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	16G023	A. BUILDING _____ B. WING _____	C 01/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

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W 000	INITIAL COMMENTS The investigation of #80588-M, #80759-I, and #80764-I was conducted 1/7/19 - 1/23/19. The investigation resulted in a determination of Immediate Jeopardy related to concerns of clients safety regarding allegations of abuse and/or mistreatment. The facility was notified of the determination on 1/9/19 and provided a plan to address the concerns, which included separation of RLA and RLA B from Client #1, thorough investigation of the allegations made against these staff, and reporting the allegations to the Department of Inspections and Appeals. Furthermore, the facility retrained supervisory staff on the facility's Child and Dependent Abuse policy, which included separation, investigation, and reporting requirements of allegations of abuse, neglect, and mistreatment. The immediate jeopardy was removed on 10/10/19. A condition-level deficiency was cited at W122. Standard-level deficiencies were cited at W149, W153, W154, and W155.	W 000	See attached POC 1/9/19	
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure the protection of all clients following allegations of abuse and/or mistreatment. The facility failed to ensure	W 122		

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 122	Continued From page 1 separation occurred between the alleged perpetrator(s) and the victim, failed to ensure the facility reported all allegations to the Department of Inspections and Appeals as required, and failed to complete a thorough internal investigation into the allegations. This led to the determination of an Immediate Jeopardy on 1/9/19. Findings follow: Cross reference W153: Based on interview and record review, the facility failed to ensure all allegations of client mistreatment and/or abuse were reported to the State Agency, the Department of Inspections and Appeals (DIA), as required. Cross reference W154: Based on interview and record review, the facility failed to ensure completion of a thorough investigation following allegations of abuse and/or mistreatment. Cross reference W155: Based on observation, interviews, and record review, the facility failed to ensure separation occurred between the alleged perpetrators and victim following an allegation of client abuse and/or mistreatment.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to consistently implement policies and procedures to prohibit abuse and/or	W 149		

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W 149	Continued From page 2	W 149		

mistreatment of clients. The facility failed to take immediate action to ensure the safety of clients when allegations of abuse and/or mistreatment were made. This affected 1 of 1 client identified as a result of investigation #80588-M, #80759-I, and #80764-I.

Findings follow:

See W153, W154, and W155 for additional information.

Record review on 1/7/19 revealed a facility internal investigation, initiated 12/9/18, following an allegation of abuse. According to the internal investigation, Residential Living Assistant (RLA) D was observed to push and pin Client #1 against a wall, dug her fingernails into the sides of his head; as well as spray Client #2 with water. The internal investigation included staff statements, the facility conclusion, and the termination discipline for RLA D given on 12/10/18. Review of the written staff statements revealed RLA C, who reported the allegation, signed her statement on 12/12/18. The other staff who worked 12/9/18 completed statements on 12/9/18 and 12/11/18.

Continued record review on 1/9/19 revealed RLA C's initial written statement, signed 12/9/18. According to the statement, RLA C wrote she observed RLA A and RLA D hit Client #1 if he would pinch them. The statement noted RLA C demonstrated a light slap to RS A's hand when RLA C explained she had witnessed RLA A, RLA B, and RLA D hit Client #1 for pinching.

Observations on 1/8/19 at 4:35 p.m. revealed Residential Living Assistant (RLA) A took accountability of Client #1 until 4:50 p.m. RLA B

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W 149	Continued From page 3 took accountability of Client #1 from 4:50 p.m. until at least 5:25 p.m., when the Surveyor left the facility. Additional record review revealed the facility's Child and Dependent Adult Abuse policy, last update 8/2/17. According to the policy, upon receiving a report of an alleged incident of abuse an investigation would immediately be initiated. The administrator should immediately separate the victim and the alleged abuser and maintain separation until the completion of the facility's and the appropriate state agency's investigations. The ICF/ID administrator should document document the facts of the investigation and any administrative actions to be taken. The internal investigation should be completed within five working days. Record review failed to produce investigation into allegations of abuse/mistreatment of Client #1 by RLA A and RLA B. When interviewed on 1/9/19 at 10:50 a.m. the Administrator confirmed the facility failed to ensure the separation of RLA A and RLA B from Client #1 when allegations of abuse and/or mistreatment were made. She further confirmed the facility failed to thoroughly investigate these allegations and report to the Department of Inspections and Appeals as required. These findings resulted in a determination of Immediate Jeopardy related to concerns of clients safety regarding allegations of abuse and/or mistreatment. The facility was notified of the determination on 1/9/19 and provided a plan to address the concerns, which included separation of RLA and RLA B from Client #1,	W 149		

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W 149	Continued From page 4 thorough investigation of the allegations made against these staff, and reporting the allegations to the Department of Inspections and Appeals. Furthermore, the facility retrained supervisory staff on the facility's Child and Dependent Abuse policy, which included separation, investigation, and reporting requirements of allegations of abuse, neglect, and mistreatment. The immediate jeopardy was removed on 10/10/19.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegations of client mistreatment and/or abuse were reported to the State Agency, the Department of Inspections and Appeals (DIA), as required. This affected 1 of 2 clients (Client #1) involved in the investigations of #80588-M, #80759-I, and #80764-I. Finding follows: Record review on 1/7/19 revealed a facility internal investigation, initiated 12/9/18, following an allegation of abuse. According to the internal investigation, Residential Living Assistant (RLA) D was observed to push and pin Client #1 against a wall. RLA D was alleged to have dug her fingernails into the sides of his head; as well as, spray Client #2 with water. The internal	W 153		

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W 153	Continued From page 5	W 153		

investigation noted RLA D moved to work in a different house on 12/9/18 and her employment was terminated on 12/10/18.

When interviewed on 1/9/19 at 7:40 a.m., Residential Living Assistant (RLA) C stated she worked both first and second shift on 12/9/18. RLA C stated she observed RLA D spray water at Client #2 and also had pushed Client #1 against the wall and dug her fingernails into his forehead. RLA C said the on-call supervisor came into the facility. RLA C explained she spoke to the on-call supervisor and wrote a statement on 12/9/18. RLA C stated after she reported concerns with RLA D she also reported she had witnessed RLA A smack Client #1's hand when Client #1 attempted to pinch her.

When interviewed on 1/9/19 at 8:50 a.m., Residential Supervisor (RS) A reported she was the p.m. on-call supervisor on 12/9/18. RS A stated she went into the facility at approximately 8:20 p.m. after she was informed of an allegation of abuse. RS A stated she spoke to RLA C and had RLA C write a statement. RS A explained RLA C began to write her statement, but was very upset so she (RS A) wrote down everything RLA C reported. RS A stated RLA C reported concerns regarding RLA D spraying water on Client #2 and pushing Client #1 against the wall, as well as digging her fingernails into the sides of his head. She stated RLA C also reported concerns staff smacked Client #1's hand after Client #1 would attempt to pinch. RS A stated she thought RLA C reported RLA B and was unable to recall if she also reported RLA A. RS A stated it was all noted in the statement from RLA C on 12/9/18. RS A stated the statement should be with the internal investigation since she turned all of them into the

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W 153	Continued From page 6 Administrator. Record review revealed Client #1 was a 24 year old male who resided at the facility since 2/11/16. Client #1 had diagnoses including, but not limited to: severe intellectual disabilities, autism, anxiety, attention-deficit hyperactivity disorder, mood disorder, organic mutism, insomnia, pica, and eosinophilic esophagitis. Client #1 ambulated independently. Client #1 had limited verbal communication skills and would use single words, short phrases, and echolalia to communicate. Client #1 had an individual program plan in place to address target behaviors of self-injurious behaviors (hitting or slapping self, hitting head on objects, hitting self with objects), destructions (banging on walls, windows, tables, wall hangings, or other objects; throwing items, jumping or plopping onto chairs), and aggression (hitting or slapping others, actual or attempts of biting others, pinching others, pushing others, or pulling others hair). Restrictive measures included the use of behavior modifying medications (Clonidine, Lorazepam, Clozaril), the use of plastic dishes at mealtimes, the use of a non-wooden chair in the dining room area, the side doors of the facility were alarmed, and Client #1 was to utilize a wheelchair on outings and/or when outside. Additional record review on 1/9/19 revealed RLA C's initial written statement, signed 12/9/18. According to the statement, RLA C wrote she observed RLA A and RLA D hit Client #1 if he would pinch them. The statement noted RLA C demonstrated a light slap to RS A's hand when RLA C explained she witnessed RLA A, RLA B, and RLA D hit Client #1 for pinching.	W 153		

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W 153	Continued From page 7 Review of the facility policy titled "Child and Dependent Adult Abuse Policy," last revised 8/2/17, instructed all allegations of abuse made within an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) were to be reported to the Department of Inspections and Appeals (DIA) within 24 hours. When interviewed on 1/9/19 at 10:50 a.m., the Administrator confirmed the facility failed to report the allegations made against RLA A and RLA B to the DIA. She stated the facility followed up on the concerns reported on 12/9/18, with more focus on the incidents reported regarding RLA D, which were reported to the DIA. The Administrator stated, based on the information provided, it appeared Client #1 was being blocked from pinching by staff brushing his hand away. She stated the facility determined no abuse occurred by RLA A or RLA B toward Client #1. The Administrator stated she would report the allegations of abuse to the DIA.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure completion of a thorough investigation following allegations of abuse and/or mistreatment. This affected 1 of 2 clients (Client #1) involved in the investigations of #80588-M, #80759-I, and #80764-I. Finding follows: Record review on 1/7/19 revealed a facility	W 154		

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W 154	Continued From page 8 internal investigation, initiated 12/9/18, following an allegation of abuse. According to the internal investigation, Residential Living Assistant (RLA) D was observed to push and pin Client #1 against a wall, dug her fingernails into the sides of his head; as well as spray Client #2 with water. RLA D's employment was terminated on 12/10/18. When interviewed on 1/9/19 at 7:40 a.m., Residential Living Assistant (RLA) C stated she worked both first and second shift on 12/9/18. RLA C stated she observed RLA D spray water at Client #2, as well as push him against the wall and dig her fingernails into his forehead. RLA C said the on-call supervisor came into the facility. RLA C explained she spoke to supervisor and wrote a statement on 12/9/18. RLA C stated after she reported concerns with RLA D she also reported she witnessed RLA A smack Client #1's hand when Client #1 attempted to pinch her. When interviewed on 1/9/19 at 8:50 a.m., Residential Supervisor (RS) A reported she was the p.m. on-call supervisor on 12/9/18. RS A stated she went into the facility at approximately 8:20 p.m. after being informed of an allegation of abuse. RS A stated she spoke to RLA C and had RLA C write a statement. RS A explained RLA C began to write her statement, but was very upset so RS A wrote down everything RLA C reported. RS A stated RLA C reported concerns regarding RLA D. She stated RLA C also reported concerns staff smacked Client #1's hand after Client #1 would attempt to pinch. RS A stated she thought RLA C reported RLA B and was unable to recall if she also reported RLA A. RS A stated it was all noted in the statement taken from RLA C on 12/9/18. RS A stated the statement should be with the internal investigation since she turned all	W 154		

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W 154	Continued From page 9 of them into the Administrator. Record review revealed Client #1 was a 24 year old male who resided at the facility since 2/11/16. Client #1 had diagnoses including, but not limited to: severe intellectual disabilities, autism, anxiety, attention-deficit hyperactivity disorder, mood disorder, organic mutism, insomnia, pica, and eosinophilic esophagitis. Client #1 ambulated independently. Client #1 had limited verbal communication skills and would use single words, short phrases, and echolalia to communicate. Client #1 had an individual program plan in place to address target behaviors of self-injurious behaviors (hitting or slapping self, hitting head on objects, hitting self with objects), destructions (banging on walls, windows, tables, wall hangings, or other objects; throwing items, jumping or plopping onto chairs), and aggression (hitting or slapping others, actual or attempts of biting others, pinching others, pushing others, or pulling others hair). Restrictive measures included the use of behavior modifying medications (Clonidine, Lorazepam, Clozaril), the use of plastic dishes at mealtimes, the use of a non-wooden chair in the dining room area, the side doors of the facility were alarmed, and Client #1 was to utilize a wheelchair on outings and/or when outside. Additional record review on 1/9/19 revealed RLA C's initial written statement, signed 12/9/18. According to the statement, RLA C wrote she observed RLA A and RLA D hit Client #1 if he would pinch them. The statement noted RLA C demonstrated a light slap to RS A's hand when RLA C explained she witnessed RLA A, RLA B, and RLA D hit Client #1 for pinching.	W 154		

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W 154	Continued From page 10 The record lacked an internal investigation following the allegation that RLA A and RLA B hit Client #1's hand after he would attempt to pinch. Review of facility policy titled "Child and Dependent Adult Abuse Policy," last revised 8/2/17, instructed an investigation was to be initiated immediately after receiving a report of an alleged incident of abuse. The policy continued to instruct the Administrator was to document the facts of the investigation and any administrative actions taken. When interviewed on 1/9/19 at 10:50 a.m., the Administrator (Ad) explained the facility followed-up on the reports made by RLA C on 12/9/18. She explained more focus was placed on the allegations made against RLA D but said staff were asked if they had witnessed other staff hit Client #1's hand after Client #1 would pinch. The Administrator stated based on the interviews, it appeared staff blocked Client #1's hand and brushed it away when he would pinch and were not actually hitting his hand. She confirmed the facility failed to document the follow-up completed regarding the report of RLA A and RLA B hitting Client #1's hand after he pinched. She stated she would initiate the internal investigation on 1/9/19.	W 154		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure separation	W 155		

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W 155	Continued From page 11 occurred between the alleged perpetrators and victim following an allegation of client abuse and/or mistreatment. This affected 1 of 2 clients (Client #1) involved in the investigation of #80588-M, #80759-I and #80764-I. Finding follows: Record review on 1/7/19 revealed a facility internal investigation, initiated 12/9/18, following an allegation of abuse. According to the internal investigation, Residential Living Assistant (RLA) D was observed to push and pin Client #1 against a wall, dug her fingernails into the sides of his head; as well as spray Client #2 with water. The internal investigation included staff statements, the facility conclusion, and the termination discipline for RLA D given on 12/10/18. Review of the written staff statements revealed RLA C, who reported the allegation, signed her statement on 12/12/18. The other staff who worked 12/9/18 completed statements on 12/9/18 and 12/11/18. Observation on 1/8/19 at 4:35 p.m. revealed Residential Living Assistant (RLA) A took accountability of Client #1 until 4:50 p.m. RLA A offered Client #1 a puzzle, walked with Client #1 to the foyer and back to the main living area, and continued to walk with Client #1. Client #1 looked into the kitchen; RLA A reminded Client #1 supper was not done and then prompted Client #1 to the living room to do an activity. Client #1 continued to walk back and forth between the foyer and the kitchen door; RLA A walked with him. The Program Coordinator/Qualified Intellectual Disability Professional (PC/QIDP) assisted Client #1 to use Facetime to call his grandmother. Client #1 smiled and jumped when his grandmother answered. Client #1 continued to walk around, carrying his tablet with his grandmother on	W 155		

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PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

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W 155	Continued From page 12 Facetime; RLA A continued to walk with him. Continued observations on 1/8/19 at 4:50 p.m. revealed RLA B took over accountability of Client #1 from RLA A. RLA B assisted Client #1 to get his supper dishes and take them to the table. At the dining room table, RLA B prompted Client #1 to set up his place setting. RLA B used verbal prompting with pointing and Client #1 set up his dishes. Client #1 picked up his tablet. RLA B encouraged Client #1 to wave back to his grandmother who was still on Facetime waving at him. Client #1 smiled, carried his tablet, and continued to walk around; RLA B walked with him. Client #1 returned to the dining room table and RLA B encouraged he sit down and talk to his grandmother on Facetime. Client #1 walked to the kitchen window, set his tablet down on the counter, and returned to the dining room table. RLA B picked up the tablet and gave it back to Client #1 who set it on the table. RLA B provided Client #1 hand-over-hand assistance to serve his supper meal. The PC/QIDP briefly took over accountability while RLA B stepped out of the area. RLA B returned to the dining room, encouraged Client #1 to use his table manners, provided Client #1 praise for using his fork, and encouraged Client #1 to take drinks between bites of his meal. Client #1 finished his supper meal and walked into the living room. RLA B followed Client #1 and prompted him to clear his supper dishes. With verbal prompting and pointing from RLA B, Client #1 took his dishes to the dirty dish bin. At 5:15 p.m., RLA B and Client #1 walked down the hallway toward Client #1's bedroom. Client #1 and RLA B were not back in the main area when the Surveyor left the facility at 5:25 p.m.	W 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G023	A. BUILDING _____ B. WING _____	C 01/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 155	Continued From page 13 When interviewed on 1/9/19 at 7:40 a.m., RLA C stated she worked both first and second shift on 12/9/18. RLA C stated she observed RLA D spray water at Client #2 and also observed RLA D push Client #1 against the wall and dig her fingernails into his forehead. RLA C said the on-call supervisor came into the facility on 12/9/18 and initiated an investigation. RLA C explained she spoke to the on-call supervisor and wrote a statement on 12/9/18. RLA C stated after she reported concerns with RLA D she also reported she witnessed RLA A smack Client #1's hand when Client #1 attempted to pinch her. When interviewed on 1/9/19 at 8:50 a.m., Residential Supervisor (RS) A reported she was the p.m. on-call supervisor on 12/9/18. RS A stated she went into the facility at approximately 8:20 p.m. after she was informed there was of an allegation of abuse. RS A stated she spoke to RLA C and had RLA C write a statement. RS A explained RLA C started to write her statement but was very upset so she (RS A) wrote down everything RLA C reported. RS A stated RLA C reported concerns that RLA D sprayed Client #2 with water and also pushed Client #1 against the wall and dug her fingernails into the sides of his forehead. She stated RLA C also reported concerns staff smacked Client #1's hand after Client #1 would attempt to pinch. RS A stated she thought RLA C reported RLA B and was unable to recall if she also reported RLA A. RS A stated it was all noted in the statement taken from RLA C on 12/9/18. RS A stated the statement should be with the internal investigation since she turned all of them into the Administrator. Continued record review on 1/9/19 revealed RLA C's initial written statement, signed 12/9/18.	W 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G023	A. BUILDING _____ B. WING _____	C 01/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 155	Continued From page 14 According to the statement, RLA C wrote she observed RLA A and RLA D hit Client #1 if he would pinch them. The statement noted RLA C demonstrated a light slap to RS A's hand when RLA C explained she had witnessed RLA A, RLA B, and RLA D hit Client #1 for pinching. Review of facility policy titled "Child and Dependent Adult Abuse Policy," last revised 8/2/17, instructed the Administrator was to immediately separate the victim and the accused abuser and maintain the separation until the abuse investigation was completed. The policy noted the investigation referred to both the internal investigation and the investigation which may be completed by the Department of Human Services or Department of Inspections and Appeals. When interviewed on 1/9/19 at 10:50 a.m., the Administrator confirmed the initial statement provided by RLA C identified RLA A, RLA B, and RLA D hit Client #1's hand after Client #1 would attempt to pinch. The Administrator confirmed the facility failed to ensure RLA A and RLA B were separated from working with Client #1 following the allegation and both RLA A and RLA B continued to work with Client #1. She reported the facility would separate RLA A and RLA B from working with Client #1 effective immediately. Additional record review on 12/10/19 revealed staff schedules from 12/10/18 - 1/9/19. According to the schedule, RLA A and RLA B continued to work in House #3 and rotated accountability of Client #1 with other staff after the allegation was made on 12/9/18.	W 155		

OK 3/12/19

✓ 3/13/19

Park View Homes Plan of Correction

W122 - A copy of the Mid-Step Services Child and Dependent Abuse Policy was reviewed with management staff. This policy addresses protecting the members and reporting and investigating incidents of abuse. A statement was signed indicating the policy was reviewed and understood. The policy will be reviewed at management meetings.

Frequency – quarterly
Responsible – Administrator
Date completed – 1/9/19

W149 - A copy of the Mid-Step Services Child and Dependent Abuse Policy was reviewed with management staff. This policy addresses protecting the members and reporting and investigating incidents of abuse. A statement was signed indicating the policy was reviewed and understood. The policy will be reviewed at management meetings.

Frequency – quarterly
Responsible – Administrator
Date completed – 1/9/19

W153 - A copy of the Mid-Step Services Child and Dependent Abuse Policy was reviewed with management staff. This policy addresses protecting the members and reporting and investigating incidents of abuse. A statement was signed indicating the policy was reviewed and understood. The policy will be reviewed at management meetings.

Frequency – quarterly
Responsible – Administrator
Date completed – 1/9/19

W154 - A copy of the Mid-Step Services Child and Dependent Abuse Policy was reviewed with management staff. This policy addresses protecting the members and reporting and investigating incidents of abuse. A statement was signed indicating the policy was reviewed and understood. The policy will be reviewed at management meetings.

Frequency – quarterly
Responsible – Administrator
Date completed – 1/9/19

W155 - A copy of the Mid-Step Services Child and Dependent Abuse Policy was reviewed with management staff. This policy addresses protecting the members and reporting and investigating incidents of abuse. A statement was signed indicating the policy was reviewed and understood. The policy will be reviewed at management meetings.

Frequency – quarterly
Responsible – Administrator
Date completed – 1/9/19