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 10/22/2018

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 At the time of investigations 78051-M & 79110-I, a deficiency was cited at W153.	W 000		
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 established procedures. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility staff failed to immediately report alleged abuse/mistreatment of clients to the administrator/designee. This affected 4 of 4 sample clients (Clients #1-4). Findings follow: Record review revealed the following incident reports completed 10/4/18: a. A report for Client #1 described: " On 10/4/18 during an investigatory interview, (Resident Treatment Worker (RTW) B) reported he saw (RTW A) place (Client #1) in a chair. (RTW B) reported (RTW A) restricted (Client #1) from getting out of it by telling her not to get up. (RTW B) could not give a specific date when he saw (RTW A) perform this." b. A report for Client #2 described: "On 10/4/18 during an investigatory interview, (RTW B) reported he saw (Client #2) throw her plate on the floor. (RTW B) reported (RTW A) took (Client #2) out of her wheelchair and he placed her on the floor. (RTW B) reported (RTW A) made (Client	W 153		

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

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

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W 153	Continued From page 1	W 153		

#2) clean and pick up her mess on the floor. (RTW B) could not have a specific date of the incident."

c. A report for Client #3 described: "On 10/4/18 during an investigatory interview, (RTW E) reported she heard (RTW A) call Client #3 stupid and lazy. (RTW E) could not have a specific date of the incident."

Review of the facility policy on Incident Management revealed employees shall immediately report all incidents, including those that may be reported to the employee by a contractor or volunteer, verbally to the employee's direct line supervisor. If the incident is an allegation of abuse and involves the supervisor, the report shall be made to the supervisor's supervisor. The supervisor shall immediately review the incident to determine whether further action is needed to protect the individual. Such action may include separating the individual and the employee. The supervisor shall complete the Supervisor's section of the electronic incident report. The policy further stated each employee is a mandatory reporter. All mandatory reporters shall follow the above reporting requirements. The supervisor notified shall immediately notify the GRC Investigation Department of an allegation of suspected abuse, neglect, or exploitation for reporting to the Department of Inspections and Appeals and Department of Human Services where applicable.

When interviewed on 10/15/18 at 1 p.m. RTW B recalled an incident with Client #2. He stated she threw her plate during an evening meal and RTW

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W 153	Continued From page 2	W 153		

A physically removed her out of her wheelchair and placed her on the floor. RTW A told Client #2 she needed to clean up her mess. He stated this was not part of the Behavior Support Plan (BSP). RTW B stated staff witnessed the incident but did not do or say anything about it to a supervisor. RTW B further stated on 7/29/18 he witnessed RTW A verbally tell Client #1 she had to remain in a chair in the living room and when she attempted to get up her told her she needed to stay in the chair. RTW B confirmed he did not report the incidents and did not follow the Incident Management Policy.

When interviewed on 10/15/18 at 2 p.m. RTW C stated she witnessed RTW A insult the women who live at 467/472. She stated RTW A used profanity and be sarcastic and mean to the clients. She stated she also heard RTW A call Client #1 and Client #3 lazy and stupid. She stated she has heard RTW A belittle the women in 467/472. She did not have specific dates of the incidents. She confirmed she did not report to a supervisor or follow the incident management policy.

When interviewed on 10/15/18 at 3 p.m. RTW D stated she heard RTW A call Client #3 fat and lazy. RTW D further stated she witnessed RTW A force Client #2 out of her wheelchair and onto the floor to clean up her plate she had thrown on the floor sometime after Christmas the past year. He told her her she made the mess and needed to clean it up and they did not have enough food to do that. RTW D stated Client #2 began to cry and cleaned up the thrown plate. RTW stated she did not report the incident to her supervisors according to policy.

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W 153	Continued From page 3 When interviewed on 10/17/18 at 2:30 p.m. RTW E stated she heard RTW A be disrespectful towards clients, name call and belittle the clients at House 467/472. She said RTW A told Client #1 she was fat and lazy. He also called her a "piece of sh**." She further stated RTW A told Client #3 she was stupid and lazy. RTW A belittled and verbally made fun of Client #4 regarding her anxiety. She stated she reported the incidents to the TPM and complained about RTW A. She did not complete an incident report or any written documentation of the incidents. When interviewed on 9/18/18, 9/19/18 and 10/16/18 at 1:30 p.m. RTW A stated he redirected Client #1 from sitting in a recline chair she prefers in the living room of house 467/472. RTW A further stated Client #1 would get aggressive after falling asleep in the chair and was occasionally incontinent so he prevented her from sitting in that chair. He further admitted to getting Client #2 out of her wheelchair and onto the floor to clean up a plate of food she threw on the floor. He stated he prompted her to clean up her mess. When interviewed on 10/16/18 at 11:30 a.m., the Treatment Program Manager (TPM) and Residential Treatment Supervisor (RTS)confirmed the RTWs failed to report the incidents according to the Incident Management Policy.	W 153		