes forget or run out of time.	W 153		

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W 153	Continued From page 9 When interviewed on 3/20/18 at 10:20 a.m., the PC reported RLA A had problems with redirection. The PC could not remember the date, but prior to 2/6/18, she talked to RLA A about swatting clients. According to the PC, Client #7 picked at his/her skin. RLA A stated if she swatted or smacked Client #7's hand he/she might stop picking. The PC did not think RLA A smacked Client #7's hand. The PC reported RLA A informed the PC how she playfully slapped Client #2 because he/she tried to bite her. The PC stated Client #2 had regularly scheduled dressing changes on a sore on his/her coccyx. Client #2, at times, was not cooperative with the dressing changes; he/she grabbed and pinched. The PC stated humor helped with Client #2. Talking or thinking about other things helped redirect Client #2. When interviewed by the PC, RLA B did not know RLA A slapped Client #2. According to the PC, if RLA B witnessed RLA A slap Client #2, she would report it. The PC was unsure if RLA B reported RLA A's admission to slapping Client #2. The PC could not recall who administered Client #2's treatment the day RLA A slapped him/her, nor did she remember interviewing the nurse. The PC stated RLA A demonstrated how she brushed her hand against Client #2's arm. In the PC's opinion, she felt RLA A's action was not abusive and she felt she handled it appropriately. The PC did not interview or talk to Client #2 about the incident until after a potential abuse incident occurred with Client #1, when she asked Client #2 if anyone hit him/her. 2. Record review on 3/20/18 revealed Client #3's injury report dated 1/31/18. The report indicated, "(Client #3) was crawling under the table and (RLA C) grabbed (him/her) by (his/her) ankles and pulled (him/her) out from under the table." A description of the injury included possible bruising	W 153		

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W 153	Continued From page 10 to the stomach, knees, and ankles. 24-hour physical assessment follow-up indicated, "Red area to (right) posterior shoulder." Administrative review indicated, "investigation started on 1/31/18 - Upon investigation it was determined that staff exercised poor judgement and did not execute proper PIA." Follow-up included, "Staff will go back through PIA and will be versed on BSP. Staff will receive a disciplinary." When interviewed on 3/20/18 at 3:28 p.m., Qualified Intellectual Disabilities Professional (QIDP) A reported RLA C retook PIA training on 2/14/18. RLA C never came back to work after the training. In QIDP A's opinion, RLA C assumed Client #3 was going to harm another client and felt he needed to stop him/her. QIDP A stated she never thought RLA C did things out of malice. She concluded the incident was not an act of aggression. Record review revealed facility child and dependent adult abuse policy dated 7/16/15. The policy indicated, "All employees are required to report any apparent abuse or mishandling of consumers. Reports are to be made immediately after they occurred or the staff member became aware of the incident. Reports of suspected abuse must be made immediately both to the supervisor/administrative officer and to the appropriate regulatory department." When interviewed on 3/22/18 at 11:00 a.m., the Administrator acknowledged the facility failed to report potential abuse involving Client #2 and Client #3.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)	W 154		

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W 154	Continued From page 11 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 potential abuse allegations. This pertained to 1 of 6 sample clients (Clients #2) reviewed during investigations #74216-M, #75128-M and #74088-A. Finding follows: Refer to W127, W153, and W155 for additional information. Record review revealed the following: a. Residential Living Assistant (RLA) A's employee chronology. An entry by the Program Coordinator (PC) dated 2/2/18 indicated, "(RLA A) told me earlier this week that if you slap (Client #7's) hands, (he/she) stops picking. I asked her to define slapping (and) she said just play, not hard, she then swatted me softly. I told her (at) no time may we "playfully swat or hit" anyone. I explained that it can be misinterpreted (and) the person may think hitting is OK. She said she understood." b. No facility investigation could be located. c. Facility child and dependent adult abuse policy dated 7/16/15. The policy indicated, "Upon receiving a report of an alleged incident of abuse the HCBS Coordinator or Administrator shall immediately initiate an investigation. The Coordinator or Administrator shall immediately separate the victim and the accused abuser and	W 154		

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W 154	Continued From page 12 maintain the separation until the abuse investigation is completed. At the discretion of the administrator or designee, separation may include relocation to another building/location or suspension from employment. "Investigation" includes both the internal agency investigation and the investigation which may be conducted by DHS or DIA. The HCBS Coordinator or ICF/Administrator shall document the facts of the investigation and the administrative actions that have or may be taken. An injury report (ICF/ID) or incident report (HCBS) shall be filled out. The internal investigation shall be completed in five working days, and in no way will the internal investigation impede or interfere with the DHS/DIA investigation." When interviewed on 3/21/18 at 3:00 p.m., RLA A reported an incident with Client #2. She stated Client #2 had a sore on his/her buttocks and she assisted with his/her dressing change. Client #2 turned towards her and RLA A's right hand rested on Client #2's right forearm. Client #2 tried to bite RLA A's hand and as a "knee jerk reaction," she hit Client #2 on the hand. According to RLA A, she did not intend to hurt him/her. As RLA A hit Client #2, she stated, "no, don't do that." Client #2 replied, "Don't do that." RLA A told Client #2 he/she was right and she was sorry. RLA A stated she distracted Client #2 enough for the nurse to apply the new dressing. According to RLA A, she continually asked Client #2 if he/she was OK and he/she replied he/she was fine. RLA A stated Client #2 did not have any injuries. RLA A could not remember who else was in the room, but there was a nurse and another staff. When interviewed on 3/19/18 at 9:30 p.m., First Shift Supervisor A reported on 2/6/18, the PC	W 154		

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	16G017	A. BUILDING _____ B. WING _____	C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE HOMES	5945 MORNINGSIDE AVENUE SIOUX CITY, IA 51106

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W 154	Continued From page 13 informed her about an incident with Client #2. RLA A stated she swatted Client #2's hand after he/she tried to bite her. First Shift Supervisor A was unaware of the date of the incident. When interviewed on 3/20/18 at 9:45 a.m., RLA B reported on 1/24/18, RLA B and RLA A assisted the nurse with Client #2's treatment. Client #2 rolled on his/her left side and he/she tried to bite RLA A. RLA A told RLA B she swatted Client #2 because he/she tried to bite. RLA B did not see or hear RLA A swat at Client #2. RLA B stated RLA A was close to Client #2's head and RLA B was at his/her hips. RLA B informed RLA A to document the behavior, but she did not. According to RLA B, RLA A talked to the PC the next day about swatting Client #2. RLA B stated RLA A also told the PIA (Physical Intervention Alternative) trainers about the incident. RLA B explained when Client #2 tried to bite or aggress they block him/her. RLA B did not report the incident, but stated she would report right away if she witnessed it. RLA B also stated they have busy days and sometimes forget or run out of time. When interviewed on 3/20/18 at 10:20 a.m., the PC reported RLA A had problems with redirection. The PC could not remember the date, but prior to 2/6/18, she talked to RLA A about swatting clients. According to the PC, Client #7 picked at his/her skin. RLA A stated if she swatted or smacked Client #7's hand he/she might stop picking. The PC did not think RLA A smacked Client #7's hand. The PC reported RLA A informed the PC how she playfully slapped Client #2 because he/she tried to bite her. The PC stated Client #2 had regularly scheduled dressing changes on a sore on his/her coccyx. Client #2, at times, was not cooperative	W 154		

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W 154	Continued From page 14 with the dressing changes; he/she grabbed and pinched. The PC stated humor helped with Client #2. Talking or thinking about other things helped redirect Client #2. When interviewed by the PC, RLA B did not know RLA A slapped Client #2. According to the PC, if RLA B witnessed RLA A slap Client #2, she would report it. The PC was unsure if RLA B reported RLA A's admission to slapping Client #2. The PC could not recall who administered Client #2's treatment the day RLA A slapped him/her, nor did she remember interviewing the nurse. The PC stated RLA A demonstrated how she brushed her hand against Client #2's arm. In the PC's opinion, she felt RLA A's action was not abusive and she felt she handled it appropriately. The PC did not interview or talk to Client #2 about the incident until after a potential abuse incident occurred with Client #1, when she asked Client #2 if anyone hit him/her. When interviewed on 3/22/18 at 11:00 a.m., the Administrator acknowledged the facility failed to conduct a thorough investigation into alleged abuse towards Client #2.	W 154		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to prevent further abuse while investigating an allegation of abuse. Due to the lack of thorough investigations, the facility failed to keep clients safe from reoccurring abuse. This affected 1 of 6 sample clients (Client #1)	W 155		

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W 155	Continued From page 15 reviewed during investigations #74216-M, #75128-M, and #74088-A. Finding follows: Refer to W127, W153, and W154 for additional information. 1. Record review revealed Residential Living Assistant (RLA) A's employee chronology. An entry by the Program Coordinator (PC) dated 2/2/18 indicated, "(RLA A) told me earlier this week that if you slap (Client #7's) hands, (he/she) stops picking. I asked her to define slapping (and) she said just play, not hard, she then swatted me softly. I told her (at) no time may we "playfully swat or hit" anyone. I explained that it can be misinterpreted (and) the person may think hitting is OK. She said she understood." Additional record review revealed no facility investigation could be located. When interviewed on 3/21/18 at 3:00 p.m., RLA A reported an incident with Client #2. She stated Client #2 had a sore on his/her buttocks and she assisted with his/her dressing change. Client #2 turned towards her and RLA A's right hand rested on Client #2's right forearm. Client #2 tried to bite RLA A's hand and as a "knee jerk reaction," she hit Client #2 on the hand. According to RLA A, she did not intend to hurt him/her. As RLA A hit Client #2, she stated, "no, don't do that." Client #2 replied, "Don't do that." RLA A told Client #2 he/she was right and she was sorry. RLA A stated she distracted Client #2 enough for the nurse to apply the new dressing. According to RLA A, she continually asked Client #2 if he/she was OK and he/she replied he/she was fine. RLA A stated Client #2 did not have any injuries. RLA A could not remember who else was in the room,	W 155		

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W 155	Continued From page 16 but there was a nurse and another staff. When interviewed on 3/20/18 at 9:45 a.m., RLA B reported on 1/24/18, RLA B and RLA A assisted the nurse with Client #2's treatment. Client #2 rolled on his/her left side and he/she tried to bite RLA A. RLA A told RLA B she swatted Client #2 because he/she tried to bite. RLA B did not see or hear RLA A swat at Client #2. RLA B stated RLA A was close to Client #2's head and RLA B was at his/her hips. RLA B informed RLA A to document the behavior, but she did not. According to RLA B, RLA A talked to the PC the next day about swatting Client #2. RLA B stated RLA A also told the PIA (Physical Intervention Alternative) trainers about the incident. RLA B explained when Client #2 tried to bite or aggress they block him/her. RLA B did not report the incident, but stated she would report right away if she witnessed it. RLA B also stated they have busy days and sometimes forget or run out of time. When interviewed on 3/20/18 at 10:20 a.m., the PC reported RLA A had problems with redirection. The PC could not remember the date, but prior to 2/6/18, she talked to RLA A about swatting clients. According to the PC, Client #7 picked at his/her skin. RLA A stated if she swatted or smacked Client #7's hand he/she might stop picking. The PC did not think RLA A smacked Client #7's hand. The PC reported RLA A informed the PC how she playfully slapped Client #2 because he/she tried to bite her. The PC stated Client #2 had regularly scheduled dressing changes on a sore on his/her coccyx. Client #2, at times, was not cooperative with the dressing changes; he/she grabbed and pinched. The PC stated humor helped with Client #2. Talking or thinking about other things helped	W 155		

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W 155	Continued From page 17	W 155		

redirect Client #2. When interviewed by the PC, RLA B did not know RLA A slapped Client #2. According to the PC, if RLA B witnessed RLA A slap Client #2, she would report it. The PC was unsure if RLA B reported RLA A's admission to slapping Client #2. The PC could not recall who administered Client #2's treatment the day RLA A slapped him/her, nor did she remember interviewing the nurse. The PC stated RLA A demonstrated how she brushed her hand against Client #2's arm. In the PC's opinion, she felt RLA A's action was not abusive and she felt she handled it appropriately. The PC did not interview or talk to Client #2 about the incident until after a potential abuse incident occurred with Client #1, when she asked Client #2 if anyone hit him/her.

2. Record review revealed Client #1's Injury Report dated 2/6/18, indicated, "(Licensed Practical Nurse (LPN) A) was walking into the living room when she heard (Resident Living Assistant (RLA) A) smack (Client #1's) hand. When asked what that noise was and what (happened), she admitted she smacked (Client #1's) hand. (LPN A) stated she didn't see what hand she smacked."

When interviewed on 3/20/18 at 8:50 a.m., LPN A reported on 2/6/18 at approximately 6:30 a.m. to 7:00 a.m., she walked from the medication room to use the restroom. As she approached the dining room and living room area, she heard a smack or slap noise. LPN A remembered Client #1 and RLA A were the only two in the living room at that time. LPN A asked RLA A what the noise was. RLA A stated she slapped him/her because he/she kept taking off his/her oxygen. LPN A told RLA A, she could not do that. RLA A did not respond. LPN A reported the incident to First

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W 155	Continued From page 18 Shift Supervisor. LPN A took Client #1 into the dining room for either his/her feeding or a breathing treatment. She completed a skin assessment for injuries. LPN A found a scratch on the back of his/her hand, but no red area. LPN A described the scratch as possibly a day old and almost sealed. The scratch was not bleeding. When interviewed on 3/21/18 at 3:00 p.m., RLA A reported on 2/6/18 she stood in the living room and watched clients. She stated she turned to document on where clients were and what they were doing. RLA A remembered a couple clients in the living room, but she could not remember who they were. She stated the client's accountability sheets would contain that information. RLA A stood less than an arm's length away from Client #1. He/she faced the opposite direction as her, but she could see him/her out of the corner of her eye. Client #1 reached for his/her tubing with the backside of his/her hand against his/her face. According to RLA A, she moved her hand over to block and redirect Client #1's hand down. RLA A stated she hit the back of his/her hand just right to make a clap sound. She did not mean to hit him/her. She stated her right hand made contact with his/her right hand. LPN A asked what the noise was and RLA A responded she swatted Client #1. LPN A stated she wished she did not say that. The PC sent her home. Record review revealed facility policy dated 7/16/15, indicated, "The Coordinator or Administrator shall immediately separate the victim and the accused abuser and maintain the separation until the abuse investigation is completed. At the discretion of the administrator	W 155		

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W 155	Continued From page 19 or designee, separation may include relocation to another building/location or suspension from employment." When interviewed on 4/19/18 at 11/15 a.m., the Administrator acknowledged the facility failed to thoroughly investigate the incident on 1/24/18, separate the alleged perpetrator from the victim, and prevent the reoccurrence of abuse.	W 155		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure clients received needed supports and services as outlined in the Individual Support Plan (ISP). This affected 1 of 6 sample client (Client #1) reviewed during investigations #74216-M, #75128-M and #74088-A. Finding follows: Intermittent observations on 3/21/18 from 8:57 a.m. to 11:35 a.m. revealed Client #1 continuously tried and succeeded in removing his/her oxygen tube. Facility staff attempted to keep Client #1 involved in activity. The activity included looking at a book, rubbing lotion on	W 249		

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W 249	Continued From page 20 his/her hands, crafts, sign language, and talking about his/her day. Each time Client #1 removed his/her oxygen tube, facility staff placed the tube back on without drawing attention to it. Redirection from the tube included moving Client #1's hand down and to an activity, moving his/her hand down without engaging in activity, holding Client #1's hand down, placing their arm over his/her hands to restrict movement, and holding an open hand in front of Client #1's face to prevent him/her from touching the tube. Observations on 3/22/18 from 9:02 a.m. to 9:12 a.m. revealed Client #1 continuously tried and succeeded in removing his/her oxygen tube. Each time Client #1 removed his/her oxygen tube, facility staff placed the tube back on without offering another activity. As Client #1 continued to remove his/her tubing, facility staff lengthened the amount of time it took to replace the tube by providing interaction with other clients in the room. At 9:12 a.m., Client #1 immediately took the tubing off after staff replaced it. At 9:14 a.m., after two minutes, facility staff replaced the tube. From 9:14 a.m. to 9:33 a.m., Client #1 continued to take his/her oxygen tube off immediately after staff replaced it. At 9:33 a.m., Client #1's staff asked for a break and another staff took over. At 9:34 a.m. to 9:45 a.m., Second Shift Supervisor A sat with Client #1. Client #1 held Second Shift Supervisor A's hand, he sang to Client #1, and he kept Client #1's hands busy with his/her turtle and bells. When Client #1 moved his/her hand towards the tube, Second Shift Supervisor A gently took Client #1's hand and moved it to an activity. Record review revealed Client #1's Individual Program Plan dated 3/9/18, indicated, "(Client #1)	W 249		

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W 249	Continued From page 21 should have (his/her) tray on (his/her) wheelchair at all times and a sensory item available for (him/her) to manipulate. (He/she) should be included in an activity at every opportunity. (He/she) enjoys playing ball, singing, dancing, conversation, silliness. (Client #1) will be involved in as many activities as possible ..." "(Client #1) may yell for attention. Staff will not directly tell (Client #1) to stop yelling but will attempt to interest (him/her) in the activity/task (he/she) is to be involved in ..." " ...If at home, the quiet area will be (his/her) bedroom with the TV or radio playing quietly, door open, and staff remaining with (him/her) for 3 minutes. Staff will not interact with (him/her) other than to redirect (him/her) from removing (his/her) oxygen. They will use physical prompts and blocking. They will not use any verbal prompts. After 3 minutes, he will return to the activity/task ..." "(Client #1) uses oxygen at all times. Staff will ensure that the oxygen is on (him/her) at all times. If (he/she) removes it from (his/her) face either partially or completely, staff will chart on the accountability card. They will replace the (cannula) or mask. If (Client #1) chews on the tubing or the mask, staff will also document that there was a PICA occurrence on the accountability card. They will seek assistance for the nursing staff to replace the damaged item." When interviewed on 3/22/18 at 11:00 a.m., the Administrator acknowledged the facility failed to follow Client #1's program by properly blocking and redirecting Client #1 from his/her oxygen tube.	W 249		

5/30/18 OK 5/29/18

May 10, 2018

Courage Homes

5945 Morningside Ave

Sioux City, IA 51106

Provider Number 16G017

Please accept this Plan of Correction:

Upon receipt of citation, all employees of Courage Homes had been re-trained on the Mandatory Reporting and Child/ Dependent Adult Abuse definitions and policies. Reporting instructions have been reviewed and posted in 2 areas of each house and at the facility's time clock. The following items have also been added to ensure compliance:

W-122 Mid-Step Services continues to have a Child and Dependent Adult Abuse Policy that is taught in initial training at our Main Office upon the start of employment and every 5 years thereafter. Mid-Step Services also trains new staff on the requirements of Mandatory Reporting. Courage Homes will also review/re-train these policies again with all new staff in their house orientation packets and at staff meetings at least quarterly. Mid Step Services has also developed a Member Rights Notification form that will be reviewed with each member at their annual IPP to ensure that individual rights are communicated to them.

Responsible: All Administrative Staff

Frequency: On-going

Target: April 30, 2018 (Upon receipt)

Mid-Step Services is also developing an ICF/ID reporting and investigation protocol for our manual to continue to ensure proper separation, investigation & reporting.

Responsible: All Administrative Staff

Frequency: On-going

Target: May 15, 2018

W-127 Mid-Step Services continues to have a Child and Dependent Adult Abuse Policy that is taught in initial training at our Main Office upon the start of employment and every 5 years thereafter. Mid-Step Services also trains new staff on the requirements of Mandatory Reporting. Courage Homes will also review/re-train these policies again, including the appropriate avenues of reporting allegations with all new staff in their house orientation packets and at staff meetings at least quarterly. Mid Step Services has also developed a Member Rights Notification form that will be reviewed with each member at their annual IPP to ensure that individual rights are communicated to them.

Responsible: All Administrative Staff

Frequency: On-going

Target: April 30, 2018 (Upon receipt)

Mid-Step Services is also developing an ICF/ID reporting and investigation protocol for our manual to continue to ensure proper separation, investigation & reporting.

Responsible: All Administrative staff

Frequency: On-going

Target: May 15, 2018

W-153 Mid-Step Services will continue to teach the Mandatory Reporting requirements and our Child and Dependent Adult Abuse Policy in new staff initial orientation, in the house orientation packet and at least quarterly in staff meetings. Mid Step Services also will follow the Policy of Injury Reports of unknown origins to notify administrative staff and begin an investigation. Brightly colored signs are posted at Courage Home's time clock, at each nurse's station and each break room to notify all staff of an administrative staff to make the report of allegations to. There is also a checklist created for the Administrative Staff conducting the investigation to help ensure proper procedure is followed for separation, interview and notifications.

Responsible: All Administrative Staff

Frequency: On-going

Target: April 30, 2018 (Upon receipt)

Mid-Step Services is also developing an ICF/ID reporting and investigation protocol to continue to ensure all allegations of mistreatment, neglect or abuse are reported and investigated.

Responsible: All Administrative Staff

Frequency: On-going

Target: May 15, 2018

W-154 Mid Step Services will follow the Policy of Injury Reports of unknown origins to notify administrative staff and begin an investigation. Brightly colored signs are posted at Courage Homes' time clock, at each nurse's station and each break room to notify all staff of an administrative staff to make the report of allegations to. There is also a checklist created for the Administrative Staff conducting the investigation to help ensure proper procedure is followed for separation, interview and notifications.

Responsible: All Administrative Staff

Frequency: On-going

Target: April 30, 2018 (Upon receipt)

Mid-Step Services is developing an ICF/ID reporting and investigation protocol to continue to ensure all allegations of mistreatment, neglect or abuse are reported and investigated.

Responsible: All Administrative Staff

Frequency: On-going

Target: May 15, 2018

W-155 All staff have been re-trained on the definitions of Child and Dependent Adult Abuse and the requirements of Mandatory Reporting. There is a checklist created for the Administrative Staff conducting the investigation to help ensure proper procedure is followed for separation, interview and notifications.

Responsible: All Administrative Staff

Frequency: On-going

Target: April 30, 2018 (Upon receipt)

Mid-Step Services is developing an ICF/ID reporting and investigation protocol to continue to ensure all allegations of mistreatment, neglect or abuse are reported and investigated.

Responsible: All Administrative Staff

Frequency: On-going

Target: May 15, 2018

W-249 Active Treatment Observations and Program Compliance Observations will be completed weekly by the QIDP/PC of the house and turned in to the Administrator. Corrections or training will take place if needed at the time of the observations to ensure individual plans are followed.

Responsible: Administrator and QIDP/PC of the house

Frequency: On-going

Target: 4/30/18 (Upon receipt)

Traci Llanos, Administrator

5/10/18