PRINTED: 12/05/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE & I	VIEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIF A. BUILDING	PLECONSTRUCTION	(X3) DATE SURVEY COMPLETED
		16G006	B. WIŅG		C 11/09/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
				330 VILLAGE CIRCLE	
VILLAGE	NORTHWESTUNLIMITED	1		SHELDON, IA 51201	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
W 000	INITIAL COMMENTS		Woo	00	
		7 - 11/9/17 resulted in W192, and W369.	000		:
W 153	resulted in deficiencie W155, and W159. STAFF TREATMENT ( CFR(s): 483.420(d)(2)	•	W 15	3 It is the mission of Village Northwes Unlimited to provide excellent care	
	The facility must ensur mistreatment, neglect injuries of unknown so immediately to the adr	re that all allegations of or abuse, as well as urce, are reported ninistrator or to other with State law through		those we serve and to have staff tre residents with respect and dignity at times. Toward that end, we have developed an ICF/ID Residential Cod Conduct to act as a teaching aid and forcement of care to be provided. A	at all : all e of rein-
	Based on staff intervie facility failed to ensure abuse/neglect are iden immediately to the low	als. This involved 1 of 1 #1) during		of this Code of Conduct, it specifical with our policy that all allegations of are to be reported when observed be This Code of Conduct was reviewed the leaders of our ICF/ID homes on 11/28/17. In addition, we are review this code at all team meetings. Each employee is required to sign the Code and the code are provided to sign the Code and the code are provided to sign the Code and the code are provided to sign the Code at all the code are provided to sign the Code at all the code are provided to sign the Code at all the code are provided to sign the Code at all the code are provided to sign the Code at all the co	abuse y staff. with all wing i de of
	Spiritual Services Cod 10/21/17, he arrived a a.m. Upon arrival, Dir (DSP) A indicated Clie bedroom because of p SSC explained Client	10/31/17 at 12:59 p.m., the ordinator (SSC) reported on t work a little before 8:00 ect Support Professional ent #1 sat in his/her public masturbation. The #1 used a locked seatbelt et/her recliner. According to		Conduct. All new employees will revand sign the code also. All future in will be reviewed by the Director of I and Program Services and promptly reported. This individual will be responsible for on-going compliance	cidents CF/ID
LABORATORY	NIBEETOR'S OR PROVIDERIS	UPPLIER REPRESENTATIVE'S SIGNATUR	₹E	TITLE .	(X6) DATE
	7 ' 7 ' 1 '	ا ۱ ا سید لا			1 1

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 pursing 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.

Event ID: 13YN11

Facility ID: IAG0057

STATEMENT OF DEFICIENCIES (X:		The second secon		TPLE	CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG_				
		4	B. WING		•			0
		16G006	B. WANG				77/	09/2017
NAME OF P	ROVIDER OR SUPPLIER			i	TREET ADDRESS, CITY, STATE, ZIP CODE			
		2			30 VILLAGE CIRCLE			
VILLAGE	NORTHWESTUNLIMITE			S	HELDON, IA 51201			
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE		(X5) COMPLETION DATE
	 		- <del></del>	1				,
201459	Continued From page	. 1	l w	153	,	•		,
W 153			- 1				•	
	the SSC, Client #1 Sa	it in his/her bedroom recliner d to work until approximately	'		·			••
. :	trom before he aniver	stated he did not step in			•			
	77:00 a.m. The SSC	p from his/her recliner, but	-		· .			
	and assist Cilent#1 u	e. The SSC compared the		1				
	Wished he would have	erses parent situation. He					•	
	Incident as a parent v	hed Client #1 for public		.	,			
	believed DSP A punis	DSP A handle it. After the		1				
	masturpation and let	ught the incident might be						
	550 jejt Work, tie uso	, the SSC sent an email to			•			
·	Dispeter of ICE/ID on	Program Services and			,			
	Director of sorth and	bout staff concerns at the	ļ					-
	house According to	the SSC, Director of ICF/ID				i		
1	nouse, According to	s set him up to talk to	1		•	,		
	Director of Human Re	securcas (HR) On			<u> </u>	•		
	ADJOSIAT THE SSC re	ported the incident to the						
1	Director of UP. The	SSC stated Director of HR	- 1	`	•			
	listored and reemed	unhappy. The SSC was						ļ
	upoware if an investig	gation started. The SSC						
	confirmed DSD 4 cor	itinued to work with Client						
	#1.							
	T 11	•		,		•		_
l	A follow-up interview	on 11/1/17 at 2:51 p.m. SSC			· ·			,
ļ	reported when he ari	rived to work on 10/21/17,						
	DSP A explained she	e put Client #1 in his/her	-					ŀ
	hedroom because he	e/she masturbated in the					•	`  ^
1	living room chair. Th	ne SSC did not believe DSP A						ļ
	used the word punis	hment nor remembered DSP						
	A verbalizing Client	#1 had to stay in his/her			•			1
		assumed DSP A disciplined						
	Client#1. The SSC	recalled DSP A irritated that				•		,
1 .	she witnessed this b	ehavior. The SSC reported						
1	Client #1 was up and	d out of his/her bedroom at						
	11:00 a.m. Someon	e came in to administer	:					
	medication and Clie	nt #1 ate lunch. He stated he						
	did not witness DSP	A check on Client #1 and the			•			
	bedroom door rema	ined closed the entire time.			1			
	According to the SS	C, he briefly received training						
1	and was aware of C	lient #1's masturbation	4		P			1

STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		16G006	B. WING			1	C (09/2017	
	ROVIDER OR SUPPLIER			. 33	TREET ADDRESS, CITY, STATE, ZIP CODE 30 VILLAGE CIRCLE HELDON, IA 51201	1 111	0312011	
' (X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUILL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE -	
W 153	implement the prograt Client #1 did not stay The SSC stated Clien the living room. The S bedroom contained so radio. The SSC did n from the bedroom and taken a nap.	ated he never needed to m. According to the SSC, in his/her bedroom a lot. t#1 liked spending time in SSC explained Client#1's ensory items, a TV and a ot hear any noise coming I stated he/she could have	W	153				
	talked to him about ge he moved to the hous Director of HR things we do not know about HR was not sure how he had many people vistened but took thing recalled DSP A told the client. Director of HR but did not recall the soverly concerning.	In the thought the SSC of the thing his job back because the to fill-in. The SSC told thappened in the house that the conversation went as who want to talk. He as with a grain of salt. He are SSC she disciplined a thought that was different, SSC reporting anything rector of HR remembered a						
	client stayed in his/he know what the progra	r bedroom, but he did not m Indicated. The Director mber if they communicated	·				ć	
	Neglect directed the person witnessing a programmed and immediately to both a Dept. (Department) of For reporting purpose soon as possible, but after discovery of the							
	When Interviewed on	10/31/17 at 4:50 p.m.,				•		

CENTER	SFUR MEDICARE &	VIEDICAID SERVICES				1	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATES COMPI	
		16G006	B. WING			4410	) 9/2017
		165000	12.7		TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/0	30/2017
NAME OF PR	ROVIDER OR SUPPLIER						
WILLYGE	NORTHWESTUNLIMITE	·		1	30 VILLAGE CIRCLE		1
VILLAGEI	101211111201 0112			s	HELDON IA 51201		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
W 153	Continued From page	. 3	W	153			
VV 100	Director of ICF/ID and		"		C.		
	Director of ICE/ID and	cility failed to report the					
	acknowledged the lac	d she called DSP A and					
	separated her from C	lient #1. The facility					
	reported the incident	to DIA on 11/1/17.					14/10/17
W 154	-		W	154	The policy of reporting allegations of	of abuse	44\ f0\'T4
AA 10-i	CFR(s): 483.420(d)(3				was reviewed at the Leadership Cal	t t	
					Meeting and with the ICF/ID Reside	ntial	٠.
	The facility must have	e evidence that all alleged			Home Leaders at their meeting on		•
	violations are thoroug	hly investigated.			11/28/17 when the Code of Condu	ct was	•
	_				reviewed. The VNU Policy and the		
				•	Conduct both require immediate re		
	This STANDARD is r	not met as evidenced by:	1.		alleged instances of abuse. This inc		
	Based on interview a	nd record review, the facility			discussion of the requirement to se		į
	failed to conduct thor	ough investigations of					
	potential allegations of	of abuse/neglect. This I clients (Clients#2-#11)		, .	the resident and the staff person u	ittii Sucii	
	living in house 358. F	Findings follow:			time as DIA had completed its		
	i iiviiig iii libuse ood. i	·			investigation. The Director of ICF/I		
	When interviewed on	10/31/17 at 12:59 p.m., the			Program Services will be responsib	e for	
'	Spiritual Services Co	ordinator (SSC) reported on			ongoing compliance. A checklis	st has	
	10/21/17, he arrived	at work a little before 8:00	l		been developed for use by		
	a.m. Upon arrival, Di	rect Support Professional			supervisory and Cabinet		
	(DSP) A indicated Cli	ient#1 sat in his/her			when an allegation of abo		
	bedroom because of	public masturbation. The			occurs. This checklist		
· .	SSC explained Clien	t#1 used a locked seatbelt			1) Identification and in		<b>†</b> .
		is/her recliner. According to			of person alleged to have	e been	
1 :	the SSC, Client #1 sa	at in his/her bedroom recliner			abused, 2) Identification	and	
	from before he arrive	d to work until approximately	'   .		interview of first hand	√it-	
		stated he did not step in			nesses (including victim		
		up from his/her recliner, but re. The SSC compared the			Collection of information		
		verses parent situation. He			lated to situation, 4) R	aport <b>i</b> r	g
,	helieved DSP A nuni	shed Client #1 for public			requirements, and 5) Sep-	aration	1
		DSP A handle it. After the			of the involved staff an		
		ought the incident might be	İ		victim. The checklist w		
		7, the SSC sent an email to			provided to all supervis		
		d Drogram Sandoes and	ļ .		gtoff by 12/18/17	-	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		•					c	
		16G006	B. WING			11/	09/2017	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		8	STREET ADDRESS, CITY, STATE, ZIP CODE			
		_		3	330 VILLAGE CIRCLE			
VILLAGE	NORTHWESTUNLIMITED			\$	SHELDON, IA 51201			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC   DENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)		DATE	
	1,				•		,	
W 154	Continued From page	:4	l w	154	1			
	asked to talk to her at	out staff concerns at the			•			
		the SSC, Director of ICF/ID			,			
	and Program Service		1					
	Director of Human Re	sources (HR). On			•			
	10/23/17, the SSC rep	ported the incident to the					·	
ψ <sub>E</sub> , ,		SSC stated Director of HR	į					
Tr.		unhappy. The SSC was	.					
	unaware if an Investig	ation started. The SSC	ļ <i>,</i>		•		·	
	1	tinued to work with Client						
	#1.			٠				
	A follow sin intensions	on 1,1/1/17 at 2:51 p.m. SSC						
		ved to work on 10/21/17,			•	•		
	DCD A evolution to airi	put Client #1 in his/her						
·		she masturbated in the	İ	•	·			
		e SSC did not believe DSP A						
•	used the word punish	ment nor remembered DSP						
		1 had to stay in his/her .		•	•			
	bedroom. The SSC a	ssumed DSP A disciplined						
		ecalled DSP A irritated that		•				
		havior. The SSC reported						
		out of his/her bedroom at			,		ļ	
		came in to administer						
•		t#1 ate lunch. He stated he						
		A check on Client#I and the						
•		ned closed the entire time.						
,		, he briefly received training						
		ent#1's masturbation			-			
		tated he never needed to					<b> </b> -	
}		m. According to the SSC,						
	Client#1 did not stay	in his/her bedroom a lot.			,			
		nt#1 liked spending time in			,			
		SSC explained Client #1's						
		ensory items, a TV and a						
		not hear any noise coming						
	1	d stated he/she could have	1					
	taken a nap.							
	When interviewed on	ı 10/31/17 at 2:40 p.m.			- Line of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the	•		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATIONNUMBER: AND PLAN OF CORRECTION A. BUILDING c, 16G006 B. WING 11/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 330 VILLAGE CIRCLE VILLAGENORTHWESTUNLIMITED SHELDON, IA 51201 SUMMARY STATEMENT OF DEFICIENCIES ΙD PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEPICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DÉFICIENCY) W 154 Continued From page 5 W 154 Director of HR reported he thought the SSC talked to him about getting his job back because he moved to the house to fill-in. The SSC told Director of HR things happened in the house that we do not know about or always see. Director of HR was not sure how the conversation went as he had many people who want to talk. He listened but took things with a grain of salt. He recalled DSP A told the SSC she disciplined a client. Director of HR thought that was different. but did not recall the SSC reporting anything overly concerning. Director of HR remembered a client stayed in his/her bedroom, but he did not know what the program indicated. The Director of HR could not remember if they communicated about anything else. Continued record review revealed no investigation into the allegation of client abuse/mistreatment. The policy and procedures titled Abuse and Neglect, "...The immediate supervisor will inform the Cabinet member responsible for the department in which the person suspected of abuse is employed. The Cabinet Member will be

specifically described."

responsible for MCO notification, investigating the incident, working with the Director of Human Resources, to decide upon appropriate disciplinary action and informing the Chief Executive Officer of the incident and outcome... The Cabinet Member may include other necessary staff as part of the investigation to ensure that the incident is thoroughly and

When interviewed on 10/31/17 at 2:15 p.m., Director of ICF/ID and Program Services acknowledged the facility falled to investigate the PRINTED: 12/05/2017

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	1		CONSTRUCTION		(3) DATE SURVEY COMPLETED	
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	•	16G006	B. WING			!	09/2017	
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE			
		•		3	30 VILLAGE CIRCLE			
VILLAGE	NORTHWESTUNLIMITED	,		s	HELDON, IA 51201			
(X4) ID		ATEMENT OF DEFICIENCIES	ID				(X5)	
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	'MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE	
,,,,			<u> </u>		DEFICIENCY)			
W 154	Continued From page	· · · · · · · · · · · · · · · · · · ·	. M	154				
•		ed she directed SCC to						
•	speak with the Directo	or of HK and had not						
MAEE	followed-up. STAFF TREATMENT:	OF CHENTS	10/	155				
W 155	CFR(s): 483.420(d)(3)		. **		line boiley for village Morthwest Onl		12/18/17	
	Of ft(0):-100; 120(4)(0)	•			was reviewed by the Leadership Cab			
	The facility must preve	ent further potential abuse			and discussion was held on the impo	rtance		
	while the investigation	is in progress.			of ensuring the safety of the residen	t, by		
					removing staff from working with th	e		
• •		at want on a statement has			resident when an allegation of abuse	e is		
		ot met as evidenced by: ws and record review, the			made. The Director of ICF/ID and Pr	ogram	,	
	facility failed to take m			•	Services is responsible for ongoing	:		
		allegation of abuse and/or			compliance. A checklist has	been		
	mistreatment. This af	fected 1 of 1 client reviewed			developed for use by super	visor	у .	
	(Client#1) during inve	știgation#72044-l.			and Cabinet staff when an	. !	· .	
•					allegation of abuse occurs			
	The findings include:	•			This checklist includes 1)			
	When interviewed on	10/31/17 at 12:59 p.m., the			Identification and intervi		1	
		ordinator (SSC) reported on			person alleged to have bee			
		t work a little before 8:00	.		abused, 2) Identification interview of first hand wi		96	
		ect Support Professional			(including victim), 3) Col			
	(DSP) A indicated Clie				of information related to			
		oublic masturbation. The			tion, 4) Reporting require			
		#1 used a locked seatbelt /her-recliner. According to		•	and 5) Separation of the i			
		t in his/her bedroom recliner			staff and the victim. The			
		I to work until approximately			list will be provided to a	.11		
		stated he did not step in		,	supervisory staff by 12/18	/17.		
,		p from his/her recliner, but			-			
		e. The SSC compared the			,		,	
	•	erses parent situation. He		٠,	·			
		hed Client #1 for public DSP A handle it. After the	ļ					
		ught the incident might be						
ļ ·		, the SSC sent an email to						
		Program Services and	Į.					
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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X0) MULTIPLE CONSTRUCTION A, BUILDING			CX3) DATE SURVEY COMPLETED C		
		16G006	B. WING		11/09	9/2017
	ROVIDER OR SUPPLIER	_L	2	STREET ADDRESS, CITY, STATE, ZIP CODE 330 VILLAGE CIRCLE SHELDON, IA 61201		
(X4) ID PREFIX TAG	/EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 155	house. According to and Program Servic Director of Human F 10/23/17, the SSC r Director of HR. The listened and seeme unaware if an invest	about staff concerns at the o the SSC, Director of ICF/ID ses set him up to talk to	W 155			
	A follow-up interview reported when he a DSP A explained shedroom because hiving room chair. To used the word punity A verbalizing Client bedroom. The SSC Client #1. The SSC she witnessed this Client #1 was up at 11:00 a.m. Someomedication and Client not witness DS bedroom door remarks.	w on 11/1/17 at 2:51 p.m. SSC rrived to work on 10/21/17, be put Client #1 in his/her re/she masturbated in the cle SSC did not believe DSP A shment nor remembered DSP #1 had to stay in his/her assumed DSP A disciplined assumed DSP A disciplined acceptable pSP A irritated that behavior. The SSC reported and out of his/her bedroom at the came in to administer ent #1 ate lunch. He stated he PA check on Client #1 and the ained closed the entire time.				
	and was aware of opprogram. The SSC implement the program the SSC stated Control the living room. The SSC different the bedroom container adio. The SSC different the bedroom taken a nap.	Client #1's masturbation C stated he never needed to gram. According to the SSC, ay in his/her bedroom a lot. ilent #1 liked spending time in he SSC explained Client #1's d sensory items, a TV and a d not hear any noise coming and stated he/she could have				

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		CONSTRUCTION		K3) DATE SURVEY COMPLETED	
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		16G006	B. WING			11/	09/2017	
NAME OF PE	ROVIDER OR SUPPLIER		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE			
WHARE	ORTHWEST UNLIMITED	)		!	30 VILLAGE CIRCLE			
A:THUMOD:				S	HELDON, IA 51201 .			
(X4) ID PREFIX TAG	(FACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
, '	•						,	
W 155	Continued From page		W	155	, ·			
}	Director of HR reporte	d he thought the SSC						
		tting his job back because					1	
Ì		e to fill-in. The SSC told						
-		nappened in the house that			·			
	we do not know about	or always see. Director of the conversation went as				:		
	he had many people v						•	
		s with a grain of salt. He	1				1	
	recalled DSP A told th	e SSC she disciplined a			*			
	client. Director of HR	thought that was different,					- 1	
	but did not recall the S	SSC reporting anything					l	
	overly concerning. Di	rector of HR remembered a					· .]	
	client stayed in his/her	bedroom, but he did not				.		
		m indicated. The Director			•			
		mber if they communicated					Ì	
	about anything else.						-	
	The policy and proced	ures titled Abuse and						
	Neglect directed the f		İ		<u> </u>		_	
	consumer's safety, du	ring the time of the			•			
	investigation, the staff	member who is being					. [	
		parated from the individual			-	ļ		
		lleged to have abused, until	Į				,	
		rnal investigations have	ĺ					
,	been completed"	•						
	When interviewed on	10/31/17 at 4·50 n m	! :			, .		
į	Director of ICF/ID and		'		·			
•		ility failed to separate DSP			· ·			
		SCC's report. She stated						
		separated her from Client					. ,	
	#1.	•			The Dissert of 107/10 and Dissert		3071071	
W 159			W		The Director of ICF/ID and Program	slan feed	12/13/17	
	CFR(s): 483,430(a)	•			Services has developed a mealtime p			
,	Englishing and and	catment program must be			this individual. The plan will provide			
1	integrated coordinate	eatment program must be eatment program must be			consistency of care amongst all staff			
	qualified intellectual d				working with his person and provide			
	quantos inteneenda d	Comments for a second second			safeguards from negative conseque	nces of		

	S FOR MEDICARE &		COLLEGE	IPLE CONSTRUC	CTION	(X3) DATE	SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATIONNUMBER:	V • · · ·				LETED
AND PLAN OF	CORRECTION	,	A. BUILDI	NG	···		c
		400000	B, WING				
		16G006	B, Wilde	O	PERSON AND CTATE THE SAME	11/	09/2017
NAME OF P	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE		
	ASSESSED TO THE RESTREET	2		330 VILLAG	•		
VILLAGE	NORTHWESTUNLIMITE			SHELDON	, IA 51201		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	DI.		PROVIDER'S PLAN OF CORREC		(X5) COMPLETION
PREFIX	(FACH DEFIGIENC)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF		EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPR		DATE
. TAG	REGULATORY OR E	SCIDENTIFTING INFORMATION	17.0		DEFICIENCY)		
			107	150 cating t	oo fast and causing chol	kina The	
W 159	Continued From page		VV				
	This STANDARD is r	not met as evidenced by:		(P-11.1)	ll be introduced and staf		
	Based on observation	ns, interviews and record			ementation by the Direc		1 1
	reviews, the Qualified	Intellectual Disabilities			and Program Services and		
	Professional (QIDP) 1	ailed to effectively monitor ses in order to meet client		residen	tial leader. The resident	iał leader	
				will hav	e immediate oversight t	o ensure	]
	needs. This affected	1 of 1 client (Client #1) stigation #72044-I. Finding		1	ance with leadership ove		
	follows:	sugation #120 TT-1: 1 many			he Director of ICF/ID and		
	TOHOWS.				s ultimately responsible	_	
	Observations on 11/6	3/17 at 11:53 a.m. Spiritual			ance. Facility wide		, !
,	Services Coordinator	(SSC) assisted Client#1					]
	with lunch. SSC gave	e Client #1 a spoon in			s have been notifi		
	his/her right hand and	i a napkin in his/her left	·  -	need	to identify an inc	ilvidua.	
	hand SSC placed C	lient #1's food in front of		who e	ats too fast and l	nas tneir	
	him/her and sat next	to Client #1. Client #1 ate at		plate	moved away and ha	ave been	
	a rapid pace, SSC as	ked Client#1 to take a		instr	ucted to develop a	a meal-	
	drink, but he/she did	not listen. SSC leaned		time	procedure, to slow	w rate of	
	closer to Client #1 an	d again prompted Client #1	. ]	eatin	g due to safety co	oncerns	1.5
	to take a drink. Clien	t #1 took a large drink and		and e	nsure consistency	of inter	<b>:</b> †
	began to eat again. /	Approximately every 2-3	•		n with staff as tl	hey super	<b>:</b> †
	bites, SSC prompted	Client #1 to take a drink. At		vise :	meal times.		·
	11:55 a.m., Client#1	finished the food on his/her		ŀ	•		
ļ	plate and ran out of li	iquids. SSC placed his/her			·		
1	plate aside and got C	Client#1 more water and a					
	cup of fruit. SSC pla	ced Client #1's plate in front	- [				
	of him/ner and contin	nued prompting. At 11:59					
	a.m., Client#1 finish	ed eating.					,
1.	Boord raviou raves	iled Client #1's dietary report	•	ļ	•		
,		ed, "(Client #1) eats with					]
1	curerision and stat	f prompting to eat slowly (at					1.
İ	meals) (Client#1)	eats very quickly, and does	] .				
	not always adequate	ely chew (his/her) foods.		l	,		
1	(Client #1) is able to	adequately swallow (his/her)					
	foods"						
	, ,		1				ļ
	When interviewed o	n 10/31/17 at 4:21 p.m.,					
1	Direct Support Profe	essional (DSP) B reported on					
İ .	10/30/17 DSP A fed	Client #1 his/her evening		1			

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MUL A. BUILD		(X3) DATE	SURVEY PLETED	
						+	С .
		16G006	B. WING			11/	09/2017
	ROVIDER OR SUPPLIER NORTHWEST UNLIMITED	)		. 33	TREET ADDRESS, CITY, STATE, ZIP CODE 30 VILLAGE CIRCLE HELDON, IA 51201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 159	he/she did not eat like take his/her food awa	al, DSP A told Client #1 if a gentieman she would	w	159	, ,		
	reported Client #1 ate she worked with him/r napkin in one hand ar DSP C stated she use drinks and slow down some people better th DSP A threaten to tak According to DSP C, to	his/her meals fast. When her, she had him/her hold a da spoon in the other, and verbal redirection to take. Client #1 will listen to an others. DSP C heard a Client #1's food away. Client #1 does not listen to is/her plate away from		the production of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of			
•		11/1/17 at 4:45 p.m., DSP D ld Client #1 to sit nicely or at.					
	A reported her training included; to sit next to attention, and let him/eat like a gentleman. down in front of him/h ask Client #1 to take I down. Again, let Client to eat like a gentlema if not. She stated she before. After Client # moved the plate back	11/2/17 at 10:27 a.m., DSP g on Client #1's meals Client #1, get his/her her know he/she needed to Then set Client #1's food er. According to DSP A, oreak and put the spoon at #1 know he/she needed in and put his/her food aside had moved his/her food 1 took, a drink then she in front of him/her. DSP A is a lot of verbal redirection.		and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s			
-	Residential Leader (F	11/8/17 at 11:10 a.m. RL) B confirmed Client#1's ation on his/her mealtime	- Line Property				

CENTER	STORWILDIO : 12 ST		Т			CONSTRUCTION .	(X3) DATE	SUBVEY
	FDEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILI				LETED
ANDPLANOF	·			M. DUILL	0740			s 1
		16G006		B, WING	·	·	11/	09/2017
	ROVIDER OR SUPPLIER				T s	TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	(OVIDER OR SUFFEILIN				1	30 VILLAGE CIRCLE		
VILLAGE	IORTHWESTUNLIMITE				s	HELDON, IA 51201		ľ
	TIMBANDV ST	ATEMENT OF DEFICIENCIES	1	iD	<u>.l</u>	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		PREI TA	FIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLÉTION DATE
					,			
W 192	Continued From page	·11			/ 192			
W 192	STAFF TRAINING PE	ROGRAM	ļ	W	/ 192	This requirement to ensure the hea	ilth	12/13/17
., .,-	CFR(s): 483.430(e)(2		Ì			needs of residents is met was discu	ssed at	
			۱ '			the nurse's meeting on 12/5/17. The	ne	
	For employees who w	ork with clients, training	ĺ			requirement for all programs and		
	must focus on skills a	nd competencies directed		*		treatments to be done completely	and	
•	toward clients' health	needs.				accurately was reviewed and discus		
	•					held. In addition, this was covered		
•	This STANDARD is t	not met as evidenced by:	ł			meeting of the residential leaders f		
	Based on observation	s, interviews, and record	}			CF/ID homes on 11/28/17. In the		
	review the facility faile	ed to ensure staff	į,			the Director of Nursing and the Dire		
	consistently performe	d their duties to meet the	` [			ICF/ID and Program Services will be		
,	health needs of the c	ients. This affected 5 of 5				_		
'	clients (Clients #2 -#6	s) reviewed during	- 1	•		responsible for ongoing compliance		
		4-C and 71401-C. Findings				The Quality Assurance Tea completes periodic mock s		
	follow:		ļ			To ensure continued compl	innes Tonce	
•	4 Observations on 1	1/7/17 at 4:00 p.m. redness	1			they will begin to test f		
•	on the right side unde	er Client #6's abdominal fold.				consistency of documentat		
	Off It to right of the white		ı			administration of treatme		Į l
	Record review revea	led Client #6's physician		•		This will be added to the		ŀ
•	order, signed on 10/1	/17, included zinc oxide to	i			survey tool for testing o		, ,
		al area, under breasts daily				compliance.		
	and PRN (as needed	).	•					
	Additional record rev treatment record ind	iew revealed Client#6's cated the following:		,				
	a. the record lacked 11 times in Septemb once in November.	documentation on zinc oxide er, 11 times in October, and			.•		•	
	b. the record lacker checks for red or op times in October.	d documentation on skin en areas every shift seven	•					
	2. Observation on 1 redness on Client#	1/7/17 at 3:53 p.m. revealed 5's coccyx area.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULT		(X3) DATE SURVEY COMPLETED		
AND DIVO	, in the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of		A. BUILDI				
		16G006	B. WING			11/	09/2017
	ROVIDER OR SUPPLIER NORTHWESTUNLIMITED	) .		33	TREET ADDRESS, CITY, STATE, ZIP CODE 30 VILLAGE CIRCLE HELDON, IA 51201		•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE '
W 192	orders, signed 10/1/17 peri-area (and) open a (four times a day) and	12 ad Client #5's physician f, included zinc oxide to areas around peri-area QID PRN. The orders also der (bandage) to coccyx,	W	192			
	Additional record revie treatment record indic	ew revealed Client #5's ated the following:					
	a. the record lacked of four times in Septemb and once in Novembe	locumentation on zinc oxide er, 12 times in October, r.		-			
·		ked documentation on twice nes in October, and three	·		. •	•	
·	orders, dated 10/1/17,	aled Client #2's physician included, moisture barrier erineal area TID (three skin irritation.					
	Additional record revi treatment record indic	ew revealed Client#2's cated the following:				. ·	
		documentation on moisture eptember and 12 times in					
	checks for red or ope	documentation on skin n areas every shift four nd nine times in October.					
	orders dated 9/30/17 (spray/lotion/ointmer creases BID (two tim	t/powder) to the groin					,

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A, BUILDING AND PLAN OF CORRECTION B. WING 16G006 11/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 330 VILLAGE CIRCLE VILLAGENORTHWESTUNLIMITED SHELDON, IA 51201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DÉFICIENCY) W 192 Continued From page 13 Additional record review revealed Client #3's treatment record documentation indicated the following: a. the record lacked documentation on antifungal powder to groin creases four times in September and seven times in October. b. the record lacked documentation for zinc oxide to the peri area twice September and twice October. c. the record tacked documentation on skin checks for red or open areas every shift three times in September and four times in October. 5. Record review revealed Client #4's physician orders, dated 9/30/17, included antifungal (spray/lotion/ointment/powder) to erythema (superficial reddening of the skin) in abdominalfold PRN. Additional record review revealed Client #4's Treatment Record indicated the following: a. the record lacked documentation on Desenex powder to right abdominal fold TID five times in September and seven times in October. b. the record lacked documentation on skin checks for red or open areas every shift three times in September and four times in October.

When interviewed on 11/1/17 at 9:33 a.m., Residential Skills Trainer (RST) D reported approximately three or four times she came into work and found treatments, including zinc oxide, moisture barriers, padding/gauze and baths not

PRINTED: 12/05/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FEATURE DOUNCED HOW			A. BUILDING		С
		16G006	B. WING_		11/09/2017
NAME OF PROVIDER OR SUPPLIER  VILLAGE NORTHWEST UNLIMITED				STREET ADDRESS, CITY, STATE, ZIP CODE 330 VILLAGE CIRCLE SHELDON, IA 51201	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
W 192	documented in the co When interviewed on RSTE reported she of E thought staff signed	otified her supervisor and mmunication book.  10/31/17 at 10:00 a.m., ompleted treatments. RST off on the treatments, but	. W		
	reported RST B and F treatments. She state get into the locked tre	olete them.  11/1/17 at 4:02 p.m., RST A RST C did not complete the ed they never had keys to atment cabinets and only they need to unlock the staff			
	reported treatments n RST B reported she c not being done if clier According to RST B, a	11/7/17 at 1:13 p.m., RST B ot consistently completed. could tell treatments were the skin did not improve. approximately once a week to not done, and would		-	
,	Advocate A reported the bathroom and did 'Advocate A stated RS treatment tray to put	10/31/17 at 10:35 p.m. RST C assisted a client in not complete a treatment. ST C did not have the on the foot cream. When C, RST C stated she forgot.			
W 369	missed treatments. DRUGADMINISTRA CFR(s): 483,460(k)(2	RL) A confirmed clients TION t) administration must assure	. W	369 At the nurse's meeting held of was reviewed about the need prescribed medication or treat the medication record prior to administration. The Director	I to verify atment against o the

CENTERS FOR MEDICARE &			CYOLANIST	PLECONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  16G006		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		COMPLETED
		,			С
		B. WING _		11/09/2017	
MANG OF DE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE
			İ	330 VILLAGE CIRCLE	
VILLAGE	NORTHWEST UNLIMITED	0		SHELDON, IA 51201	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION DATE DATE
W 369	This STANDARD is a Based on observation review, the facility fall medications without o	e administered without error.  not met as evidenced by:  n, interview and record  led to administer error. This affected 1 of 2  ng medication administration	W3	Services will be responsible compliance. The Qualifeam completes perious administration will the mock survey too will be done by the Assurance Team as periods.	e for ongoing  ty Assurance  odic mock  of medication  be added to  1 and testing  Quality  art of their
	Nurse (RN) A cleane his/her abdominal fol the area and noted re what treatment to ap area. The staff told it	7/17 at 3:57 p.m. Registered d Client #6's area under d. The Surveyor checked edness. RNA asked staff ply to Client #6's abdominal RNA to use antifungal histered the powder and f the toilet.		and accuracy.	•
	order, signed on 8/2 Moisture Antifungal Oxide to tummy fold	aled Client#6's physician 3/17, Indicated: "Discontinue Barrier Cream and add Zinc- skin, peri(perineal)/rectal asts daily and PRN (as			
·	Advocate A reported She stated they rec	n 11/7/17 at 4:08 p.m. d Client #6's area not healing. eived an order to discontinue er and switch back to zinc			
	confirmed she adm Client #6's abdomin informed RN A of C Zinc Oxide. RN A 6	on 11/7/17 at 4:12 p.m., RN A inistered antifungal powder to nal area. The Surveyor lient #6's Physician Order for assisted Client #6 back to the nged the treatment to Zinc	•		

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING . С B, WING 16G006 11/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 330 VILLAGE CIRCLE VILLAGENORTHWESTUNLIMITED SHELDON, IA 51201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE -TAG TAG DEFICIENCY) W 369 Continued From page 16 W 369 When interviewed on 11/8/17 at 1:05 p.m. Director of ICF/ID and Program Services acknowledged RN A failed to administer Client #6's treatment according the physician order.

1.	***************************************		<u></u>	·	······