DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

7/24/19 OK 7/18/19

PRINTED: 07/10/2019
FORM APPROVED
OMB NO. 0938-0391

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 06/20/2019

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 Investigation #83723-I was conducted 6/10/19 - 6/20/19 On 6/13/19 at approximately 10:50 a.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure staff competency to implement Individual Support Plan (ISP) and facility policy and procedure. The facility was notified on 6/13/19 at 10:55 a.m. The facility developed a plan to remove the IJ which included re-training staff and revisions to documents to provide specific information and guidance to staff. The IJ was removed on 6/20/19 at 8:15 a.m. The investigation of #83723-I resulted in the following deficiencies cited: W189 and W249.	W 000	See attached POC 7/19/19	
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to maintain minimum compliance with the condition of participation (CoP) - Facility staffing. The facility failed to ensure staff competently demonstrated appropriate skills to ensure client safety. Cross reference W189: Based on interview and record review, the facility failed to ensure staff consistently demonstrated competency in implementation of facility policy and procedures to keep clients safe.	W 158		

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 158	Continued From page 1 Cross reference W249: Based on observations, interviews and record review, the facility failed to ensure staff consistently followed a client's Individual Support Plan (ISP) to assure his safety and well-being. On 6/13/19 at approximately 10:50 a.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure staff competency to implement Individual Support Plan (ISP) and facility policy and procedure. The facility was notified on 6/13/19 at 10:55 a.m. The facility developed a plan to remove the IJ which included re-training staff and revisions to documents to provide specific information and guidance to staff. The IJ was removed on 6/20/19 at 8:15 a.m.	W 158		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff consistently demonstrated competency in implementation of facility policy and procedures to keep clients safe. This affected 1 of 1 client identified as a result of investigation of #83723-I (Client #1). Findings follow: Record review on 6/10/19 revealed Client #1's Incident Report (IR) dated 6/5/19. Resident Treatment Supervisor (RTS) A documented Client #1 was found unresponsive on the back patio and	W 189		

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W 189	Continued From page 2 was transported to the hospital via ambulance at 3:23 p.m. The Registered Nurse noted a STAT call for nursing at 3:10 p.m. She arrived at the house and found Client #1 unresponsive and "clearly in respiratory distress". She documented administration of oxygen and placement of wet cloths on Client #1's body surface to cool him off. She recorded a temporal (forehead) temperature of 103.3 degrees. Her assessment included respirations at 38 per minute and tachycardia (rapid heartbeat) at 157 BPM (beats per minute). The RN documented Client #1 appeared flushed and felt hot to the touch and recorded he had been sitting on the patio prior to the incident. According to the IR, staff called 911 at 3:11 p.m. and Client #1 left for the hospital per ambulance at 3:23 p.m. Further record review on 6/10/19 revealed Client #1's Individual Support Plan (ISP) last updated on 7/11/18. According to the ISP, Client #1 could be outside for one hour with 15-minute checks. He should not be seated in direct sunlight and should be offered fluids due to the possibility of heat exhaustion or dehydration. The ISP noted Client #1 liked to sit outside in the sun and further noted a heat restriction due to the medication he took. His Doctor Orders active from 3/11/19 - 6/11/19 included an order as follows; "If temperature/heat index above 90 degrees, restrict outdoor activities NO MORE THAN 10 MINUTES OUTSIDE". Continued record review revealed Client #1's Client Information/Transfer form. His diagnoses included, Profound Intellectual Disability, Bipolar II disorder, Intermittent Explosive Disorder, Parkinsonism, Complex Partial Seizures, Degenerative Arthritis, Osteoporosis, and Compression vertebral fractures of the lumbar	W 189		

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W 189	Continued From page 3 spine. According to the birthdate on the information sheet, Client #1 was 76 years old at the time of the incident on 6/5/19. Record review on 6/11/19 revealed the facility shift zone sheets for the morning and afternoon on 6/5/19. The document identified Zone 1 as "Big Living Room/Big Dining Room/Hall Off Big Living Room/Kitchen/Back Patio. The document established one-hour time frames and space to write client names and activities. Resident Treatment Worker (RTW) D signed in for responsibility for the zone from 1:00 p.m. - 2:00 p.m. and from 2:00 p.m. - 2:05 p.m. RTS A signed in for the zone from 2:05 p.m. to 2:07 p.m. RTW A signed the shift zone sheet at 2:00 p.m. The shift zone sheet lacked documentation of Client #1 going outside to the patio on 6/5/19. Record review on 6/12/19 revealed the facility Zoning policy. The policy statement established staff held the responsibility for ensuring all individuals residing at the facility live and work within a safe environment. A standard noted the whereabouts of individuals supported at the facility should be known by staff throughout the day, night and during the crossover time between staff. Implementation guidance including knowledge of client whereabouts by maintaining a zoning sheet. The document directed a verbal and physical communication exchange between staff at shift change and/or when staff is going off duty for the remainder of the shift and being replaced by another staff. The Quality Assurance portion identified the Resident Treatment Supervisor (RTS) as the person responsible for reviewing zoning sheets. According to the policy, the RTS review "will focus on whether the information was accurately	W 189		

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W 189	Continued From page 4 documented and if the information appropriately captured what transpired for that day". When interviewed on 6/11/19 at 9:45 a.m., RTW C confirmed she saw Client #1 outside at 1:45 p.m. on 6/5/19. She recalled she took Client #6 outside and saw Client #1 sitting on a metal chair in the sun. She noted she saw Client #1 outside again at 2:15 p.m. and recalled RTW A held responsibility for him at the time. She further noted RTW D took Client #1 outside prior to RTW A's arrival on shift. She confirmed the shift zone sheet lacked any documentation of when Client #1 went outside. She said staff should have communicated the time Client #1 went outside during shift change. When interviewed on 6/11/19 at 10:25 a.m., RTW A confirmed she worked with Client #1 on 6/5/19. She said she talked with some of the morning shift staff but did not talk with RTW D because she attended a WIG (Wildly Important Goal) meeting until approximately 2:10 p.m. or 2:15 p.m. and RTW D left the home before the meeting was over. She further stated she did not see the morning shift zone sheet and had no knowledge of what time RTW D took Client #1 outside. She stated a morning shift staff told her RTW D "just took Client #1 out" and estimated the time to be 2:15 p.m. She recalled she saw Client #1 sitting in a metal chair on the patio with his face exposed to the sun. RTW A said she engaged the other clients in an activity at the table and looked out the window to check on Client #1. She recalled RTW E came into the area between 2:45 p.m. and 3:00 p.m. and asked about Client #1. RTW A said she went to the door and saw Client #1 slumped over in the chair with his chin on his chest. She recalled his eyes	W 189		

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W 189	Continued From page 5 were closed and he was breathing rapidly. She said she and RTW E moved him out of the sun and RTW F made a STAT nursing call and called 911. She said other staff came and assisted Client #1 into a wheelchair and took him in the house at approximately 3:10 p.m. RTW A confirmed knowledge of Client #1's restriction to be outside no longer than 1 hour but emphasized no one told her the exact time he went on the patio so she assumed his hour started at 2:15 p.m. She said she checked on him at 2:30 p.m. and he seemed fine. When interviewed on 6/11/19 at 11:25 a.m., RTS A confirmed he took over responsibility for Client #1 on 6/5/19 at approximately 2:05 p.m. so RTW D could go work at another home. He recalled seeing Client #1 outside on the patio but did not ask RTW D what time he went outside. He recalled he had to leave and go help at another house and at that time, RTW A took over responsibility for Client #1 and the clients in Zone 1. He confirmed Client #1 sat outside for more than an hour on 6/5/19. When presented with the shift zone sheet and asked how staff knew what time Client #1 went outside, RTS A noted he expected staff to write the time on the shift zone sheet. He acknowledged no documentation of the time Client #1 went outside on the shift zone sheet on 6/5/19. He said staff could make a note on the sheet to communicate the information to staff if a verbal communication did not occur. When interviewed on 6/11/19 at 2:15 p.m., RTW F said she took responsibility for Client #1 at 2:07 p.m. on 6/5/19. She recalled Client #1 sat outside on the patio at the time and she thought RTW D took him outside at approximately 1:45 p.m. and gave him a drink. She said RTS A	W 189		

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W 189	Continued From page 6 checked on him prior to her arrival. She noted Client #1 moved into the sun if staff set him in the shade. She recalled RTW A attended a WIG meeting that day so supervision of the clients changed several times. She estimated RTW A took over for the clients at approximately 2:10 p.m. RTW F said she went to the other side of the house to help RTW E reposition clients. She recalled she came back to help RTW A and saw Client #1 with his chin on his chest panting. She recalled RTW A and RTW F pulled his chair into the shade and offered him water. She made a STAT nursing call and called 911. She acknowledged she rode with Client #1 in the ambulance and stayed with him while hospital staff assessed him. RTW F thought staff should write down the time Client #1 went outside to assure staff knew when to check on him and when to bring him inside. She denied ever being told staff should document that information. She recalled the day was "hectic" with staff coming and going throughout the day. She was unaware whether staff told RTW A what time Client #1 went outside. When interviewed on 6/11/19 at 3:00 p.m., RTW E recalled she went to help RTW A after 3:00 p.m. on 6/5/19. She was unsure what time Client #1 went outside and identified lack of documentation/communication of exit time as an issue that contributed to the incident. She noted if staff failed to verbally communicate, they should document client whereabouts and health related information. When interviewed on 6/11/19 at 3:30 p.m., the Licensed Practical Nurse (LPN) confirmed he heard a nursing STAT call and immediately went to Client #1's home. He estimated he heard the	W 189		

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W 189	Continued From page 7 call at 3:10 p.m. and arrived on site at 3:12 p.m. He further confirmed Client #1 did not respond to verbal or physical stimuli when he arrived. He said he asked RTS A how long Client #1 had been outside and RTS A replied, "a little bit". The LPN stated he thought Client #1's symptoms suggested prolonged heat exposure. The LPN noted staff failure to communicate/document the time Client #1 went outside might have contributed to the heat exposure. When interviewed on 6/11/19 at 4:05 p.m., RTS B confirmed she responded to a call for help at house 254 on 6/5/19. She estimated she arrived at Client #1's home at 3:15 p.m. and described Client #1 as non-responsive. She recalled his head was down in his chest and his head shook almost constantly. She said she rubbed his cheek but he did not respond. She noted staff had to physically help him stand and pivot into a wheelchair on the patio. She mentioned the lack of documentation on the shift zone sheet noting staff did not document what time Client #1 went outside or if 15 minute checks were conducted. When interviewed on 6/11/19 at 4:37 p.m., the Investigator 2 confirmed the shift zone sheet lacked documentation of Client #1's exit from the home. When re-interviewed on 6/12/19 at 11:25 a.m., RTW A confirmed if Client #1 went outside at 1:45 p.m. he should have come back inside at 2:45 p.m., but emphasized she had no awareness of when he left the house. Referring to the shift zone sheet on 6/5/19, she noted the time frame from 1:00 p.m. - 2:00 p.m. did not reflect Client #1 went outside. The time frame 2:00 p.m. - 3:00 p.m. read "outside" under the activities column,	W 189		

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W 189	Continued From page 8 but lacked identification of what client(s) went outside. When interviewed on 6/12/19 at 2:40 p.m., the Director of Quality Management confirmed staff failed to communicate what time Client #1 went outside. She further noted staff failed to accurately document/communicate Client #1's whereabouts on 6/5/19. When interviewed on 6/13/19 at 9:00 a.m., RTW D confirmed he took Client #1 outside at 1:45 p.m. on 6/5/19. He said he assumed staff would bring him back inside by 2:45 p.m. He recalled he told RTS A what time he took Client #1 outside and assumed he would communicate with other staff on duty. RTW D said he wrote the word "outside" on the shift zone sheet but acknowledged his documentation did not identify which client went outside. RTW D said he did not speak to RTW A because she attended a WIG meeting and he left to work at another house. He reiterated he told RTS A what time Client #1 went outside but acknowledged a lack of documentation on the shift zone sheet. He said no supervisory staff ever directed him to document exit times on the zoning sheet to ensure communication between staff. When interviewed on 6/19/19 at 11:25 a.m., RTW G confirmed RTS A trained staff on use of the zoning shift sheet every month. When interviewed on 6/19/19 at 11:30 a.m., the TPM confirmed she supervised RTS A. She noted he trained staff on use of the shift zone sheet on monthly basis. When interviewed on 6/19/19 at 12:40 p.m., RTS	W 189		

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W 189	Continued From page 9 A confirmed he trained staff using a "Zone Probes" document on a monthly basis. He produced a document with nine questions regarding zones, their purpose and staff responsibilities when supervising clients in a zone. He said the probes indicated if staff had an understanding of the zone policy and procedure. Record review on 6/19/19 revealed a Zone Probe sheet signed by RTW A on 5/14/19. Further record review revealed a Zone Probe sheet signed by RTW D on 3/26/19. RTS A's signature appeared on both documents. According to their scores, both RTW A and RTW D exhibited "excellent" understanding of the zoning process. When interviewed on 6/19/19 at 4:45 p.m., the Superintendent confirmed staff are trained on the zoning policy and procedure. He further confirmed his expectation that staff follow the policy and procedures. In summary, according to the zoning policy staff are to know the whereabouts of the clients at all times. In addition, staff are to verbally communicate and use zoning sheets to maintain awareness of client location and well-being. Staff failed to communicate verbally or in writing, information related to Client #1's health and safety. The failure resulted in Client #1 experiencing an incident of heat related illness. On 6/13/19 at approximately 10:50 a.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure staff competency to implement Individual Support Plan (ISP) and facility policy and procedure. The facility was notified on 6/13/19 at 10:55 a.m. The facility developed a plan to remove the IJ which included	W 189		

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W 189	Continued From page 10 re-training staff and revisions to documents to provide specific information and guidance to staff. The IJ was removed on 6/20/19 at 8:15 a.m.	W 189		
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 review, the facility failed to ensure staff consistently followed a client's Individual Support Plan (ISP) to assure his safety and well-being. This affected 1 of 1 client identified during investigation #83723-I (Client #1). Findings follow: Record review on 6/10/19 revealed Client #1's Incident Report (IR) dated 6/5/19. According to the IR, Client #1 was found unresponsive on the back patio. The Registered Nurse arrived at the house and found Client #1 unresponsive and "clearly in respiratory distress". She started oxygen and placed wet cloths on Client #1's body surface to cool him off. She recorded vital signs as follows: temperature 103.3 degrees, respirations 38 per minute and tachycardia (rapid heartbeat) 157 BPM (beats per minute). The RN	W 249		

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W 249	Continued From page 11	W 249		

documented Client #1 appeared flushed and felt hot to the touch and recorded he had been sitting on the patio prior to the incident. Staff called 911 at 3:11 p.m. and Client #1 left for the hospital per ambulance at 3:23 p.m. Client #1 returned back to house at 7:50 p.m. after receiving 2 liters fluid.

Further record review on 6/10/19 revealed Client #1's ISP last updated on 7/11/18. The document noted Client #1 liked to sit in the sun but noted a heat restriction due to medications he received. The ISP provided direction regarding Client #1 being outside and noted he could be outside for one hour with 15-minute checks, he should not be seated in direct sunlight and he should be offered fluids due to the possibility of heat exhaustion or dehydration. His Doctor Orders active from 3/11/19 - 6/11/19 included an order as follows; "If temperature/heat index above 90 degrees, restrict outdoor activities NO MORE THAN 10 MINUTES OUTSIDE".

Client #1's Client Information/Transfer form, reviewed on 6/10/19 noted his diagnoses included, Profound Intellectual Disability, Bipolar II disorder, Intermittent Explosive Disorder, Parkinsonism, Complex Partial Seizures, Degenerative Arthritis, Osteoporosis, and Compression vertebral fractures of the lumbar spine. According to the birthdate on the information sheet, Client #1 was 76 years old at the time of the incident on 6/5/19.

Record review on 6/11/19 revealed a report from the hospital dated 6/5/19. The report noted Client #1's arrival at the hospital on 6/5/19 and administration of intravenous (IV) fluids and acetaminophen for fever. The report indicated tests performed including various laboratory

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W 249	Continued From page 12 blood tests, a CT scan and an EKG. The physician documented a discussion with Client #1's facility Primary Care Physician (PCP) and noted his symptoms were most likely secondary to heat related illness with unknown etiology; however, seizure activity could not be ruled out. The Assessment Plan included heat pyrexia (heat exhaustion/heat cramps/heat stroke due to an inability for the body to cool itself), altered mental status and seizure disorder. The incident report dated 6/6/2019 documented a sunburn to bilateral arms/forearms. Also described probable sunburn to arms, neck and face. Corrective action was to follow the sun screen protocol for reapplying. No further follow up warranted as area resolving. Observation on 6/10/19 at 4:15 p.m. on the patio of House 254, revealed a black metal chair in the unshaded area of the patio. No thermometer could be located on the patio. Further observation revealed no clock on the patio. When interviewed on 6/10/19 at approximately 4:20 p.m., the Treatment Program Manager (TPM) confirmed she updated Client #1's ISP in June 2018 due to a WIG (Wildly Important Goal) meeting. She said staff requested permission for Client #1 to be outside for more than 10 minutes because he enjoyed sitting on the patio. She recalled receipt of an e-mail from the Registered Nurse (RN) Nurse Supervisor following a discussion with Client #1's Primary Care Physician (PCP). According to the e-mail, Client #1 could sit outside for up to an hour with 15-minute checks by staff, no direct sun exposure and fluids offered when checks were completed. She acknowledged a conversation with Resident	W 249		

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	16G003	A. BUILDING _____ B. WING _____	C 06/20/2019

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W 249	Continued From page 13 Treatment Worker (RTW) A on 6/5/19 and recalled RTW A told her she did not know how long Client #1 had been on the patio that day. When interviewed on 6/11/19 at 9:00 a.m., RTW B confirmed knowledge of Client #1's restriction to be outside with 15-minute checks when the temperature was below 90 degrees per his ISP. She further confirmed Client #1 should not sit directly in the sun, should be offered fluids, and should only be outside for one hour. When interviewed on 6/11/19 at 9:45 a.m., RTW C confirmed she saw Client #1 outside at 1:45 p.m. on 6/5/19. She recalled she took Client #6 outside and saw Client #1 sitting on a metal chair in the sun. She said she had checked her phone and the temperature was 86 degrees at the time. She noted she saw Client #1 outside again at 2:15 p.m. and recalled RTW A held responsibility for him at the time. She further noted RTW D took Client #1 outside prior to RTW A's arrival on shift. She confirmed knowledge of his ISP and noted staff should check on him every 15 minutes, give him drinks and not exceed an hour exposure outside. When interviewed on 6/11/19 at 10:25 a.m., RTW A confirmed she worked with Client #1 on 6/5/19. She confirmed knowledge of Client #1's ISP and heat restrictions. She explained he could be outside for up to an hour with 15-minute checks and fluids offered. She noted he should not be in direct sunlight but stated in her experience with him, Client #1 sat in the sun and would scoot his chair out of the shade. RTW A confirmed knowledge of Client #1's restriction to be outside no longer than 1 hour but emphasized no one told her the exact time he went on the patio so she	W 249		

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W 249	Continued From page 14 assumed his hour started at 2:15 p.m. She said she checked on him at 2:30 p.m. and he seemed fine. She stated she offered him a drink but he looked away and did not take any fluid. RTW A recalled she engaged the other clients in an activity at the table and looked out the window to check on Client #1. Between 2:45 p.m. and 3:00 p.m., she said RTW E came into the area and asked about Client #1. RTW A went to the door and saw Client #1 slumped over in the chair with his chin on his chest. She recalled his eyes were closed and he was breathing rapidly. She said she and RTW E moved him out of the sun and RTW F made a STAT nursing call and called 911. She stated RTW E got a glass of water and offered Client #1 sips. She said other staff came and assisted Client #1 into a wheelchair and took him in the house at approximately 3:10 p.m. When interviewed on 6/11/19 at 11:25 a.m., Resident Treatment Supervisor (RTS) A confirmed he signed in to take responsibility for Client #1 on 6/5/19 at approximately 2:05 p.m. so RTW D could go work at another home. He recalled Client #1 sat outside on the patio but he failed to ask RTW D what time he went outside. He said Client #1 did not appear to be sitting in the sun when he saw him. RTS A left the home to provide assistance at another house and at that time, RTW A held responsibility for the clients, including Client #1. RTS A said he returned to the home and described Client #1 as "not good" when he saw him on the patio around 3:00 p.m. He confirmed Client #1 remained outside for over one hour on 6/5/19. When interviewed on 6/11/19 at 12:07 p.m., the	W 249		

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W 249	Continued From page 15 TPM confirmed according to his ISP, Client #1 should not sit directly in the sun when out on the patio. Observation at the home on 6/11/19 at 2:07 p.m., revealed a metal chair on the patio. RTW E pointed to the chair on the patio and confirmed Client #1 sat in the chair on 6/5/19. She noted she helped pull him out of the sun when staff found him unresponsive that day. When interviewed on 6/11/19 at 2:15 p.m., RTW F confirmed she took responsibility for Client #1 at 2:07 p.m. on 6/5/19. She recalled Client #1 sat outside on the patio at the time because RTW D took him outside at approximately 1:45 p.m. She estimated RTW A took over for the clients at approximately 2:10 p.m. so she went to the other side of the house to help RTW E reposition clients. She recalled she came back to help RTW A and saw Client #1 on the patio with his chin on his chest panting. She recalled RTW A and RTW F pulled his chair into the shade and offered him water. She made a STAT nursing call and called 911. She said Client #1 could not be outside if the temperature exceeded 90 degrees and she used her phone to check the temperature when she took him outside. She was unsure if he required 15-minute checks, but assumed staff should check on him and offer fluids. She said Client #1 could sit in the sun and noted staff applied sunscreen to keep him from getting sunburn. When interviewed on 6/11/19 at 3:00 p.m., RTW E said Client #1 could sit in direct sunlight as long as staff applied sunscreen. She knew staff should do 15 minute checks and offer fluids. She again confirmed she saw Client #1 sitting in	W 249		

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W 249	Continued From page 16	W 249		

the sun in a metal patio chair on 6/5/19. She said she went to help RTW A at approximately 3:00 - 3:10 p.m. on 6/5/19 and saw Client #1 shaking in his chair on the patio. She recalled she immediately went to him and shook his shoulder but he did not respond. She was unsure what time he went outside on 6/5/19.

When interviewed on 6/11/19 at 3:30 p.m., the Licensed Practical Nurse (LPN) confirmed he heard a nursing STAT call at 3:10 p.m. and arrived on site at 3:12 p.m. He said Client #1 did not respond to verbal or physical stimuli when he arrived on the patio. He recalled Client #1's legs were in the sun but his upper body was in the shade. He noted Client #1's upper extremities were shaking and he thought he was experiencing heat exhaustion. He confirmed the administration of oxygen due to a blood oxygen reading of 70 and explained the facility standard is 90. The LPN stated he thought Client #1's symptoms suggested prolonged heat exposure. He confirmed the client was in respiratory distress on 6/5/19, experienced rapid heartbeat and increased respirations. He explained the risks to him included stress on his heart, dehydration and heat stroke.

When interviewed on 6/11/19 at 4:05 p.m., RTS B recalled she responded to a call for help at House 254 on 6/5/19. She estimated she arrived at Client #1's home at 3:15 p.m. She said Client #1 was sitting in the sun on the patio and she described him as non-responsive when she rubbed his cheek. RTS B did not know the details of Client #1's ISP but said she knew where to find the information. She thought the incident could have been prevented if staff had followed the guidance in the ISP to check him every 15

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W 249	Continued From page 17 minutes, keep him out of direct sunlight and bring him inside after 1 hour. When interviewed on 6/12/19 at 10:38 a.m., the RN, Nurse Supervisor confirmed she discussed a request to allow Client #1 to be outside for more than ten minutes at a time with his PCP in June 2018. She recalled staff requested a new order, and then explained nursing staff only request orders for extreme temperatures. She added Client #1 took medications that made him susceptible to ill effects in extreme temperatures and noted a risk of dehydration and heat exhaustion. She acknowledged she provided "parameters" via e-mail to the TPM and the TPM then added the information to Client #1's ISP. She noted staff followed the order in place at the time because the order allowed Client #1 to be outside if the temperature was below 90 degrees. However, she confirmed staff failed to communicate what time he went outside. She confirmed staff failed to follow the guidance in the ISP. When re-interviewed on 6/12/19 at 11:25 a.m., RTW A stated she checked on Client #1 at 2:30 p.m. She acknowledged she repositioned Client #6 and attempted to calm Client #5 after checking on Client #1. She was unsure if she checked on Client #1 at 2:45 p.m., because she "was dealing with a lot that day". She acknowledged RTW D may have come to offer help at 3:00 p.m. rather than 2:45 p.m. She confirmed Client #1 was outside when RTW E and RTW F came to her side of the house. She again noted Client #1 refused a drink of water when she offered it to him at the 2:30 p.m. check. RTW A stated Client #1 should have come inside at 2:45 p.m. if RTW D took him outside at 1:45 p.m. She said	W 249		

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W 249	Continued From page 18 she did not bring Client #1 in the house at 2:45 p.m. because she had no awareness of when he went outside. When interviewed on 6/12/19 at 1:55 p.m., Client #1's PCP explained he attempted to give staff guidance regarding heat restrictions per their request in June 2018. He explained Client #1 had a restriction due to his seizure disorder and because of some of his medications. He noted the medications reduce the body's ability to sweat so heat stays in the body resulting in potential overheating. He confirmed the guidance to supervise Client #1 every 15 minutes, give him fluids and keep him out of the direct sunlight was discussed with him in 2018. He noted staff should have followed the guidance in the ISP to keep Client #1 safe from heat related illnesses. When interviewed on 6/13/19 at 9:00 a.m., RTW D confirmed he took Client #1 outside at 1:45 p.m. on 6/5/19. He stated he followed the ISP because he checked on him at 1:55 p.m. and offered him a drink. He stated he checked his phone and the temperature was 88 degrees when he took Client #1 outside. He said he assumed staff would bring him back inside by 2:45 p.m. He said Client #1 sat in the shade on a metal chair when he took him outside, but noted Client #1 was capable of scooting the chair into the sun. When re-interviewed on 6/13/19 at 9:55 a.m., the TPM confirmed staff failed to follow the parameters for heat exposure in Client #1's ISP. She confirmed the failure resulted in Client #1's incident of a heat related illness on 6/5/19. On 6/13/19 at approximately 10:50 a.m., Immediate Jeopardy (IJ) was determined based	W 249		

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W 249	Continued From page 19 on the facility's failure to ensure staff competency to implement Individual Support Plan (ISP) and facility policy and procedure. The facility was notified on 6/13/19 at 10:55 a.m. The facility developed a plan to remove the IJ which included re-training staff and revisions to documents to provide specific information and guidance to staff. The IJ was removed on 6/20/19 at 8:15 a.m.	W 249		

OK 7/18/19

Glenwood Resource Center
Plan of Correction
DIA Investigation #83723-I

✓ 7/24/19

W158

Individual Response:

GRC administered appropriate personnel action to the trained staff responsible for implementation of the ISP at the time of the incident.

Responsible: Treatment Program Administrator
Date Completed: 6/12/19

TPM revised Client #1's ISP to include that a staff must be with Client #1 any time he/she is outdoors. TPM re- trained assigned staff.

Responsible: Treatment Program Manager
Responsible to Monitor: Treatment Program Administrator
Date Completed: 6/13/19

TPM re-trained RTWs assigned to H 254 on the zone policy, emphasizing communication regarding clients' whereabouts, relevant incidents and cross shift exchange.

Responsible: Treatment Program Manager
Responsible to Monitor: Treatment Program Administrator
Date Completed: 6/13/19

Systemic Response:

GRC continues to train employees on hire and annually on ISPs, this training is competency based. In addition, RTWs continue to receive individualized ISP training on assigned clients. Appropriate implementation of the ISP is an expectation of the RTW position.

Responsible: Education and Training Services, Psychology Assistants
Responsible to Monitor: Superintendent, Treatment Program Managers
Date Completed: 7/12/19 and ongoing

RTSs and/or TPMs continue to be present for/participate in cross shift exchange; discussion includes individual's supports plans, active treatment needs and health status changes. RTSs/TPMs will provide immediate feedback on areas of needed attention.

Responsible: Resident Treatment Supervisors, Treatment Program Managers
Responsible to Monitor: Treatment Program Administrators
Date Completed: 7/12/19 and ongoing

W189

Individual Response:

GRC administered appropriate personnel action to the trained staff responsible for implementation of the ISP at the time of the incident.

Responsible: Treatment Program Administrator
Date Completed: 6/12/19

TPM revised zone sheets for House 254 to include specific documentation of when an individual is outdoors. TPM re-trained assigned staff.

Responsible: Treatment Program Manager
Responsible to Monitor: Treatment Program Administrator
Date Completed: 6/13/19

TPM re-trained RTWs assigned to H 254 on the zone policy, emphasizing communication regarding clients' whereabouts, relevant incidents and cross shift exchange.

Responsible: Treatment Program Manager
Responsible to Monitor: Treatment Program Administrator
Date Completed: 6/13/19

Systemic Response:
GRC re-trained TPMs, RTSs and Psychology Assistants on the zone policy, with an emphasis on accurate review of zone sheets, comprehensive review of zones for adequate coverage and providing immediate training for identified concerns.

Responsible: Treatment Program Administrators
Responsible to Monitor: Assistant Superintendent
Date Completed: 7/19/19

The Quality Management Department will implement random checks of zone activities in correspondence with zone sheets, giving immediate feedback and providing follow up to TPAs for areas of needed attention.

Responsible: Quality Management Director
Responsible to Monitor: Superintendent
Date Completed: 7/19/19 and ongoing

RTSs and/or TPMs continue to be present for/participate in cross shift exchange; discussion includes individual's supports plans, active treatment needs and health status changes. RTSs/TPMs will provide immediate feedback on areas of needed attention.

Responsible: Resident Treatment Supervisors, Treatment Program Managers
Responsible to Monitor: Treatment Program Administrators
Date Completed: 7/12/19 and ongoing

W249
Individual Response:
GRC administered appropriate personnel action to the trained staff responsible for implementation of the ISP at the time of the incident.

Responsible: Treatment Program Administrator
Date Completed: 6/12/19

TPM revised Client #1's ISP to include that a staff must be with Client #1 any time he/she is outdoors. TPM re- trained assigned staff.

Responsible: Treatment Program Manager
Responsible to Monitor: Treatment Program Administrator
Date Completed: 6/13/19

Systemic Response:

GRC continues to train employees on hire and annually on ISPs, this training is competency based. In addition, RTWs continue to receive individualized ISP training on assigned clients. Appropriate implementation of the ISP is an expectation of the RTW position.

Responsible: Education and Training Services, Psychology Assistants
Responsible to Monitor: Superintendent, Treatment Program Managers
Date Completed: 7/12/19 and ongoing

RTSs and/or TPMs continue to be present for/participate in cross shift exchange; discussion includes individual's supports plans, active treatment needs and health status changes. RTSs/TPMs will provide immediate feedback on areas of needed attention.

Responsible: Resident Treatment Supervisors, Treatment Program Managers
Responsible to Monitor: Treatment Program Administrators
Date Completed: 7/12/19 and ongoing