✓ 9/24/18 OK 9/20/18

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 08/21/2018

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

(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 incidents #76774-I, #76775-I, #76776-I, #76887-I, and #76888-I were conducted 7/2/18 - 8/21/18. As a result of investigation of #76774-I, #76775-I, and #76887-I, no deficiencies were cited. As a result of investigation of #76776-I and #76888-I, a deficienicy was cited at W186	W 000	See attached POC 9/10/18	
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure sufficient staff present to consistently meet the needs of the clients, as evidenced by failure to provide adequate supervision, which resulted in non-consensual sexual contact between clients (Client #1 and #5) involved in the investigation of incident #76776-I and 76888-I. Finding follows: Record review on 7/2/18 revealed a facility reported incident to the Department of Inspections and Appeals (DIA) on 6/13/18 after Client #1 made statements to staff he did not like	W 186		

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.

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 08/21/2018

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

(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 186	Continued From page 1 when Client #5 went into his bedroom, Client #5 had forced himself on Client #1 and it hurt, and Client #1 stated his butt hurt. The facility initiated an immediate investigation.. When interviewed on 7/2/18 at 11:55 a.m., the Quality Assurance and Investigations Coordinator (QAIC) explained the facility was in the process of completing the internal investigation regarding the incident. She explained when Client #5 returned from his home visit, he refused to meet with the facility investigator until the morning of 7/2/18. She stated Client #5 did interview with the police officer when he returned to the facility the week prior. The QAIC stated when Client #5 initially returned from his home visit he was placed on one-on-one staffing after Client #1 reported he felt safe. She explained when Client #5 told the police officer the sexual contact was non-consensual the facility decided to move Client #5 to another house on campus by himself with a one-on-one staff. The QAIC explained it sounded as all the incidents had occurred during the morning hours, between 7:30 a.m. and 8:30 a.m.; after one of the staff left the locked unit to take a client to work, which left one staff with four clients on the locked unit. The QAIC explained Client #5 was very quick, manipulative, and would take advantage of any opportunity that arose. Additional record review on 7/2/18 revealed the following: a) Client #1 was re-admitted to the facility on 8/22/17 by court order. Client #1 had diagnoses including, but not limited to: obsessive compulsive disorder, impulse control disorder, mild intellectual disability, and fetal alcohol syndrome.	W 186		

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 08/21/2018

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

(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 186	Continued From page 2 b) Client #1 had a behavior support plan (BSP) in place, to address the following behaviors: inappropriate sexual behavior -offense cycle behavior (witnessed, alleged, or self-reported attempts to set-up individuals for sexual encounters and/or be victimized), sexual contact/exposure (witnessed, alleged, or self-reported sexual act between Client #1 and another person), sexual assault (forced sexual contact with another person), aggression (pushing, hitting, kicking, and/or using weapons to harm another person), destruction (breaking, disassembling, damaging, or making items unusable including when an broken item was found in Client #1's possession), and compulsive behavior (completing a series of behavior, or insisting on repeating the same behavior over and over, hoarding or hiding objects, arranging items a specific way, the need to finish one task before moving to the next task, repetitive behavior interfere with daily schedules and/or activities). Client #1's BSP included the following restrictive measures: a motion monitor over his bedroom doorway (activated on the overnight shift), bedroom door to remained closed whenever he was in his bedroom (unless he had a roommate then it was to remain open), resided on the locked unit which included a locked bedroom window with no access to curtains and the window was alarmed, not wearing clothing he or others found sexually arousing, to avoid access to sexually arousing materials which included stimuli which depicted underage females and violence towards adult women, access to mass media which showed/depicted adolescent and school-aged females and female children and/or	W 186		

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 08/21/2018

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

(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 186	Continued From page 3 depicted violence towards adult women. Client #1 was not allowed to send or receive any mail which was sexually arousing, send mail to children or previous victims, and all mail was to be reviewed with Client #1 prior to sending or receiving it; not allowed to engage in activities deviant arousing including activities geared toward children, have supervised access to technology which could be used to engage in deviant sexual behavior; and Client #1 was not allowed contact with adolescent and school-aged females, female children, or previous victims include adult females. Client #1 received behavior modifying medications of Paxil and Zyprexa. Client #1 required general supervision when on the locked unit. Staff were to complete five minute checks on the a.m. and p.m. shift whenever Client #1 was off the locked side of 101 Franklin; he was to have staff with him while outside. Prior to community outings, Client #1 was to obtain approval to ensure the activities were age appropriate, not designed for children, and did not have an overly violent or sexual theme. Client #1 was to review and carry a copy of his Safety Plan before the outing. If he refused, it was recommended he not attend the outing since he was not considered being safe. While in the community, Client #1 was to remain with staff. He was to use the bathroom prior to leaving the facility but while out he was to use a bathroom with only one stall, a family restroom, or staff were to go into the multi-stall bathroom with him, ensure it was empty and then staff could wait outside the bathroom door for him. c) Client #5 resided at the facility since 5/12/03. Client #5 had diagnoses including, but not limited to: bipolar disorder, pedophilia, and mild	W 186		

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 08/21/2018

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

(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 186	Continued From page 4 intellectual disabilities. d) Client #5 had a behavior support plan (BSP) in place which addressed: disruptive behaviors (arguing, breaking item to render them unusable, ignoring staff redirections, bossing others, interfering with others, slamming doors, throwing items (not at others), and/or making threats) and inappropriate sexual behaviors- offense cycle behavior (behaviors which if not interrupted would imminently lead to sexual contact or assault which included: entering a bathroom without knocking or speaking loud enough to let others know when in the bathroom, stealing items of clothing from others he is sexually aroused by, leaving his bedroom door open when in there, attempting to engage in sexual activities with another person (this included asking peers to meet for sexual activity), adjusting his pants repeatedly, teasing staff/peers (not able to be redirected and/or becomes "giddy" around others), patting his stomach, winking at others, wearing pants/shorts that are way too large without a belt, attempting to and/or actually engaging in horseplay with staff/peers, or sitting with his legs spread wide open or sitting in a way so people could look up the legs of his shorts). Client #5's BSP noted by history Client #5 had: unauthorized leave (leave the designated area of supervision without staff knowledge), aggressive behavior, inappropriate sexual behavior - exposure (exposing his genitals or buttocks to another person), and inappropriate sexual behavior - sexual contact (mutual sexual interaction that is not victimizing which included being caught in various stages of undress, fondling, sexual intercourse, etc.). Behavior data was not taken for behaviors noted by history; staff were instructed to notify the nurse, Residential	W 186		

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 08/21/2018

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

(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 186	Continued From page 5	W 186		

Treatment Supervisor, and complete an Incident Report for any Sexual Contact.

Client #5's BSP included the following restrictive measures: a motion monitor over his bedroom doorway (activated on the overnight shift), bedroom door to remain closed whenever in his bedroom (unless he had a roommate then it was to remain open), resided on the locked unit which included a locked and alarmed bedroom window with no access to curtains, not wearing clothing others may find sexually arousing, to wear appropriate clothes when he left his bedroom, access to deviant sexually arousing materials was minimized which included auditory and visual representations of children and violence, not to exchange property with others without permission of the group leader, minimized access to mass media which was sexually arousing, all mail was reviewed with Client #5 prior to sending or receiving it, minimized engagement in activities that were sexually arousing or might provide Client #5 the opportunity to victimize others, minimized access to technology which was sexually arousing or could provide the opportunity to victimize others, and minimized his ability to have access to any individual he could sexually victimize. Client #5 received behavior modifying medications of Depakote Extended Release and Clozaril.

At the facility, Client #5 required general supervision. Prior to community outings, Client #5 was to review and carry a copy of his Safety Plan. If he refused, it was recommended he not attend the outing as he was not considered safe. While in the community, Client #5 was to remain with staff. He was to use the bathroom prior to leaving the facility but while out he was to use a bathroom

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 08/21/2018

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

(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 186	Continued From page 6 with only one stall, a family restroom, or staff were to go into the multi-stall bathroom with him, ensure it was empty and then staff could wait outside the bathroom door for him. When interviewed on 7/2/18 at 1:05 p.m., Client #5 reported he would sneak into Client #1's bedroom during the workweek because one staff would leave with another client at 7:30 a.m. and only one staff remained on the locked unit until 8:30 a.m. when everyone else left for work. Client #5 reported the first incident occurred sometime before June, around mid-May, but could not recall the exact date. He said Client #1 was lying down listening to music when he entered Client #1's bedroom. Client #5 stated he and Client #1 kissed each other and then he performed oral sex on Client #1. Client #5 then snuck back out of Client #1's bedroom. Client #5 stated it was RTW A then stated he thought it was RTW B was working and had been in the living room area when he snuck in and out of Client #1's bedroom. Client #5 stated the next incident occurred around the end of May and RTW C worked but was on his cellular phone while supervising the hallway. Client #5 stated he snuck into Client #1's bedroom and performed oral and anal sex on Client #1. Client #5 stated afterwards he snuck back out of Client #1's bedroom and RTW C was still in the hallway on his cellular phone. Client #5 said the last time was one or two days before he left for his home visit on 6/10/18. He stated he again snuck into Client #1's bedroom and performed oral and anal sex on Client #1. Client #5 stated he was able to sneak back out without staff seeing him. Client #5 was unable to recall what staff was working on this day. Client #5 stated Client #1 let him perform oral and anal sex on him but Client #5 stated it	W 186		

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 08/21/2018

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

(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 186	Continued From page 7	W 186		

was not consensual. Client #5 further explained he did not think it was consensual because Client #1 did not say anything. Client #5 stated he was caught attempting to sneak into Client #1's bedroom by RTW D one or two days before the last time he had sex with Client #1.

When interviewed on 7/2/18 at 1:45 p.m., Psychologist (Psy) A explained Client #5 was an opportunist. She stated he did not have a specific target and was very subtle when he would attempt to set-up a situation. Psy A explained Client #5 was very aware of what everyone was doing and took advantage of every opportunity he could. She explained Client #5's behavior would increase when he had an upcoming home visit and then would state his behavior did not matter because he was going home. Psy A said Client #5 would be honest about an incident if he was caught or would tell on himself if he thought he had been caught. Psy A explained Client #5 knew what consent was. She explained Client #5 didn't appear to care, didn't show empathy or regret for his actions.

When interviewed on 7/2/18 at 2:35 p.m., Client #1 said Client #5 went into his bedroom, didn't knock on the door, and explained the clients were not supposed to go into each other's bedrooms. Client #1 reported he thought it occurred at night because Client #5 was in his night clothes and he had been asleep when Client #5 came into his bedroom. Client #1 said Client #5 got on top of him, kissed him, and performed oral sex on him. Initially when asked, Client #1 denied anything else happened. Client #1 stated he did not report the incident. The Surveyor reassured Client #1 he was not in trouble but the Surveyor wanted to find out what had happened. Client #1 said Client #5

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 08/21/2018

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

(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 186	Continued From page 8 took his clothes off and performed anal sex on him and it hurt. Client #1 said he was taken to the hospital where the police and Crisis Service Center met with him also. When interviewed on 7/2/18 at 4:15 p.m. Client #4 said Client #5 had told him he (Client #5) liked to go into Client #1's bedroom during the day because the alarms were not on. Client #4 said he observed Client #5 sneak in and out of Client #1's bedroom one day before leaving for work while he was in the hallway talking to the staff. He said he could not remember who the staff working was. Client #4 looked away when asked why he did not tell the staff what he observed. When interviewed on 7/3/18, the QAIC stated the facility initiated another investigation and reported the incident to DIA on 7/2/18. She said during a follow-up interview with Client #5 on the afternoon of 7/2/18, Client #5 reported the first time he snuck into Client #1's room and had sexual contact occurred around mid-May. When interviewed on 7/3/18 at 7:45 a.m., RTW D said he worked on the p.m. shift on 6/7/18 on the locked unit. He explained he was talking to another client by his bedroom door and he turned to observe Client #5 attempting to go into Client #1's bedroom; Client #5 had his hand on Client #1's bedroom door handle and turned it. RTW D said he immediately asked Client #5 what he was doing; Client #5 said "Nothing." RTW D said he told Client #5 he was attempting to go into Client #1's bedroom and Client #5 left the door. RTW D stated he thought this occurred around 6:15 p.m. or 6:30 p.m. RTW D reported to the Residential Treatment Supervisor (RTS) who then spoke to both Client #1 and Client #5. RTW D stated Client	W 186		

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 08/21/2018

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

(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 186	Continued From page 9 #5 stayed in his room the remainder of the shift except when he came out to get his medication. When interviewed on 7/3/18 at 9:15 a.m., RTW A said Client #1 randomly stated, "He forced me." and she asked, "Who?". Client #1 said "(Client #5)" and then commented Client #5 went into his (Client #1's) bedroom. RTW A stated she informed the Treatment Program Manager (TPM) of the comments Client #1 made and the TPM stated she would follow-up on them. RTW A stated she was unable to remember the exact date Client #1 made the comments but knew it was after Client #5 left on his home visit on 6/10/18. RTW A explained when one staff was on the locked unit, the staff stayed in the hallway to supervise the clients. She explained during medication pass, one staff stayed in the living room with all the clients while the other staff assisted the clients with the medication pass but kept the door open. RTW A explained there was some variances depending on the staff and the scheduling. She said she was the staff whom normally left at 7:30 a.m. with the client who went to work early but explained if he was running late, a staff would be able to supervise the living room and the hallway so not all the clients would have to go to the living room area or the hallway. RTW A said the clients would attempt to distract, manipulate, and/or try to get away with things especially with new staff and relief staff who worked. She said she had known Client #5 for about 20 years. She explained Client #5 would manipulate and take advantage of any opportunity he could with anyone sexually. She stated he had made comments in the past that he had no regrets about what he does. Additional record review on 7/11/18 revealed the	W 186		

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 08/21/2018

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

(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 186	Continued From page 10	W 186		

following:

a) 101 Franklin Locked Side Review Group Minutes which noted the Interdisciplinary Team (IDT) met on 11/2/17 to determine Client #1 moving to the locked unit. The meeting minutes noted Client #1's sexual acting out was violent and coercive, specifically noting five times he had sexually acted out toward females (both children and adults) since 2011 and "numerous instances of masturbating in public." The IDT discussed since Client #1's return to Woodward Resource Center he was found by staff naked with his legs hanging out of his window and appeared to be masturbating. Client #1 had also admitted to targeting several female staff he was attracted to at the facility. The IDT determined he was at high risk for reoffending and the recent behaviors he had exhibited indicated he was a danger to the community. The IDT recommended Client #1 move to the locked unit and was not to be alone with female staff.

b) Client #1's Safety Plan included the following: "Triggers/Set-ups - seeing or hearing school-aged females, adult females, and female children; looking at magazines or pictures of female children or young adults, looking at naked pictures, staring at females I am attracted to, following females I am attracted to, trying to get attention from the females I am attracted to, watching school-aged females, adult females, and female children on TV or in movies; when I make weapons and think about hurting women or children, when I act selfish and don't care about others, excessive violence in music, movies, clothing, video games, especially if women are portrayed in a degrading way; making up thinks that are not true to get attention, when I am being

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 08/21/2018

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

(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 186	Continued From page 11	W 186		

rude to women. High Risk Situations (persons, places, things and/or situations I should avoid) - Being along or unsupervised with children or young adults especially females, working at a job with female peers or job coach I am attracted to, trying to lure females into my bedroom, sneaking down the hallway to stare at female staff, going to activities or placed geared towards children, schools, parks, or playgrounds; making threatening gestures or comments toward women, when I am bored and don't have anything to do, being alone with animals, when I try to put support staff in a blue circle instead of the yellow, touching females. Coping Strategies - Tell the truth when talking to direct care staff, counselors, or other support people; leave the area and do something to distract myself, listen to music, get busy working on a puzzle, do house work, clean my room, draw a picture, write a letter, choose movies and TV shows that are not all about school-aged females, adult females, or female children; look down and away instead of staring at females. Support People (to help me be safe and not offending) - Support staff, Group Facilitators, Counselors."

c) 101 Franklin Locked Side Review Group Minutes noted the IDT reviewed Client #5's placement on the locked unit on 6/14/16. The IDT determined Client #5 should remain on the locked unit based on Client #5 being sexually motivated, opportunistic, and predatory, would not seek out others of his same intellect, and would take advantage of or set up situations he was able to. The IDT also noted he had not eloped due to residing on the locked unit but identified concerns if Client #5 was not on the locked unit, he would elope and seek out a victim immediately. Client #5 was considered high risk for reoffending.

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 08/21/2018

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

(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 186	Continued From page 12 d) Client #5's Safety Plan included: "Triggers-Children (hearing and visual), horseplay, and Teen-Aged Males. Dangerous Places- Beaches, McDonald's Playland, Schools, Swimming Pools, Places with no supervision, Shopping Malls, Pak with Playground Equipment. Coping Skills-Conversations with Others, Mindfulness, Activities/DBT, Counting items on shelves, Watching movies. Expectations in the Community- Remain Close to Staff and/or my mom so they can see what I am doing, Use bathroom before I leave the house, Review my safety plan with staff before I go off campus, Use bathroom after staff check it." When interviewed on 7/11/18 at 3:35 p.m., RTW C reported he worked on the locked unit various days and shifts for overtime and as a relief staff. He explained in the morning, after the other staff would leave with one of the clients, the other clients did not go into the living room area because they were finishing getting ready to leave for work. He stated he would sit at the table in the hallway supervising. He explained Client #4 would come out and talk to him. RTW C denied being on his cellular phone or asleep while supervising the hallway; he stated there was too much to worry about and too much going on. RTW C explained during medication pass, the medication aide would assist one client and could see the living room area while the staff in the hallway would ensure the client came from the living room area before another client entered. RTW C stated Client #1 was an easy target for the other clients who resided on the locked unit because Client #1 was so quiet and did not tend to report. He explained the other clients on the locked unit had more predatory behaviors than Client #1 was	W 186		

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 08/21/2018

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

(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 186	Continued From page 13 used to being around from the previous home he resided in on-campus. RTW C stated Client #5 did not appear to care or have any remorse, and would target anyone to have sex. When interviewed on 7/12/18 at 8:35 a.m., RTW B explained he did hear Client #1 make comments about Client #5 entering his (Client #1's) bedroom and Client #1 stated his butt hurt. RTW B stated RTW A heard more of the comments Client #1 had made. He confirmed the concerns were reported to the TPM. RTW B explained supervision on the locked unit included whenever two clients were in the hallway area (which included bedrooms and bathrooms) or in the living room area, a staff was to be present to supervise. RTW B stated during the workweek, between 7:30 a.m. and 8:30 a.m., he was normally the only staff on the locked unit. RTW B explained he would ask the clients to stay out of the living room area except one at a time, and the clients complied with this and took turns if they wanted to be in the living room. RTW B stated if he needed to step away, he would get another staff to come supervise. He also stated supervisors normally came into work between 7:00 a.m. and 8:00 a.m., the RTS office was on the locked unit, and the supervisors would normally check-in to see if the staff needed anything. RTW B explained since the increase with supervision and monitoring, the clients on the locked unit have tried to learn new ways to get away with things and stated the clients could be very sneaky. When interviewed on 7/12/18 at 10:40 a.m., RTS A confirmed on 6/7/18 RTW D reported he had intervened when Client #5 attempted to enter Client #1's bedroom on the p.m. shift. He stated	W 186		

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 08/21/2018

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

(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 186	Continued From page 14 initially Client #5 denied it but then stated he was attempting to enter Client #1's bedroom to see if he could. The RTS said he thought the incident on 6/7/18 stemmed from RTW D being a relief staff and Client #5 attempting to manipulate and take advantage of things because relief staff do not know the "ins and outs" as well. RTS A explained hall monitoring included one staff was to be present to supervise the hallway area whenever two or more clients were in the area; this was the same for the living room area. RTS A said the staff are able to sit at the table in the hallway as long as they are able to provide supervision of the clients. He explained if two or more clients are in the "L" of the hallway, the staff would need to go over the corner to provide visual supervision, and stated clients would try to go there when relief staff worked. RTS A said between 7:30 a.m. and 8:30 a.m. was a harder time because only one staff was present. He stated the clients had a choice, all were in the hallway area or all were in the living room area, unless only one client wanted to be in the unsupervised area. He explained Client #4 was normally the only client who would go into the living room in the morning and would wait for breakfast. He stated no other clients showed interest because they were getting ready for work. RTS A explained if a staff was sleeping, on their phone, and/or not supervising appropriately, the clients on the locked unit would normally tell on the staff within a couple days to take any accountability off themselves. RTS A stated it was odd to hear an incident occurred a month or so before and explained normally when a client on the unit tried to keep a secret their entire mannerisms would change and they could identify something was not right.	W 186		

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 08/21/2018

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

(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 186	Continued From page 15 Additional interviews were conducted between 7/11/18 - 7/17/17 with RTW E, RTW, F, RTW G, RTW H, RTW I, RTW J, RTW K, RTW L, RTW M, RTW N, RTW O, RTW P, RTW Q, RTW S, RTW T, RTW U, and RTS B. All interviewees consistently reported when supervising, anytime more than one client was present in an area a staff was to be present to supervise; this included both in the hallway area and in the living room area of the locked unit. No one was able to recall a time Client #5 had attempted to enter or leave Client #1's bedroom. During a follow-up interview on 7/16/18 at 1:00 p.m., Client #1 reported he did not want to have sex with Client #5. He stated he told Client #5 "No. I don't want to do this." Client #1 said he did not try to stop him or push him away after telling Client #5 "No." When interviewed on 7/17/18 at 11:40 a.m., the Woodward Police Officer stated Client #5 had admitted Client #1 said "No." and he (Client #5) knew Client #1 did not want to. He said Client #5 admitted to having sex with Client #1 one time around May 2018. He stated Client #1 reported it occurred around the time Client #5 left for his home visit. During a follow-up interview on 7/17/18 at 1:00 p.m., Client #5 explained he knew about consent, he had learned about it in groups he attended. He explained to obtain consent the other person had to be other same functioning level, be over 18 years old, and had to verbally say "yes". Client #5 said Client #1 had told him "No" but stated he had sex with him anyway. Client #5 said Client #1 just let him do it but said he knew Client #1 didn't want to because he already said "No."	W 186		

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 08/21/2018

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

(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 186	Continued From page 16 Record review on 8/20/18 revealed Client #5's Comprehensive Functional Assessment (CFA), undated. The CFA identified "Does not accept no to sexual advances" as a need for Client #5. When interviewed on 8/20/18 at 2:30 p.m., the TPM confirmed Client #5's CFA was completed and then reviewed during his last Individual Support Plan meeting in May 2018 but she had printed the wrong copy prior to coming to be interviewed by the Surveyor. The TPM explained the only time during waking hours one staff worked alone (besides during breaks) on the locked unit was from 7:30 a.m. until 8:30 a.m. because the second staff left with another client who went to work earlier than the other four clients. She stated this was in place when she started at the facility approximately four years ago. The TPM said management would stop in on the locked side in the mornings but were not a second staff and were not there for the entire hour. The TPM confirmed Client #5 would seek out a victim or willing participant at any given opportunity. She explained while staff supervised the hallway, if the staff were answering or assisting another client, such as unlocking the closet to get the mop out, this could provide Client #5 the opportunity. She stated Client #5 was able to recognize the staff momentary distractions and routines. The TPM stated, looking back, it seemed like it became routine, what everyone knew for the mornings, and almost like it was believed it wouldn't happen during the time because of the busyness of getting ready for work. She explained during 7:30 a.m. and 8:30 a.m., the clients were getting ready, taking their medication, having breakfast, brushing their teeth, finishing chores, and then would leave at	W 186		

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 08/21/2018

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

(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 186	Continued From page 17 8:30 a.m. so it didn't seem like a possibility. The TPM said following the investigation, she could see where the sexual opportunities the clients sought out could happen at any time, even during the busy, structured times. The TPM continued to state, how one staff to four clients on the locked unit could be a struggle to provide enough supervision. Record review on 8/20/18 revealed Staff Expectations training for 101 Franklin, both the locked and unlocked unit. The document instructed staff were to monitor the hallways when there was more than one client in their bedroom and/or bathroom on all shifts. The training further instructed staff were to monitor the living room when more than one client was in the living room area. The QAIC confirmed the staff expectation to have a staff present when two or more clients were in an area was put in place in May 2016.	W 186		

OK 9/21/18

√ 9/24/18

Woodward Resource Center (WRC)
Standard Level Plan of Correction for DIA Investigation #76776-I and #76888-I
Tag W-186 – Direct Care Staff – CFR(s): 483.430(d)(1-2): (1) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. **(2)** Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

On June 14, 2018, the TPM reported that house staff heard Client 1 saying Client 5 comes in my room all the time, Client 5 forced himself/herself on me, my butt hurts. On July 2, 2018, during an investigation interview with Client 5, Client 5 reported that there was oral sexual contact between Client 5 and Client 1 that occurred in mid-May. Client 5 had left on a home visit prior to these allegations from June 10, 2018, to June 24, 2018, and was immediately placed on 1:1 supervision when he/she returned on June 24, 2018. Client 5 was moved to a house by himself/herself with 1:1 supervision on June 28, 2018, following an interview with Client 5 on June 28, 2018.

Through WRC's internal investigation and WRC's Incident Review Committee, WRC found programs belonging to Client 1 and Client 5 were being followed by staff but identified the need to add additional measures to meet client needs. This included:

- Client 5 was placed on 1:1 supervision immediately following his/her home visit on June 24, 2018.
- Client 5 was moved to a house by himself/herself with 1:1 supervision on June 28, 2018, following an interview with him/her on June 28, 2018.
- Between June 26, 2018, and June 29, 2018, monitoring of the hallways was retrained with the last staff trained on July 2, 2018, when they returned from time off.
- On June 25, 2018, overnight staff implemented ensuring monitors are functioning properly and recorded on the DAR. Staff were trained between June 22, 2018, and June 28, 2018, with the last staff trained on July 2, 2018, when they returned from time off. (Staff were already documenting the use of the monitor, but documentation did not reflect checking the functionality.) This motion monitor is only used on the overnight shift.
- On June 27, 2018, a second door alarm was installed that is on at all times. Staff were trained between June 27, 2018, and June 29, 2018, with the last staff trained on July 2, 2018, when they returned from time off. WRC also implemented staff to ensure the alarms are on and operating correctly. At the beginning of each shift of (AM, PM, and overnight) staff will check to ensure the alarms are on and operating correctly. Staff will also check after each meal on the AM and PM shift (breakfast, lunch, and dinner). This is recorded on the DAR.
- Maintenance staff put a reminder on the adaptive equipment calendar to remind him/her to change the batteries in the sensors (motion monitors) every 6 months.
- On June 29, 2018, a convex mirror was installed in the living room. This allows staff to monitor both the living room and the hallway.
- Effective July 3, 2018, the client that left for work early now goes to work at the same time as his/her peers. This was completed immediately following an interview with Client 5 on July 2, 2018.
- Effective July 13, 2018, all bedroom doors at this house automatically lock when the door closes and each individual has their own key.

DIA found the facility failed to ensure sufficient staff present to consistently meet the needs of clients, as evidenced by failure to provide adequate supervision, which resulted in non-consensual sexual contact between client 1 and client 5.

Individual response

Effective July 3, 2018, the client that left for work early now goes to work at the same time as his/her peers to ensure adequate staffing.

Responsible: Assistant Superintendent
Date due: July 3, 2018, and on-going

Systemic response

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

WRC management team will continue to develop, monitor, and revise, as necessary, policies and operating directions which ensure the necessary staffing, training resources, equipment and environment to keep individuals safe.

Responsible: Superintendent
Date completed: September 10, 2018, and on-going