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W 000	INITIAL COMMENTS Investigations #109791-M, #109790-I, #110000-I, #110265-I and #110638-M were conducted from 1/19/23 - 2/7/23. Investigation #110638-M resulted in the determination of Immediate Jeopardy (IJ) on 2/2/23 at 3:53 p.m. based on failure to develop policy and/or procedures to ensure and monitor the safety of clients when using mechanical lifts. The facility developed a plan to remove the IJ which included the development and training of the Dependent Mechanical Lift procedure, and retraining the use of a mechanical lift with assistance from a second staff. The IJ was removed on 2/6/23 at 2:53 p.m. The facility was determined to be out of compliance with the Condition of Participation (COP) Governing Body. A condition-level deficiency was cited at W102 and a standard-level deficiency at W104. Investigation #109791-M resulted in a deficiency cited at W149. Investigation 109790-I resulted in a deficiency cited at W368. Investigation 110000-I resulted in a deficiency cited at W368. Investigation 110265-I did not result in any deficiencies.	W 000	See Attached POC 4/17/23	
W 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing	W 102		

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 102	Continued From page 1 body and management requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to maintain minimal compliance with the Condition of Participation (COP) - Governing Body. Finding follows: Cross-reference W104: Based on interviews and record reviews, the facility failed to ensure and monitor client safety when using mechanical lifts. These finding resulted in the determination of Immediate Jeopardy (IJ) on 2/2/23 at 3:53 p.m., based on the facility's failure to develop policy and/or procedures to ensure and monitor client safety when using mechanical lifts. The facility developed, trained and implemented a Dependent Mechanical Lift procedure, which included retraining the use of a mechanical lift with assistance from a second staff. The IJ was removed on 2/6/23 at 2:53 p.m.	W 102		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure and monitor client safety when using mechanical lifts. This affected 1 of 1 clients who utilized a mechanical lift (Client #1). Finding follows: Record review on 1/31/23 revealed Client #1's	W 104		

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incident report documented by Residential Treatment Worker (RTW) A dated 1/29/23, indicated, "I was in the process of getting (Client #1) up for the evening activities and supper. I had hooked all (four) corners up onto the lift pivoted to put him in his chair. As I was turning, I saw the right side of the sling slip off the lift then I reached out to grab it but he slipped out fast. I started screaming before he hit the ground. When he landed, he first landed on his left hip then his head hit on the left side. I screamed for help and yelled for the others to call the nurse." The facility called 911 and paramedics took Client #1 to the Emergency Room (ER).

Record review on 2/1/23 revealed Client #1's hospital report dated 1/31/23, indicated Client #1 sustained a subarachnoid hemorrhage at the right frontal region and left frontal scalp laceration, closed with staples. Client #1 stayed in intensive care for two days before discharged back to the facility. Clinical notes dated 1/31/23, indicated Client #1's injuries included a large abrasion to his left arm and reddened areas on his left knee.

Continued record review revealed facility training dated 5/2021, indicated, "All individuals who use a dependent mechanical lift to transfer must be assisted by (two) people." A facility procedure for use of mechanical lifts could not be located.

When interviewed on 2/6/23 at 10:53 a.m. RTW A reported house 462 as her normal house. She stated she normally worked four-hour increments at different houses during the day, wherever the need was. On 1/29/23, RTW A worked at house 462 all day. She took over Client #1's group at 2:00 p.m. She remembered she went in his bedroom to transfer Client #1 from his bed to his

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W 104	Continued From page 3 wheelchair. She completed personal cares, dressed him, and placed the sling for the hoyer lift under him. After she connected the sling to the hoyer lift, she lifted Client #1 up over the bed to ensure all connections were good. RTW A then put the bedrail down, holding onto his feet as his head was up by her chest. RTW A turned Client #1 off his bed and he fell out of the sling. She said she tried to reach for him, but it happened fast. RTW A stated Client #1 fell onto his left "bum" then his head. She screamed for help and another staff called the nurse. Nobody moved Client #1, although RTW D moved his clothing protector off his face so he could breath. Staff stood over Client #1 until the nurse arrived. According to RTW A, the facility trained her to use a second staff when using the hoyer lift to transfer clients. She did not know why she did not get a second staff to help her because they had plenty of staff. RTW A admitted on two prior occasions she completed hoyer transfers without a second staff. One time the house had three staff, one staff with a one-to-one client, another staff as the medication administrator, and RTW A left to transfer clients. She stated she called a supervisor for help, but they could not get help to the house until 9:00 p.m. The other time happened during a COVID outbreak. The facility left her with three clients at the house while everyone else moved over to the COVID house. She called a supervisor for help with the transfers and the supervisor told her they did not have enough staff and she had to do the best she could. RTW A denied witnessing anyone using a hoyer lift without a second staff and usually assisted others as the second staff. She believed if the facility left her in a position she had to complete hoyer lift transfers without a second staff, she is sure other staff completed them	W 104		

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without a second staff.

When interviewed on 1/31/23 at 4:26 p.m. RTW B reported on 1/29/23 he had a one-to-one client in the client's bedroom. He heard a scream and heard RTW C ask if they wanted her to call a code blue. He believed they called the nurse, but he did not witness anything. He could not remember how many staff they had on-duty that day. RTW B stated staff should use a second staff during all mechanical hoyer lifts. He explained one staff holds onto the client and one maneuvers the lift. One staff is able to assist during a standing transfer. RTW B denied using a hoyer lift without a second staff or witnessing anyone else using a hoyer lift without a second staff. He stated if other staff were busy, they needed to wait until someone was available to assist with the lift.

Additional interview on 2/2/23 at 12:36 p.m. RTW B called the Surveyor and stated he was sorry, but he was dishonest during his first interview. During the morning shift on 1/29/23, he believed he had three clients in his group who used a hoyer lift to transfer. RTW B stated he did not use a second staff to assist him with the hoyer lift transfers. He did not know why he did not ask another staff to assist him. He stated he was busy and just completed the transfers alone. He also did not remember how many staff worked on the morning of 1/29/23. RTW B admitted he completed hoyer transfers without a second staff on a routine basis and especially when they are short staff.

When interviewed on 1/31/23 at 3:30 p.m. the Director of Quality Management confirmed the facility failed to provide a policy and/or procedure

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W 104	Continued From page 5 to ensure and monitor the safety of clients using a mechanical lift.	W 104		
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 interviews and record reviews, the facility failed to consistently ensure policies and procedures related to investigation of injuries of unknown origin were followed as written. This affected 1 of 1 client's (Client #1) involved in 109791-M. Finding follows: Record review on 1/24/23 revealed Client #1's nursing assessment dated 12/13/22, completed by Licensed Practical Nurse (LPN) A, indicated staff reported a bruise on Client #1's head. The nurse described the bruise as a yellow, red and purple bruise on the right side of the clients head and measured 1 cm x 2 cm at the bottom and 2cm x 2 1/2 cm yellow discoloration surrounding up to the hairline. The summary further noted staff were instructed by the supervisor to complete a health care note for a "previous issue." Record review on 1/24/23 revealed Client #1's incident report (IR) dated 12/9/22 at 12:35 p.m. indicated Residential Treatment Worker (RTW) A punched Client #1 in the head while the staff worked with her in her bedroom during a behavioral episode. Record review of the facility investigation initiated on 12/9/22, found no record of the nursing	W 149		

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assessment from 12/13/22 or an IR for the injury of unknown origin discovered by RTW B on 12/13/22. The outcome of the facility investigation was "inconclusive" as to whether or not RTW A punched Client #1 in the head as alleged on 12/9/22.

Continued record review of the facility policy regarding incident management and abuse revised 3/28/22, indicated injuries of unknown origin should be documented in an incident report (IR), tracked and immediately reported to a supervisor. The policy further required supervisors to report the injury of unknown origin to the Superintendent or designee. The policy further noted "suspicious injuries of unknown origin" would be investigated by a qualified investigator (Investigator 2 or higher).

When interviewed on 1/25/23 at 11:50 a.m. RTW B confirmed she found the bruise near Client #1's right temple area by the hairline on 12/13/22. RTW B confirmed she did not know how the injury occurred and to her it was an injury of unknown origin. She was aware one of the staff in the home had been accused of punching the client in the head a few days earlier and wondered if the injury was related to the alleged assault. The RTW further confirmed she did not complete an incident report as her supervisor told her it would be taken care of.

When interviewed on 1/25/23 at 12:10 p.m. LPN A confirmed she was called to House 470 on 12/13/22 to look at an injury to Client #1's head. She indicated it was hard to see due to much of the bruising being inside the hairline, but some did stick out. She stated the yellow color of some of the bruise indicated it was at least a couple

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W 149	Continued From page 7 days old. She stated while in the home RTW C told her the bruise was the same place she witnessed the client get punched a few days earlier. The LPN indicated the staff who discovered the injury did not witness it occur, so she was surprised no IR for an injury of unknown origin was filled out. She explained when that happened it usually required an IR and an investigation. She stated Resident Treatment Supervisor (RTS) A told her staff had been asked to do a health care note on the injury. She thought this was strange but wondered if it was related to the abuse allegation from a few days earlier so she just completed her assessment and left. When interviewed on 1/25/23 at 11:45 a.m. the Director of Quality Management (DQM) confirmed completion of an IR should have occurred when the bruise was discovered on 12/13/22. She also confirmed the injury qualified as an injury of unknown origin since the person who found the injury didn't see it happen. She further confirmed an IR was never completed and the investigations department was not notified of a bruise in the same location associated with an allegation of abuse on 12/9/22. She conceded neither she, nor the GRC investigator who investigated the situation, was informed of the injury/bruise or the 12/13/22 nursing assessment until the surveyor brought it to her attention on 1/19/23. She confirmed the injury was highly relevant to the investigation completed and failure to complete an IR, and report the injury to a qualified investigator, was failure to follow GRC policy.	W 149		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1)	W 368		

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The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.
This STANDARD is not met as evidenced by:
Based on interviews and record reviews, facility staff failed to consistently ensure medications were administered as ordered by the prescribing physician. This affected 2 of 2 clients (Client #2 and Client #3) involved in incidents #110000-I and 109790-I. Findings follow:

1. Record review on 1/31/23 revealed the facility investigation documented on 12/6/22, during the evening (HS) medication administration, Residential Treatment Worker (RTW) D administered Client #2 another client's medication. The report noted Client #2 was never provided with his own medications that evening, just the medications of another client discharged to another facility earlier in the day. The report further indicated the error was not discovered until the next morning when RTW E noticed the client didn't seem to be acting right. RTW E checked Client #2's medications and found his medications from HS on 12/6/22 were still in the pack although signed off, but his discharged peer's medications were not in their pack. RTW E suspected Client #2 had been provided the wrong medications the night before on 12/6/22, and notified the nurse. The Advanced Registered Nurse Practitioner (ARNP) was contacted and labs were drawn and sent to the hospital. Around 4:00 p.m. Client #2's lab results showed high levels of Valproic Acid and the presence of Lithium in his system. The facility contacted Poison Control, who recommended Client #2 go to the hospital for observations. The facility sent Client #2 to the hospital. The facility

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investigation indicated Client #2 received the following medications on 12/6/22 that belonged to another client: Divalproex 2250 mg, Lithium 750 mg, Lorazepam 2 mg, Reguloid 1.04 mg, Stimuland 8.6mg-50mg Senna Docusate.

Record review of Client #2's file revealed he was 22 years old, ambulatory and had been at Glenwood Resource Center (GRC) around 14 years. The client was diagnosed with severe intellectual disability, autism spectrum disorder, attention deficit hyperactivity disorder (ADHD) and had seizures. Client #2's Behavior Support Plan (BSP) revealed behaviors of aggression, self-injurious behavior (SIB), property destruction and leaving assigned areas.

Review of Client #2's Medication Administration Record (MAR) for 11/2022 revealed he should have received the following medications on 12/6/22 and they were marked off as received: Atropine Solution 2 drops, Calcium Carbonate, Divalproex Sodium 600 mg, Guanfacine 1 mg, Daily Multivitamin 2 gummies, Risperidone 2 mg and Vitamin D3 25 mgs. The MAR also indicated the client received his 8:00 a.m. medications the next morning on 12/7/22 which included: Atropine Solution 2 drops, Divalproex Sodium 600 mg, Risperidone 2 mg and Poly Glycol 17 grams.

Record review revealed labs results for Client #2, completed 12/7/22, identified his Lithium level as 0.4 millimoles per liter (mmol/L) with a reference range of 0.4 - 1.3 mmol/L and his valproic acid level to be 176 micrograms per milliliter (ug/mL) with a reference range of 40-100 ug/mL. The level was identified as "critical ' .

Additional record review revealed the facility

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medication administration policy revised 8/8/22, listed the 8 rights of medication administration: right patient, right medication, right dosage, right route, right time, right documentation, right reason and right response. The policy also provided such directives to medications administrators as staying focused/avoiding distractions, assure proper identification of the individual about to receive medications, perform three label checks and match the bubble pack against the MAR.

Further record review revealed the facility procedure about medication disposal revised 6/4/21, documented proper destruction of medications. The policy did not include procedures for medication disposal after a client moved from the facility.

When interviewed on 2/2/23 at 11:15 a.m., RTW E reported on 12/7/22 he was responsible for Client #2 on the am.m. shift. Client #2 appeared "groggy and stumbly." RTW E reported this was not totally abnormal for Client #2, but he appeared to have difficulty tracking and appeared "intoxicated," as his appeared lethargic and weak while ambulating. RTW E reported his concerns to the nurse and checked Client #2's medications. At that time he discovered Client #2's p.m. medications were still available. He noted a discharged individuals medications were still in the cart, checked the cassette, and identified that client's p.m. medications were not there, despite him not being at the facility. Labs were ordered for Client #2 and he ended up being transported to the hospital. While at the hospital RTW E heard discussion regarding the presence of Lithium, which only the discharged client had taken in that home. The physician at the hospital

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also noted Client #2's levels of valproic acid were "dangerous" and gave him a liter of fluids by IV.

When interviewed on 1/30/23 at 1:45 p.m. RTW D confirmed she passed Client #2 the wrong medications on 12/6/22. She admitted she was distracted by things at her personal residence and by clients who stayed in the room and doorway with her after they received their medications. She stated she asked another staff to get Client #2 and bring him to the medication room. She stated she already popped out what she thought were his medications, but later found out they belonged to another client who moved. She remembered when Client #2 failed to show up after a few minutes she took the cup of meds down his room and administered them to him there. She returned and signed off the MAR that she gave him his medications although the meds he received weren't his. She confirmed she failed to follow many of the facets of facility policy regarding medication administration on 12/6/22 despite being trained on several occasions.

When interviewed on 1/31/23 at 11:30 a.m. the ARNP confirmed she was contacted the morning of 12/7/22 regarding a possible medication error from the night before on 12/6/22 for Client #2. The ARNP remembered after she was told Client #2 received another client's medications on 12/6/22 at hour of sleep (HS) and then received his own regular medications on the morning of 12/7/22, she looked over the medications for any potential problems. She stated she was mostly concerned about the amount of Valporic Acid (VA) potentially in his system. She ordered labs to be completed and around 4:00 p.m. the lab results returned with high levels of VA. The ARNP stated she called Poison Control and was advised to

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have the client go to the Emergency Room (ER) for observation. She stated she followed the recommendation and sent Client #2 for observation. Client #2 received an IV and observation and was sent home. The ARNP recommended the client stay at the ER all night, but the physician in the ER disagreed and sent him home. She remembered the next morning when they did labs again and the client was no longer at a concerning level of VA. She indicated the only client in the house who received Lithium was discharged on 12/6/22 which further cemented her belief they had discovered the medication variance.

2. Record review on 1/31/23 revealed the facility investigation indicated on 12/24/22 Qualified Intellectual Disabilities Professional (QIDP) A provided Client #3 an extra 100 mg of Clozapine at the 12:00 p.m. medication administration. The report further detailed the QIDP recognized her error right after she passed the medications, when she counted the medication. She notified supervisory staff, the Superintendent was contacted and the client was sent to the hospital by ambulance. At the hospital Client #3 ate lunch, acted normal and maintained vitals within normal limits. The client was sent home around 2:30 p.m. on 12/24/22 after a brief stay. The attending physician ordered the client to be monitored for dizziness and sedation for the next four hours starting at 12:55 p.m.

Further record review of Client #3's file revealed diagnoses including moderate intellectual disability and autism spectrum disorder (ASD). The client is ambulatory and had a behavior support plan to address behaviors of

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 02/07/2023

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
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aggression, self-injurious behavior (SIB), disruptive behavior and periods of uncontrollable crying. The client also used a picture board to communicate with staff.

Record review of Client #3's MAR confirmed she was prescribed 100 mg of Clozapine at 12:00 p.m. medication pass on 12/24/22. Review of the count sheet revealed QIDP A counted the medications after administration as she was supposed to and identified she provided two 100 mg tabs of Clozapine instead of one.

Record review revealed the facility medication administration policy last revised 8/8/22, listed the 8 rights of medication administration: right patient, right medication, right dosage, right route, right time, right documentation, right reason and right response. The policy also provided directives such as staying focused/avoiding distractions, assure proper identification of the individual about to receive medications, perform three label checks and match the bubble pack against the MAR.

When interviewed on 1/30/23 at 2:25 p.m. QIDP A confirmed she passed medications to Client #3 on 12/24/22. She indicated in her job she doesn't pass medications often, but was trained to pass them and knows how to pass them. She indicated on 12/24/22 she's not sure what happened, but instead of popping out 1x100mg tablet of Clozapine as ordered and then popping out the 20 mg of Propranolol from another bubble pack, she popped out another Clozapine from the pack she just popped one out of. She stated the medication she popped out and provided the client was the one scheduled for the next day (12/25/22). She stated she allowed herself to be

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 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 368	Continued From page 14 distracted, taking phone calls and attending to other matters while she passed the meds which she knew violated the facility's medication policy. When interviewed on 1/31/23 at 11:45 a.m. the ARNP confirmed she was made aware of the situation on 12/24/22. She stated once she was told what happened she decided the best decision was to just cut back on the 200 mg of Clozapine Client #3 was scheduled to receive later in the day to 100 mg. The client then received only 100 mg instead of 200 mg in the evening which would ensure at the end of the day the client still received the same total she was prescribed. The ARNP stated Client #3 was never in any distress and she wouldn't have sent her to the hospital, but the decision had already been made before she had a chance to assess the situation completely. When interviewed on 2/2/23 at 11:30 a.m. the Director of Quality Management (DQM) confirmed in both cases staff failed to follow the policy and training provided, which resulted in clients receiving the wrong medications.	W 368		

Glenwood Resource Center (GRC)
GRC Standard Level Plan of Correction: Investigation #109791-I, #109790-I, #110000-I, #110265-I & #110638-M

TAG-W102 GOVERNING BODY AND MANAGEMENT CFR(s): 483.410: failed to maintain minimal compliance with the Condition of Participation (COP) – Governing Body.

DIA found facility failed to ensure and monitor client safety when using mechanical lifts.

Cross reference TAG-104.

Individual Response:

RTW A was given appropriate management action on 1/29/2023.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 1/29/2023

RTW A was retrained on the expectation that "Two Staff are Required for ALL Lifts" and the Dependent Mechanical Lift Procedure.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 3/12/2023

All staff working with individuals in house 462, including client #1, will be retrained on the expectation that "Two Staff are Required for ALL Lifts".

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 3/12/2023

Systemic Response:

All staff working with individuals will be retrained on the expectation that "Two Staff are Required for ALL Lifts".

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 3/12/2023

The Dependent Mechanical Lift Procedure was developed and implemented on 2/2/2023. The procedure will be trained to Occupational Therapists (OTs), Physical Therapists (PTs), Speech Language Pathologists (SLPs), Registered Dietitians (RD), Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Qualified Intellectual Disability Professionals (QIDPs), Resident Treatment Supervisors (RTSs), Treatment Program Administrators (TPAs), Resident Treatment Workers (RTWs), Psychology Assistants, Psychologists, Activity Aides, Activities Specialists, Vocational & Recreation Activities Aides, and Administrators on Duty.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 3/12/2023

RTSs, TPMs, TPAs, Assistant Superintendent of Treatment Program Services, and AODs, when present in the homes while dependent mechanical lifts are being used will complete an observation to ensure the use of dependent mechanical lifts are being implemented correctly.

Responsible: Assistant Superintendent of Treatment Program Services

Glenwood Resource Center (GRC)
GRC Standard Level Plan of Correction: Investigation #109791-I, #109790-I, #110000-I, #110265-I & #110638-M
Date to be completed: 2/2/2023 and ongoing

TAG-W104 GOVERNING BODY CFR(s): 483.410(a)(1): The governing body must exercise general policy, budget, and operating direction over the facility.

DIA found facility failed to ensure and monitor client safety when using mechanical lifts.

Cross Reference TAG-W102.

Individual Response:

RTW A was given appropriate management action on 1/29/2023.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 1/29/2023

RTW A was retrained on the expectation that "Two Staff are Required for ALL Lifts" and the Dependent Mechanical Lift Procedure.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 3/12/2023

All staff working with individuals in house 462, including client #1, will be retrained on the expectation that "Two Staff are Required for ALL Lifts".

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 3/12/2023

Systemic Response:

All staff working with individuals will be retrained on the expectation that "Two Staff are Required for ALL Lifts".

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 3/12/2023

The Dependent Mechanical Lift Procedure was developed and implemented on 2/2/2023. The procedure will be trained to Occupational Therapists (OTs), Physical Therapists (PTs), Speech Language Pathologists (SLPs), Registered Dietitians (RD), Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Qualified Intellectual Disability Professionals (QIDPs), Resident Treatment Supervisors (RTSs), Treatment Program Administrators (TPAs), Resident Treatment Workers (RTWs), Psychology Assistants, Psychologists, Activity Aides, Activities Specialists, Vocational & Recreation Activities Aides, and Administrators on Duty.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 3/12/2023

RTSs, TPMs, TPAs, Assistant Superintendent of Treatment Program Services, and AODs, when present in the homes while dependent mechanical lifts are being used will complete an observation to ensure the use of dependent mechanical lifts are being implemented correctly.

Glenwood Resource Center (GRC)
GRC Standard Level Plan of Correction: Investigation #109791-I, #109790-I, #110000-I, #110265-I & #110638-M
Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 2/2/2023 and ongoing.

TAG-W149 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.

DIA found facility failed to consistently ensure policies and procedures related to investigation of injuries of unknown origin were followed as written.

Individual Response:

RTW B will be retrained to complete an incident report for injuries of unknown origin and follow incident reporting requirements.

RTS A will be retrained to ensure incident reports are completed for injuries including injuries of unknown origin, follow incident reporting requirements and complete follow-up through a Type 2 investigation.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 3/29/2023

LPN A will be retrained to complete an incident report for injuries of unknown origin and follow incident reporting requirements.

Responsible: Administrator of Nursing
Date to be completed: 3/29/2023

Systemic Response:

All staff who routinely work with individuals will be retrained to complete an incident report for injuries of unknown origin and follow incident reporting requirements.

All Treatment Program Services supervisory staff will be retrained to ensure incident reports are completed for injuries including injuries of unknown origin, follow incident reporting requirements and complete follow-up through a Type 2 investigation.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 4/12/2023

Qualified Intellectual Disability Professionals (QIDP) will monitor the event log of individuals on their caseloads to ensure that injuries have an incident report completed.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 3/29/2023 and ongoing

TAG-W368 DRUG ADMINISTRATION CFR(s): 483.460(k)(1): The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

Glenwood Resource Center (GRC)
GRC Standard Level Plan of Correction: Investigation #109791-I, #109790-I, #110000-I, #110265-I & #110638-M
DIA found facility staff failed to consistently ensure medications were administered as ordered by the prescribing physician.

Individual Response:

RTW D was given appropriate management action on 2/7/2023.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 2/7/2023

QIDP A was given appropriate management action on 1/18/2023.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 1/18/2023

QIDP A will be retrained on the Eight Rights of Medication Administration.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 1/11/2023

Systemic Response:

Nurses will be trained to remove medications upon individual's discharge to reduce potential for medication variances.

Responsible: Administrator of Nursing
Date completed: 2/7/2023

All CMAs and Nurses will be retrained on the Medication Administration Procedure, which includes the Eight Rights of Medication Administration.

Responsible: Administrator of Nursing
Date to be completed: 4/17/2023

GRC will continue to provide annual medication aide update training to all CMAs. Each CMA is monitored quarterly by nursing staff using the Medication Administration Observation Form.

GRC will continue to provide competency-based training and monitor employees to enable them to perform their duties effectively, efficiently, and competently.

Responsible: Administrator of Nursing
Date to be completed: 3/17/23 and ongoing.