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 05/01/2019

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 The investigation of #82557-I resulted in deficiencies cited at W153, W155 and W267. The investigation of #82769-C resulted in a deficiency cited at W227.	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 failed to ensure staff immediately reported all allegations of abuse, in accordance with facility policy. This affected 1 of 1 sample client identified during the investigation of #82557-I (Client #1). Finding follows: 1. Record review of facility investigations and Incident Reports revealed Client #1 involved in various behavior management incidents on the overnight shift of 3/21/19 (approximately 1:00 a.m. to 3:00 a.m.). Client #1 became upset and called 911. Other staff arrived to assist with the situation. A short time after the ambulance and police arrived, Resident Treatment Supervisor (RTS) A arrived to provide assistance. Client #1 saw him and said he hit her, so RTS A left. The Administrator on Duty (AOD), Resident Treatment Worker (RTW) A, RTW B and RTW C all said they heard Client #1 make the allegation RTS A	W 153		

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

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 05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 153	Continued From page 1	W 153		

hit her. Client #1 continued to be upset and left her house at approximately 1:00 a.m., wearing shorts, a T-shirt and nothing on her feet. Staff followed Client #1 and tried to convince her to return to the house. Client #1 walked off the campus grounds and ended up near a ravine with a flooded creek at the bottom. Client #1 indicated she wanted to end her life and threatened to jump into the ravine. Several staff and a police officer blocked Client #1 and were able to convince her to return to the house, uninjured. Client #1 continued to be upset at the house and became aggressive toward the staff as the night went on.

After returning to the house on the overnight of 3/21/19, Client #1 took a bath. She pulled off or broke the faucet so the water could not be turned off. Client #1 plugged the tub drain with a washcloth. Staff reminded Client #1 that bathing was not good for a medical condition she was dealing with and told her she should only stay in the tub for a short time. While in the bathroom, RTW A and RTW B heard Client #1 allege that RTA B hit Client #1. RTW B reported the allegation to RTS B and RTS C, but was told to continued working with Client #1. After a period of time, RTA B told Client #1 it was time to get out of the tub and the RTW removed the washcloth from the drain. Client #1 tried to plug the drain again with some clothing items and RTW B tried to prevent her from doing this. Client #1 reportedly grabbed RTW B by the hair as she yanked the staff person's head. RTW A tried to intervene and also had her hair pulled. Other staff were able to separate the two staff from Client #1, but Client #1 got out of the tub and went to the hall to continue to aggress toward RTW A. Staff intervened and put Client #1 into a two minute hold on the floor due to continued

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 05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD RESOURCE CENTER	711 SOUTH VINE STREET GLENWOOD, IA 51534

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W 153	Continued From page 2	W 153		

aggression. During the hold or shortly after her release, Client #1 said RTW A and RTW B pulled her hair in the bathroom before she pulled their hair. Client #1 told the AOD that RTW A and RTW B pulled her hair. Other staff in the area also heard the allegation. RTW A and RTW B were not immediately separated at that time, but were dismissed from the house later in the night when Client #1 continued to target them with aggression.

After Client #1 was released from the hold and got dressed, she continued to be upset. Client #1 went to the hallway and picked up a jug of water and a bottle of water, throwing the water on the staff. The AOD said she saw RTW B throw a small cup of water on Client #1, saying something about how did she like it and water didn't hurt anyone. RTS B also witnessed part of the incident. RTW B was dismissed from the house a short time later. RTW B and RTS C said they heard the AOD curse at Client #1 during the incident.

Record review on 4/16/19 revealed Client #1 was 16 years old with a diagnosis including mild intellectual disability, reactive attachment disorder, bipolar disorder with recurrent depression, anxiety disorder, cluster B personality traits and diabetes mellitus, type II.

According to the facility Incident Management Policy, staff should immediately report all allegations of abuse to a supervisor. The supervisor should immediately notify the agency Investigation Department of the alleged or suspected abuse. The Director of Quality Management (DM) is the director for the agency Investigations Department.

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 05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD RESOURCE CENTER	711 SOUTH VINE STREET GLENWOOD, IA 51534

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W 153	Continued From page 3	W 153		

Review of the facility investigation revealed the allegation Client #1 made that RTS A hit her during the overnight of 3/21/19. was not immediately reported. It was not reported until the AOD was interviewed about the incident on 3/22/19, which was over 24 hours after the incident.

When interviewed on 4/17/19 at 10:30 p.m. RTW A said RTS A arrived at the house to assist with an incident on the overnight shift of 3/21/19. Client #1 and some other staff were in the yard at the time. Client #1 saw RTS A and accused him of hitting her, so RTS A left.

When interviewed on 4/16/19 at 3:30 p.m. RTW B stated RTS A arrived at the house in his car to assist with an incident on the overnight shift of 3/21/19. RTS A began to walk toward Client #1 and some staff standing in the yard, when Client #1 said RTS A hit her. The AOD told RTS A to leave, which he did.

When interviewed on 4/16/19 at 2:15 p.m. the AOD acknowledged she did not immediately report the allegation Client #1 made that RTS A hit her. The AOD said she forgot to immediately report it because there was so much going on that night.

2. Review of the facility investigation revealed the allegation Client #1 made that RTW B hit her in the bathroom on the overnight of 3/21/19 was not immediately reported and the staff person was not immediately separated. It was not reported to the investigations unit until 3/25/19.

When interviewed on 4/16/19 at 3:30 p.m. RTW

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 05/01/2019

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 153	Continued From page 4	W 153		

B said after she removed the washcloth from plugging the drain in the bathtub on the overnight of 3/21/19, Client #1 said RTW B hit her. RTW B reported to RTS B and RTS C that Client #1 made an allegation that RTW B hit her, but they told her to continue working with Client #1 because they hadn't heard the allegation.

When interviewed on 4/17/19 at 10:30 p.m. RTW A stated she was present in the bathroom on the overnight of 3/21/19 when Client #1 said RTW B hit her. Client #1 was in the bathtub when she made the allegation. RTW B reported the allegation to RTS B and the AOD, but was told to continue working with Client #1 because they hadn't heard it.

When interviewed on 4/16/19 at 2:45 p.m. RTS B stated RTW B approached her shortly after Client #1 returned to the house from leaving the campus. RTW B was sort of laughing and said Client #1 accused RTW B of hitting her, so she was "out of there." RTS B said she didn't know if RTW B was serious at the time, so she told her to return to working with Client #1. RTS B acknowledged she should have separated RTW B from Client #1 at that time.

When interviewed on 4/16/19 at 10:55 p.m. RTS C stated he was present when RTW B told RTS B that Client #1 accused RTW B of hitting her. This was on the overnight of 3/21/19 when Client #1 was in the bathroom. RTS B told RTW B to continue working with Client #1 since no other staff person heard the allegation. RTS C said in hindsight, he and RTS B should have separated RTW B from Client #1 at that time.

3. Review of the facility investigation revealed the

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 05/01/2019

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 153	Continued From page 5	W 153		

allegation Client #1 made that RTW A and RTW B pulled her hair on the overnight of 3/21/19 was not immediately reported. It was not reported to the investigations unit until the morning of 3/22/19, over 24 hours later.

When interviewed on 4/16/19 at 10:55 p.m. RTS C stated Nurse A came to assess Client #1 after the first restraint hold when Client #1 got out of the tub. RTS C said he heard Client #1 tell Nurse A that RTW A and RTW B pulled her hair. He said he didn't report the allegation because the AOD was there and she said she would report it.

When interviewed on 4/16/19 at 2:45 p.m. RTS B said after Client #1's first restraint hold, she heard Client #1 make the allegation that RTW A and RTW B pulled her hair. RTS B didn't report it because she thought the AOD would report it.

When interviewed on 4/16/19 at 11:25 p.m. Nurse A said she recalled going to the house around 2:30 a.m. and Client #1 alleged that two staff pulled her hair. The nurse assessed Client #1's head and saw no sign of injury.

When interviewed on 4/16/19 at 2:15 p.m. the AOD said during the first restraint hold, Client #1 told her that RTW A and RTW B pulled her hair. The AOD said she didn't immediately report the allegation or separate RTW A and RTW B from Client #1 because there were ongoing behavioral issues to deal with. Client #1 continued to aggress toward staff and was put into two additional restraint holds. The AOD said she thought she reported the allegation of hair pulling later in the day on 3/21/19.

4. Review of the facility investigation revealed the

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 05/01/2019

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 153	Continued From page 6	W 153		

allegation that RTW B threw a glass of water on Client #1 was not immediately reported. The incident happened during the overnight shift of 3/21/19, likely around 2:30 or 3:00 a.m. The AOD sent an email to administrative staff at 5:27 a.m., notifying them that RTW B thrown a cup of water in Client #1's face and should face disciplinary action. The allegation was not reported to the investigations unit until 8:33 a.m. by the forwarded email, several hours after the incident.

When interviewed on 4/16/19 at 2:15 p.m. the AOD stated she saw RTW B throw a paper cup of water on Client #1, after Client #1 threw water on RTW B, the AOD and other staff. The AOD said RTW B said to Client #1, "See how it feels? You don't scare me. Water doesn't hurt anyone." The AOD saw RTW B throw the cup of water in Client #1's face. The AOD stated Client #1 immediately charged at RTW B and was put into a restraint hold.

When interviewed on 4/16/19 at 2:45 p.m. RTS B said Client #1 threw water on the staff after the hair pulling incident and the first restraint hold. RTS B said she turned her head away as Client #1 threw water on the staff, from a jug and a bottle of water. RTS B heard RTW B say something like, "Water doesn't hurt anyone. Why are you throwing water on us?" When RTS B turned back around, she saw RTW B holding a paper cup in her hand and the front of Client #1's shirt was wet. It appeared that RTW B thrown a cup of water on Client #1.

5. Review of the facility investigation revealed the allegation the AOD cursed/used profanity toward Client #1 was not immediately reported. It was not reported to the investigations unit until

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 05/01/2019

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 153	Continued From page 7 3/26/19. When interviewed on 4/17/19 at 10:30 p.m. RTW A stated during the incidents involving Client #1 on the overnight of 3/21/19, she heard the AOD use profanity toward Client 1. RTW A said she heard Client #1 say that RTA A and RTW B pulled her hair. The AOD told Client #1 the staff had not pulled her hair and to "knock your shit off." When interviewed on 4/16/19 at 10:55 p.m. RTS B stated at one point during the overnight shift of 3/21/19, he heard the AOD use a harsh tone with Client #1 and it sounded like she might have used profanity, but RTS B didn't recall exactly what she said. When interviewed on 4/22/19 at 3:30 p.m. the DQM stated she was always on-call and should have been notified immediately of all allegations of abuse that occurred at House 240 on the overnight shift of 3/21/19. The DQM is the director for the facility investigation unit. She said she and the facility investigations unit staff learned of the allegations in the days following the incidents, as they conducted an investigation into Client #1's unauthorized departure from the campus and her suicide gesture/ideation. The allegation that RTW B threw a cup of water at Client #1 was reported a few hours after the incident, but it was not immediately reported to the Investigations Unit, per facility policy.	W 153		
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.	W 155		

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 05/01/2019

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 155	Continued From page 8 This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to take prompt, appropriate action to safeguard client's after an allegation of abuse. This pertained to 1 of 1 client (Client #1) identified as a result of facility self-reported incident 82257-I. Finding follows: See W153 for additional information Record review revealed a facility investigation indicated on the overnight of 3/21/19, Client #1 took a bath. She pulled off or broke the faucet so the water could not be turned off. Client #1 plugged the tub drain with a washcloth. Staff reminded Client #1 that bathing was not good for a medical condition she was dealing with and told her she should only stay in the tub for a short time. While in the bathroom, Resident Treatment Worker (RTW) A and RTW B heard Client #1 allege that RTW B hit Client #1. RTW B reported the allegation to Resident Treatment Supervisor (RTS) B and RTS C, but was told to continue working with Client #1. After a period of time, RTW B told Client #1 it was time to get out of the tub and the RTW removed the washcloth from the drain. Client #1 tried to plug the drain again with some clothing items and RTW B tried to prevent her from doing this. Client #1 reportedly grabbed RTW B by the hair as she yanked the staff person's head. RTW A tried to intervene and also had her hair pulled. Other staff were able to separate the two staff from Client #1, but Client #1 got out of the tub and went to the hall to continue to aggress toward RTW A. Staff intervened and put Client #1 into a two minute hold on the floor due to continued aggression.	W 155		

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 05/01/2019

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 155	Continued From page 9	W 155		

During the hold or shortly after her release, Client #1 said RTW A and RTW B pulled her hair in the bathroom before she pulled their hair. Client #1 told the Administrator on Duty (AOD) that RTW A and RTW B pulled her hair. Other staff in the area also heard the allegation. RTW A and RTW B were not immediately separated at that time, but were dismissed from the house later in the night when Client #1 continued to target them with aggression.

After Client #1 was released from the hold and got dressed, she continued to be upset. Client #1 went to the hallway and picked up a jug of water and a bottle of water, throwing the water on the staff. The AOD said she saw RTW B throw a small cup of water on Client #1, saying something about how did she like it and water didn't hurt anyone. RTS B also witnessed part of the incident. RTW B was dismissed from the house a short time later. RTW B and RTS C said they heard the AOD curse at Client #1 during the incident.

Record review revealed the facility ' s Incident Management Policy indicated the supervisor should immediately review the incident to determine whether further action is needed to protect the individual. If necessary, the staff and individual would be separated.

When interviewed on 4/16/19 at 2:45 p.m., RTS B stated when first returning to the house from a behavioral episode, RTW B came up, sort of laughing, to RTS B and RTS C and said she was out of there because Client #1 said RTW B hit her. RTS B stated she did not hear it, so RTW B could continue working with Client #1. RTS B wondered if RTW B just wanted released from

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 05/01/2019

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 155	Continued From page 10 the house and did not believe RTW B was being serious. RTS B stated, in hindsight she should have separated RTW B from Client #1 at that time. When interviewed on 4/16/19 at 10:55 p.m. RTS C reported at one point on the evening of 3/21/19 RTW B came out of the bathroom and told RTS B that Client #1 said RTW B hit her. RTS B told her Client #1 had not reported it to anyone else, so RTW B returned to the bathroom to work with Client #1. RTS C reported, in hindsight, they should have separated RTW B from Client #1 at that time.	W 155		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to develop and implement program objectives to address identified client needs as identified by the comprehensive functional assessment and considered priority by the interdisciplinary team (IDT). This affected 1 of 1 sample client identified in the investigation of #82769-C. Finding follows: Observation on 4/18/19 at 3:15 p.m. revealed Client #1 sitting on the couch in her home, eating potato chips from a large bag. There was also a container of ice cream nearby on the table. The	W 227		

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 05/01/2019

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 227	Continued From page 11	W 227		

Treatment Program Administrator (TPA) sat next to Client #1 on the couch. Client #1 had been displaying inappropriate target behaviors that day. She did not engage in conversation with the surveyor.

Record review on 4/16/19 revealed Client #1 was 16 years old with a diagnosis including mild intellectual disability, reactive attachment disorder, bipolar disorder with recurrent depression, anxiety disorder, cluster B personality traits and diabetes mellitus, type II. Client #1 was admitted to the facility in December 2017. According to facility records, Client #1 was 5' 10" and 257.5 pounds when admitted, with a Body Mass Index (BMI) of 36.9. Based on the facility Height and Weight record, Client #1 remained at 5'10" and her weight as of April 2019 was 313 pounds, with a BMI of 44.9. Client #1's weight had been relatively stable until September/October 2018, when it began to steadily rise. Client #1 gained almost 60 pounds since September 2019.

Record review revealed Client #1's current diet order for an 1,800 calorie diet with a double entree at supper, extra fruits and vegetables and a daily yogurt, which would total approximately 2,500 calories per day.

A review of Client #1's Comprehensive Functional Assessment dated January 2019, identified needs in the areas of portion control, appropriate serving sizes, eating only food that was part of regular meals and snacks and participating in wellness programs, such as exercise.

A review of Client #1's annual Individual Support Plan (ISP), dated 1/16/19 revealed a priority goal

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 05/01/2019

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 227	Continued From page 12	W 227		

"To promote a healthy lifestyle and maintain a healthy weight." The ISP noted Client #1 at risk for Diabetes, Cardiac/Cardiovascular Disease and Deep Vein Thrombosis/Pulmonary Embolism. Health supports for Client #1 included following her diet.

Additional record review revealed Client #1's goal to promote a healthy lifestyle and maintain a healthy weight included an objective to exercise for 30 minutes at least once per day. According to the program data, Client #1 met the objective 15 days in December 2018, 2 days in January 2019, 9 days in February, 9 days in March and 4 days in April as of 4/29/19. The program to maintain a health weight (by exercising) contained no information regarding Client #1's diet or food intake. Client #1's behavior support program (BSP) also listed no information regarding Client #1's diet or any dietary/snack restrictions.

Additional record review revealed an undated Restricted Access Consent letter to Client #1's acting guardian, to limit Client #1's snack consumption to one additional snack per day.

A review of Client #1's Monthly Integrated Review (MIR) from December, 2018 to April, 2019 revealed the following:
a. The MIR dated 12/26/18 noted a food restriction had been removed.

b. The MIR dated 1/09/19 noted Client #1 was doing well overall, but "remains preoccupied with food."

c. The MIR dated 4/17/19 noted Client #1's exercise program had been revised to include

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 05/01/2019

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 227	Continued From page 13	W 227		

information on how exercise impacts Client #1's ability to lift her restriction on snacks. The facility also held regular Interdisciplinary Team (IDT) meetings, usually at least weekly, which primarily focused on Client #1's behavioral issues.

Continued record review revealed IDT meeting notes for February through April 2019 noted the following:
a. IDT meeting on 2/17/19 noted Client #1 ate so much at a restaurant that she made herself sick.

b. IDT meeting dated 2/07/19 noted a family member had pizza delivered to Client #1, which the team supported, as long as Client #1 was encouraged to stay within her calorie limits for the day.

A review of Client #1's Event Log revealed notes made by the facility dietitian since the beginning of 2019. The dietitian wrote a lengthy note on 4/19/19 expressing concern regarding Client #1's continued weight gain. The dietitian had been meeting with Client #1 weekly to review menu options, appropriate portion sizes and focus on good nutrition. The dietician noted in the 4/19/19 entry, "The continued significant weight gain is concerning and can have numerous health impacts. A snack restriction was in place to help limit excessive snacking. It appears the snack restriction is no longer in the BSP." The dietitian also noted it appeared Client #1 was replacing her meals with snacks, which was detrimental to helping her consume nutritionally balanced meals. "Per notes and verbal reports, her intake outside of her prescribed diet is likely the source of weight gain. RD's (registered dietitian) recommendations are not being followed." The

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 05/01/2019

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 227	Continued From page 14 dietitian noted Client #1's fasting blood glucose levels had been steadily rising. The dietitian recommended staying consistent with Client #1's diet and to keep snacks limited to a scheduled snack time. The dietitian made an entry on 2/21/19 noting a 21% weight gain in the previous six months. The dietitian wrote she informed the team of concerns about continued intake outside of the prescribed diet. On 2/01/19, the dietitian made a quarterly nutrition note for November and December 2018 and January 2019. The dietitian noted ongoing weight gain and recommended consistency with Client #1's diet and limited diet changes. When interviewed on 4/23/19 at 11:00 a.m. the Dietitian confirmed she was concerned about Client #1's ongoing weight gain. The Dietitian said additional snacks had been restricted to once per day, but she didn't know if the restriction was still in place or being followed. She noted Client #1's weight remained fairly stable in the first several months after admission, but then began rising. The Dietitian said she had discussed the weight gain many times with the team. She said it was her understanding Client #1 sometimes received additional food or money for food approved by facility administrative staff. Client #1 recently had a housewarming party with cupcakes and the leftover food remained at her house, which she ate. Client #1 also frequently went out to eat. The Dietitian met with Client #1 weekly to review the menu and help make substitutions for food she didn't like. The dietitian said she believed Client #1 consumed additional food/calories beyond her diet order, with additional snacks being at least part of the problem.	W 227		

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 05/01/2019

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 227	Continued From page 15	W 227		

When interviewed on 4/23/19 at 11:15 p.m. the Primary Care Provider (PCP) for Client #1 said she was concerned regarding Client #1's continued weight gain. The PCP said Client #1 was admitted with a diagnosis of type II diabetes, but didn't actually meet the criteria for the diagnosis based on her A1c levels and blood sugar levels. However, Client #1's A1c levels and fasting blood sugar levels continued to rise as her weight has increased. The PCP explained the weight increase contributed to Client #1's likelihood of developing type 2 diabetes and hypertension, could exacerbate her asthma and lead to eventual end stage kidney disease. Client #1 was supposed to be on a calorie restricted diet, with only one additional snack per day. The PCP said she believed Client #1 received additional food and snacks. She said facility administrative staff provided Client #1 with money to buy additional snacks. Client #1 recently had a housewarming party with cupcakes and ice cream. The PCP said she believed the team needed to focus more on weight loss for Client #1.

When interviewed on 4/23/19 at 3:00 p.m. Resident Treatment Worker (RTW) E stated she worked regularly with Client #1 on the PM shift. She reported Client #1 bought her own snacks and was supposed to only have one serving of the snack in the evening. When Client #1 went shopping, she sometimes immediately ate snacks after she purchased them, ignoring staff requests to wait. Client #1 often overate when she dined out. RTW E said Client #1 spent her money on junk food. She usually refused to exercise.

When interviewed on 4/24/19 at 9:15 a.m. RTW F said he worked regularly with Client #1 on the AM

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 05/01/2019

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 227	Continued From page 16	W 227		

shift. He worked with Client #1 during breakfast and lunch time. RTW F said Client #1 often slept through breakfast, which was then saved for her in the refrigerator. She often ate her breakfast and lunch together at the same time. RTW F said he had been present twice when Client #1 had pizza delivered to the house, ordered by family members. RTW F said Client #1 was obsessed with food. He said she didn't go out to eat on AM shift, other than sometimes eating lunch at the facility canteen. RTW F said Client #1 didn't get snacks on AM shift. RTW F worked some PM shifts and Client #1 went out to eat sometimes on PM shift. He recalled a time when Client #1 had $15 to spend at McDonalds and she ate multiple sandwiches and orders of french fries.

When interviewed on 4/24/19 at 9:30 a.m. RTW G stated she worked regularly with Client #1 on the AM shift. She Client #1 often slept through breakfast, but staff saved the food for her. Client #1 frequently ate her breakfast and lunch together. RTW G said it was her understanding that Client #1 ate out a lot on the PM shift and might have snacks on the PM and overnight shifts. It was difficult for staff to refuse to allow Client #1 to have certain foods, because she would become aggressive. RTW G said she thought administrative and management staff made the situation worse by allowing Client #1 money to eat out and buy snacks.

When interviewed on 4/29/19 at 1:35 p.m. Nurse B stated she had previously been Client #1's primary facility nurse. She said she had shared her concerns regarding Client #1's continued weight gain with a nursing supervisor. Nurse B said she had been told that administrative staff gave candy and snacks to Client #1, but she

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 05/01/2019

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 227	Continued From page 17	W 227		

didn't have first hand knowledge of this.

When interviewed on 4/29/19 at 2:15 p.m. RTW H stated she worked regularly with Client #1 on the PM shift. She also sometimes covered on the overnight shifts. She said Client #1 frequently tried to solicit food. Client #1 went to the administration building to get candy. She got spending money and spent it on food/snacks. After she bought the snacks, Client #1 would typically eat them immediately. She regularly went out to eat. Client #1's family members have had pizzas delivered to the house. Client #1 sometimes called administrative staff and got permission for the kitchen to send extra food items. RTW H recalled a package of pasta coming from the kitchen that contained 10 servings. Client #1 cooked the pasta and ate it all in one sitting.

When interviewed on 4/29/19 at 3:00 p.m. RTW I said he worked regularly with Client #1 on the PM shift. He said the staff tried to encourage Client #1 to make healthy choices, but usually without success. Client #1 would go to the administration building and get money for snacks and sweets. She ate the snacks as soon as she bought them, refusing to save them for later. Client #1 often went out to restaurants to eat. Her family had pizzas delivered to the house. RTW I said Client #1 was very focused on food and and wanted all of her rewards and reinforcers to be food. She could become aggressive if she didn't get the food she wanted. RTW I said he didn't know if there was a snack restriction in place, but he said Client #1 didn't follow it.

When interviewed on 4/30/19 at 11:50 a.m. RTW J said she had worked with Client #1 on the AM

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 05/01/2019

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 227	Continued From page 18	W 227		

shift and also had covered on overnight shifts. RTW J said there was a fund of money that Client #1 could access whenever she wanted to buy snacks. Client #1 ate the snacks as soon as she bought them. She sometimes slept through breakfast and would eat that food later. If leftover food built up in the refrigerator, Client #1 would eat it all at once. Client #1's family had pizzas delivered to the house. Client #1 also went out to eat quite a bit. RTW I described Client #1 as being very food driven.

When interviewed on 4/24/19 Staff A said she worked regularly with Client #1. She said Client #1 was food driven. Staff A reported the menu was not closely followed. Client #1 often called or visited administrative staff and got permission for extra food or money to buy snacks or to go out to eat. She noted the snack restriction had been removed from Client #1's BSP. Client #1 recently had a housewarming party with cupcakes and ice cream. All of the leftover food was left at the house and Client #1 ate it.

When interviewed on 4/23/19 at 10:45 a.m. the Superintendent said Client #1 was able to purchase snacks and extra food with her $50 per month spending money. He confirmed that Client #1 was only supposed to have one extra snack per day. The Superintendent said Client #1 sometimes went out to eat. He said he didn't know of any staff who were giving Client #1 extra food or snacks. The Superintendent reported it was difficult to create a balance with Client #1's desire for food and her behavioral challenges.

When interviewed on 4/30/19 at 2:30 p.m. the TPA and the Treatment Program Manager (TPM) acknowledged Client #1's weight gain. They said

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 05/01/2019

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 227	Continued From page 19 the snack restriction of only one extra snack (normal size serving) per day was still in effect, but it was not part of any program. They confirmed there was no program in place to address Client #1's food intake. The TPM said the team had discussed Client #1's weight gain at various weekly and monthly IDT meetings, but he might have focused on more immediate concerns when he wrote the summaries. The TPA and TPM said there had been an IDT meeting earlier in the day and the team had focused on ideas to address Client #1's ongoing weight gain.	W 227		
W 267	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff consistently complied with facility policy regarding conduct toward clients. This affected 1 sample client identified in the investigation of #82557-I (Client #1). Finding follows: 1. Record review of facility investigations and Incident Reports revealed Client #1 was involved in various behavior management incidents on the overnight shift of 3/21/19 (approximately 1:00 a.m. to 3:00 a.m.). Client #1 became upset and had called 911. Other staff arrived to assist with the situation. Client #1 continued to be upset and left her house at approximately 1:00 a.m., wearing shorts, a T-shirt and nothing on her feet. Staff followed Client #1 and tried to convince her	W 267		

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 05/01/2019

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 267	Continued From page 20	W 267		

to return to the house. Client #1 walked off the campus grounds and ended up near a ravine with a flooded creek at the bottom. Client #1 indicated she wanted to end her life and threatened to jump into the ravine. Several staff and a police officer blocked Client #1 and were able to convince her to return to the house, uninjured. Client #1 continued to be upset at the house and became aggressive toward the staff as the night went on.

After returning to the house on the overnight of 3/21/19, Client #1 took a bath. She pulled off or broke the faucet so the water could not be turned off. Client #1 plugged the tub drain with a washcloth. Staff had reminded Client #1 that bathing was not good for a medical condition she was dealing with and had told her she should only stay in the tub for a short time. After a period of time, RTW B told Client #1 it was time to get out of the tub and the RTW removed the washcloth from the drain. Client #1 tried to plug the drain again with some clothing items and RTW B tried to prevent her from doing this. Client #1 reportedly became aggressive toward staff and was put into a two minute restraint hold on the floor.

After Client #1 was released from the hold and got dressed, she continued to be upset. Client #1 went to the hallway and picked up a jug of water and a bottle of water, throwing the water on the staff. The AOD said she saw RTW A throw a small cup of water on Client #1, saying something about how did she like it and water didn't hurt anyone. RTS B also witnessed part of the incident. RTW A and RTS C said they heard the AOD curse at Client #1 during the incidents on the night of 3/21/19.

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 05/01/2019

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 267	Continued From page 21	W 267		

Record review revealed Client #1 had a BSP with target behaviors including aggression, self-injurious behavior, leaving assigned areas, suicide threats and attempts and property destruction. According to the BSP, the staff should use facility approved techniques as necessary to maintain safety during episodes of target behavior. Per the BSP, "Staff should maintain a neutral tone of voice and demeanor."

When interviewed on 4/16/19 at 2:15 p.m. the AOD stated she saw RTW B throw a paper cup of water on Client #1, after Client #1 threw water on RTW B, the AOD and other staff. The AOD stated RTW B said to Client #1, "See how it feels? You don't scare me. Water doesn't hurt anyone." The AOD saw RTW B throw the cup of water in Client #1's face. The AOD stated Client #1 immediately charged at RTW B and was put into a restraint hold.

When interviewed on 4/16/19 at 2:45 p.m. RTS B said Client #1 threw water on the staff after the hair pulling incident and the first restraint hold. RTS B said she turned her head away as Client #1 threw water on the staff, from a jug and a bottle of water. RTS B heard RTW B say something like, "Water doesn't hurt anyone. Why are you throwing water on us?" When RTS B turned back around, she saw RTW B holding a paper cup in her hand and the front of Client #1's shirt was wet. It appeared that RTW B had thrown a cup of water on Client #1.

When interviewed on 4/17/19 at 10:30 p.m. RTW A stated during the incidents involving Client #1 on the overnight of 3/21/19, she heard the AOD use profanity toward Client 1. RTW A said she heard Client #1 say that RTW A and RTW B had

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 05/01/2019

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 267	Continued From page 22	W 267		

pulled her hair. The AOD told Client #1 the staff had not pulled her hair and to "knock your shit off."

When interviewed on 4/16/19 at 10:55 p.m. RTS C stated at one point during the overnight shift of 3/21/19, he heard the AOD use a harsh tone with Client #1 and it sounded like she might have used profanity, but RTS B didn't recall exactly what she said.

When interviewed on 4/30/19 at 9:35 a.m. the Treatment Program Coordinator/Qualified Intellectual Disability Professional confirmed staff should try to maintain a neutral tone of voice and demeanor when working with Client #1 and cursing or throwing water at Client #1 would not be acceptable.

Record review of the agency policy entitled "Incident Management" revealed the policy addressed expected staff conduct toward clients. According to the policy, "Individuals served shall be provided opportunities to develop independent skills in a safe humane environment, free from abuse or harm. The policy included swearing as a type of verbal abuse. Mental or psychological abuse was defined as "Actions which result or may result in a negative impact on an individual's sense of well-being, safety, integrity or self-esteem. Per the agency policy staff "shall treat people with dignity, respect and concern for safety."