STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

(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 During Investigation # 81267-I, a deficiency was cited at W193.	W 000		
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interviews, and record review, the facility failed to ensure staff consistently demonstrated skills and techniques necessary to provide behavior management as identified per a Client's Behavior Support Plan. This affected 1 of 1 client involved in Investigation #81267-I (Client #1). Findings follow: Record review revealed the following: a. According to the Facility's Incident Report, written by Residential Treatment Worker (RTW) A, dated 1/4/19 at 8:31 a.m., she got Client #1 up and noticed him drooling a lot. RTW A reported she dressed Client #1 and took him to the medication room. She stated the Client was having trouble swallowing his medications, saw something green in his mouth and pulled out a plastic object approximately two inches long. RTW A responded by notifying the Residential Treatment Supervisor (RTS) and Nurse. The Incident Report noted no injury to Client #1. b. According to the Facility's Nursing Assessment, completed by the covering LPN on 1/4/19 at 9:00 a.m., "S (subjective): Staff called to	W 193	See attached pac 5/1/19	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

(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 193	Continued From page 1 report that Client #1 was having trouble swallowing his meds, they saw something green in his mouth and pulled out a plastic object. Client #1 was able to take his meds and eat breakfast after without difficulty). O (objective): Client #1 is sitting in a chair in the TV room. Nos/s of distress noted. No coughing or nasal discharge noted. Breath sounds clear. Lungs clear. Abdomen is soft. Bowel sounds active. Shows no s/s of pain or discomfort. A (assessment): Object found in mouth. P (plan): Dr. notified. No new orders. Continue with plan of care. Staff to report any changes or concerns. c. A review of Client #1's ID Sheet revealed he was 35 years old and admitted to the Facility on 6/26/2006. Client #1's diagnoses included: severe intellectual disability, post-traumatic stress disorder, PICA (ingestion of inedibles) in adults, autism spectrum disorder. History: foreign body removal and colostomy placement 2011, bowel resection and foreign body removal 11/2015. Review of Client #1's Behavior Support Plan (BSP), implemented 9/7/2018, indicated Client #1 required 1:1 supervision due to his PICA and risk of choking. Client #1's assigned staff should be within two arm's length and be able to visually observe. The BSP indicated the following environmental needs: locked sensory cabinets in his bedroom (included locked drawer on his bedside table and protection of electoral cord in a wall outlet). Restricted access to the key to his safe and snack box due to PICA. Locked bedroom door from the outside (but not the inside) to prevent others from gaining access to his bedroom. The BSP further indicated twice per shift (on a.m. and p.m. shifts), staff assigned to Client #1 would complete the PICA sweeps in	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

(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 193	Continued From page 2 Client #1's bedroom and living room areas. At the beginning of the third shift, staff should complete a PICA sweep in Client #1's bedroom. Further review of the BSP revealed, as much as possible, staff should keep inedible items that client #1 could ingest out of his reach and sight. As often as possible, familiar staff should work with Client #1 so that he felt more comfortable. The BSP directed the following for attempted/actual PICA: i f he started to move an object towards his face staff should ask him to put it down and offer him suggestions of what he could be doing instead. At the same time, if needed, staff should block by physically guiding his hand away from the object. If he had an inedible in his mouth, staff should ask him to spit out the item in the trash or toilet. In an interview, on 2/26/19, at 10:00 a.m. , RTW A revealed on 1/4/19 at approximately 5:45 a.m., she arrived at 109 Franklin and was assigned to Client #1. She added he slept in his bed when she arrived to relieve the Noc staff working with Client #1. RTW A recalled that morning 1/4/19 when she relieved the Noc staff, staff reported nothing unusual occurred with Client #1 that night. RTW A pointed out when she entered the client's room she searched his room, for potential PICA items (per his BSP), and found no items. RTW A said at approximately 8:00 a.m. she awoke Client #1 and noticed him salivating excessively. She explained she told the client to swallow; however, he continued to salivate. She added Client #1 tended to salivate; however, that morning he salivated more than usual. According to RTW A, she then took Client #1 to the bathroom, dressed him and went to the medication office, where he was to receive his	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

(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 193	Continued From page 3	W 193		

medication. She mentioned she was with the client, and RTW B was administered medications to him. RTW A remarked Client #1 would not swallow his medications; she looked in his mouth, saw a green peg and took it out of his mouth. She described the green peg as being approximately three inches long. She said the peg belonged to a client who lived on the other side of the home, nowhere near Client #1's room or area where he usually remained while in the home. RTW A indicated, prior to the finding the peg in his mouth, she remained at arm's length with Client #1 at all times.

RTW A said she was trained on Client #1's PICA BSP. She noted the client required 1:1 staff supervision and staff were to be within two arm's length with him at all times. When describing Client #1's PICA behavior, RTW A stated he went after items on the ground all the times. She added staff could turn away from him for a second and he would attempt to PICA. RTW A also noted lately there had been many relief staff working at 109 Franklin.

In an interview, on 2/26/19, at 10:30 a.m., RTW B stated when he started the morning shift; he was assigned to work on the side where Client #1 lived. He noted when he walked by the client's room he saw the client sleeping in his room, with staff near him. According to RTW B at approximately 8:00 a.m. he passed medications at 109 Franklin. RTW A and Client #1 came to the medication office to receive the client's medications. He noted the client sat in a chair in the medication room. RTW B administered the client's medications and he spit out a pill. RTW B recalled he gave Client #1 water and the client would not swallow. He said he looked into the client's mouth and saw a green peg. RTW B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

(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 193	Continued From page 4	W 193		

reported RTW A then took the peg from the client's mouth. RTW B noted he was familiar with the green peg as he had seen another client with the pegs. He pointed out the client lived on the other side of the home, far from Client #1 bedroom.
RTW B described Client #1's PICA behavior as "the whole day, he is trying to get something in his mouth." He noted when Client #1 attempted PICA; he was quick to get something from the ground and took advantage of new staff. He explained new staff may not have been as experienced in working with Client #1 and were not as familiar with his PICA behaviors.

In an interview, on 2/28/19, at 5:20 a.m., RTW C stated she arrived to work at 109 Franklin at approximately 10:00 p.m. She said she was assigned to work with Client #1, who required 1:1 supervision. She said Client #1 sat in a chair in the living room on "left side of the home," with the p.m. staff assigned to him. She recalled the client had a leisure item with him. She reported she, the p.m. staff, and Client #1 went to a cabinet in dining room and put away the leisure item in the cabinet. RTW C pointed out they went to Client #1's bedroom, the client undressed and went to bed. According to RTW C she sat in a chair next to Client #1 in a rocking chair the whole night. She pointed out Client #1 never got out of his bed during the whole shift. She mentioned the only time she got up from the chair was approximately 5:00 a.m. to go to the bathroom. RTW C explained another staff relieved her at that time and she was only away for the time it took to go to the bathroom. She said at approximately 5:45 a.m., a first shift staff came in the bedroom said she could leave the home. RTW C offered she did not usually work at 109

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

(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 193	Continued From page 5 Franklin; however she was familiar with Client #1 and worked with him prior to 1/4/19. She thought she had been trained on his PICA BSP, but the training had been a long time ago. She added she was comfortable working with the Client #1 as she had plenty of experience in working with clients with PICA behaviors. RTW C clarified she did not notice Client #1 salivating that night. She was shown the green peg and stated she had never seen the peg prior to it being shown to her during the facility's investigation of the incident and had no idea how the client obtained the peg. RTW C acknowledged she was trained on Client #1's ISP and BSP on 2/25/19. In an interview, on 2/28/19, at 5:35 a.m., RTW D stated she normally worked at 201 Cedar; however she was relieving at 109 Franklin from 6:00 p.m. to 10:00 p.m. on 1/3/19. She said she was assigned to Client #1 who required 1:1 supervision. She recalled when she came to work with Client #1, he sat in a chair in the living area. She remembered they sat in the area until it was time to take the client's medications. She noted the client took his medication, at approximately 8:50 p.m.; they went down to his bedroom, got his pajamas and went to the bathroom where he showered and brushed his teeth. According to RTW D she and Client #1 went back to the living room and sat there until the Noc shift staff arrived at the home. RTW D offered she took no breaks from 6:00 p.m. to 10:00 p.m. and Client #1 was at her arm's length at all times. She was shown the green peg and stated she had never seen the peg prior to it being shown to her during the facility's investigation of the incident and had no idea how the client obtained the peg. RTW D acknowledged she had not been trained on Client #1's PICA BSP until she was trained on his ISP	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

(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 193	Continued From page 6 and BSP on 2/25/19. In an interview, on 2/26/19, at 12:05 p.m., the Residential Treatment Supervisor (RTS) for 109 Franklin stated she witnessed RTW B give Client #1 his medications on the 1/4/19 a.m. shift. She recalled RTW A bringing the client to the medication room where she saw the client receive his medications. She remembered seeing a green peg on his tongue and RTW A taking it out of his mouth. The RTS noted she was familiar with the green peg as the peg belonged to a client whose bedroom was on the opposite side of client #1's bedroom. She mentioned Client #1 rarely went to that opposite side of the home. The RTS described Client #1's PICA behavior as being "quick." She explained that Client #1 would watch his 1:1 staff and if they turned away from him he would immediately go to the ground and attempt PICA. The RTS reported she had no idea how Client #1 obtained the peg. A review of the Facility's training sheets, on 2/28/19, for Client #1 revealed RTW C and RTW D did not receive training on the Client's ISP and BSP, until 2/25/19.	W 193		

OK 5/21/19

Woodward Resource Center (WRC)
Standard Level Plan of Correction for DIA Investigation #81267-I
Tag W-193 – Staff Training Program – CFR(s): 483.430(e)(3): Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

On January 04, 2019, RTW A noticed Client 1 was drooling more than usual when he/she assisted him/her with getting up and dressed for the day. RTW A then assisted Client 1 to the medication room and noticed Client 1 was having trouble swallowing his/her medications. RTW A then noticed something green in Client 1's mouth and pulled out a plastic object approximately 2 inches long. The incident was immediately reported to the Resident Treatment Supervisor and to the RN. On January 04, 2019, the RTS immediately separated RTW A from Client 1 and reported the incident to the Quality Assurance Coordinator. The RN immediately assessed Client 1 for injuries. There were no injuries associated with this attempted PICA incident and no medical attention was required. Following report, an internal investigation was initiated and report was made to DIA. It was determined that the plastic piece was from another Client's activity box that was stored on the other side of the house. It was not determined how Client A was able to obtain the activity piece.

WRC's internal investigation did not find abuse. Through WRC's internal investigation and WRC's Incident Review Committee an issue was identified with RTW C and RTW D not being trained on Client 1's Behavior Support Plan.

Staff regularly assigned to work with Client 1 had been trained on Client 1's Behavior Support Plan; RTW C and RTW D were not regularly assigned to work with Client 1, but they were both familiar with Client 1 and his/her PICA protocol.

DIA found the facility failed to ensure staff consistently demonstrated skills and techniques necessary to provide behavior management as identified per a Client's Behavior Support Plan.

Individual response

On February 25, 2019, Resident Treatment Worker C and Resident Treatment Worker D were trained on Client 1's Behavior Support Plan.

Responsible: Assistant Superintendent
Date completed: February 25, 2019

Systemic response

WRC will continue to provide competency-based training and monitor employees to enable them to perform their duties effectively, efficiently, and competently.

Responsible: Superintendent
Date completed: February 25, 2019, and on-going

5/15/19

A training component has been added to routine core meetings to review the status of BSP training to ensure staff are trained. Treatment Program Managers are sending minutes to the Treatment Program Administrators to monitor for compliance.

Responsible: Assistant Superintendent
Date completed: May 1, 2019, and on-going

OK
5/21/19

Woodward Resource Center (WRC)
Citation Level Plan of Correction for DIA Investigation FC#6950
Tag W-193 – Staff Training Program – CFR(s): 483.430(e)(3): Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

On January 04, 2019, RTW A noticed Client 1 was drooling more than usual when he/she assisted him/her with getting up and dressed for the day. RTW A then assisted Client 1 to the medication room and noticed Client 1 was having trouble swallowing his/her medications. RTW A then noticed something green in Client 1's mouth and pulled out a plastic object approximately 2 inches long. The incident was immediately reported to the Resident Treatment Supervisor and to the RN. On January 04, 2019, the RTS immediately separated RTW A from Client 1 and reported the incident to the Quality Assurance Coordinator. The RN immediately assessed Client 1 for injuries. There were no injuries associated with this attempted PICA incident and no medical attention was required. Following report, an internal investigation was initiated and report was made to DIA. It was determined that the plastic piece was from another Client's activity box that was stored on the other side of the house. It was not determined how Client A was able to obtain the activity piece.

WRC's internal investigation did not find abuse. Through WRC's internal investigation and WRC's Incident Review Committee an issue was identified with RTW C and RTW D not being trained on Client 1's Behavior Support Plan.

Staff regularly assigned to work with Client 1 had been trained on Client 1's Behavior Support Plan; RTW C and RTW D were not regularly assigned to work with Client 1, but they were both familiar with Client 1 and his/her PICA protocol.

DIA found the facility failed to ensure staff consistently demonstrated skills and techniques necessary to provide behavior management as identified per a Client's Behavior Support Plan.

Individual response

On February 25, 2019, Resident Treatment Worker C and Resident Treatment Worker D were trained on Client 1's Behavior Support Plan.

Responsible: Assistant Superintendent
Date completed: February 25, 2019

Systemic response

WRC will continue to provide competency-based training and monitor employees to enable them to perform their duties effectively, efficiently, and competently.

Responsible: Superintendent
Date completed: February 25, 2019, and on-going

6/5/19

A training component has been added to routine core meetings to review the status of BSP training to ensure staff are trained. Treatment Program Managers are sending minutes to the Treatment Program Administrators to monitor for compliance.

Responsible: Assistant Superintendent
Date completed: May 1, 2019, and on-going