STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE NORTHWEST UNLIMITED	330 VILLAGE CIRCLE SHELDON, IA 51201

(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 000	INITIAL COMMENTS Investigations #71464-C and #71401-C conducted on 10/30/17 - 11/9/17 resulted in deficiencies written at W192, and W369. Investigation #72044-I was also completed and resulted in deficiencies written at W153, W154, W155, and W159.	W 000	POC 12/18/17	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure all allegations of potential abuse/neglect are identified and failed to report immediately to the Iowa Department of Inspections and Appeals. This involved 1 of 1 client reviewed (Client #1) during investigation#72044-I. The findings include: When interviewed on 10/31/17 at 12:59 p.m., the Spiritual Services Coordinator (SSC) reported on 10/21/17, he arrived at work a little before 8:00 a.m. Upon arrival, Direct Support Professional (DSP) A indicated Client #1 sat in his/her bedroom because of public masturbation. The SSC explained Client #1 used a locked seatbelt when he/she sat in his/her recliner. According to	W 153	It is the mission of Village Northwest Unlimited to provide excellent care to those we serve and to have staff treat all residents with respect and dignity at all times. Toward that end, we have developed an ICF/ID Residential Code of Conduct to act as a teaching aid and reinforcement of care to be provided. As part of this Code of Conduct, it specifically aligns with our policy that all allegations of abuse are to be reported when observed by staff. This Code of Conduct was reviewed with all the leaders of our ICF/ID homes on 11/28/17. In addition, we are reviewing this code at all team meetings. Each employee is required to sign the Code of Conduct. All new employees will review and sign the code also. All future incidents will be reviewed by the Director of ICF/ID and Program Services and promptly reported. This individual will be responsible for on-going compliance.	11/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy W Whitcroft	CEO	12/13/17

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 153	Continued From page 1 the SSC, Client #1 sat in his/her bedroom recliner from before he arrived to work until approximately 11:00 a.m. The SSC stated he did not step in and assist Client #1 up from his/her recliner, but wished he would have. The SSC compared the incident as a parent verses parent situation. He believed DSP A punished Client #1 for public masturbation and let DSP A handle it. After the SSC left work, he thought the incident might be neglect. On 10/22/17, the SSC sent an email to Director of ICF/ID and Program Services and asked to talk to her about staff concerns at the house. According to the SSC, Director of ICF/ID and Program Services set him up to talk to Director of Human Resources (HR). On 10/23/17, the SSC reported the incident to the Director of HR. The SSC stated Director of HR listened and seemed unhappy. The SSC was unaware if an investigation started. The SSC confirmed DSP A continued to work with Client #1. A follow-up interview on 11/1/17 at 2:51 p.m. SSC reported when he arrived to work on 10/21/17, DSP A explained she put Client #1 in his/her bedroom because he/she masturbated in the living room chair. The SSC did not believe DSP A used the word punishment nor remembered DSP A verbalizing Client #1 had to stay in his/her bedroom. The SSC assumed DSP A disciplined Client #1. The SSC recalled DSP A irritated that she witnessed this behavior. The SSC reported Client #1 was up and out of his/her bedroom at 11:00 a.m. Someone came in to administer medication and Client #1 ate lunch. He stated he did not witness DSP A check on Client #1 and the bedroom door remained closed the entire time. According to the SSC, he briefly received training and was aware of Client #1's masturbation	W 153		

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W 153	Continued From page 2	W 153		

program. The SSC stated he never needed to implement the program. According to the SSC, Client #1 did not stay in his/her bedroom a lot. The SSC stated Client #1 liked spending time in the living room. The SSC explained Client #1's bedroom contained sensory items, a TV and a radio. The SSC did not hear any noise coming from the bedroom and stated he/she could have taken a nap.

When interviewed on 10/31/17 at 2:40 p.m. 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.

The policy and procedures titled Abuse and Neglect directed the following to the staff: Any person witnessing a possible act of abuse is mandated by law and Village policy to report it immediately to both a supervisor and to the Iowa Dept. (Department) of Inspections and Appeals. For reporting purposes, "immediately" means as soon as possible, but not to exceed 24 hours after discovery of the incident..."

When interviewed on 10/31/17 at 4:50 p.m.,

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W 153	Continued From page 3 Director of ICF/ID and Program Services acknowledged the facility failed to report the allegation. She stated she called DSP A and separated her from Client #1. The facility reported the incident to DIA on 11/1/17.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct thorough investigations of potential allegations of abuse/neglect. This potentially affected all clients (Clients #2-#11) living in house 358. Findings follow: When interviewed on 10/31/17 at 12:59 p.m., the Spiritual Services Coordinator (SSC) reported on 10/21/17, he arrived at work a little before 8:00 a.m. Upon arrival, Direct Support Professional (DSP) A indicated Client #1 sat in his/her bedroom because of public masturbation. The SSC explained Client #1 used a locked seatbelt when he/she sat in his/her recliner. According to the SSC, Client #1 sat in his/her bedroom recliner from before he arrived to work until approximately 11:00 a.m. The SSC stated he did not step in and assist Client #1 up from his/her recliner, but wished he would have. The SSC compared the incident as a parent verses parent situation. He believed DSP A punished Client #1 for public masturbation and let DSP A handle it. After the SSC left work, he thought the incident might be neglect. On 10/22/17, the SSC sent an email to Director of ICF/ID and Program Services and	W 154	The policy of reporting allegations of abuse was reviewed at the Leadership Cabinet Meeting and with the ICF/ID Residential Home Leaders at their meeting on 11/28/17 when the Code of Conduct was reviewed. The VNU Policy and the Code of Conduct both require immediate report of alleged instances of abuse. This included discussion of the requirement to separate the resident and the staff person until such time as DIA had completed its investigation. The Director of ICF/ID and Program Services will be responsible for ongoing compliance. A checklist has been developed for use by supervisory and Cabinet staff when an allegation of abuse occurs. This checklist includes 1) Identification and interview of person alleged to have been abused, 2) Identification and interview of first hand witnesses (including victim), 3) Collection of information related to situation, 4) Reporting requirements, and 5) Separation of the involved staff and the victim. The checklist will be provided to all supervisory staff by 12/18/17.	12/18/17

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W 154	Continued From page 4 asked to talk to her about staff concerns at the house. According to the SSC, Director of ICF/ID and Program Services set him up to talk to Director of Human Resources (HR). On 10/23/17, the SSC reported the incident to the Director of HR. The SSC stated Director of HR listened and seemed unhappy. The SSC was unaware if an investigation started. The SSC confirmed DSP A continued to work with Client #1. A follow-up interview on 11/1/17 at 2:51 p.m. SSC reported when he arrived to work on 10/21/17, DSP A explained she put Client #1 in his/her bedroom because he/she masturbated in the living room chair. The SSC did not believe DSP A used the word punishment nor remembered DSP A verbalizing Client #1 had to stay in his/her bedroom. The SSC assumed DSP A disciplined Client #1. The SSC recalled DSP A irritated that she witnessed this behavior. The SSC reported Client #1 was up and out of his/her bedroom at 11:00 a.m. Someone came in to administer medication and Client #1 ate lunch. He stated he did not witness DSP A check on Client #1 and the bedroom door remained closed the entire time. According to the SSC, he briefly received training and was aware of Client #1's masturbation program. The SSC stated he never needed to implement the program. According to the SSC, Client #1 did not stay in his/her bedroom a lot. The SSC stated Client #1 liked spending time in the living room. The SSC explained Client #1's bedroom contained sensory items, a TV and a radio. The SSC did not hear any noise coming from the bedroom and stated he/she could have taken a nap. When interviewed on 10/31/17 at 2:40 p.m.	W 154		

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W 154	Continued From page 5 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 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 specifically described." When interviewed on 10/31/17 at 2:15 p.m., Director of ICF/ID and Program Services acknowledged the facility failed to investigate the	W 154		

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W 154	Continued From page 6 allegations. She stated she directed SCC to speak with the Director of HR and had not followed-up.	W 154		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on staff interviews and record review, the facility failed to take measures necessary to protect clients after an allegation of abuse and/or mistreatment. This affected 1 of 1 client reviewed (Client #1) during investigation#72044-I. The findings include: When interviewed on 10/31/17 at 12:59 p.m., the Spiritual Services Coordinator (SSC) reported on 10/21/17, he arrived at work a little before 8:00 a.m. Upon arrival, Direct Support Professional (DSP) A indicated Client #1 sat in his/her bedroom because of public masturbation. The SSC explained Client #1 used a locked seatbelt when he/she sat in his/her recliner. According to the SSC, Client #1 sat in his/her bedroom recliner from before he arrived to work until approximately 11:00 a.m. The SSC stated he did not step in and assist Client #1 up from his/her recliner, but wished he would have. The SSC compared the incident as a parent verses parent situation. He believed DSP A punished Client #1 for public masturbation and let DSP A handle it. After the SSC left work, he thought the incident might be neglect. On 10/22/17, the SSC sent an email to Director of ICF/ID and Program Services and	W 155	The policy for Village Northwest Unlimited was reviewed by the Leadership Cabinet and discussion was held on the importance of ensuring the safety of the resident, by removing staff from working with the resident when an allegation of abuse is made. The Director of ICF/ID and Program Services is responsible for ongoing compliance. A checklist has been developed for use by supervisory and Cabinet staff when an allegation of abuse occurs. This checklist includes 1) Identification and interview of person alleged to have been abused, 2) Identification and interview of first hand witnesses (including victim), 3) Collection of information related to situation, 4) Reporting requirements, and 5) Separation of the involved staff and the victim. The checklist will be provided to all supervisory staff by 12/18/17.	12/18/17

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W 155	Continued From page 7 asked to talk to her about staff concerns at the house. According to the SSC, Director of ICF/ID and Program Services set him up to talk to Director of Human Resources (HR). On 10/23/17, the SSC reported the incident to the Director of HR. The SSC stated Director of HR listened and seemed unhappy. The SSC was unaware if an investigation started. The SSC confirmed DSP A continued to work with Client #1. A follow-up interview on 11/1/17 at 2:51 p.m. SSC reported when he arrived to work on 10/21/17, DSP A explained she put Client #1 in his/her bedroom because he/she masturbated in the living room chair. The SSC did not believe DSP A used the word punishment nor remembered DSP A verbalizing Client #1 had to stay in his/her bedroom. The SSC assumed DSP A disciplined Client #1. The SSC recalled DSP A irritated that she witnessed this behavior. The SSC reported Client #1 was up and out of his/her bedroom at 11:00 a.m. Someone came in to administer medication and Client #1 ate lunch. He stated he did not witness DSP A check on Client #1 and the bedroom door remained closed the entire time. According to the SSC, he briefly received training and was aware of Client #1's masturbation program. The SSC stated he never needed to implement the program. According to the SSC, Client #1 did not stay in his/her bedroom a lot. The SSC stated Client #1 liked spending time in the living room. The SSC explained Client #1's bedroom contained sensory items, a TV and a radio. The SSC did not hear any noise coming from the bedroom and stated he/she could have taken a nap. When interviewed on 10/31/17 at 2:40 p.m.	W 155		

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W 155	Continued From page 8 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. The policy and procedures titled Abuse and Neglect directed the following: "...For the consumer's safety, during the time of the investigation, the staff member who is being investigated will be separated from the individual that they have been alleged to have abused, until both internal and external investigations have been completed..." When interviewed on 10/31/17 at 4:50 p.m., Director of ICF/ID and Program Services acknowledged the facility failed to separate DSP A from Client #1 upon SCC's report. She stated she called DSP A and separated her from Client #1.	W 155		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.	W 159	The Director of ICF/ID and Program Services has developed a mealtime plan for this individual. The plan will provide consistency of care amongst all staff working with his person and provide safeguards from negative consequences of	12/13/17

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W 159	Continued From page 9 This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the Qualified Intellectual Disabilities Professional (QIDP) failed to effectively monitor and coordinate services in order to meet client needs. This affected 1 of 1 client (Client #1) reviewed during investigation #72044-I. Finding follows: Observations on 11/6/17 at 11:53 a.m. Spiritual Services Coordinator (SSC) assisted Client #1 with lunch. SSC gave Client #1 a spoon in his/her right hand and a napkin in his/her left hand. SSC placed Client #1's food in front of him/her and sat next to Client #1. Client #1 ate at a rapid pace, SSC asked Client #1 to take a drink, but he/she did not listen. SSC leaned closer to Client #1 and again prompted Client #1 to take a drink. Client #1 took a large drink and began to eat again. Approximately every 2-3 bites, SSC prompted Client #1 to take a drink. At 11:55 a.m., Client #1 finished the food on his/her plate and ran out of liquids. SSC placed his/her plate aside and got Client #1 more water and a cup of fruit. SSC placed Client #1's plate in front of him/her and continued prompting. At 11:59 a.m., Client #1 finished eating. Record review revealed Client #1's dietary report dated 11/23/16, noted, "(Client #1) eats with supervision and staff prompting to eat slowly (at meals). (Client #1) eats very quickly, and does not always adequately chew (his/her) foods. (Client #1) is able to adequately swallow (his/her) foods..." When interviewed on 10/31/17 at 4:21 p.m., Direct Support Professional (DSP) B reported on 10/30/17 DSP A fed Client #1 his/her evening	W 159	eating too fast and causing choking. The plan will be introduced and staff trained in its implementation by the Director of ICF/ID and Program Services and the home residential leader. The residential leader will have immediate oversight to ensure compliance with leadership oversight under the Director of ICF/ID and Program Services ultimately responsible for facility compliance. Facility wide, ICF/ID QIDP's have been notified they need to identify an individual who eats too fast and has their plate moved away and have been instructed to develop a meal-time procedure, to slow rate of eating due to safety concerns and ensure consistency of interaction with staff as they supervise meal times.	

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W 159	Continued From page 10 meal. During the meal, DSP A told Client #1 if he/she did not eat like a gentleman she would take his/her food away. When interviewed on 11/2/17 at 9:29 a.m., DSP C reported Client #1 ate his/her meals fast. When she worked with him/her, she had him/her hold a napkin in one hand and a spoon in the other. DSP C stated she used verbal redirection to take drinks and slow down. Client #1 will listen to some people better than others. DSP C heard DSP A threaten to take Client #1's food away. According to DSP C, Client #1 does not listen to DSP A and she sets his/her plate away from him/her. When interviewed on 11/1/17 at 4:45 p.m., DSP D reported other staff told Client #1 to sit nicely or you are not going to eat. When interviewed on 11/2/17 at 10:27 a.m., DSP A reported her training on Client #1's meals included; to sit next to Client #1, get his/her attention, and let him/her know he/she needed to eat like a gentleman. Then set Client #1's food down in front of him/her. According to DSP A, ask Client #1 to take break and put the spoon down. Again, let Client #1 know he/she needed to eat like a gentleman and put his/her food aside if not. She stated she had moved his/her food before. After Client #1 took, a drink then she moved the plate back in front of him/her. DSP A stated Client #1 takes a lot of verbal redirection. When interviewed on 11/8/17 at 11:10 a.m. Residential Leader (RL) B confirmed Client #1's plan lacked staff direction on his/her mealtime behaviors.	W 159		

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W 192	Continued From page 11 STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure staff consistently performed their duties to meet the health needs of the clients. This affected 5 of 5 clients (Clients #2 -#6) reviewed during investigations #71464-C and 71401-C. Findings follow: 1. Observations on 11/7/17 at 4:00 p.m. redness on the right side under Client #6's abdominal fold. Record review revealed Client #6's physician order, signed on 10/1/17, included zinc oxide to tummy fold skin, rectal area, under breasts daily and PRN (as needed). Additional record review revealed Client #6's treatment record indicated the following: a. the record lacked documentation on zinc oxide 11 times in September, 11 times in October, and once in November. b. the record lacked documentation on skin checks for red or open areas every shift seven times in October. 2. Observation on 11/7/17 at 3:53 p.m. revealed redness on Client #5's coccyx area.	W 192	This requirement to ensure the health needs of residents is met was discussed at the nurse's meeting on 12/5/17. The requirement for all programs and treatments to be done completely and accurately was reviewed and discussion held. In addition, this was covered at the meeting of the residential leaders for ICF/ID homes on 11/28/17. In the future the Director of Nursing and the Director of ICF/ID and Program Services will be responsible for ongoing compliance. The Quality Assurance Team completes periodic mock surveys. To ensure continued compliance, they will begin to test for consistency of documentation of administration of treatments. This will be added to the mock survey tool for testing of compliance.	12/13/17

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	16G006	A. BUILDING _____ B. WING _____	C 11/09/2017

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W 192	Continued From page 12 Record review revealed Client #5's physician orders, signed 10/1/17, included zinc oxide to peri-area (and) open areas around peri-area QID (four times a day) and PRN. The orders also included, "mepilex border (bandage) to coccyx, change PRN." Additional record review revealed Client #5's treatment record indicated the following: a. the record lacked documentation on zinc oxide four times in September, 12 times in October, and once in November. b. the record also lacked documentation on twice in September, eight times in October, and three times in November. 3. Record review revealed Client #2's physician orders, dated 10/1/17, included, moisture barrier antifungal cream to perineal area TID (three times a day) PRN for skin irritation. Additional record review revealed Client #2's treatment record indicated the following: a. the record lacked documentation on moisture barrier four times in September and 12 times in October. b. the record lacked documentation on skin checks for red or open areas every shift four times in September and nine times in October. 4. Record review revealed Client #3's physician orders dated 9/30/17, included antifungal (spray/lotion/ointment/powder) to the groin creases BID (two times a day) and barrier cream/zinc oxide BID to peri (perineal) area	W 192		

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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 lacked 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 abdominal fold 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	W 192		

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W 192	Continued From page 14 completed. RST D notified her supervisor and documented in the communication book. When interviewed on 10/31/17 at 10:00 a.m., RST E reported she completed treatments. RST E thought staff signed off on the treatments, but failed to actually complete them. When interviewed on 11/1/17 at 4:02 p.m., RST A reported RST B and RST C did not complete the treatments. She stated they never had keys to get into the locked treatment cabinets and only asked for keys when they need to unlock the staff restroom. When interviewed on 11/7/17 at 1:13 p.m., RST B reported treatments not consistently completed. RST B reported she could tell treatments were not being done if client's skin did not improve. According to RST B, approximately once a week she noticed treatments not done, and would complete them. When interviewed on 10/31/17 at 10:35 p.m. Advocate A reported RST C assisted a client in the bathroom and did not complete a treatment. Advocate A stated RST C did not have the treatment tray to put on the foot cream. When she confronted RST C, RST C stated she forgot. When interviewed on 11/1/17 at 9:59 a.m., Residential Leader (RL) A confirmed clients missed treatments.	W 192		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are	W 369	At the nurse's meeting held on 12/5/17 it was reviewed about the need to verify prescribed medication or treatment against the medication record prior to the administration. The Director of Nursing	12/13/17

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W 369	Continued From page 15 self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications without error. This affected 1 of 2 clients observed during medication administration (Client #6). Finding follows: Observations on 11/7/17 at 3:57 p.m. Registered Nurse (RN) A cleaned Client #6's area under his/her abdominal fold. The Surveyor checked the area and noted redness. RN A asked staff what treatment to apply to Client #6's abdominal area. The staff told RN A to use antifungal powder. RN A administered the powder and assisted Client #6 off the toilet. Record review revealed Client #6's physician order, signed on 8/23/17, indicated: "Discontinue Moisture Antifungal Barrier Cream and add Zinc Oxide to tummy fold skin, peri(perineal)/rectal area, and under breasts daily and PRN (as needed)." When interviewed on 11/7/17 at 4:08 p.m. Advocate A reported Client #6's area not healing. She stated they received an order to discontinue the antifungal powder and switch back to zinc oxide. When interviewed on 11/7/17 at 4:12 p.m., RN A confirmed she administered antifungal powder to Client #6's abdominal area. The Surveyor informed RN A of Client #6's Physician Order for Zinc Oxide. RN A assisted Client #6 back to the bathroom and changed the treatment to Zinc Oxide.	W 369	and the Director of ICF/ID and Program Services will be responsible for ongoing compliance. The Quality Assurance Team completes periodic mock surveys. Accuracy of medication administration will be added to the mock survey tool and testing will be done by the Quality Assurance Team as part of their mock surveys to ensure compliance and accuracy.	

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W 369	Continued From page 16 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.	W 369		