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 11/17/2020

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GLENWOOD RESOURCE CENTER	711 SOUTH VINE STREET GLENWOOD, IA 51534

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W 000	INITIAL COMMENTS The following onsite survey actions were completed 9/14/20 - 11/17/20. A summary of our findings is as follows: Investigation #92297-M was completed and resulted in a deficiency written at W331. On 10/30/20 at 4:20 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to provide nursing care as identified by client needs. The facility developed a plan to remove the IJ, which included retraining on emesis assessments and who can call 911. On 11/4/20 at 3:47 p.m., the IJ was removed from the facility. Investigation #91534-I resulted in a deficiency cited at W153. Investigation #91535-I resulted in a deficiency cited at W153. Investigation #91536-I resulted in a deficiency cited at W153. Investigation #91538-I resulted in a deficiency cited at W153. Investigation #91684-I resulted in a deficiency cited at W288. Investigation #92343-I resulted in deficiencies cited at W153 and W267. Investigation #92346-I resulted in deficiencies cited at W153. Investigation #92436-I resulted in deficiencies	W 000	See attached POC 1/8/21	

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 000	Continued From page 1 cited at W153, W192 and W267. Investigation #93070-I resulted in a deficiency cited at W193. Investigation #93434-I resulted in a deficiency cited at W288. Investigation #93741-I resulted in a deficiency cited at W193. Investigation #93815-I resulted in deficiencies cited at W288. No deficiencies were cited as a result of investigations: #90207-C, #90408-I, #90774-C, #91257-I, #91531-I, #91532-I, #91533-I, #91537-I, #92338-I, #92345-I, #92347-I, #92452-I, #92570-I, #93280-I, #93741-I and #94081-I. The following revisits were also completed. A summary of findings is as follows: Investigations and Revisits completed 10/09/19: Investigations #85377-I, #86003-I and #86006-I previously resulted in deficiencies cited at W186 and W249. A revisit for the annual survey and investigations #80823-I, #80822-I, #80772-I, #80773-I, #81264-I, #81265-I, #81653-I, #81670-I, #81789-I, #8185-I, #81879-I and #81878-I had deficiencies not met and re-cited at W249, W296, W374. Based on the current revisit, all previously cited deficiencies were determined to be corrected and met. Investigations competed 1/15/20: Investigations #87434-I, 87037-C, 87515-I, 87340-I, 87338-I	W 000		

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W 000	Continued From page 2 and #87695-I resulted in deficiencies cited at W125, W155, W193, W249, W288. The previously cited deficiencies have been corrected and met, with the exception of W193 and W288 as noted above. Annual Survey and Investigations completed 3/10/20: The annual survey resulted in deficiencies cited at W125, W159, W189, W268, and W289. Investigations #89317-I, #89366-I, #89363-I and #87631-I resulted in deficiencies cited at W153, W154, W249 and W339. The previously cited deficiencies have been corrected and met, with the exception of W153, as noted above. Investigation completed 3/05/20: Investigation #87783-I resulted in a deficiency cited at W368. The previously cited deficiency has been corrected and met. Investigation completed 4/23/20: Investigation #87699-I resulted in a deficiency cited at W322. The previously cited deficiency was determined to be corrected and met. As the result of the current visit, a new deficiency was cited at W 192, based on observations during medication administration. There were no deficiencies cited as a result of the onsite focused infection control survey.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)	W 153		

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W 153	Continued From page 3 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 client abuse/mistreatment. This affected 1 of 1 client identified during the investigation of #92346-I (Client #1), 3 of 3 clients identified during the investigation of #92436-I (Clients #2, #9, #10), 5 of 5 clients identified during the investigation of #92343-I (Client #3, Client #4, Client #11, Client #12 and Client #13), 1 of 1 client identified during the investigation of #91538-I (Client #8), 1 of 1 client identified during the investigation of 91536-I (Client #17), 1 of 1 client identified during the investigation of #91535-I (Client #18) and 1 of 1 client identified during the investigation of #91534-I (Client #19). Findings follow: 1. Record review on 9/22/20 revealed a facility investigation regarding an allegation made at House 465. An Incident Report for Client #1 dated 7/10/20 noted, "Staff came to my office this afternoon, and reported while (Client #1) was on the toilet last night, that she suspects that another staff was recording the client's verbal outbursts. She believes this because she talked to the individual while he was yelling, and heard her voice played back a short moment later." The facility investigation indicated the alleged incident occurred on 7/9/20. The investigation also indicated the facility reported the incident to the	W 153		

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W 153	Continued From page 4 Department of Inspections and Appeals (DIA) on 7/10/20 at 6:49 p.m. When interviewed on 9/23/20 at 10:00 a.m. RTW CC reported she witnessed the potential abuse on 7/9/20 during the evening shift. She stated she did not report the incident right away because she had to think about it. She did not want anyone to get into trouble. When interviewed on 9/23/20 at 9:35 p.m. RTS J confirmed the staff person failed to report the incident of potential abuse immediately. She stated RTW CC should have reported the incident right away, instead of the following day. 2. Record review on 9/14/20 revealed a facility investigation regarding allegations made at House 464. Resident Treatment Worker (RTW) A reported in a written statement dated 7/12/20 RTW B and RTW C mistreated Client #2, Client #9 and Client #10 during June and July of 2020. RTW A wrote she witnessed RTW B and RTW C call Client #9 a "broke [expletive]" and then laugh as the client repeated, "broke [expletive]." According to the written statement RTW A also heard heard RTW B say she had given Client #2 a taste of her slushy. Client #2 received all nutrition, liquids and medication via jejunostomy tube (J-tube). He had a physician's order for NPO (nothing by mouth). RTW A also wrote she had heard RTW C say she sprayed Client #10 in the face during his shower because he tried to hit her and she did that when "they piss me off." When interviewed on 9/16/20 at 3:25 p.m. RTW A stated she wrote a statement on 7/12/20 regarding her concerns about RTW B and RTW	W 153		

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W 153	Continued From page 5 C. She gave the written statement to LPN A on 7/13/20, who notified administrative staff of the allegations of client mistreatment. One of the concerns she noted was an evening in late June or early July, RTW B came into a common area of the house and said she had given Client #2 a little taste of her slushy by putting a small amount on his lips. RTW B said Client #2 loved it. RTW A said RTW B came up behind her after making the statement and put something that felt like a pen in RTW A's back as RTW B said if anyone said anything, she would "kick their [expletive]." RTW A also reported RTW B and RTW C called Client #9 a "broke [expletive]" on the evening of 7/10/20 and laughed as Client #9 repeated the phrase. RTW A said she also heard RTW C say "broke [expletive]" to Client #9 two other times in the week prior to 7/10/20. RTW B and RTW C would laugh when Client #9 repeated the phrase. A third allegation noted was the evening of 7/10/20, RTW C said she sprayed Client #10 in the face during a shower after he tried to hit her. RTW C reportedly said she did that "when they piss me off." RTW A did not immediately report these allegations. She didn't work on 7/11/20 or 7/12/20. RTW A said she wrote a statement with her concerns on 7/12/20 and handed the statement to LPN A on the afternoon of 7/13/20. LPN A contacted management staff to report the allegations. When asked why she had not reported the allegations immediately, RTW A said she was a new staff and she wasn't sure who to report to. She said she didn't see much of Resident Treatment Supervisor (RTS) A on the PM shift. RTW A was hired at the facility in May 2020 and began working at House 464 in mid-June 2020. Since she reported the incident, RTW A said she received additional training on immediately reporting allegations of abuse.	W 153		

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W 153	Continued From page 6 3. Record review on 9/29/20 revealed a facility investigation regarding allegations made at House 250. RTW H wrote an email to RTS B on 7/05/20 expressing concerns about RTW G. RTW H wrote RTW G told Client #3 and Client #4 they could not have their dessert if they didn't eat their other food items at meal time. RTW H also alleged RTW G told Client #3 she would not get her chocolate milk unless she ate her other food. RTS B saw the email on the morning of 7/06/20 and the allegation was reported to the facility investigations department the same morning, but two days to one week after the alleged incidents. During the course of the facility investigation, other staff reported they heard RTW G tell Client #13 to shut up and heard her tell Client #11 she needed to finish her lunch if wanted dessert, which had not been reported to the investigations department at the time the incidents occurred. When interviewed on 10/02/20 at 10:00 a.m. RTW H said she sent an email to RTS B on 7/05/20 regarding concerns she had about RTW G. RTW H said during either lunch or dinner on 7/04/20 she was in the same dining room with RTW G. RTW G was assisting Client #3 and Client #4 during the meal. RTW G told Client #3 she could not have her dessert or her chocolate milk if she didn't eat her other food. RTW G also told Client #4 she couldn't have her dessert if she didn't eat her other food. RTW H didn't know whether RTW G actually withheld the dessert and chocolate milk from the two clients. RTW H said about one week prior to the incident on 7/04/20, RTW G insisted Client #12 eat her peas during a meal. Client #12 said, "No!," and turned her head away, but RTW G shoved peas into Client #12's	W 153		

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W 153	Continued From page 7 mouth at one point. RTW G also told Client #12 she wouldn't get her chocolate milk if she didn't eat her peas. Another time about one week prior to 7/04/20, RTW H heard RTW G yell at Client #12 to eat her vegetables. RTW H said she thought she reported the incidents regarding Client #12 at the time they occurred, but she didn't recall who she reported to. When interviewed on 9/23/20 at 1:00 p.m. RTS B stated he saw the email from RTW H on the morning of 7/06/20, which she sent on 7/05/20. RTS B said RTW H made complaints about RTW G in the email, including RTW G telling Client #3 and Client #4 they could not get their dessert until they ate their meals. RTS B said he forwarded the email to Qualified Intellectual Disability Professional (QIDP) C on 7/06/20. RTS B also stated he saw an email from RTW K on 6/28/20, which had been sent on 6/27/20. RTW K wrote in the email RTW G told Client #13 to shut up. RTW K indicated he talked with QIDP C about the incident on 6/27/20. RTS B forwarded the email to Treatment Program Administrator (TPA) A and questioned why QIDP C had not addressed the issue when it was brought to his attention. RTS B said if a staff person was accused of telling a client to shut up, it should have been immediately reported, an Incident Report written and reported to the facility investigations department. RTW K reportedly told QIDP C about the incident on 6/27/20, so QIDP C should have immediately reported it to the investigations department, but he didn't. RTS B said he forwarded RTW K's email to the TPA on 6/28/20 and he spoke to her about it. He assumed either QIDP C or TPA A reported the allegation of mistreatment (RTW G allegedly telling Client #13 to shut up) to the facility investigations department.	W 153		

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W 153	Continued From page 8 When interviewed on 9/23/20 at 3:00 p.m. RTW K stated he talked with RTW G in the past about her voice tone with clients, because sometimes she spoke in a harsh, demanding tone. There was an incident in late June when RTW G walked Client #13 to the medication room. RTW K, the med passer, heard Client #13 tell RTW G to "shut up." RTW G responded to Client #13 in a harsh tone and said, "No, you shut up!" RTW K said he told RTW G she could not talk to clients like that. RTW K said he reported the incident to QIDP C within about 40 minutes of its occurrence. QIDP C told RTW K to send an email to RTS B about the incident. RTW K thought he sent the email the same evening, on 6/27/20. A review of the email sent by RTW K to RTS B on 6/27/20 at 10:14 p.m. revealed RTW K expressed concerns about RTW G. RTW K wrote RTW G was 'mouthy" with the clients and it was increasingly malicious. He wrote Client #13 told RTW G to shut up and she told Client #13 she was the one who needed to shut up. RTW K noted in the email he brought up his concerns to QIDP C, who told him to email RTS B. RTS B forwarded the email to TPA A on 6/28/20 at 6:39 a.m., complaining QIDP C had not dealt with the issue. When interviewed on 9/23/20 at 1:45 p.m. QIDP C stated he recalled RTW K told him of concerns about RTW G in late June. QIDP C acknowledged RTW K told him he heard RTW G say to Client #13, "No, you shut up!" QIDP C told RTW K to email RTS B regarding the concern. When asked why he didn't report the allegation of possible mistreatment, QIDP C said he just didn't think about it.	W 153		

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W 153	Continued From page 9 When interviewed on 9/23/20 at 3:15 p.m. TPA A confirmed RTS B forwarded her an email on 6/28/20 from RTW K regarding concerns about RTW G. She recalled RTW K had concerns about RTW G's tone of voice with the clients and telling Client #13, "No, you shut up!" TPA A contacted RTS B about the email and his primary concern seemed to be about QIDP C's lack of follow through to address the situation. TPA A saw the issue as a conflict between RTS B and QIDP C. She assumed one of them reported the allegation to the facility Investigations department. She talked with QIDP C about his job duties and being more supportive of RTS B. TPA A acknowledged she did not check to ensure the allegation regarding RTW G had been reported to the investigations department. When interviewed on 9/23/20 at 10:45 a.m. RTW I stated she worked first shift at House 250 on 7/04/20. During lunch, RTW I heard RTW G tell someone they couldn't have dessert until after they ate their lunch. RTW G was in the other dining room, so RTW I didn't know who RTW G was talking to. She said RTW G's tone sounded serious, but she didn't know if the client(s) got their dessert or not. RTW I said she didn't say anything to RTW G about it or report the incident. When interviewed on 9/23/20 at 10:20 a.m. RTW J said she worked first shift on 7/04/20. She was with RTW G in the same dining room during lunch time. RTW J said she heard RTW G tell Client #11 she needed to finish her meal if she wanted dessert. RTW J recalled Client #11 didn't like the meat they had for lunch. She was turning her head away and kind of spitting out the meat. RTW G told Client #11 she needed to eat the	W 153		

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W 153	Continued From page 10 meat so she could have dessert. RTW J said she told RTW G Client #11 didn't like certain meats, but RTW G continued to try to get Client #11 to eat the meat. RTW J didn't notice whether Client #11 got dessert or if it was withheld. RTW J didn't report the incident because it didn't seem abusive to her. She thought RTW G just wanted to make sure Client #11 ate a good meal. 4. Record review on 9/22/20 revealed a facility investigation regarding allegations made at House 242. RTW S reported to RTS H on 4/27/20 Client #19 accused RTW T of calling Client #19 a racial slur on 4/25/20. RTW S did not immediately report the allegation according to facility protocol. Client #19 alleged RTS H also heard RTW T say the racial slur. RTW S failed to follow the Incident Management Policy regarding immediate reporting. RTW T stated he did not use a racial slur toward Client #19 and he would never do that. When interviewed on 9/29/20 at 9:30 a.m. RTW S stated she wrote a statement on 4/27/20 regarding her concerns about RTW T and the allegation made by Client #19. She stated Client #19 told her on 4/25/20 RTW T called him a racial slur. When asked if anyone heard this, Client #19 said RTS H heard the racial slur and told RTW T to take a walk. RTW S said she asked Client #19 about this three more times on 4/25/20 and he provided the same information. On 4/27/20 RTW S asked Client #19 about it again and he said it never happened. She stated Client #19 seemed scared. RTW S said she was aware of the incident management policy and did not report it on 4/25/20 as she was shocked. She reported the incident to RTS H on 4/27/20. RTW S said Client #19 sometimes said things that were not true to	W 153		

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W 153	Continued From page 11	W 153		

get attention and she did not believe RTS T actually called Client #19 the n-word.

When interviewed on 9/23/20 at 9:30 a.m. Client #19 said the issue was resolved. When asked if RTW T called him a racial slur, Client #19 indicated he had not. When asked if he was scared or mistreated, Client #19 said he was not scared or mistreated and the staff RTW T was a good staff and nice.

When interviewed on 9/29/20 RTS H stated RTW S notified him of the allegation on the morning of 4/27/20. Client #9 told RTW S of the allegation on 4/25/20. RTS H said RTW S reported the conversation to him around 8:30 a.m. on 4/27/20 and he reported the allegation to the appropriate facility authority around 2:00 p.m. the same day, which was not within the facility two hour protocol. RTS H confirmed both he and RTW S should have reported the allegation immediately according to policy.

5. Record review on 9/22/20 revealed a facility investigation regarding allegations made at House 473. RTS C reported while reviewing end of shift reports on 4/10/20 at 11:30 p.m., he read the body of an incident report regarding Client #18. The report, completed at 7:18 p.m. on 4/10/20 by RTW U, stated Client #18 made an allegation she was going to report RTW U for kicking and stepping on her. RTS C said the allegation was not reported to a supervisor and the facility policy regarding reporting allegations of abuse was not followed.

When interviewed on 9/29/20 at 11:00 a.m. RTW U stated she wrote an incident report on 4/10/20 when Client #18 made the allegation on the PM

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W 153	Continued From page 12 shift. RTW U said Client #18 punched her on the back of the head. She went to her room and started self-injurious behaviors of banging her head. RTW U said she and other staff blocked and redirected the behaviors but did not use a restraint. Client #18 stated after the incident RTW U kicked and stepped on her. RTW U said she reported the incident to RTS F when he was at House 473. RTW U stated she completed the incident report and reported it to RTS F so she felt she followed her responsibilities. When interviewed on 10/7/20 at 9:30 a.m. Client #18 confirmed staff kicked and stepped on her during the incident. She said she was being restrained and did not remember all of the staff involved, other than RTW U. Client #18 also said RTW U is nice to her and a good staff. When interviewed on 9/30/20, RTS F stated he was at House 473 on 4/10/20, but did not remember being notified of the allegation of abuse on that date. He said RTW U reported Client #18 had self-injurious behaviors, but did not recall RTW U told him of an allegation of abuse made by Client #18. RTS F further stated he looked at the incident reports but must have missed the allegation and he did not report the allegation. He acknowledged both he and RTW U should have reported the allegation immediately according to policy Record review on 9/22/20 revealed and Incident report dated 4/10/20. The incident report stated Client #18 reported staff kicking and stepping on her. The incident report was completed on 4/10/20 at 7:18 p.m. by RTW U. When interviewed on 9/22/20 at 3:30 p.m. the	W 153		

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W 153	Continued From page 13 Director of Quality Management stated the staff were required to immediately report any allegation of abuse, in accordance with the facility Incident Management policy. 6. Record review on 9/22/20 revealed a facility investigation regarding allegations made at House 470. Client #17 wrote a note claiming a staff member touched her inappropriately. RTS F reported while working the PM shift on 5/21/20 he received a call from RTW V. She stated she was given a note by Client #17 and wanted to give the note to RTS F. RTS F gave a note to RTS C, who was the covering Administrator On Duty (AOD), the next day, on 5/22/20. RTS C stated the note was an allegation by Client #17 RTW V touched her inappropriately. RTS C gave the note to the investigations department on 5/22/20, which began an investigation. RTS C acknowledged the allegation was not reported immediately by RTS F and the facility policy was not followed. When interviewed on 10/8/20 at 3:00 p.m. RTW V stated she received a handwritten note from Client #17 on 5/21/20. She stated the note was hard to read or understand so she gave it to RTS F. She was told the next day she could not sign into Client #17. The note accused RTW V of inappropriate touching of Client #17. RTW V stated she never touched Client #17 in any way. When interviewed on 9/30/20 at 5:15 a.m. RN A stated she went to House 470 to complete an assessment after an alleged sexual assault. RN A stated Client #17 made a sexual allegation against staff RTW V. The assessment showed no signs or symptoms of sexual assault. RN A said Client #17 would frequently make allegations that	W 153		

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W 153	Continued From page 14 were not true. When interviewed on 9/29/20 at 11:30 a.m. RTS C, who was the covering AOD, stated RTS F received a note on 5/21/20 that was an allegation of inappropriate touching. RTS F failed to immediately report the allegation and gave the note to RTS C on 5/22/20. RTS C then reported the incident and gave the note to the facility investigation department on 5/22/20. 7. Record review on 9/22/20 revealed a facility investigation regarding allegations made at House 473 on 5/20/20. RTS E stated he arrived at House 473 on the morning of 5/20/20 and began reviewing records from the previous night. He stated he found an Incident Report dated 5/19/20 at 7:33 p.m. regarding Client #8's behavioral incident and a nursing assessment for Client #8. The reason noted for the nursing assessment was for reported abuse, but RTS E stated he did not find any corresponding incident report for the abuse allegation. RTS E contacted RTW W and asked why an incident report was not completed for the allegation of abuse. RTW W said RTS F, who was the covering RTS and AOD at the time, told RTW W he did not need to complete an Incident Report as Client #8 made an allegation but did not specifically name anyone who abused her. RTS E wrote an incident report on 5/20/20 regarding the allegation made on 5/19/20. He gave the information and report to the investigations department and an investigation was started. RTS E acknowledged the allegation was not reported immediately by RTS F and the facility policy was not followed. Client #8 was questioned during the facility investigation and she alleged RTW W grabbed and pinched her left arm. She also alleged RTW	W 153		

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W 153	Continued From page 15 V said she was going to "f****" her up, referring to Client #8. When interviewed on 10/8/20 at 3:00 p.m. RTW W stated he worked with Client #8 the evening she made the allegations. RTW W stated between 6-6:45 p.m. Client #8 became upset. She was not allowed to go to Camp Campbell as she was still under restrictions. Client #8 became agitated so RTS F was contacted as he was the AOD. RTW W stated Client #8 started to grab silverware and make threats. He had to block this behavior and redirect Client #8. RTW W said Client #8 was screaming she had been abused so he called LPN A who came to the house to do an assessment. He completed an Incident Report and called to nurse for an assessment. He also reported to RTS F the allegations made by Client #8. When interviewed on 9/30/20 at 5:15 a.m. LPN A stated she went to House 473 to complete an assessment after an alleged assault. LPN A stated Client #8 made an allegation against RTW W. The assessment showed no signs or symptoms of assault. LPN A said Client #8 would make allegations that were not true and no marks or bruising could be found during the assessment. When interviewed on 10/14/20 at 12:45 a.m. RTS E stated on 5/20/20 he saw the behavioral Incident Report and nursing assessment written on 5/19/20 while reviewing information from the day before. He stated the allegation had been reported to RTS F who did not do the proper reporting. As soon as it was reported to him as potential abuse, RTS F should have followed the facility policy and reported as potential abuse.	W 153		

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W 153	Continued From page 16 RTS F did not do this, so an Incident Report was completed the following day for potential abuse by RTS E. The allegation of abuse should have been reported immediately. 8. Review of the facility Incident Management Policy on 9/22/20 revealed staff should immediately report all allegations of abuse to a supervisor, who will then immediately report the allegation to the facility superintendent or the superintendent's designee. When interviewed on 9/23/20 at 4:30 p.m. the Interim Superintendent confirmed staff should report all allegations of abuse immediately. She reported staff were trained to report allegations of abuse/neglect/mistreatment within two hours of the incident.	W 153		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD Is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure staff consistently addressed clients' individual health care needs. This affected 1 of 3 clients identified during the investigation of #92436-I (Client #2) and 1 of 12 clients observed during a medication pass (Client #11). Findings follow: 1. Record review on 9/14/20 revealed a facility investigation regarding allegations made at House 464. Resident Treatment Worker (RTW)	W 192		

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W 192	Continued From page 17 A reported in a written statement dated 7/12/20 RTW B gave Client #2 a taste of her slushy in June or July of 2020. Client #2 received all nutrition, liquids and medication by a jejunostomy tube (J-tube). He had a physician's order for NPO (nothing by mouth). Record review on 9/16/20 revealed Client #2 had diagnoses including reactive airway disease and dysphagia. Client #2 required 1-to-1 staff supervision due to a history of pulling out his J-tube. Client #2 had surgery to insert a tracheostomy tube in early July 2020. According to Client #2's Individual Support Plan (ISP) dated 5/06/20, he had a nursing care plan with the goal to remain free of complications related to respiratory compromise/pneumonia. He received chest percussions daily from the respiratory therapist and received oxygen when in bed and as needed to keep his oxygen saturations above 90%. Client #2 had gastrostomy tube (G-tube) and J-tube placement in 2008. According to the ISP, Client #2 received all nutrition, hydration and medication via enteral tube. He had no functional chew, no swallow response and no cough after aspiration. The ISP noted, "Remember that (Client #2) is at risk for choking, moderate risk for pneumonia and high risk for aspiration. Don't give (Client #2) anything by mouth." According to the ISP, Client #2 had profound Dysphagia with silent aspiration. He was NPO and not a candidate for oral feeding trials. Client #2's Physical Nutritional Management Plan (PNMP) also noted that he was at risk for choking, pneumonia and aspiration, received all nutrition via external tube and was NPO (nothing by mouth). Client #2 had a nursing assessment on 7/13/20, the day after RTW A wrote RTW B had given him a taste of her slushy in late June.	W 192		

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W 192	Continued From page 18 There were no known adverse side effects of the taste of slushy reported by RTW A. When interviewed on 9/16/20 at 3:25 p.m. RTW A said she wrote a statement on 7/12/20 regarding her concerns about RTW B and RTW C. She gave the statement to LPN A on 7/13/20, who notified administrative staff of the allegations of client mistreatment. One of the concerns was an evening in late June or early July, RTW B came into a common area of the house and said she had given Client #2 a little taste of her slushy, by putting a small amount on his lips. RTW B said Client #2 loved it. RTW A said RTW B came up behind her after making the statement and put something that felt like a pen in RTW A's back as she said if anyone said anything, she would kick their ass. RTW A was a newer staff at House 464 and did not immediately report the allegation. When interviewed on 9/16/20 at 10:30 a.m. RTW D stated she regularly worked at House 464 and was very familiar with Client #2. RTW D said Client #2 was not allowed to have anything to eat or drink orally, not even pleasure tastes. She said the staff knew this. RTW D said Client #2 aspirated on his own saliva. RTW D recalled a time in June or July of 2020 when RTW B said she would like to let Client #2 taste something on her finger to see his reaction. RTW D reminded RTW B Client #2 couldn't have anything by mouth. RTW D told RTW B of a staff person at another house who had done something similar and got into trouble. RTW D stated she didn't know whether RTW B gave Client #2 a taste of a food or a drink. She said it was not uncommon for staff to bring drinks into work with them. When interviewed on 9/16/20 at 4:00 p.m. RTW F	W 192		

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W 192	Continued From page 19 confirmed he was a regular PM shift staff at House 464. He said he had concerns about the lack of work ethic by RTW B. She sometimes didn't complete their job duties. RTW F had concerns about RTW B not doing client showers and oral hygiene. RTW B became defensive when he tried to talk to her about his concerns regarding client care. RTW F said he has also told Resident Treatment Supervisor (RTS) A of his concerns regarding RTW B. RTW F said it was well known among staff Client #2 could not have anything to eat or drink by mouth. When interviewed on 9/16/20 at 2:20 p.m. RTW E stated she typically worked the overnight shift at House 464, but also filled in on the AM and PM shift. RTW E said she tried to teach newer staff how to do things correctly. She noticed RTW B didn't always do things correctly and RTW E pointed things out to her, such as elevating beds correctly. RTW B didn't like it when RTW E tried to correct her actions and she said RTW E was rude. There were also times when it seemed like RTW B had not given clients their showers. RTW E spoke to RTW B about that, but RTW B became "obnoxious" when RTW E tried to discuss concerns with her. RTW E told RTS A about concerns RTW B did not give client showers. RTW E said RTW B didn't like taking advice from others. RTW B acted like she knew it all. RTW E said Client #2 was not supposed to have anything by mouth and this was well known among all the staff. When interviewed on 9/17/20 at 10:00 a.m. RTS A stated she had been the supervisor at House 464 for many years. She said it was made clear to all staff Client #2 could not have anything to eat or drink by mouth. He had a history of aspiration	W 192		

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W 192	Continued From page 20 pneumonia. He even aspirated his saliva. RTS A said RTW B began working at House 464 in December 2019. RTS A had reports from other staff about RTW B not showering and shaving clients. She addressed this with RTW B in the spring of 2020. RTS A also did retraining with RTW B regarding documentation. RTS A didn't support RTW B staying past her six month probationary period, but that was not her decision to make. According to RTS A, RTW B didn't always make good decisions. When interviewed on 9/30/20 at 3:00 p.m. RTW B denied she ever gave Client #2 anything to eat or drink by mouth. She said she recalled bringing a slushy into work one day and Client #2 reached for it, but she put it away and didn't give him any of it. RTW B said she knew she would get into trouble if she gave Client #2 a drink. When asked if she knew what might happen if Client #2 had food or drink by mouth, RTW B said she didn't know, but she speculated he might vomit. RTW B gave no indication she was aware food or drink could lead to aspiration pneumonia for Client #2, which could be life threatening. 2. Observation on 10/06/20 at 4:10 p.m. revealed RTW K set up and administered medications to Client #11. During the medication pass, RTW K chatted to Client #11 and to the surveyor. He mentioned Client #11 was on a pureed diet and many of her medications had been switched to liquids. RTW K set up liquid medications for Client #11, but also set up two pills: a Senna-Docusate 8.6 MG-50 MG tablet and a Calcium/Vitamin D 500 MG-5 MCG tablet. The Calcium/Vitamin D tablet was a large pill. RTW K mixed the two pills with yogurt and began to spoon the medication mixture into Client #11's	W 192		

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W 192	Continued From page 21 mouth. The surveyor asked if the medication should be crushed since Client #11 was on a pureed diet. RTW K said Client #11's pills did not need to be crushed and he proceeded to give the medication to Client #11. Record review on 10/07/20 revealed Client #11's Physical Nutritional Management Plan (PNMP), which indicated Client #11 received a textured pureed diet. Under the Medication Administration section on the form, the plan noted, "Meds not in liquid form are to be: Meds to be crushed in pureed medium." When interviewed on 10/07/20 at 10:25 a.m. the Administrator of Nursing confirmed Client #11's tablets/pills should have been crushed prior to administration.	W 192		
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff provided the level of client supervision as required by client behavior programs/plans. This affected 2 of 2 clients identified in the investigation of #93070-I (Client #14 and Client #15) and 1 of 1 client identified during the investigation of #93741-I (Client #5). Findings follow: 1. Record review on 10/06/20 revealed a facility investigation regarding an incident on 8/06/20,	W 193		

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W 193	Continued From page 22 when Client #15 and Client #16 had a physical altercation, resulting in facial injuries to Client #15. According to the investigation, Client #15 was supposed to have 1-to-1 staff supervision, but Resident Treatment Worker (RTW) M, who was assigned to Client #15, had gone outside for a cigarette break. She left RTW N with Client #15 and six other clients to supervise, including Client #16. While RTW M was gone on a break, Client #15 and Client #16 had a physical altercation with only RTW N present to manage the situation. RTW O was in another part of the house supervising a 1-to-1 client and paged for staff assistance to the house. Staff from other areas arrived to help deal with the situation. RTW M came back into the house after other staff arrived to provide assistance. Record review on 10/06/20 revealed Client #15 had a behavior support program (BSP) in place with target behaviors of aggression, skin picking and problematic sexual behavior. According to Client #15's BSP, he required a 1-to-1 level of supervision, 24 hours per day. The BSP noted staff must be prepared to interrupt aggression or problematic sexual behavior. Staff assigned to Client #15 could interact with Client #15's peers and do other RTW duties such as charting and cleaning, but could not provide direct care/supervision for other clients. A nursing assessment conducted after the altercation on 8/06/20 noted Client #15 had a 1.5 cm diameter red open area to the right medial aspect of eyebrow with slight swelling, a 0.5 cm but to the top of his left ear with redness swelling, a 1.2 cm diameter red area to left upper forehead, 1 cm cut to the inner aspect of lower lip with swelling and an L-shaped cut to the upper gum line near central incisor.	W 193		

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W 193	Continued From page 23 Record review on 10/06/20 revealed Client #16 had a BSP with target behaviors of aggression and self-injurious behavior. According to the BSP, Client #16 had a general level of supervision at the time of the incident. Client #16 had a nursing assessment after the incident and no injuries were observed, although Client #16 complained of pain in a finger when making a tight fist. An x-ray on 8/07/20 of the hand revealed no fractures. When interviewed on 10/12/20 at 3:00 p.m. RTW N stated she and RTW M worked on Side A of House 248 on the PM shift of 8/06/20. RTW M was assigned to Client #15, who required 1-to-1 supervision, and RTW N was assigned to the other five or six clients, who required general supervision. After supper, RTW M said she was going out for a cigarette and she asked RTW N to keep an eye on Client #15. RTW N said she responded in an affirmative way, indicating that she would keep an eye on Client #15. RTW M didn't asked RTW N to sign into Client #15's accountability sheet. The clients were doing their after supper chores. Client #15 swept in the dining room. He had just shut a closet door. Client #16 was in the kitchen and he came out and opened the door. Client #15 closed the door again and called Client #16 a baby. Client #16 told RTW N to mark on Client #15's program that he used verbal aggression because he called Client #16 a baby. RTW N told Client #15 not to call people names. Client #16 was in the kitchen yelling at Client #15 when he threw a hard plastic dish from the kitchen into the dining room. The dish shattered and one of the pieces flew up and hit Client #15 in the forehead, causing a cut/laceration. Client #16 came out of the	W 193		

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kitchen, pushed the table into Client #15 and then flipped the table. Client #16 then came around the table and began punching Client #15 in his head and face. Client #15 was trying to block Client #16. RTW N got between the two clients and and tried to block Client #16 from punching Client #15. RTW N also yelled for help. RTW O called for staff assistance. Other staff began arriving at the house to provide assistance. RTW N noted that Client #15 was bleeding above his right eyebrow. Client #16 had reddened hands from punching Client #15. RTW N had worked at House 248 for a couple of months at the time of the incident, but had worked at the facility for 10 years and said she understood the rules regarding client supervision, accountability and supervision of a 1-to-1 client. RTW N was aware that when RTW M went outside RTW N should not have been responsible for Client #15 and the other clients at the same time, but she didn't tell RTW M not to go out. In hindsight, RTW N said she either should have told RTW M not to go on a break or immediately called a supervisor to tell them that RTW M left her 1-to-1 client. RTW M knew that RTW N was supervising the other clients on Side A. RTW O was the med passer and float staff, so she was covering for staff breaks, but RTW O was covering for another staff break at the time. It was common for RTW M to leave her assigned clients and go outside to smoke, without having another staff sign into the client accountability sheets. RTW N said she had not reported that in the past. RTW N received a work directive and retraining since the incident.

When interviewed on 10/12/20 at 2:30 p.m. RTW O confirmed she worked at House 248 on the second shift of 8/06/20. The house was divided into two sides: Side A and Side B. RTW O

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worked on Side B that shift. RTW M and RTW N worked on Side A. RTW M was assigned to Client #15, who had 1-to-1 staff supervision. RTW N was responsible for the other six clients on Side A, which included Client #16. Client #16 required general supervision at that time. RTW O said staff were trained and clearly understood that staff assigned to a 1-to-1 client could not be responsible/accountable for other clients. The staff signed accountability sheets for the clients they were responsible for. If a staff person went on break, that staff person should have another staff person sign into their clients' accountability sheets so the other staff person could temporarily take responsibility for those clients. A staff person who had already had accountability for other clients was not allowed to also take accountability for a 1-to-1 client. RTW O was on Side B of the house when the altercation occurred between Client #15 and Client #16. RTW O was supervising a 1-to-1 client for another staff person who had gone on a break. RTW O said she was a float staff that shift and available to provide breaks for other staff as needed. She said RTW M had not asked her to supervise Client #15 while she took a break. RTW O didn't know that RTW M had gone outside for a break. RTW O said she heard Client #16 and another client yelling. When she looked over toward the yelling she saw Client #16 trying to flip over a dining room table. RTW O could not leave her 1-to-1 client, so she paged for staff assistance.

RTW M was not available during the DIA investigation, but provided statements on 8/06/20 and 8/12/20 as part of the facility investigation. RTW M acknowledged she was signed in for Client #15's accountability when she asked RTW

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W 193	Continued From page 26 N to take over accountability for Client #15 while she went out to smoke around 6:00 p.m. on 8/06/20. RTW N indicated she would supervise Client #15, so RTW M left Client #15's accountability sheet for RTW N to sign and she went outside for a break. While she was outside on break, RTW M saw other staff pull up in their cars and go inside the house. RTW M went inside and saw that Client #15 was bleeding and Client #16 was yelling. RTW M initially claimed she didn't realize RTW N already had a group of clients when she asked her to supervise Client #15. During a follow-up interview on 8/12/20, RTW M acknowledged since she and RTW N were the only two staff on Side A, it should have indicated to her that RTW N was assigned to the rest of the clients on Side A. When interviewed on 10/12/20 at 3:30 p.m. Resident Treatment Supervisor (RTS) G stated he heard the page for staff assistance on the evening of 8/06/20 and he went to House 248. Another RTS was already there when RTS G arrived and the two clients were separated. Someone said Client #16 and assaulted Client #15. As RTS G talked with RTW N about what happened, RTW M walked into the house. RTS G asked who was assigned to Client #15 and RTW M said she was. RTW N said RTW M had gone outside to smoke. RTW M said she had RTW N sign Client #15's accountability sheet when she left for her break, but RTS G checked the accountability sheet and RTW N had not signed it. At the time of the altercation, RTW M was signed into Client #15 and RTW N was signed into the other group of six clients on Side A. RTS G said it was well known among staff that a staff person could not be assigned to/responsible for other clients when responsible for a 1-to-1 client.	W 193		

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W 193	Continued From page 27 RTS G said it was possible the altercation between Client #15 and Client #16 might not have happened or been as severe if two staff had been present when it occurred. When interviewed on 10/12/20 at 2:00 p.m. QIDP B stated he was in another area on facility grounds on the evening of 8/06/20 when he heard the page for staff assistance. QIDP B called the house and spoke with RTW M, who told him that she had gone outside for a cigarette and there was an altercation between Client #15 and Client #16 while she was gone. QIDP B didn't go to the house that night but later talked with Client #15 and Client #16 about the incident. QIDP B said Client #16 had been struggling with the COVID-19 restrictions and limited contact with his family, resulting in some increased behavioral challenges. After the incident on 8/06/20, the Interdisciplinary Team met and made some changes to Client #16's medications and programming. QIDP B said RTW M worked at the facility for 2-3 years and should have known a staff person could not be responsible for other clients when supervising a 1-to-1 client. RTW M should have realized that RTW N was responsible for the other six clients on Side A and could not also be accountable/responsible for Client #15 at the same time. RTW N was a long-term staff who should not have agreed to supervise Client #15, in addition to her other group of clients. QIDP B said it was hard to say if a second staff person's presence might have prevented or minimized the altercation, which resulted to injury to Client #15. 2. Record review on 10/6/20 revealed a facility investigation regarding an incident on 9/24/20, when Client #5 eloped from the facility for	W 193		

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W 193	Continued From page 28 approximately 18-20 minutes. According to the investigation, Client #5 was supposed to have staff supervision anytime he went outside and staff should be outside with Client #5. However, RTW P who was assigned to Client #5, sat down at the computer and logged in doing documentation. RTW P did not immediately follow Client #5 outside when he exited out the front door. Client #5 stated when he left he was going to the fence line and never coming back. Other staff arrived and helped deal with the situation. A search was conducted and Client #5 was located behind House 474 in the corn field. RTW P did not follow the supervision level in accordance with the emergency plan put in place due to a previous elopement and increased behavioral incidents. Additional review on 10/07/20 revealed Client #5's BSP included target behaviors of aggression, property destruction, and self-injurious behaviors. An Emergency Rights Restriction (ERR) had been developed by the Interdisciplinary Team (IDT) for Client #5 on 9/22/20. According to the ERR, "When staff becomes aware that (Client #5) is outside, staff must be outside and be able to visually observe him." The ERR was put into place by the IDT due to an elopement on 8/20/20 and subsequent increased behavioral issues. When interviewed on 10/7/20 at 1:15 p.m. RTW P stated she had just returned from vacation and was signed into Client #5 at House 474 on the AM shift of 9/24/20. RTW P said she sat down at the computer to do some documentation. Client #5 did not require 1-to-1 supervision while he was in the house. RTW P said she had been trained that morning when she got to work that Client #5 was to be supervised any time he went outside	W 193		

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W 193	Continued From page 29 because of an ERR put in place 9/22/20. RTW P said she did not follow Client #5 right away when he went outside and when she went to find Client #5 he had eloped. She acknowledged she signed the training document and was aware of the supervision level for Client #5 at the time of the incident. When interviewed on 10/6/20 at 10:45 a.m. RTW R stated on the first shift of 9/24/20 Client #1 came out in the living room area to use the phone. He was upset and told his staff, RTW P, he was going to the fence line and never coming back. Client #5 exited out the front door and RTW P did not immediately follow him. RTW R told RTW P within 10-15 seconds of Client #5 leaving that she needed to go outside with Client #5 as his supervision had changed. RTW R informed her staff was supposed to be with Client #5 anytime he went outside. RTW P went outside and could not see or locate Client #5 when she looked in the back yard. RTW P called for assistance and facility staff located the client in 18-20 minutes. When interviewed on 10/6/20 at 11:45 a.m. Psych Assistant A stated he arrived at House 474 the morning of 9/24/20 at 6:20 a.m. and provided training to RTW P. They reviewed the ERR and RTW P signed the training document. Psych Assistant A stated RTW P indicated she understood the supervision level of Client #5 and she had been trained when Client #5 went outside staff must be aware of his location and all times and keep visual contact the client.	W 193		
W 267	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)	W 267		

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W 267	Continued From page 30 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 reviews, the facility failed to ensure staff consistently treated clients with respect and dignity. This affected 1 of 3 clients identified during the investigation of 92436-I (Client #9) and 5 of 5 clients identified during the investigation of #92343-I (Client #3, Client #4, Client #11, Client #12 and Client #13). Findings follow: 1. Record review on 9/14/20 revealed a facility investigation regarding allegations made at House 464. Resident Treatment Worker (RTW) A reported in a written statement dated 7/12/20 RTW B and RTW C mistreated Client #9 and and other clients during approximately June and July of 2020. RTW A wrote she witnessed RTW B and RTW C call Client #9 a "broke [expletive]" and then laughed as the client repeated, "broke [expletive]." Record review on 9/16/20 revealed Client #9's annual Individual Support Plan, dated 2/24/20, revealed Client #9 was a verbal communicator who primarily used words and phrases to communicate. Her vocabulary was limited and she typically did not initiate conversation. The ISP also noted Client #9 sometimes repeated words that other people said to her. She had deficits in speech intelligibility and could be difficult to understand to people unfamiliar with her. When interviewed on 9/16/20 at 3:25 p.m. RTW A	W 267		

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said after the evening meal on 7/10/20, RTW B and RTW C sat at a dining room table with Client #9. RTW B and RTW C were talking and laughing. They asked Client #9 if she had any money. RTW C asked Client #9 if she could borrow some money. Client #9 didn't respond. RTW C told Client #9 that if she didn't have any money, she was a "broke [expletive]." Client #9 then repeated, "broke [expletive]." RTW B and RTW C laughed and continued to say "broke [expletive]" to Client #9 as she repeated it. RTW A said she heard RTW B and RTW C say "broke [expletive]" to Client #9 on two other occasions and the client would repeat it. The evening of 7/10/20 was the first time the two staff actually referred to Client #9 as a "broke]expletive]."

When interviewed on 9/16/20 at 4:00 p.m. RTW F said he had concerns about the work ethic of both RTW B and RTW C. RTW F said he heard RTW C use the term, "broke [expletive]" while working at House 464. He didn't know if RTW C was talking to a client at a time or if any clients were present when she said it. RTW F said he never heard Client #9 say or repeat the phrase, "broke [expletive]." He said Client #9 sometimes did repeat what was said to her.

When interviewed on 9/21/20 at 3:15 p.m. RTW L stated she heard RTW C use the term, "broke [expletive]" at work, referring to herself as being broke. RTW L said she never heard RTW C say it to a client and she never heard Client #9 use the phrase.

When interviewed on 9/30/20 at 3:00 p.m. RTW B stated she recalled a time when RTW C told Client #9 she was a "broke [expletive]" because Client #9's purse was empty. RTW B said Client

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W 267	Continued From page 32 #9 sometimes repeated the phrase, "broke [expletive]." RTW B said she didn't report the incident because she didn't believe RTW C intended to be insulting. It was said in more of a joking manner, like younger people use the word. When interviewed on 9/21/20 at 4:15 p.m. RTW C denied she ever said, "broke [expletive]" while working at House 464. She said she didn't curse. RTW C said she never used the phrase in front of Client #9 and never heard Client #9 use the phrase. 2. Record review on 9/29/20 revealed a facility investigation regarding allegations made at House 250. RTW H wrote an email to RTS B on 7/05/20 expressing concerns about RTW G. RTW H wrote RTW G told Client #3 and Client #4 they could not have their dessert if they didn't eat their other food items at meal time. RTW H also alleged RTW G told Client #3 that she would not get her chocolate milk unless she ate her other food. During the course of the facility investigation, other staff reported they heard RTW G tell Client #13 to shut up and heard her tell Client #11 she needed to finish her lunch if wanted dessert, which had not been reported to the investigations department at the time the incidents occurred. When interviewed on 10/02/20 at 10:00 a.m. RTW H said she sent an email to RTS B on 7/05/20 regarding concerns she had about RTW G. RTW H said during either lunch or dinner on 7/04/20 she was in the same dining room with RTW G. RTW G assisted Client #3 and Client #4 during the meal. RTW G told Client #3 she could not have her dessert or her chocolate milk if she	W 267		

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W 267	Continued From page 33	W 267		

didn't eat her other food. RTW G also told Client #4 she couldn't have her dessert if she didn't eat her other food. RTW H didn't know whether RTW G actually withheld the dessert and chocolate milk from the two clients. RTW H said about one week prior to the incident on 7/04/20, RTW G was insisting that Client #12 eat her peas during a meal. Client #12 said, "No," and turned her head away, but RTW G shoved peas into Client #12's mouth at one point. RTW G also told Client #12 she wouldn't get her chocolate milk if she didn't eat her peas. Another time about one week prior to 7/04/20, RTW H heard RTW G yell at Client #12 to eat her vegetables.

When interviewed on 9/23/20 at 3:00 p.m. RTW K stated he had talked with RTW G in the past about her voice tone with clients, because sometimes she spoke in a harsh, demanding tone. There was an incident in late June when RTW G walked Client #13 to the medication room. RTW K, the med passer, heard Client #13 tell RTW G to "Shut up." RTW G responded to Client #13 in a harsh tone and said, "No, you shut up." RTW K said he told RTW G that she could not talk to clients like that. RTW K said he reported the incident to QIDP C within about 40 minutes of the occurrence. QIDP C told RTW K to send an email to RTS B about the incident. RTW K thought he sent the email the same evening, on 6/27/20.

A review of the email sent by RTW K to Resident Treatment Supervisor (RTS) B on 6/27/20 at 10:14 p.m. revealed RTW K expressed concerns about RTW G. RTW K wrote RTW G was 'mouthy" with the clients and it was increasingly malicious. He wrote Client #13 told RTW G to shut up and she told Client #13 she was the one

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W 267	Continued From page 34 who needed to shut up. RTW K noted in the email that he brought up his concerns to QIDP C, who told him to email RTS B. When interviewed on 9/23/20 at 10:45 a.m. RTW I stated she worked first shift at House 250 on 7/04/20. During lunch, RTW I heard RTW G tell someone they couldn't have dessert until after they ate their lunch. RTW G was in the other dining room, so RTW I didn't know who RTW G was talking to. She said RTW G's tone sounded serious, but she didn't know if the client(s) got their dessert or not. RTW I said she didn't say anything to RTW G about it or report the incident. When interviewed on 9/23/20 at 10:20 a.m. RTW J said she worked first shift on 7/04/20. She was with RTW G in the same dining room during lunch time. RTW J said she heard RTW G tell Client #11 she needed to finish her meal if she wanted dessert. RTW J recalled that Client #11 didn't like the meat they had for lunch. She turned her head away and kind of spit out the meat. RTW G told Client #11 she needed to eat the meat so she could have dessert. RTW J said she told RTW G that Client #11 didn't like certain meats, but RTW G continued to try to get Client #11 to eat the meat. RTW J didn't notice whether Client #11 got dessert or if it was withheld. 3. A review of agency policies revealed a Philosophy of Service policy, which read, "Each person is to be treated with respect. Each person served or supported by GRC is a human being with value and dignity." According the agency Human Rights policy, each resident should have the same legal and civil rights of all US citizens, "including the right to a dignified, self-directed existence in a safe and	W 267		

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W 267	Continued From page 35 humane environment."	W 267		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure staff utilized facility approved restrictive measures only as specified in the clients' behavior plans or in emergency situations. This affected 1 of 1 client identified during the investigation of #93434-I (Client #20), 1 of 1 client identified during the investigation of #91684-I (Client #21) and 1 of 1 client identified during the investigation of #93815-I (Client #22). Findings follow: 1. Record review on 10/8/20 revealed Client #20's Incident Report (IR) dated 8/14/20. Investigator A documented he received a call from the Assistant Superintendent who reported RTW X grabbed Client #20. Further review revealed Client #20's Behavior Support Plan (BSP) with a start date of 5/11/20. The plan identified screaming, dropping to the floor, aggression, self-injurious behavior (SIB), property destruction, inappropriate elimination, teasing/provoking others and leaving assigned areas as target behaviors. The plan directed staff to prompt, redirect or switch out staff when Client #20 engaged in aggression, SIB, leaving assigned areas and property destruction.	W 288		

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W 288	Continued From page 36 When interviewed on 10/6/20 at 1:00 p.m., the Assistant Superintendent said he stopped by Client #20's house to do rounds on 8/14/20 in the late afternoon. After being there a few minutes, he heard a loud noise behind him. When he turned around, he saw RTW X with his arms wrapped around Client #20 like a "bear hug." He did not ask RTW X why he held Client #20 but he called and reported the intervention to Investigator 2 because he did not think staff should hold clients in the way he observed. When interviewed on 10/6/20 at 3:10 p.m., RTW Y confirmed she worked with RTW X on 8/14/20. She recalled the Assistant Superintendent stopped by the house and confirmed he spent time in the room with RTW X and Client #20. She said Client #20 attempted to hit a peer and RTW X put his arms around Client #20 to protect the peer. She confirmed Client #20's BSP did not include the use of a hold. When interviewed on 10/7/20 at 3:05 p.m., RTW X confirmed he had responsibility for Client #20 on 8/14/20. He recalled Client #20 stood up, walked toward a peer and verbally threatened to hit him. RTW X redirected Client #20 away from the client and back to the couch. Then Client #20 stood up, went to the dining room and threw the cordless phone on the floor. RTW X said Client #20 aggressed toward him and he put his arms out beside Client #20's arms to prevent him from hitting anyone. RTW X initially denied touching or holding Client #20 but later said he may have put his arms on Client #20's arms between his elbows and shoulders to redirect him. RTW X confirmed the use of physical contact did not exist in Client #20's BSP.	W 288		

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W 288	Continued From page 37 When interviewed on 10/8/20 at 10:15 a.m., Training Specialist II explained she trained staff in the use of Mandt (an approach used to de-escalate and if necessary intervene in aggressive behavior) to deal with inappropriate client behavior. She confirmed staff should not use a "bear hug" to intervene in Client #20's behavior. 2. Record review on 10/13/20 revealed a facility investigation regarding the use of an unauthorized restraint involving Client #21 on 5/15/20. According to the report, Investigator B interviewed staff and discovered staff carried Client #21 to her room due to episodes of aggressive behavior. Further record review on 10/13/20 revealed Client #21's Behavior Support Plan (BSP), implemented on 3/25/20. Target behaviors included verbal aggression, aggression, property destruction, social disturbance, self-harm, leaving assigned area, refusing requests and suicidal behavior. Techniques to use if Client #21 exhibited aggression included limiting attention, removal of dangerous items, encouraging peers to leave the area, and body positioning, blocking and redirecting the behavior. The use of lifting and carrying Client #21 to another area was not included in the BSP. When interviewed on 10/13/20 at 4:05 p.m., Training Specialist 1 confirmed she worked as the Psychology Assistant in Client #21's house on 5/15/20. She confirmed she saw staff carry Client #21 to her bedroom following acts of aggression in the day room. The Training Specialist 1 said she was unsure if carrying a client was an	W 288		

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W 288	Continued From page 38 approved client management technique at that time. When interviewed on 10/15/20 at 4:15 p.m., Investigator B confirmed she conducted the investigation of an unauthorized restraint on Client #21. She further confirmed Training Specialist 1 and Resident Treatment Supervisor (RTS) I admitted staff carried Client #21 to her room on 5/15/20. When interviewed on 10/19/20 at 10:35 a.m., RTS I recalled being in the house on 5/15/20 when Client #21 became aggressive and staff implemented an approved hold in the day room. He said staff released her from the hold and she became aggressive again so they carried her to her room. RTS I acknowledged he supported Client #21's head during the carry. He stated he later learned that the use of lift and carry was prohibited at the facility. When interviewed on 10/19/20 at 11:37 a.m., Resident Treatment Worker (RTW) Z confirmed she worked with Client #21 on 5/15/20. She denied seeing any staff lift and carry Client #21 and felt the technique should not be used with any clients. When interviewed on 10/20/20 at 10:20 a.m., Psychology Assistant (PA) B recalled she assisted in an approved restraint with Client #21 on 5/15/20. She said Client #21 aggressed at the nurse and staff restrained her on the floor outside the medication room. She confirmed she helped Client #21 to her feet but denied participating in a lift and carry technique. PA B said she taught Critical Incident Training (CIT) and considered lift and carry to be an approved technique.	W 288		

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W 288	Continued From page 39 Record review on 10/20/20 revealed a facility In-Service training report with a revision date of 1/1/20. "No Lift and Carries" appeared as the identified training topic. Training Specialist 1, RTS I and PA B signed the report on 1/23/20. When interviewed on 10/15/20 at 1:00 p.m., the Director of Quality Management confirmed the facility prohibited lifting and carrying clients unless an extreme emergency existed (e.g. client sitting in the road with traffic). She confirmed staff used an unauthorized restraint on Client #21 on 5/15/20. 3. Record review on 10/21/20 revealed a facility investigation regarding an incident at House 360 on 9/25/20. According to the investigation, the Assistant Superintendent (AS) was doing rounds on the morning of 9/25/20 and witnessed RTW BB holding onto Client #22's wrist/forearm area with both of her hands to prevent/restrict Client #22's movement. When interviewed on 10/21/20 at 10:45 a.m. the Assistant Superintendent stated he was in House 360 when he saw RTW BB hold Client #22's right wrist/forearm area with both of her hands. Client #22 tried to back away from RTW BB as she held onto his wrist/arm and said something like, "No, you can't go there." It appeared RTW BB tried to keep Client #22 contained to an area. RTW BB let go of Client #22 and put her hands up in a defensive gesture as Client #22 came toward her. As Client #22 got closer to her, RTW BB grabbed his arms with hands to try to keep the client from bumping into her, but he did make contact with her. Client #22 then turned and left the area, with RTW BB following, but not holding him. The AS	W 288		

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W 288	Continued From page 40 reported the incident to QIDP E, who was at the house. She relieved RTW BB from Client #22 and the facility began an internal investigation. During a follow-up interview on 10/26/20 at 10:15 a.m. the AS said he could not see any valid reason for RTW BB to restrict Client #22's freedom of movement when he observed the incident on the morning of 9/25/20. He said Client #22 did come toward RTW BB at one point and make contact with her after she had been holding onto his wrist, but it didn't appear to be an act of aggression. When interviewed on 10/22/20 at 9:30 a.m. RTW BB stated she worked 1-to-1 with Client #22 on the morning of 9/25/20, until she was relieved by QIDP E around 7:40 a.m. RTW BB said Client #22 paced around the house that morning and she followed him. At times Client #22 would stop and turn "aggressively" toward her, but he didn't actually try to aggress toward her. When asked what she meant by Client #22 turning "aggressively", RTW BB said Client #22 would turn quickly. When Client #22 turned toward her, RTW BB said she put her palms up in a defensive type of stance and Client #22 would touch her palms with his right hand and then walk away again. RTW BB denied that she ever held onto Client #22's wrist, arm or hand to restrict his movement or keep him from going anywhere in the house. She said Client #22 didn't like to be touched and he was allowed to walk around the house. RTW BB said staff would only need to try to block Client #22 if he became aggressive or tried to leave the house. When interviewed on 10/21/20 at 11:30 a.m. QIDP E stated Client #1 had a 1-to-1 level of staff	W 288		

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W 288	Continued From page 41 supervision due to pica (ingestion of non-edibles) and leaving the assigned area (elopement). QIDP E said Client #22 should be allowed to freely walk about the house, with his 1-to-1 staff following him and keeping him in sight. The 1-to-1 staff person should not get too close to Client #22, or he might get upset. Staff should give him some space when agitated. QIDP E said it was not in Client #22's program for staff to hold onto him or try to prevent him from moving around the house. Record review on 10/26/20 revealed Client #22's Behavior Support Program (BSP) with target behaviors of pica, pica attempts and aggression. If Client #22 engaged in target behaviors, staff could block and redirect him as needed to maintain safety. The BSP noted that Client #22 needed 1-to-1 staff supervision, with his assigned staff person in the same room with him to visually observe him. The BSP did not indicated staff could restrict Client #22's freedom of movement in his house. A nursing assessment completed on 9/25/20 at 8:00 a.m. noted no injuries to Client #22's wrist and full range of motion in the wrist. 4. Record review on 10/13/20 revealed the facility Hierarchy of Behavioral Interventions Procedure dated 4/29/19. The procedure noted a range of techniques available to staff to increase appropriate behavior and decrease harmful behaviors. Level III techniques included use of a programmatic physical restraint when client behavior warranted such an intervention. Programmatic physical restraints were approved by the Interdisciplinary Team and incorporated into clients' programing. Record review on 10/15/20 revealed the facility Management of Inappropriate Behavior policy	W 288		

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W 288	Continued From page 42 updated 11/20/18. The policy defined a physical restraint as any manual hold that restricts a client's free movement. According to the policy, programmatic restraints required supervisor approval.	W 288		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to comply with the Condition of Participation: Health Care Services. The facility failed to respond in a timely manner to clients medical needs. This affected 1 of 1 client (Client #23) reviewed during investigation #92297-M. Finding follows: Based on interviews and record reviews, the facility failed to provide clients with nursing services in accordance with identified needs. See W331. On 10/30/20 at 4:20 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to provide nursing care as identified by client needs. The facility developed a plan to remove the IJ, which included retraining on emesis assessments and who can call 911. On 11/4/20 at 3:47 p.m., the IJ was removed from the facility.	W 318		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing	W 331		

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W 331	Continued From page 43 services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide clients with nursing services in accordance with identified needs. This affected 1 of 1 client (Client #23) reviewed during investigation #92297-M. Findings follow: Record review revealed the following: a. Type 1 Incident Investigation dated 6/13/20, indicated, "Client #23 left the unit at 9:41 p.m. by 911. While at the hospital Client #23 had another emesis and coded. The hospital staff could not revive." b. Client #23, at the time of the incident, was a 65-year old man with a diagnosis of Profound ID, Autism Spectrum Disorder, Rumination Disorder, pica, Slow Transit Constipation, Dysphagia, and Hyperthermia. He also had a history of bowel obstruction and aspiration pneumonia. c. Client #23's Individual Support Plan (ISP) dated 4/2/20, indicated the facility provided Client #23 with a one-to-one staff because of his history to eat inedible items. He was at risk of hyperthermia and the facility took his temperature rectally three times a shift. His diet was a texture puree consistency. He independently fed himself unless too fatigued. d. Client #23's Autopsy Report dated 7/15/20 indicated the cause of death to be artherosclerotic cardiovascular disease.	W 331		

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W 331	Continued From page 44 e. Client #23's nursing assessment completed on 6/13/20 at 7:00 p.m. by LPN B, included vital signs and indicated his blood pressure was 126/81, his pulse was 97, his respirations were 18, his oxygen was 90%, and a rectal temperature was 97.8. The nursing assessment also indicated, "Client awakens while sleeping but actually more drowsy... S: Staff report client had an emesis. Staff also state that client is just not acting himself. O: Witnessed yellowish thick emesis with remnants of undigested food from supper possibly. No odor noted. Moist pharyngeal sounds noted bilat (bilateral) - as if client needs to cough. A: Emesis assessment. P: Continue per protocol. Staff to notify nursing with any concerns." f. Client #23's nursing assessment completed on 6/13/20 at 9:25 p.m. by LPN B indicated his oxygen was 81% and they tried to give Client #23 oxygen via nasal cannula but he would not leave it on. The nursing assessment also indicated, "S: Staff called stating that client was having more emesis. O: Received call from staff at 9:20 p.m. that client was still having emesis. Called (RN A) before arriving at 9:25 p.m. at 465. Client was having an emesis upon arrival that was thick yellow with food particles and had a "chicken" aroma. Informed (Medical On Duty) at 9:27 p.m. that client had had 13 emesis since supper and she gave an order to send the client out 911 and to notify her where the ambulance was going to go so she could call up before he got there. Client was then placed on O2 via concentrator with NC d/t O2 at 81% RA, however, he would not leave it on even with staff assisting him. Client left via 911 on a stretcher. Ambulance staff informed that the client would engage in pica and	W 331		

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W 331	Continued From page 45 will grab anything and everything to place in his mouth. (Medical ON Duty) informed that he was going to JEMH and she stated she would call and give them a head's up. A: Transfer to hospital/possible aspiration. P: Will f/u with hospital with diagnosis." g. House 465 call log included a call received at 7:01 p.m. from the clinical wing, at 7:55 p.m. from LPN B's desk, at 8:09 p.m. from LPN B's desk, and at 9:16 p.m. from LPN B's desk. h. RTW/CMA DD's notes from 6/13/20 indicated Client #23 had an emesis at 6:30 p.m., 6:45 p.m., 7:03 p.m., 7:19 p.m., 7:24 p.m., 7:44 p.m., 7:53 p.m., 8:00 p.m., 8:10 p.m., 8:18 p.m., 8:45 p.m., 8:57 p.m., 9:10 p.m., 9:24 p.m., and at 9:30 p.m. i. Assessment/Reassessment guidelines indicated after notification of an emesis, the nurse should do a physical assessment upon notification and notify the RN for clinical oversight. A client is reassessed after an emesis every shift for 24 hours and then twice daily for 48 hours. If another emesis occurs, the nurse should complete another physical assessment upon notification. j. Nursing Services Procedure dated 3/4/19, indicated, "1. First Employee discovering a medical emergency will assume the role of "First responder... 2. The First responder will activate the Emergency Response System by dialing *9-911 and: a. Notify via radio, telephone (overhead page:83-555), or unit staff that there is a medical emergency 'Nurse Stat' or 'Code Blue,' repeating twice (include location of event) and request the AED..."	W 331		

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W 331	Continued From page 46 When interviewed on 9/23/20 at 2:45 p.m. RTW/CMA DD reported he worked the morning shift on 6/13/20 and Client #23 was good. Client #23 finished dinner at approximately 5:00 p.m. He was the first one done eating. He had pureed chicken, but did not eat much. RTW/CMA DD stated Client #23 was normal until about 5:30 p.m. At approximately 5:30 p.m., RTW EE took Client #23 to the bathroom. During transfer to the toilet, Client #23 let go of the stand. RTW EE yelled for help and they decided to take him to his bed because that was a safer option. RTW EE changed Client #23 and he stayed in bed for approximately 30 minutes. RTW/CMA DD took over Client #23's one-to-one supervision from 6:00 p.m. to 6:30 p.m. while RTW EE went to break. Took two people to transfer him out of bed and back into his wheelchair for 7:00 p.m. medication. At 6:30 p.m., RTW/CMA DD got ready to administer medication to clients and RTW EE was Client #23's one-to-one staff when Client #23 had his first emesis. RTW/CMA DD called LPN B and did not get a response before Client #23 had another emesis. RTW/CMA DD wrote down the exact times Client #23 had an emesis and the exact time LPN B showed up to complete an assessment. RTW/CMA DD asked the surveyor to refer to his timeline he gave the facility investigator for the times as he could not remember. RTW/CMA DD stated he documented the exact time everything happened. According to RTW/CMA DD, he called LPN B after each emesis. RTW/CMA DD did say he did not believe the first two pages went through, but he continued to page to make sure LPN B received them. Client #23 had vomited three to four times and RTW/CMA DD completed a set of vitals for LPN B before he arrived at the home the first time. RTW/CMA DD gave LPN B the vitals.	W 331		

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W 331	Continued From page 47 RTW/CMA DD observed LPN B with the stethoscope but did not see him do any assessments. RTW/CMA DD could not report if LPN B completed the assessment as he was in and out of the room administering medications to other clients. RTS K also came to the house around the same time LPN B was there. Before LPN B left the home, RTW/CMA DD asked if he should still administer medication to Client #23. LPN B told him yes and to let him know if there were problems. RTW/CMA DD told LPN B he would wait to administer his medications last so Client #23 had RTW/CMA DD's full attention. RTW/CMA DD administered Client #23's medication and they came right back up. RTW/CMA DD paged LPN B again and did not hear anything until closer to 8:00 p.m. LPN B told RTW/CMA DD to monitor Client #23 and report changes. RTW/CMA DD took over Client #23's one-to-one supervision to monitor him. Client #23 continued to have emesis and RTW/CMA DD continued to try to get a hold of LPN B. He would not return his page. RTW/CMA DD called his supervisor and asked her if he should call the nursing supervisor because LPN B was not responding. RTS K stated she would be right over. LPN B and RN A arrived before RTS K after 9:00 p.m. They called 911 and Client #23 left in the ambulance with RTW EE. RTW/CMA DD stated the EMT's (Emergency Medical Technicians) placed Client #23 on his back on the stretcher. He did not understand why they would place him on his back when he was vomiting. RTW/CMA DD described Client #23's appearance and actions. He said he was pale, but always had a ghostly look. He did not seem happy and he was limp. Client #23 was not opening his mouth the emesis was just coming out of his mouth. RTW/CMA DD stated Client	W 331		

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W 331	Continued From page 48 #23 is usually active grabbing at items to pica. He did not have pica and could not click his wheelchair belt. When you looked into his eyes, he seemed like he was still there. Client #23's emesis was more mucus and at the end of the night, it was clear. It seemed like a lot of built up drool. RTW/CMA DD reported LPN B was not responding to RTW/CMA DD's calls. The nurse in charge of the house was not their normal nurse. Their normal nurse would come right out when he called her. RTW/CMA DD felt like he could not talk to LPN B. When he did talk to him, RTW/CMA DD felt like he was bugging him. When LPN B did respond, he would just inform RTW/CMA DD to keep an eye on Client #23 and let him know. RTW/CMA DD told LPN B he was concerned. RTW/CMA DD felt like LPN B shrugged it off as if it was a normal thing. RTW/CMA DD stated he never hounded nurses, but he felt like he needed to call about Client #23. Brandon also stated he understood it could be nothing, but clients that had less of a medical issue had more assessments completed. RTW/CMA DD felt sad for Client #23 that he was not getting the response and medical attention that he was paying for. He understood people were busy but he felt ignored. RTW/CMA DD reported staff can call 911, but some staff told him he had to wait for a nurse and others told him to call. RTW/CMA DD believes Client #23 would have been more comfortable at the hospital as they may have been able to do something for him. When interviewed on 10/30/20 at 12:37 p.m., RTW E reported he was Client #23's one-to-one supervision. Client #23 started vomiting and continued to vomit. RTW/CMA DD called LPN B after every emesis. According to RTW E, LPN B	W 331		

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did not come to the home as soon as RTW/CMA DD called him. RTW E believes it was approximately 7:00 p.m., when LPN B came to the house, but he could not remember. When LPN B came into the home, Client #23 was vomiting. RTW E stated LPN B stood behind Client #23 and did not see him complete an assessment. He did not remember LPN B using a stethoscope on Client #23. RTW EE stated LPN B could not have completed an assessment without him witnessing it. He was Client #23's one-to-one and was right next to Client #23. RTW EE stated RTW/CMA DD completed vital signs on Client #23 before LPN B arrived. Before LPN B left the home, he told staff to keep an eye on Client #23 and let him know of any changes. RTW EE reported Client #23 continued to vomit and RTW/CMA DD called LPN B after each emesis. RTW EE stated RTW/CMA DD called so he did not see how he called the nurse, if it was by phone or radio. According to RTW EE, RTW/CMA DD called the nurse more than three or four times. He stated RTW/CMA DD called six or seven times at a minimum. RTW EE stated Client #23 had no problems before he started to vomit. His vomit was yellow and did not have food particles or anything in it. Client #23 was up in his wheelchair. RTW EE stated Client #23 had a pica diagnosis, but did not get a hold of anything when he was supervising him. As Client #23 continued to vomit, his breathing got deeper. LPN B and another nurse came out to the house. They said to call 911. RTW EE rode with Client #23 to the hospital. The doctor told RTW EE, Client #23 aspirated on his vomit and his heart was not strong enough to continue. In RTW EE's opinion, LPN B was not a good nurse. When they had their regular nurse, she came to the house when they called. When LPN B came to

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W 331	Continued From page 50 the house, he did not do anything. When interviewed on 9/23/20 at 10:00 a.m. RTW CC reported Client #23 was in RTW EE or RTW/CMA DD's care constantly. Client #23 usually ate on his own, but RTW EE fed him most of his meal. She stated early in the evening she assisted Client #23 into his stander. He tried to slide through. She stated they had him in the stander correctly, but she believed he was weak. He had a couple of large bowel movements and she retrieved rags to help. Client #23 started vomiting after supper. RTW/CMA DD called the nurse after each emesis. According to RTW CC, RTW/CMA DD called LPN B five times before he arrived at the home. She stated he did not complete an assessment, just stared at the back of Client #23's head. RTW CC remembered LPN B was at the home for approximately five minutes. After LPN B left, staff took Client #23 to his bedroom. She took clothing protectors to his bedroom. When they brought him back out to the living area, Client #23 continued to vomit. RTW CC remembered Client #23 had labored breathing. According to RTW CC, his coloring did not look good. She thought he had a gray complexion. He looked tired and not real alert. They discussed calling someone. RTW/CMA DD called the supervisor. RTW CC stated Client #23 vomited approximately 13 times. LPN B came out to the home with another nurse. They called the doctor and she told them to call 911. He was still breathing when they took him out. She could not remember times at which things took place. RTW CC stated she talked to an overnight staff and they told her his ankles looked swollen overnight, but a regular staff stated it was normal swelling in his legs. RTW CC did not know RTWs could call 911.	W 331		

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W 331	Continued From page 51 When interviewed on 9/28/20 at 3:00 p.m. RTW FF reported she came in at 2:00 p.m. that day and did not notice anything different with Client #23 until after dinner, but she was new and had not dealt with him that much. She had not worked with him because she had not been trained on him yet. She did not know of any pre-existing conditions, but knew he had pica. After dinner, Client #23 had emesis after emesis. She knew RTW/CMA DD called LPN B a few times before he came to the home. When LPN B arrived, he stood behind Client #23 watching him. RTW FF stated she was right there when LPN B came in giving new bibs to staff after each episode. She did not remember LPN B using a stethoscope on Client #23. She believes he just said to observe him and then left. Client #23 continued to vomit and RTW/CMA DD continued to call the nurse. Client #23 sounded "gurgly." His vomit looked like a thicker yellow/golden colored fluid. She stated there his vomit did not have chunks. A nurse arrived at the home at approximately 9:20 p.m. to 9:30 p.m., before they called 911 and the ambulance took him to the hospital. She was unsure if the nurse completed an assessment at that time. RTW FF remembered there was an issue of the nurse not responding in a timely manner. She felt the nurse should have been there sooner. She believed they did not call 911 beforehand because RTW/CMA DD tried to get a hold of someone. When interviewed on 9/28/20 at 2:35 p.m. RTS K reported she stopped at House 465 at approximately 7:00 p.m. She witnessed Client #23 have two emesis. RTS K stated there was not any bulky stuff in his emesis. She believed LPN B was there when she arrived and wanted	W 331		

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them to monitor him. She could not remember if LPN B completed an assessment. She remembered LPN B thought Client #23 had a cold because he had raspy breathing. LPN B stated it sounded like he needed to clear his throat. LPN B also thought his food might not be agreeing with his tummy. RTS K thought LPN B must have completed an assessment since he suggested a cold. RTS K left the house after they changed his clothing protector. She suggested taking him somewhere more comfortable, such as his bedroom to watch T.V. Client #23 had hyperthermia and his bedroom was warmer than other parts of the home. RTS K stated Client #23 did not look pale. Client #23 was not his usual self, he was not trying to grab. According to RTS K, Client #23 had not been as active since they put him on one-to-one supervision. RTS K stated RTW/CMA DD called her after he administered Client #23's medication, at approximately 8:00 p.m. He did not think LPN B was responding in a timely manner. Client #23 did not take the medication and RTW/CMA DD was concerned. RTS K instructed RTW/CMA DD to page LPN B again and they sent Client #23 out a little bit later. She also instructed RTW/CMA DD to page the nursing supervisor if he still did not get a response. According to RTS K, she did not think RTW/CMA DD called after every apparent episode. They are to call the nurse and the supervisor after each episode. They do not document the time they receive calls. The supervisor would include the time on each apparent episode form. They did not notify her after every emesis. RTW/CMA DD notified her one time before rounds and then again after RTW/CMA DD administered medications. They should have notified her more than that, but they get busy with supper and getting change of

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W 331	Continued From page 53 position completed with clients. They ask that the staff notify the supervisors as soon as possible or within 30 minutes of an apparent episode. RTS K believed the staff did what they were supposed to do. She is hoping LPN B also did what he was supposed to do. If the nurse does not respond, they can call the nursing supervisor. If they still do not get a response, they call the AOD (Administrator on Duty). They did not think Client #23 would pass that night. Andy thought it was a bug, but should have gotten outside help. When interviewed on 10/12/20 at 10:45 p.m. RN A reported she worked on 6/13/20 and had house 465. She always had houses on the hill, 465 is one of her regular houses. She heard approximately three pages for 465. It could be possible there were more pages that she did not hear, but unlikely. If anyone heard 16 pages or several pages for 465, one of the RN's would have shown up at the house. All of the nurses hear the pages over the radio; when you call for a nurse, it does not just go to one radio. LPN B called her at approximately 9:30 p.m. and requested she went to the house with him. When she arrived, Client #23 sat in the dining room with staff around him. He had an emesis and staff informed her he had multiple. Client #23's respirations were audible. He was struggling. RN A asked if vitals were completed, and they said yes. RN A put on the pulse oximeter and then directed staff to get vitals. RN A told LPN B to call the doctor and asked staff to get the oxygen. They sent out within minutes. RN A stated Client #23 was hypothermic, so they always kept him warm. He had one-to-one supervision because of pica diagnosis. RN A felt like someone should have notified her sooner. If staff cannot get a hold of the LPN, they can get a	W 331		

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hold of the RN. RN A did not see LPN B's original assessment. She stated everything was gone by the time she tried to look at it. She stated the RN's oversee the LPN's. There are some assessments that only RN's can complete, such as after a chemical injection. The LPN's can complete an emesis assessment. The LPN's notify the RN's of anything happening in the houses. As medical issues come up during the shift, they document on a spreadsheet for the triage nurse to call the physician on-call at 9:00 p.m. The triage nurse reads right off of the spreadsheet. She stated they could call the physician anytime; they do not have to wait until 9:00 p.m. She worked with LPN B before and had no problem with him. She believed he was a great worker.

When interviewed on 9/29/20 at 1:00 p.m. the Interim AON reported she was on campus for a few hours on the evening of 6/13/20. Within a few hours, she heard at least two pages early in the evening. She had another house and could not state if she heard another page. When someone calls for a nurse, you can use the house phone or a radio, both come through the nurse radio. Maintenance is on a different frequency. The nurses hear all the calls, as long as their knobs are on the right frequency. The Interim AON talked to LPN B at approximately 7:30 p.m. to 8:00 p.m. He went to her office and asked how he should document Client #23's level of consciousness. The drop down boxes on the nurse assessment did not reflect what he wanted to say. He told her Client #23 had an emesis and was not alert, but was not lethargic. She told him to mark non-responsive. The Interim AON stated Client #23 could be like that with medications. He reflected that in his assessment. He also told her

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he had stuff in his throat and needed to cough. She agreed with him that Client #23 is sometimes like that. The Interim AON explained some of Client #23's history. She stated he did not have a strong history of emesis. He did have a history of gastrointestinal issues. He wore oxygen at night while in bed; she believed he had sleep apnea. They also have to monitor his oxygen after a seizure. Anything less than 90%, he needed oxygen. She did look at his past oxygen levels to determine what was normal for him. The Interim AON stated they originally assumed 91% was normal for him. After she reviewed his past oxygen levels, his normal was in the middle 90's. His lowest oxygen level was at 92% on one occasion. After her review, she determined 91% to be low for him. They are usually OK with 88% for most people. The Interim AON stated when a client has an emesis their assessment would include, at a minimum, vitals, lung sounds, bowel sounds, and level of consciousness. After you complete the assessment, you need to make sure you document. After every emesis, a nurse should assess the client. The Interim AON stated there was no timelines on how long the LPN had to notify an RN of an emesis. They are trying to work on getting that on the guidelines, but it would vary from client to client. She believed the LPN should notify an RN after a client had a couple of emesis, but it would depend on the assessment. They should notify the RN just to give a heads up or get a second opinion. The Interim AON could not say if the LPN notified the RN appropriately. The Interim AON could not say if the LPN notified the RN appropriately. She stated he could have documented the number of times Client #23 had an emesis. If the medical issue is an emergency, the site nurse can call the provider. If it is a non-emergency, they put it on

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the call log, just for information. At 9:00 p.m., the triage nurse calls the on-call physician and reads the document. If the on-call physician has questions, they may ask to clarify. The physicians not necessarily notified for an emesis, especially if it is one emesis during a meal. The Interim AON confirmed an LPN could give permission to administer medications after an emesis. It does not have to come from the speech therapist. She stated it was important that he received his medications, even if they have had an emesis. The Interim AON reported the autopsy report indicated Client #23 passed away from a heart attack. She stated the ambulance hook up did not bring up cardiac issues. She is unsure if the hospital would have caught it. The Interim AON stated LPN B was one of the nurses picked to provide treatment in a COVID-19 home. She is unsure why he did not appear attentive, but she questioned why he responded so quickly to the last call. She stated RTWs do not always complete vitals, but the CMAs could do some of the vitals. Some of the nurses ask staff to get the vitals, but you really do not know if they completed them. When the Interim AON does an assessment, she completes the vitals herself. The Interim AON stated if Client #23 would have had one emesis, he should have completed another assessment within four hours. Even if he just took his oxygen level, especially if it sounded like he needed to cough.

When interviewed on 9/29/20 at 3:35 p.m. RN B reported she worked the evening of 6/13/20. RN B and RN A were at the infirmary and she believed she heard three pages for house 465. They heard each page answered. After the third call, they both thought something must be going on and then LPN B called RN A. RN A left for

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house 465. According to RN B, she did not hear the pager 16 times. She stated she would respond if any house paged 16 times. She thought three pages was a lot. The only time she would not have heard a page is if she had her stethoscope in her ears. She does not believe she missed any of the pages. There could possibly be a time when the radio would cut someone out, if another house paged at the same time. RN B did know of a time this has happened. She said sometimes there is static and you only hear part of it. RN B stated the staff could call the nurse's desk, but they usually use the radio. After a nurse receives a page over the radio, they will call the house number. RN B is curious why there was not a nurse stat call from the staff at the house. They sent Client #23 out as soon as RN A saw him. RN B stated the nurse could complete the vital signs during their assessment or ask the CMA do them, it depended on the situation. If she were unfamiliar with a client, she would ask staff. The RTWs are well versed in the clients. They know when clients are not acting like themselves and can provide information when completing assessments or treatments. RN B explained an RN's duty. She stated the RNs have their own assignments and cover the LPN's if there are issues. The LPN's report incidents and changes of condition to the RN. They can also ask for second opinions or if they are concerned with anything. RN B stated there is not much difference between an LPN and an RN. There are certain assessments only an RN can complete. A couple of the assessments only an RN can complete include suicidal threats or attempts and sexual assaults. LPN's can do an emesis assessment, but they should report anything concerning to the RN. Not all LPN's

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W 331	Continued From page 58 would report an emesis to an RN, unless it is a significant change. They should also notify the physician. The triage nurse calls the physician on-call at 9:00 p.m. and informs them of any non-emergency medical issues. The triage nurse puts in any orders from the physician. If you believe a client needs an order for something, then you can call the physician and get the order. You do not have to wait until 9:00 p.m. to notify or receive an order from the physician. When interviewed on 9/29/20 at 3:24 p.m. LPN D reported she worked the evening of 6/13/20. She stated when she hears a page on the radio she makes sure a nurse responds with a "10-4." She believed she heard between three and four pages for house 465, but she cannot be sure. She thought the pages were after supper, between 6:00 p.m. and 8:00 p.m. She also believed she heard a "10-4" with every page. She knew they had an emergency call at another house after the last 465 page. She did not hear 16 pages for house 465 and the last she heard Client #23 had a small emesis. LPN D explained the difference in duties between an LPN and an RN. She stated the LPN's could not do some assessments, such as initial assessments and suicidal assessments. LPN's could do most of the other assessments. LPN's are able to implement their nursing judgement. The LPNs had to notify RN's of incident reports and change of conditions. LPN D believed the LPNs had 30 minutes to notify the RN's of non-emergency issues. If it is an emergency, they should notify RN's right away. She stated when RN B is her RN, RN B documents when LPN D informs her of medical issues. If she is unfamiliar with a client, she looks at the client's ID sheet and recent and/or past assessments. LPN D will also ask RTWs about	W 331		

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W 331	Continued From page 59 the client or any other familiar nurse. When LPN D completes an emesis assessment, she asks what size and color the emesis was. She also listens to lung and bowel sounds. RTWs and CMA's usually help. LPN D notifies the physician if the client is stable and starts the emesis protocol. She stated if a client has more than one emesis, she goes back to the home and reassess. LPN D documents the number of emesis in the S portion of the SOAP (Subjective, Objective, Assessment, and Plan) note. It depended on how spaced out the emesis are and if vitals were different if she documented a new assessment. She would monitor the vital signs. They document the vital signs on a separate log on the computer. LPN D stated she would stay at the home and monitor the client if they are vomiting continuously. She also stated she could get an order for Zofran from the physician. According to LPN D, Client #23 is pica so she would want to listen for a bowel obstruction in case he ate something he should not. When interviewed on 9/29/20 at 3:00 p.m. LPN C reported he worked the evening of 6/13/20. The LPNs usually have three houses during a shift. He was the triage nurse for the evening. He gave the 9:00 p.m. report to the physician on-call. Nurses write their concerns or questions on an excel document for the 9:00 p.m. report. LPN C calls the physician on-call and reads from the document. Sometimes the physician gives orders, but most of the time it is just information relayed to the physician. If a nurse needs an order, they call the physician themselves. They would not wait for the 9:00 p.m. report for an order. It is possible there was a page and he did not hear it. According to LPN C, between 6:00 p.m. and 8:00 p.m., LPN C heard three pages for	W 331		

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	16G003	A. BUILDING _____ B. WING _____	C 11/17/2020

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 331	Continued From page 60	W 331		

house 465. He stated he heard the pages answered with a "10-4". Another nurse would have offered to help if the nurses heard more pages. LPN C did not know what was going on at 465. He stated they sent another client to the hospital around the same time they sent Client #23. LPN C stated RN's have to do certain assessments, such as admissions, chemical injections, and restraint assessments. LPN C explained when an LPN should notify the RN's of medical issues. He stated if the issue is an emergency deal with it first and then the LPN notifies the RN. For other concerns or conditions, the LPN can notify the RN at the end of the shift. If a client has an emesis, the nurse should assess within 20 minutes and notify physician if fever or possible aspiration. The nurse can notify the physician within 24 hours if it is not extreme. Per protocol, they should reassess the client every shift for 24 hours after an emesis then twice daily for 48 hours. If the client has another emesis, the protocol starts over. According to LPN C, if the client has more than one emesis in a short amount of time, they can compile them into one assessment. If the emesis is 20 minutes apart, enter as one assessment. The process starts over unless close together. Notify the RN depending on the condition. LPN C would try to be at the home while the client had an emesis and would not leave the home until the client was stable. The RTW/CMA could do the vital signs, but with this situation, he would do it himself. If the RTW/CMA completed the vital signs, LPN C would redo them. LPN C would also listen to the lung sounds and take temperature right away. If there is a low-grade temperature, it could indicate aspiration. If LPN C did not know the client, he would ask his supervisor or other nurses that have worked with the client before. He may also

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W 331	Continued From page 61 look at progress notes. LPN C believed LPN B was a solid nurse and he could rely on him. When interviewed on 11/4/20 at 1:30 p.m. LPN B reported his main houses are 133 and 241. Those are the houses he completes quarterly nursing assessments and other exams on a regular basis. The facility assigns different houses during his shift. The evening of 6/13/20, his assignment included house 465 and 2 or three other houses. On 6/13/20 at approximately 7:00 p.m., LPN B received a page via the radio that Client #23 had an emesis. He needed to go over to 465 to do catheter irrigation, so he went right away. Staff completed vitals before he arrived. He stated it was ideal for staff to complete vitals, but it was not always the case. When he arrived at the home, Client #23 and staff sat in the dining room. LPN B believed he had another emesis while he was there. LPN B completed an assessment and vitals. He listened to his lungs and there was nothing unusual. He did not know why anyone would say he did not complete an assessment. He stated he used the stethoscope at the house, the one they keep on their vitals stand. He checked the client's blood pressure and pulse oxygen. Vitals were within normal limits. Surveyor read LPN B his documented assessment and he agreed with the documentation. The assessment only indicated one emesis, because LPN B only remembered Client #23 had one emesis before he arrived at the home. He stated the incident was five months ago. He listened to his lungs and bowel sounds, they do not put vitals in the assessment. They document on a different log on the computer. If he completed the vitals, he would have documented them on the log. LPN B believed he told facility staff if there were	W 331		

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 11/17/2020

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W 331	Continued From page 62	W 331		

problems to call. LPN B believed the next phone call from house 465 was at 8:30 p.m., but someone told him that was not one of the times. The surveyor told LPN B from the facility call log there was a phone call from his desk at 7:55 p.m. and 8:09 p.m. He stated the page he believed happened at 8:30 p.m. must have been at 8:09 p.m. He explained the staff usually used the radio to page the nurses, but could use the overhead. The staff told him at that time Client #23 had another emesis. LPN B told the staff that he let the physician know and would call them after 9:00 p.m. with any order from the physician. LPN B did not think there would be an order from the physician, but he could tell staff the physician was aware or going to keep an eye on him. LPN B explained how information passed on to the physician on-call. He stated they document on a spreadsheet for the triage nurse to read to the physician at 9:00 p.m. LPN B would hear from the triage nurse if there they prescribed an order. LPN B reported the documentation on the assessment was different from the spreadsheet for the physician on-call because some physicians did not want a lot of information. LPN B heard the triage nurse call in the information. According to LPN B, staff did not indicate it was an emergency, until the final page. He believed the page came at 9:16 p.m. He stated he could hear it in their voices that something was not right the last time he talked to them. LPN B asked why the staff did not call 911 or a nurse stat if they thought it was an emergency. LPN B notified RN A to meet him over at the house because he felt something was wrong. He arrived about the same time as RN A. Client #23 was still in his wheelchair next to the break room. LPN B stated Client #23's face did not look bad, but he could hear audible lung

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	16G003	A. BUILDING _____ B. WING _____	C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 331	Continued From page 63	W 331		

sounds. LPN B went to the medication room to call the physician. RN A attempted to get vitals. LPN B asked the physician if they could send Client #23 out, as he sounded in distress. The physician gave approval. LPN B did not know what went on in the home while he was in the medication room. He stated he wasted a lot of time getting on the computer and trying to find the house printer on the computer. LPN B did not remember a certain number of emesis; he believed Client #23 had two to three. He did not consider two or three to be excessive. He did not recall there being that many emesis, if there had been a large amount he would have been worried. He stated he would have been worried because of his history of bowel obstruction and aspiration pneumonia. He knew of his history from working there so long. Client #23's lungs and bowel sounds were normal, so he knew he did not have an obstruction. LPN B just got back to his office to chart on Client #23 and received a nurse stat at another house. LPN B thought he received pages at 7:00 p.m., 8:30 p.m., and 9:15 p.m. He did not remember the calls at 7:55 p.m. and 8:09 p.m., but he remembered he responded every time the CMA called. LPN B stated staff claimed they notified him after each emesis, but if that were the case, another nurse would have responded. He explained the evening nurses have an understanding and someone would have called him to see if he needed help. He saw other nurses and they did not say anything to him. According to LPN B, there are times someone tries to use the radio and it does not go through. LPN B reported there were so many policies, but he believed they are to go back and check a client after an hour if there is an emesis. He thought he had an hour after the page to complete an assessment. He would have gone

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out to the house after the 8:30 p.m. page, but wanted to wait to find out if the physician gave an order. He stated they notify the RN of what goes on during the shift if out of the normal. They use their nursing judgement on when to notify the RN, but let them know at some point during the shift what is going on. He did not feel it was an emergency that night until the final call from staff. He called the RN right after that last page. LPN B stated if he had more schooling in heart attacks, he would have known Client #23 was having one. He could not tell he was in pain. LPN B does not feel he did anything wrong. He does not put a lot of stock in the staff that worked. He saw their charting the next day and felt like they were coached on what to document. The documentation was too medical for a staff to write, unless they walked around with a notebook writing down times. He did not know many nurses that did that. Other nurses have had clients pass away and they were not suspended. The Interim AON was right next door at 463. If she heard several pages, she would have gone over to the house. LPN B asked why the staff did not have RTS K, the operator, or another nurse get a hold of him. He also asked why the staff did not call 911.

When interviewed on 9/29/20 at 4:05 p.m. the Interim Medical Director (MD) reported he reviewed Client #23's case. His first concern was aspiration, but the autopsy indicated Client #23's lungs were clear. The autopsy indicated Client #23 died of a heart attack. He believed the delay in Client #23's care was problematic. He stated LPN B should have notified RN A of what was happening sooner than he did. After LPN B notified RN A, she did the right thing and sent him to the emergency room. In the Interim MD's

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W 331	Continued From page 65 opinion, if there is a delay in responding to a heart attack the person has a less chance of survival. He stated if LPN B responded two hours earlier the outcome could have potentially been reversible. The delay did not make things easier. Timeliness is of the essence when someone is having a heart attack. The client could not communicate chest pains, but some people vomit when they are in pain. Vomiting is also a symptom of a heart attack. The Interim MD stated it did not seem right that the CMA could not get a hold of LPN B and his assessment lacked information. The assessments did not give detail on what was going on, such as the number of emesis. LPN B also completed only two assessments. He did not feel LPN B had an attentive response and he did not understand the delay of sharing information. He stated the easiest thing to do is tell someone. When interviewed on 10/30/20 at 4:20 p.m. the Superintendent confirmed the facility failed to provide nursing services to Client #23's needs. On 10/30/20 at 4:20 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to provide nursing care as identified by client needs. The facility developed a plan to remove the IJ, which included retraining on emesis assessments and who can call 911. On 11/4/20 at 3:47 p.m., the IJ was removed from the facility.	W 331		

OK 12/18/20

Glenwood Resource Center (GRC)
Standard Level Plan of Correction for DIA Investigation #92346-I, 92436-I, 92343-I, 91538-I, 91536-I, 91535-I, & 91534-I

Tag 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 protocols.

DIA found the facility failed to ensure staff immediately reported all allegations of client abuse/mistreatment.

Individual response:

92346-I: RTW CC was trained on Recognizing, Preventing & Reporting Abuse, and Neglect on 7/21/20.
92346-I: RTW A was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/21/20
92343-I: RTW I was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/21/20.
RTW J was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/23/20.
QIDP C was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 8/25/20.
RTS B was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/20/20.
TPA A was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/20/20.
91534-I: RTW S was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 9/09/20.
RTS H was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/20/20.
91535-I: RTW U was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/21/20.
RTS F was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/23/20
91536-I: RTS F was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/23/20
91538-I: RTW W was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/23/20
RTS F was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/23/20.

Responsible: Assistant Superintendent for Treatment Program Services
Date Completed: 9/10/20

Systemic response:

GRC developed Recognizing Preventing & Reporting Abuse, Neglect curriculum and completed in-person training for staff, including new hire employees.

GRC will continue to provide training on Recognizing Preventing & Reporting Abuse, Neglect stressing recognizing and reporting abuse and/or neglect immediately to a supervisor, in New Employee Orientation and annually thereafter, monitoring employees to enable them to perform their duties effectively, efficiently and competently.

Responsible: Superintendent
Date to be completed: 1/8/21

Tag W-192 – Staff Training Program – CFR(s): 483.430 (e)(2): For employees who work with clients, training must focus on skills and competencies directed towards client's health needs.

DIA found the facility failed to ensure staff consistently addressed clients' individual health care needs.
Individual response:

92436-I: RTW B has not returned to work at GRC.

Observation: RTW K will be retrained on Client #11's physician nutritional management plan (PNMP).

Responsible: Assistant Superintendent for Treatment Program Services
Date to be completed: 1/8/21

Systemic response:

Area 2 teams will be retrained on following physical nutritional management plans as written.

Responsible: Superintendent
Date to be completed: 1/8/21

Tag W-193 – Staff Training Program – CFR(s): 483.430(e)(3): Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

DIA found the facility failed to ensure staff proved the level of client supervision as required by client behavior programs/plans.

Individual response:

93070-I: RTW M was retrained on the Accountability and Level of Supervision policies on 9/2/20.

RTW N was retrained on the Accountability and Level of Supervision policies on 9/2/20 and was given appropriate management action 10/6/20.

97341-I: RTW P was retrained on Client #5's behavioral support plan on 11/18/20.

Responsible: Assistant Superintendent for Treatment Program Services
Date Completed: 11/18/20

Systemic response:
GRC will retrain all staff who regularly take accountability for individuals on Accountability and the Level of Supervision policies.

Responsible: Superintendent
Date to be completed: 1/8/21

Tag 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.

DIA found the facility failed to ensure staff consistently treated clients with respect and dignity.

Individual response:

92436-I: RTW B was retrained on the Human Rights Policy on 9/25/20.
RTW C was retrained on the Human Rights Policy on 8/31/20.
92343-I: RTW G is no longer employed at GRC effective 11/20/20.

Responsible: Assistant Superintendent for Treatment Program Services
Date Completed: 11/20/20

Systemic response:

GRC will re-train all staff who regularly take accountability for individuals on Guiding Principles of the Philosophy of Service Policy and on the Human Rights Principles section of the Human Rights Policy.

Responsible: Superintendent
Date to be completed: 1/8/21

Tag W – 288 – Management of Inappropriate Client Behavior – CFR(s): 483.450(b)(3): Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.

DIA found the facility failed to ensure staff utilized facility approved restrictive measures only as specified in the clients' behavior plans or in emergency situations.

Individual response:

93434-I: RTW X will be retrained on the policy section of the Restraints Policy.
91684-I: RTW Z will be retrained on the policy section of the Restraints Policy.
RTS I will be retrained on the policy section of the Restraints Policy.
Training Specialist 1 will be retrained on the policy section of the Restraints Policy.
Psych Assistant B will be retrained on the policy section of the Restraints Policy.
93185-I: RTW BB will be retrained on the policy section of the Restraints Policy.

Responsible: Assistant Superintendent
Date to be completed: 1/8/21

Systemic response:

GRC will re-train all staff who regularly take accountability for individuals on the policy section of the Restraints Policy, emphasizing floor restraint is prohibited and lift and carry is not an approved and trained technique to be used in the MANDT system. CIT taught lift and carry is no longer an approved technique to be used at GRC.

Responsible: Superintendent

Date to be completed: 1/8/21
Tag W – 318 – Health Care Services – CFR(s): 483.460 – The facility must ensure that specific health care services requirements are met.

DIA found the facility failed to comply with the Condition of Participation: Health Care Services. The facility failed to respond in a timely manner to clients medical needs.

Individual response:

Nurses assigned to house 465 were retrained on the "Emesis" section of the Nursing Assessment Reassessment Procedure including completion of a physical nursing assessment upon notification of emesis. LPNs must notify the RN for clinical oversight and repeat with each new emesis.

The PNM Risk Management Quick Reference Card was revised to include the statement "Stop activity and ensure safety (emergency response if needed)" – completed September 2020.

RTWs, RTSs, and QIDP of house 465 were re-trained to call 911 when an individual is in need of emergency care.

Responsible: Administrator of Nursing & Assistant Superintendent for Treatment Program Services
Date completed: 11/2/20

Systemic response:

All nurses were retrained on the "Emesis" section of the Nursing Assessment Reassessment Procedure including completion of a physical nursing assessment upon notification of emesis. LPNs must notify the RN for clinical oversight and repeat with each new emesis.

The PNM Risk Management Quick Reference Card was revised to include the statement "Stop activity and ensure safety (emergency response if needed)" – completed September 2020.

All staff who regularly take accountability for individuals were re-trained to call 911 when an individual is in need of emergency care.

GRC's Code Blue/Emergency Response Protocol has been revised and trained to all medical providers, nursing staff and staff who regularly take accountability for individuals.

GRC's Nurse Stat Protocol will be discontinued once Code Blue/Emergency Response Protocol has been implemented and trained.

Responsible: Superintendent
Date to be completed: 1/8/21

Tag W – 331 – Nursing Services – CFR(s): 483.460(c) – The facility must provide clients with nursing services in accordance with their needs.

DIA found the facility failed to provide clients with nursing services in accordance with identified needs.

Individual response:

92297-M: LPN B will receive appropriate level of disciplinary action pending outcome of DIA Mandatory Abuse/Neglect Investigation.

Responsible: Assistant Superintendent for Treatment Program Services
Date to be completed: Within 30 days of receipt of findings from DIA Mandatory Abuse/Neglect Investigation

Systemic response:
All nurses were retrained on the "Emesis" section of the Nursing Assessment Reassessment Procedure including completion of a physical nursing assessment upon notification of emesis. LPNs must notify the RN for clinical oversight and repeat with each new emesis.

The PNM Risk Management Quick Reference Card was revised to include the statement "Stop activity and ensure safety (emergency response if needed)" – completed September 2020.

All staff who regularly take accountability for individuals were re-trained to call 911 when an individual is in need of emergency care.

GRC's Code Blue/Emergency Response Protocol has been revised and trained to all medical providers, nursing staff and staff who regularly take accountability for individuals.

GRC's Nurse Stat Protocol will be discontinued once Code Blue/Emergency Response Protocol has been implemented and trained.

Responsible: Superintendent
Date to be completed: 1/8/21

Glenwood Resource Center (GRC)
Citation Level Plan of Correction for DIA Investigation FC#8031

Tag 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 protocols.

DIA found the facility failed to ensure staff immediately reported all allegations of client abuse/mistreatment.

Individual response:

92346-I: RTW CC was trained on Recognizing, Preventing & Reporting Abuse, and Neglect on 7/21/20.
92346-I: RTW A was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/21/20
92343-I: RTW I was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/21/20.
RTW J was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/23/20.
QIDP C was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 8/25/20.
RTS B was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/20/20.
TPA A was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/20/20.
91534-I: RTW S was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 9/09/20.
RTS H was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/20/20.
91535-I: RTW U was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/21/20.
RTS F was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/23/20
91536-I: RTS F was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/23/20
91538-I: RTW W was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/23/20
RTS F was trained on Recognizing, Preventing & Reporting Abuse, Neglect on 7/23/20.

Responsible: Assistant Superintendent for Treatment Program Services
Date Completed: 9/10/20

Systemic response:

GRC developed Recognizing Preventing & Reporting Abuse, Neglect curriculum and completed in-person training for staff, including new hire employees.

GRC will continue to provide training on Recognizing Preventing & Reporting Abuse, Neglect stressing recognizing and reporting abuse and/or neglect immediately to a supervisor, in New Employee Orientation and annually thereafter, monitoring employees to enable them to perform their duties effectively, efficiently and competently.

Responsible: Superintendent
Date to be completed: 1/8/21

Glenwood Resource Center (GRC)
Citation Level Plan of Correction for DIA Investigation FC#9033

Tag W – 318 – Health Care Services – CFR(s): 483.460 – The facility must ensure that specific health care services requirements are met.

DIA found the facility failed to comply with the Condition of Participation: Health Care Services. The facility failed to respond in a timely manner to clients medical needs.

Individual response:

Nurses assigned to house 465 were retrained on the "Emesis" section of the Nursing Assessment Reassessment Procedure including completion of a physical nursing assessment upon notification of emesis. LPNs must notify the RN for clinical oversight and repeat with each new emesis.

The PNM Risk Management Quick Reference Card was revised to include the statement "Stop activity and ensure safety (emergency response if needed)" – completed September 2020.

RTWs, RTSs, and QIDP of house 465 were re-trained to call 911 when an individual is in need of emergency care.

Responsible: Administrator of Nursing & Assistant Superintendent for Treatment Program Services
Date completed: 11/2/20

Systemic response:

All nurses were retrained on the "Emesis" section of the Nursing Assessment Reassessment Procedure including completion of a physical nursing assessment upon notification of emesis. LPNs must notify the RN for clinical oversight and repeat with each new emesis.

The PNM Risk Management Quick Reference Card was revised to include the statement "Stop activity and ensure safety (emergency response if needed)" – completed September 2020.

All staff who regularly take accountability for individuals were re-trained to call 911 when an individual is in need of emergency care.

GRC's Code Blue/Emergency Response Protocol has been revised and trained to all medical providers, nursing staff and staff who regularly take accountability for individuals.

GRC's Nurse Stat Protocol will be discontinued once Code Blue/Emergency Response Protocol has been implemented and trained.

Responsible: Superintendent
Date to be completed: 1/8/21