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 02/06/2019

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 The investigation of #80532-M and #80251-A was conducted 1/8/19 - 2/6/19. As a result, deficiencies were cited at W153 and W155.	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 interview and record review, the facility staff failed to immediately report an allegation of abuse to the supervisor, per facility policy. This affected 1 of 1 client (Client #1) involved in the investigation of #80532-M and #80251-A. Finding follows: Record review on 2/4/19 revealed a facility internal investigation, initiated 12/2/18. According to the internal investigation, on 12/2/18 Residential Living Assistant (RLA) A reported to Residential Supervisor (RS) A she observed RLA B slap Client #1 on the hand while RLA B yelled at Client #1 on 12/1/18 (Saturday). The investigation noted RLA A informed Residential Living Assistant 2 (RLA2) C of the allegation on 12/1/18 (Saturday) and RLA2 C instructed RLA A to report to the on-duty supervisor. RLA A failed to report the allegation to the on-duty supervisor on 12/1/18 (Saturday) and waited to report until	W 153		

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

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W 153	Continued From page 1 12/2/18 (Sunday) when RS A worked. Additional record review revealed intake information indicated the allegation was reported to the Department of Inspections and Appeals (DIA) on 12/3/18 (Monday) at 3:40 p.m. Additional record review revealed Client #1 was 23-years old and had resided at the facility since 12/15/09. Client #1 had diagnoses including severe intellectual disabilities, cerebral palsy, autism, seizure disorder, allergic rhinitis, bladder incontinence, bilateral hamstring release, and gingivitis. Client #1 utilized a gait trainer while ambulating around the facility and utilized a wheelchair for long distances. Client #1 had limited communication skills and primarily used one-word and vocalizations to communicate. Client #1 had an Individual Program Plan in place to display appropriate social responses throughout the day. The plan addressed target behaviors of physical aggression (biting, hitting, grabbing, pushing, scratching, head-butting staff or peers), self-injurious behavior (hitting parts of his body with his hand or hitting his head against objects), stuffing and dunking (placing items, other than the appropriate amount of toilet paper, in the toilet or sink and turning the water on), tearing (deliberately pulling apart and damaging articles of clothing, books/magazines, paper, and other items or apparel that is purposely torn), wetting (deliberately soiling his pants or intentionally pouring liquids on his clothing), and out of bounds (leaving the room he is occupying without the assistance of staff). Restrictive measures included the use of behavior modifying medications (Thorazine, Naltrexone, Lorazepam, Seroquel, Trazadone, Trileptal, and Prozac), a wheelchair seatbelt lock, restricted access to his	W 153		

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W 153	Continued From page 2 bathroom, a bedroom door alarm, his clothes were kept in another area outside of his bedroom, the night stand removed from his bedroom, the use of a helmet, and a clasp was placed on a Rubbermaid Cabinet which contained toilet paper, the towel rack, paper towel dispenser, and the soap dispenser from his bathroom. Client #1's bedroom was modified to have tile flooring. Review of facility policy titled "Mid-Step Services Inc. Child and Dependent Adult Abuse Policy," last revised 8/2/17, instructed all employees were required to report any abuse immediately after it occurred, or they became aware of the incident, to the supervisor/administrative officer. When interviewed on 2/4/19 at 1:55 p.m., the Administrator (Ad) confirmed RLA A failed to immediately report the allegation of abuse to the on-duty supervisor. The Ad explained the reporting procedures were reviewed at each monthly staff meeting and the facility had signs posted throughout with the reporting procedure. When interviewed on 2/6/19 at 10:25 a.m., RLA A reported on 12/1/18 she witnessed RLA B slap Client #1 on the top of the hand twice as RLA B was yelled at Client #1. RLA A said she went to the nurse's station and told RLA2 C about the incident and RLA2 C told her to write a statement. RLA A stated the only supervisor who was on-duty was the dietary supervisor so she waited until 12/2/18 and reported the allegation to RS A, the house supervisor.	W 153		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse	W 155		

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W 155	Continued From page 3 while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure continued separation between the client and alleged perpetrator following an allegation of abuse. This affected 1 of 1 client (Client #1) involved in the investigation of #80532-M and #80251-A. Finding follows: Record review on 2/4/19 revealed a facility internal investigation, initiated 12/2/18. According to the investigation, on 12/2/18 Residential Living Assistant (RLA) A reported to Residential Supervisor (RS) A she witnessed RLA B slap Client #1 on the hand while RLA B was yelling at him. The investigation noted RLA B was sent home on 12/2/18 following the allegation being reported. When interviewed on 2/5/19 at 9:20 a.m., Residential Living Assistant 2 (RLA2) C reported on 12/1/18 RLA A told her she witnessed RLA B slap Client #1 on the hand two times; RLA2 C said she instructed RLA A to report to the on-duty supervisor. RLA2 C stated she was in the nurse's station when RLA A told her of the allegation and then she heard RLA B yell at Client #1 in the dining room. RLA2 C said she initially told RLA B to stop but RLA B continued to yell at Client #1. RLA2 C reported she went to the dining room and told RLA B to leave the area and RLA B walked away. RLA2 C stated on 12/2/18, RS A was informed of the allegation and RLA B was sent home. RLA2 C stated RLA B returned to work and had contact with Client #1 until the facility was informed the Department of Inspections and Appeals (DIA) would be investigating the	W 155		

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W 155	Continued From page 4	W 155		

allegation. RLA2 C said RLA B was then moved to work in a different house, away from Client #1.

When interviewed on 2/5/19 at 10:15 a.m., RS A reported on 12/2/18 RLA A reported she witnessed RLA B slap Client #1 on the hand as she yelled at him. RS A said she immediately initiated an internal investigation and after speaking to RLA B, she sent RLA B home. RS A stated RLA B was allowed to return to work following the internal investigation. She explained RLA B worked in House #1 where Client #1 resided but was instructed not to have contact with Client #1 until she was retrained on Physical Intervention Alternatives, the facility behavior management system. RS A confirmed after the facility was served notice the DIA would be investigating the allegation, RLA B was moved to House #3 to ensure she did not have any contact with Client #1.

Additional record review on 2/5/19 revealed staff schedules dated 12/1/18 - 2/5/19. According to the schedules, RLA B was responsible to assist Client #1 with getting up and his morning routine on 12/23/18 and 1/3/19. The schedules revealed RLA B was moved to work in House #3 on 1/8/19 after the facility received notice the allegation would be investigated by the DIA.
Review of facility policy titled "Mid-Step Services Inc. Child and Dependent Adult Abuse Policy," last reviewed 8/2/17, instructed the alleged abuser was to be separated from the victim until the abuse investigation was completed. The policy noted the investigation included both the internal investigation and any investigation which may be conducted by the DIA.

When interviewed on 2/5/19 at 11:05 a.m., the

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W 155	Continued From page 5 Administrator (Ad) confirmed RLA B had accountability to assist Client #1 with getting up on two occasions following the reported allegation. She said it was unclear if RLA B had any other contact with Client #1 because all staff were to assist all clients after their morning routines are completed. The Ad said she assumed RS A knew RLA B was not to have contact with Client #1 but could not recall if she specifically stated this. When interviewed on 2/6/19 at 1:35 p.m., RLA B reported she returned to work on 12/9/18 in House #1. RLA B stated it was discussed she would not work with Client #1 until things with the other staff calmed down. RLA B confirmed she was assigned to assist Client #1 to get up and complete his morning routine on two occasions after she returned to work. She stated on 1/8/19 she was moved to work in House #3.	W 155		