12/14/17 dl

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 10/30/2017

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WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

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W 000	INITIAL COMMENTS During the course of the annual health facilities survey, investigation #71217-I, #71219-I, #71439-I, and #69417-I were also conducted. No deficiencies were cited as a result of investigations #71219-I, #71439-I, and #69417-I. As a result of investigation #71217-I, deficiencies were cited at W189 and W249. A deficiency was cited at W268 during the annual health facilities survey.	W 000	See attached POC 12/15/17	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure effective staff training to ensure staff competently demonstrated the appropriate skills and provided adequate supports to ensure client safety. This affected 1 of 1 sample clients (Client #2) involved in investigation #71217-I. Findings follow: Record review on 10/2/17 revealed the facility's Type 1 Investigation, dated 9/12/17. The investigation documented Client #2 fell from the back seat of the facility van while being transported to the facility Medical Center. As a result of the fall, Client #2 lost a tooth and received scratches.	W 189		

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 189	Continued From page 1 Continued record review revealed an incident report, dated 9/12/17 at 1:00 p.m., documented the incident with Client #2. The report noted, "... staff went to turn into Med Center when I heard a loud noise... staff looked back and observed (Client #2) on the floor of the van, bleeding from (his/her) mouth.... RTW saw another staff walking up to the Med Center and yelled for assistance... assisted (Client #2) into the Med Center trauma room where it was observed that (Client #2) lost a front tooth. (Client #2) also has several scratches from the fall as well. The following scratches were observed: about a two inch mark on the upper left arm, quarter inch scratch on the top of left shoulder, quarter inch scratch on (his/her) left collarbone as well as scratches on (his/her) chin and under (his/her) neck." Record review revealed an assessment, completed 9/12/17 at 1:05 p.m. by Registered Nurse A, documented, "...bleeding from mouth, staff reports a tooth was knocked out. Also has a red/bluish bruise starting on (his/her) chin, left should bruise 1 1/4 inch, and left clavicle 1/2 inch. Faint reddish linear shaped scrapes on left upper arm. (Client #2) is walking per (his/her) norm, wanting to leave the trauma room area, spitting. No new mark or injuries noted on (his/her) knees. Cool compress applied to (his/her) mouth... bleeding is controlled." Assessment documented: "mouth injury, missing tooth. Neuro check at baseline." Continued record review revealed Client #2 had diagnoses including, but not limited to: autism spectrum disorder, severe intellectual disability, and osteopenia. Record review on 10/2/17 revealed Client #2's	W 189		

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W 189	Continued From page 2	W 189		

Behavior Support Plan, dated 7/18/16. The plan provided information to staff to ensure Client #2's safety including the following: "Vehicles: (She/He) will attempt to PICA items off the floor of the vehicle-keep vehicles (Client #2) rides in as clean as possible. Support staff should sit where they can block PICA. (Client #2) would need an additional staff, besides the driver to ensure PICA safety while in the vehicle."

Record review on 10/2/17 revealed Client #2's Individual Support Plan (ISP), dated 1/10/17. The plan noted "What we need to know to keep (Client #2) safe. Vehicles: (She/He) will attempt to PICA items off the floor of the vehicle-keep vehicles (Client #2) rides in as clean as possible. Support staff should sit where they can block PICA. (Client #2) would need an additional staff besides the driver to ensure PICA safety while in the vehicle." The ISP further documented, "(Client #2) needs physical prompts to put on a seatbelt, but will leave it on until reaching the destination."

When interviewed on 10/4/17 at 10:00 a.m., Resident Treatment Worker (RTW) G reported she was Client #2's group leader on 9/12/17. The Resident Treatment Supervisor (RTS) A asked RTW G to take Client #2 to the Medical Center to implement his/her dental desensitization program. RTW G reported she asked RTS A if she would be the only staff going, and the RTS said yes. RTW G reported she told RTS A that Client #2 required five minute checks and had pica behavior, so she thought there should be two staff. According to RTW G, RTS A told her Client #2 did require five minute checks, but she had taken the client by herself before and had no issues. RTW G reported she had not taken

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W 189	Continued From page 3	W 189		

Client #2 to implement the program before, so she followed the directive of RTS A. RTW G reported she assisted Client #2 into the van and fastened the seat belt. As they arrived to the Medical Center, RTW G reported she heard a thump and then heard Client #2 scream. RTW G looked back and saw Client #2 on the floor of the van. She stated she immediately got help and Client #2 was taken into the Medical Center for treatment.

On 10/2/17 at 2:45 p.m. the RTS was interviewed and stated she received a call at 1:18 p.m. from RTW G. RTW G informed her that Client #2 had fallen in the van. RTS and the nurse went to the Med Center and Client #2 bleeding from the mouth. RTS stated she thought it was only 2 staff to 1 client when going off campus. The facility investigator stated that according to the ISP plan, there should be 2 staff with a resident that has pica and the RTS stated she was unaware of that and thought only 1 staff person with 1 client on campus.

Record review revealed RTW G's statement to the facility, included in the facility's Type 1 investigation. RTW G reported she placed the seat belt around Client #2's chest and snapped it in. When asked by the facility investigator if she heard the belt snap in, RTW G reported she could not be positive, she did not pay attention. Record review revealed Woodward Resource Center (WRC) Procedures for Transporting Clients, dated 3/5/10. The procedures provided the following guidance:

a. Adaptive seating security: Only regular plant operations drivers are not required to apply wheelchair passenger waist and shoulder belts

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WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

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W 189	Continued From page 4 for travel exclusively limited to the WRC campus. All other drivers will apply wheelchair passenger waist/shoulder belts for all on and off campus travel. b. Specific procedures for transporting clients in non-handicapped equipped vehicles: staff should assist clients with using waist/shoulder belts. On 10/30/17, in an email, the Superintendent confirmed staff failed to ensure Client #2 was secured while traveling in the van.	W 189		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure staff consistently provided adequate supports and services in accordance with the individual program plan. This affected 1 of 1 sample clients (Client #2) involved in investigation #71217-I. Findings follow: See W189 for additional information regarding the incident. Record review on 10/2/17 revealed the facility's Type 1 Investigation, dated 9/12/17. The investigation documented Client #2 fell from the	W 249		

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W 249	Continued From page 5 back seat of the facility van while being transported to the facility Medical Center. As a result of the fall, Client #2 lost a tooth and received scratches. Record review on 10/2/17 revealed Client #2's Behavior Support Plan, dated 7/18/16. The plan provided information to staff to ensure Client #2's safety including the following: "Vehicles: (She/He) will attempt to PICA items off the floor of the vehicle-keep vehicles (Client #2) rides in as clean as possible. Support staff should sit where they can block PICA. (Client #2) would need an additional staff, besides the driver to ensure PICA safety while in the vehicle." Record review on 10/2/17 revealed Client #2's Individual Support Plan, dated 1/10/17. The plan noted "What we need to know to keep (Client #2) safe. Vehicles: (She/He) will attempt to PICA items off the floor of the vehicle-keep vehicles (Client #2) rides in as clean as possible. Support staff should sit where they can block PICA. (Client #2) would need an additional staff besides the driver to ensure PICA safety while in the vehicle." When interviewed on 10/4/17 at 10:00 a.m., Resident Treatment Worker (RTW) G reported she was Client #2's group leader on 9/12/17. The Resident Treatment Supervisor (RTS) A asked RTW G to take Client #2 to the Medical Center to implement his/her dental desensitization program. RTW G reported she asked RTS A if she would be the only staff going, and the RTS said yes. RTW G reported she told RTS A Client #2 required five minute checks and had pica behavior, so she thought there should be two staff. According to RTW G, RTS A told her Client	W 249		

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W 249	Continued From page 6 #2 did require five minute checks, but she had taken the client by herself before and had no issues. RTW G reported she had not taken Client #2 to implement the program before, so she followed the directive of RTS A. RTW G reported she assisted Client #2 into the van and fastened the seat belt. As they arrived to the Medical Center, RTW G reported she heard a thump and then heard Client #2 scream. RTW G looked back and saw Client #2 on the floor of the van. She stated she immediately got help and Client #2 was taken into the Medical Center for treatment. When interviewed on 10/2/17 at 2:45 p.m., RTS A reported she believed Client #2 required two staff during transport only when leaving campus. After the incident, she said she was informed it was always supposed to be two staff. When interviewed on 10/2/17 at 2:15 p.m. Treatment Program Manager (TPM) C confirmed Client #2's individual program plan directed two staff during transport of Client #2, due to pica behavior. TPM C reported some staff seemed to believe only two staff were necessary when leaving campus.	W 249		
W 268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure staff consistently offered meaningful activities to	W 268		

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W 268	Continued From page 7 clients, in order to promote independence and skill acquisition. Staff also failed to consistently treat all clients with dignity and respect. This affected 6 of 14 sample clients (Clients #3, #4, #6, #9, #10, #11) and 1 client added to the sample (Client #15). Findings follow: 1. Observations at 107 Franklin from 10/02/17 to 10/04/17 revealed staff failed to attempt to engage Client #3 in meaningful activities as follows: a. Intermittent observations on 10/02/17 from approximately 2:25 p.m. - 3:15 p.m. revealed Client #3 sat on the floor or in a wheelchair in the sunroom. Client #3 did nothing but rub a cord/string on his/her face. Staff checked on Client #3 occasionally, but did not offer sensory items or activities. At approximately 3:15 p.m., Client #3 began to propel his/her wheelchair around the area with his/her feet. Client #3 participated in a medication pass in the hallway at 3:50 p.m. Staff pushed Client #3 in the wheelchair back to the sunroom at approximately 3:55 p.m. and turned on music. No additional activity was offered. b. Intermittent observations on 10/03/17 from approximately 7:15 a.m. - 8:35 a.m. revealed Client #3 not offered any activity. Client #3 sat in his/her wheelchair, at times slowly propelling the wheelchair with his/her feet. Client #3 had a shoestring tied to the strap of the bib overalls he/she wore. Client #3 rubbed the shoestring against his/her face and mouth at times. Staff explained Client #3 liked to have the shoestring to manipulate and would pull and rip his/her clothing otherwise. Staff pushed Client #3's wheelchair to the dining room for breakfast at 8:35 a.m.	W 268		

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W 268	Continued From page 8 c. Observations on 10/04/17 from approximately 11:10 a.m. - 12:10 p.m. revealed Client #3 was not offered any activities or sensory items. Client #3 was in his/her wheelchair and occasionally slowly propelled around with his/her feet. Client #3 had a shoestring tied to his/her bib overall strap, which he/she rubbed on face or mouth at times. Staff wheeled Client #3 to the dining room at 11:16 a.m. for lunch, which did not arrive until around 11:45 a.m. At 11:20 a.m., a staff person moved Client #3 in his/her wheelchair out of the way, without saying anything to the client, who is blind. Client #3 remained in the dining room with no interaction until around 11:55 a.m. when the client removed his/her shirt. A staff person then moved the client out of the dining room and into the sunroom. d. Observations on 10/04/17 from approximately 3:35 p.m. - 4:20 p.m. revealed Client #3 primarily sat in the sunroom with no activities offered. A staff person assisted Client #3 to walk around the hallway for less than 5 minutes at 3:40 p.m., returning the client to the sunroom. No other activities or sensory items were offered, other than the shoestring tied to Client #3's overall shoulder strap. 2. Observations at 107 Franklin from 10/02/17 - 10/04/17 revealed staff failed to attempt to engage Client #4 in meaningful activities as follows: a. Intermittent observations on 10/02/17 from approximately 6:10 p.m. - 6:50 p.m. revealed Client #4 sat in his/her wheelchair with no activities or sensory items offered other than TV Client #4 sat with a blanket over his/her head for	W 268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 268	Continued From page 9 most of the time, which was reportedly a preferred activity. b. Observations on 10/04/17 from approximately 10:35 a.m. until at least 10:55 a.m. revealed Client #4 was offered minimal activity or sensory items. Staff brought Client #4 back from the day program at 10:33 a.m. Client #4 sat in his/her wheelchair in the living room. Staff gave Client #4 a soft pillow to hold. Client #4 almost continually engaged in self-stimulating behavior of lightly tapping his/her fingers to his/her head. Staff also gave Client #4 a crocheted blanket at one point. c. Observations on 10/04/17 from approximately 11:25 a.m. - 11:55 a.m. revealed Client #4 sat in his/her wheelchair in the living room or dining room. Client #4 pulled a blanket over his/her head at one point and almost constantly tapped his/her fingers on head. Staff began feeding Client #4 lunch around 11:55 a.m. d. Observations on 10/04/17 from approximately 3:55 p.m. - 4:35 p.m. revealed Client #4 sat in the living room in his/her wheelchair holding a soft pillow and tapping the side of head with his/her fingers. Music was playing on the television. No other activities or sensory items were offered. 3. Observations at the 105 Franklin day program on 10/03/17 from approximately 10:10 a.m. - 10:20 a.m. revealed Client #4 sat in a wheelchair in a sensory type of room with a music video playing. Staff present played a small triangle at times. Observations at the same day program on 10/03/17 from approximately 2:55 p.m. to 3:05 p.m. revealed Client #3 and Client #4 were in the same sensory room with a music video playing.	W 268		

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W 268	Continued From page 10 Observations at the day program on 10/04/17 from approximately 2:50 p.m. to 3:30 p.m. revealed Client #3 and Client #4 sat in the sensory room while a music video played. At times staff attempted to interest other clients in musical instruments, but not Client #3 or Client #4. Client #3 sat in his/her wheelchair unengaged. Client #4 tapped his/her fingers on his/her head. When interviewed on 10/04/17 at 3:15 p.m. the Vocational Specialist at 105 Franklin stated the staff from 107 Franklin routinely took the clients to the same room (Sensory Room) when they came to the day program twice per day. The Sensory Room activity was to play music videos. There were also musical instruments that clients or staff could use. The surveyor noted there were several activity rooms at the 105 Franklin day program with a variety of activities and asked why clients did not go different rooms when they came to the day program. The Vocational Specialist indicated that had been the plan originally, but staff had fallen into the habit of taking clients to the same room each time. 4. Observations at 105 Cherry on 10/2/17 from 5:30 p.m. - 5:55 p.m. revealed Client #11 sat in a recliner and intermittently walked down the hall and/or to the entrance to the dining room. Resident Treatment Worker (RTW) B prompted him/her to sit down each time the client left his/her seat. RTW B offered no functional task or activity to Client #11. Further observations at 105 Cherry on 10/3/17 from 7:45 a.m. - 8:05 a.m. revealed Client #11 walked to the dining room while staff prepared plates of food. RTW C stated, "No!" and Client	W 268		

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W 268	Continued From page 11 #11 walked to the living room and sat in a recliner. At 7:50 a.m., RTW C continued to prepare plates of food for clients and directed Client #11 to sit down each time her/she entered the dining room. At 7:55 a.m., Client #11 stood by the table while RTW C prepared his/her plate. She failed to involve him/her in any preparation of the food. At 8:05 a.m., RTW C stated, "Good waiting" and prompted Client #11 to sit down to eat. Continued observation at 105 Cherry on 10/4/17 at 12:20 p.m. revealed RTW C held Client #11's right arm above the bicep as she directed him to place dishes in the sink. Further observation at 5:15 p.m. revealed RTW F pointed to the sink and Client #11 carried his/her dishes to the sink. When interviewed on 10/4/17 at 12:25 p.m. Treatment Program Manager (TPM) B confirmed staff should provide the least amount of support needed when prompting clients to complete a task. 5. Observation at 109 Franklin on 10/4/17 at 8:40 a.m. revealed RTW D stated, "It's early." when another staff noted Client #6 appeared to be having a good morning. The statement implied the RTW expected Client #6 to exhibit inappropriate behavior. Further observation on 10/9/17 at 11:55 p.m. revealed RTW E held onto Client #6's shoulders and pulled him/her back without verbally prompting him/her to move away from the sink. RTW E engaged in some hand play with the client, then pulled him/her to the sink and verbally prompted the client to place a plate in the dishwasher.	W 268		

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W 268	Continued From page 12 When interviewed on 10/9/17 at 12:10 p.m. TPM D confirmed Client #6 could move independently with verbal prompts. She confirmed staff should not place hands on clients unless a safety issue arose. 6. Observation at Westwood work site on 10/10/17 at 9:20 a.m. revealed Client #6's work station included access to a switch on the right side of his/her chair. Observations from 9:30 a.m. - 9:40 a.m. revealed RTW E prompted him/her to push the button and hand her bags. Record review on 10/9/17 revealed Client #6's identification sheet. The document noted Client #6 was left handed. When interviewed on 10/10/17 at 3:35 p.m. TPM D confirmed Client #6 was left handed. She could not explain why his/her work was set up on the right side. 7. Observations at 103 Cherry on 10/4/17 revealed the following: a. At 4:15 p.m., when Client #10 invited the surveyor to see his/her bedroom; RTW A told Client #10 the surveyor did not want to see the client's room. The surveyor looked at Client #10's bedroom and walked back out to the living room with Client #10. Client #10 conversed with the surveyor about TV shows and singers. RTW A told Client #10 to stop talking because the surveyor did not want to listen to the client and needed to work. Client #10 stated, "NO!" RTW A firmly asked Client #10 if he/she wanted to watch TV in his/her room, which sounded like a demand rather than a question. Client #10 said no and	W 268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 10/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

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W 268	Continued From page 13 quieted. RTW A instructed Client #10 to set the table. At 5:10 p.m., Client #10 sat at the dining table with peers. Client #10 tried to assist a peer with his/her drink. RTW A sat behind the table and instructed Client #10 that the peer could do it himself/herself. RTW A repeated herself and told Client #10 to eat. Client #10 told RTW A he/she could not start eating yet because there was not a staff at the table. RTW A stated, "I am telling you. I am sitting behind you. You can eat." RTW A's demeanor indicated dissatisfaction with Client #10's behavior, yet she failed to offer any positive interaction or instruction. b. At 4:42 p.m. RTW A asked surveyor if she "Got a look at (Client #9)?," then stated, "Told you, hasn't changed." referring to Client #9 and some of his/her inappropriate behaviors. RTW A indicated she was surprised Client #9 had not ran out the door yet. Several of Client #9's peers were present at the time. c. At 5:13 p.m., Client #15 stood in the living room watching others eat and RTW A stated, "Come on (Client #15)!" At 5:15 p.m. Client #15 stood in the living room and RTW A directed him/her to throw away his/her food if he/she did not want to eat it. At 5:16 p.m., RTW A held up a spoonful of Client #15's food and stated, "Come on (Client #15)." At 5:22 p.m., Client #15 walked to the table, picked up the plate and emptied it in the trash. At 5:30 p.m., Client #15 walked to the kitchen and RTW A asked Client #15 if he/she wanted anything to eat. Client #15 made no response. At 5:35 p.m., Client #15 walked back into the kitchen, RTW A opened a cabinet and asked Client #15 what he/she wanted. Client #15 grabbed a bag of chips and walked into the living room. RTW A stated, "No, if you want to eat you have to sit	W 268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 268	Continued From page 14 down". She took the bag of chips and put them on a plate, then asked him to pour water or milk. At 5:37 p.m., Client #15 refused to pour liquids and RTW A took his/her plate away. RTW A gave Client #15's plate back after she poured him/her apple juice. When interviewed on 10/5/17 at 8:45 a.m. TPM A confirmed RTW A failed to be respectful to clients. 8. Record review on 10/10/17 revealed an agency policy entitled "Philosophy of Service", last reviewed on 10/25/16. According to the policy, each client was a "human being with value and dignity... to be treated with respect." The facility must "provide opportunities for learning" and "any activity may be an opportunity for learning." Facility staff "must always be role models and teachers." The policy also read, "Programs and training must focus on increasing the abilities of people so they may live the lives they wish. Independence will be a constant goal. The supports and services must build on the strengths a person demonstrates. The emphasis must be on learning, development and support rather than on treating problems." 9. When interviewed on 10/10/17 at 3:15 p.m., the Superintendent confirmed the information in the "Philosophy of Service" policy and acknowledged staff should consistently offer meaningful activities to clients and treat all clients with dignity and respect.	W 268		

OK

Plan of Correction for WRC 10/2/17 – 10/11/17 Annual Survey-Statement of Deficiencies

✓ 12/14/17

Investigation #71217-I- Citation #6691

Tag W-189 – Staff training program – 483.430(e)(1): The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently

On September 12, 2017, RTW G drove Client #2 to his/her desensitization program, located at the WRC Medical Center. RTW G reported that he/she was driving at approximately 5 MPH while turning the van into the Medical Center parking lot. RTW G heard a noise, turned around and saw that Client #2 had fallen to the floor and was bleeding. RTW G parked the van and provided immediate assistance to help Client #2 into the Medical Center for assessment. An RN Supervisor joined them, assessed Client #2, and helping him/her to the trauma room. Bleeding was managed successfully by applying a cold compress. Client #2 lost a front tooth and received abrasions during his/her fall. Client #2's dentist was notified and decided not to restore the tooth. Client #2 was released to return to his/her house.

WRC took immediate action on 9/12/17 to address the accident and to ensure the ongoing safety of Client #2. WRC concurrently initiated a thorough incident investigation and RTW G was placed on administrative leave, pending the investigation findings. WRC also reported the incident to DIA within the required 24 hours on 9/13/17.

WRC's internal investigation and WRC's Incident Review Committee determined that staff did not follow Client #2's level of supervision in the vehicle as stated in Client #2's Individual Support Plan (ISP) and Behavior Support Plan (BSP). WRC determined that RTW G did not ensure Client #2's safety in the vehicle by ensuring the seatbelt was securely latched. WRC also found that the house Treatment Program Manager, Resident Treatment Supervisor, and Psych Assistant did not consistently ensure proper supervision was occurring when Client #2 was in the vehicle.

DIA found that facility staff failed to ensure effective staff training to ensure staff competently demonstrated the appropriate skills and provided adequate supports to ensure Client #2's safety.

Individual response

WRC fully reviewed this self-reported incident. WRC completed a Self-Identification and Correction Form for this incident on 10/11/17.

- Client #2's ISP was retrained to all available staff regularly assigned to Client #2.
- Client #2's BSP was retrained to all available staff regularly assigned to Client #2.
- Client #2's ISP Information Sheet was revised and trained to all available staff regularly assigned to Client #2.
- Seatbelt Safety was trained to all available staff regularly assigned to Client #2.
- RTW G was retrained, on 9/29/17, to make sure the seat belt for Client #2 is properly secured.
- RTS A received appropriate discipline on 9/29/17 for not ensuring proper supervision while Client #2 was in the van.
- The TPM received appropriate discipline on 9/29/17 for not ensuring proper supervision while Client #2 was in the van.
- The Psych Assistant received appropriate discipline on 9/28/17 for not ensuring proper supervision while Client #2 was in the van.

Responsible: Team 2 Treatment Program Administrator
Completed: 9/29/17

Systemic response

As identified in the Self-Correction and Identification Form submitted 10/11/17, WRC will continue to provide competency-based training to employees to enable them to perform their duties effectively, efficiently, and competently and will continue to monitor the implementation of procedures, BSPs and other programs through Program Implementation Monitors completed at each house on campus. WRC has and will continue to take appropriate personnel action with staff not performing as trained.

Responsible: Assistant Superintendent, Director of Psychology and Treatment Program Administrators
Completed: 9/29/17 and ongoing

W249
Individual response

WRC fully reviewed this self-reported incident. WRC completed a Self-Identification and Correction Form for this incident on 10/11/17.

- Client #2's ISP was retrained to all available staff regularly assigned to Client #2.
- Client #2's BSP was retrained to all available staff regularly assigned to Client #2.
- Client #2's ISP Information Sheet was revised and trained to all available staff regularly assigned to Client #2.
- Seatbelt Safety was trained to all available staff regularly assigned to Client #2.
- RTW G was retrained, on 9/29/17, to make sure the seat belt for Client #2 is properly secured.
- RTS A received appropriate discipline on 9/29/17 for not ensuring proper supervision while Client #2 was in the van.
- The TPM received appropriate discipline on 9/29/17 for not ensuring proper supervision while Client #2 was in the van.
- The Psych Assistant received appropriate discipline on 9/28/17 for not ensuring proper supervision while Client #2 was in the van.

Responsible: Team 2 Treatment Program Administrator
Completed: 9/29/17

Systemic response

As identified in the Self-Correction and Identification Form submitted 10/11/17, WRC will continue to provide competency-based training to employees to enable them to perform their duties effectively, efficiently, and competently and will continue to monitor the implementation of procedures, BSPs and other programs through Program Implementation Monitors completed at each house on campus. WRC has and will continue to take appropriate personnel action with staff not performing as trained.

Responsible: Assistant Superintendent, Director of Psychology and Treatment Program Administrators
Completed: 9/29/17 and ongoing

The TPMs will be retrained on the expectations of completing quality active treatment observations.

TPMs will complete weekly active treatment observations and the Human Services Quality Assurance Coordinator will complete quarterly active treatment observations at each home.

Responsible: Team 1 & 2 Treatment Program Administrators and Assistant Superintendent
Due date: 12/15/17

W 268
Individual response

1. 107FR

- The staff assigned to 107FR will be retrained on W268 (483.450(a)(1)(i) requirements and guidance, including providing the least amount of support needed when prompting clients to complete a task.
- The staff assigned to 107FR will be trained to offer Client #3 and Client #4 meaningful activities that promote independence and skill acquisition at home and work.
- The staff assigned to 107FR will be retrained on WRC's Philosophy of Service Policy regarding dignity and respect.
- The staff assigned to 107FR will be trained to talk to Client #4 before moving him/her in his/her wheelchair.

2. 105CH

- The staff assigned to 105CH will be retrained on W268 (483.450(a)(1)(i) requirements and guidance, including providing the least amount of support needed when prompting clients to complete a task.
- The staff assigned to 105CH will be trained to offer Client #11 meaningful activities that promote independence and skill acquisition at home and work.
- The staff assigned to 105CH will be retrained on WRC's Philosophy of Service Policy regarding dignity and respect.
- The staff assigned to 105CH will be trained on Mandt techniques using body positioning which includes not holding Client #11 by the arm before trying verbal/gestural prompting.

3. 109FR

- The staff assigned to 109FR will be retrained on W268 (483.450(a)(1)(i) requirements and guidance, including providing the least amount of support needed when prompting clients to complete a task.
- The staff assigned to 109FR will be retrained on WRC's Philosophy of Service Policy regarding dignity and respect.
- The staff assigned to 109FR will be trained on Mandt techniques using body positioning which includes not holding Client #6 by the shoulders before trying verbal/gestural prompting.
- TPM will ensure the work station for Client #6 is set up properly.
- RTW E received appropriate discipline on 10/31/17, for inappropriate tone of voice and physical intervention with Client #6.

4.103CH

- The staff assigned to 103CH will be retrained on W268 (483.450(a)(1)(i) requirements and guidance, including providing the least amount of support needed when prompting clients to complete a task.
- The staff assigned to 103CH will be trained to offer Client #9, #10, and #15 meaningful activities that promote independence and skill acquisition at home and work.

- The staff assigned to 103CH will be retrained on WRC's Philosophy of Service Policy regarding dignity and respect, including interacting with Client #9, #10, and #15 in a respectful way that promotes opportunities for learning and independence.
- RTW A is no longer employed by WRC.

Responsible: Team 1 & 2 Treatment Program Administrators
Due date: 12/15/17

Systemic response
All staff with regular contact with clients (TPMs, RTSs, Vocational staff, Leisure staff, Psych Assistants, and RTW's) will be retrained on W268 (483.450(a)(1)(i) requirements and guidance, including providing the least amount of support needed when prompting clients to complete a task.

All staff with regular contact with clients (TPMs, RTSs, Vocational staff, Leisure staff, Psych Assistants, and RTW's) will be retrained on WRC's Philosophy of Service Policy regarding dignity and respect.

The TPMs will be retrained on the expectations of completing quality active treatment observations.

TPMs will complete weekly active treatment observations and the Human Services Quality Assurance Coordinator will complete quarterly active treatment observations at each home.

Responsible: Team 1 & 2 Treatment Program Administrators and Assistant Superintendent
Due date: 12/15/17