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 04/10/2018

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 The investigation of 73924-M and 74037-A resulted in a deficiency cited at W153.	W 000		
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 interviews and record review, facility staff failed to immediately report allegation of abuse/mistreatment. As a result, allegations of abuse/mistreatment were not reported to the Department of Inspections and Appeals in a timely manner. This affected 1 of 1 client identified during the course of the investigation of 73924-M. Finding follows: Record review revealed the facility's investigation into allegations of abuse/mistreatment of Client #1. According to the investigation, on 1/23/18 Residential Leader A, reported she read a text message from Residential Skills Trainer (RST) A which alleged RST C hit Client #1 the day prior (1/22/18). The facility investigated the allegation. During the course of the investigation, RST A reported on 1/18/18 she requested assistance from other staff when Client #1 began to aggress towards her while in the restroom. RST C responded to assist, followed by RST B. Client	W 153	It is the policy of Village Northwest Unlimited to report all allegations of mistreatment, neglect, abuse, and injuries in a timely manner. Our policy is to report it to a supervisor immediately, but not to exceed 24 hours. This policy was reviewed in detail at the ICF-ID Residential Leaders meeting held on April 24, 2018. The Residential Leaders will hold individual meetings with their house staff members. During those individual staff meetings, the Residential Leaders will review with the staff members that any observation or witness of mistreatment abuse or neglect must be reported immediately. We will also review the definition of abuse. Each house staff member will sign to acknowledge the meeting being held. The ICF-ID Services and Program Director will be responsible for on-going compliance with support from the Residential Leaders, who will monitor for compliance in their individual homes on a daily basis.	4/24/18 with Residential Leaders

POC 4/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President/CEO	4/30/18

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 #1 continued to aggress towards RST A and RST C reacted by hitting and grabbing Client #1. RST A described RST C described the hit as a slap to Client #1's forearm. When asked why the incident had not been reported, RST A had no response. During the course of the facility's investigation, RST B also reported RST C slapped Client #1. When asked why she did not report the incident, RST C had no response. Record review revealed the facility's policy regarding Abuse and Neglect documented any person witnessing a possible act of abuse is mandated by law and Village (Northwest Unlimited) policy to report it "immediately" to both a supervisor and to the Iowa 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. Any mandatory reporters (all Village Northwest Unlimited employees) who knowingly and willingly fail to report SUSPECTED abuse may be guilty of a simple misdemeanor (30 days in jail and /or $500 fine) and terminated from their employment at Village Northwest Unlimited. When interviewed on 2/28/18 at 11:30 p.m., Director of ICF/ID Services and Program Director confirmed staff failed to report the allegation of abuse/neglect as required by facility policy. She stated RST A sent a text to her supervisor on 1/19/18; however, the supervisor did not get the message until 1/23/18. She further stated RST B did not report the incident at all until interviewed as part of the facility investigation. She stated according to the policy RST A and RST B both should have called the on call supervisor. She confirmed both RST A and RST B were trained to report immediately and to report any and all	W 153		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 153	Continued From page 2 allegations of abuse. She further reported as soon as the facility became aware of the allegation of abuse they reported it to the Department. RSTs A, B, and C were all terminated by the facility for the incident on 1/18/18.	W 153		