STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G017	A. BUILDING _____ B. WING _____	C 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE HOMES	5945 MORNINGSIDE AVENUE SIOUX CITY, IA 51106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The investigation of #85217-C and #85611-I were conducted 9/9/19 - 9/12/19. As a result of #85217-C, no deficiencies were cited. As a result of #85611-I, deficiencies were cited at W153 and W155.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegations of abuse were reported to the Iowa Department of Inspections and Appeals (DIA), as required. This affected 1 of 1 client (Client #2) involved in the investigation of #85611-I. Finding follows: Record review on 9/10/19 revealed a facility Injury Report (IR), dated 7/5/19, for Client #2. The IR noted it was reported Residential Living Assistant (RLA) A spit on Client #2. RLA A was separated from Client #2 and the facility initiated an internal investigation. The IR Investigation section noted "Upon investigation there are no witnesses to any incident of spitting at (Client #2)."	W 153		

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

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W 153	Continued From page 1 When interviewed on 9/10/19 at 11:15 a.m., the Qualified Intellectual Disability Professional (QIDP) confirmed the allegation was not reported to the DIA. She stated the facility had not reported the allegation because the internal investigation revealed it was issues between staff and no one had witnessed the alleged incident. The QIDP reviewed the facility policy and stated the allegation could have been considered a type of personal degradation, based on the facility policy definitions. The facility reported the allegation to the DIA on 9/10/19 after instructed to by the Surveyor. Additional record review revealed facility policy "Mid-Step Services, Inc. Child and Dependent Adult Abuse Policy" last revised 8/2/17. The policy instructed all allegations of abuse were to be immediately reported to the administrative officer and the DIA.	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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure continued separation between an alleged perpetrator and victim following an allegation of abuse. This affected 1 of 1 client (Client #2) involved in the investigation of #85611-I. Finding follows: Record review on 9/10/19 revealed a facility Injury Report (IR), dated 7/5/19, for Client #2. The IR	W 155		

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W 155	Continued From page 2	W 155		

noted it was reported Residential Living Assistant (RLA) A spit on Client #2. RLA A was separated from Client #2 on 7/5/19 after the allegation was reported and the facility immediately initiated an internal investigation.

When interviewed on 9/10/19 at 11:15 a.m., the Qualified Intellectual Disability Professional (QIDP) explained RLA A was sent home as soon as the allegation was reported. She explained the facility conducted an internal investigation into the allegation and found there were no witnesses to the alleged incident and it appeared to be staff issues. The QIDP confirmed RLA A was allowed to return to work in House 2 following the internal investigation. She said she was unsure if RLA A had been assigned to Client #2's group but explained RLA A would have had contact with Client #2 because all staff were responsible for all clients who resided in the house.

Additional record review revealed House 2 staff schedules dated 7/5/19 - 9/10/19. According to the schedules RLA A worked on: 7/6/19, 7/7/19, 7/10-13/19, 7/18-21/19, 7/24-28/19, 8/2-4/19, 8/7-11/19, 8/15-18/19, 8/21-25/19, 8/30-9/1/19, and 9/5-8/19. The staff schedules revealed no group assignments were noted on 7/19/19, 7/20/19, and 7/21/19; all other days RLA A had worked she was not assigned to Client #2's group. On 9/10/19, the Surveyor instructed the facility RLA A was to have no contact with Client #2 pending the outcome of the DIA investigation into the allegation. The facility moved RLA A to work in another house when she returned to work on 9/11/19.

When interviewed on 9/11/19 at 1:20 p.m., RLA A reported on 7/5/19 she was sent home and

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W 155	Continued From page 3 returned to work in House 2 on 7/6/19 after the QIDP had finished the investigation. She said she could not recall being assigned to Client #2 but explained she had contact with Client #2 since all staff work together with all of the clients in the home. Review of facility policy titled "Mid-Step Services Inc. Child and Dependent Adult Abuse Policy", last revised 8/2/17, instructed the alleged abuser was to be separated from the victim until the abuse investigation was completed. The policy noted the investigation included both the internal investigation and any investigation which may be conducted by the DIA.	W 155		