STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G137	A. BUILDING _____ B. WING _____	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESS NORTH	815 EAST 15TH STREET NORTH NEWTON, IA 50208

(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 As the result of the investigation of #90183-M a deficiency was 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, the facility failed to ensure staff immediately reported allegations of abuse. This affected 1 of 1 sample client identified during the investigation of #90183-M (Client #1). Findings follow: Review of an internal facility investigation on 1/05/21 revealed two co-workers witnessed Direct Support Professional (DSP) A drag Client #1 out of the kitchen by his feet/ankles on the afternoon of Saturday, 3/14/20. DSP B wrote a note regarding the incident for the supervisor, but the supervisor didn't see the note until Monday, 3/16/20. DSP C also witnessed the incident, but did not report it until questioned about it on 3/16/20. Additional review of the facility investigation revealed the note written on 3/14/20 by DSP B. She wrote that DSP A yelled and swore at Client #1 to get out of the kitchen. Client #1 didn't leave the kitchen, but dropped to the kitchen floor. DSP A held onto Client #1 by his ankles and dragged	W 153	POC 2/11/21 The following steps have been implemented to correct current deficiencies & prevent future reoccurrence. 1. New employees will continue completing state mandatory reporting training during new employee orientation prior starting direct support duties. 2. Reporting review training will be completed at next scheduled team meeting. 3. Reporting protocol will be posted in office at ICF/ID facilities. 4. DSP will document each work shift in therap shift log acknowledgement of reporting requirements. 5. DSP responsible for immediate reporting to management. 6. Facility manager, QIDP & ICF/ID Director responsible for completing internal investigation & reporting to DIA in collaboration with HR director.	2-11-2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ruth Neal	*ICF/ID Director*	*2-11-2021*

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	W 153		

him out of the kitchen to the front hall entryway. (A distance of 15 to 18 feet).

The Human Resource Director (HRD), who completed the facility investigation, interviewed DSP C on 3/16/20 and wrote a summary of the interview. In the summary, the HRD noted DSP C corroborated DSP B's written statement and reported DSP A dragged Client #1 by his ankles from the kitchen to an area near the front door of the facility. When asked why she didn't report the incident, DSP C said she thought DSP B reported it.

The facility suspended DSP A on 3/16/20 and terminated her employment on 5/07/20. DSP A last worked at the agency on 3/16/20.

When interviewed at 4:20 p.m. on 1/05/21, DSP B confirmed she witnessed DSP A drag Client #1 by his feet/ankles from the kitchen to the front entry way. DSP B said DSP A had been yelling and cursing at Client #1 to leave the kitchen. She said Client #1 had been pushing against DSP A in the kitchen and then dropped to the floor. DSP A then dragged Client #1 out of the kitchen. DSP B acknowledged she wrote a note on 3/14/20 and left it for the supervisor. When asked why she didn't immediately report the incident, DSP B said she was a newer staff person and not sure what to do. The supervisor saw the note on the morning of 3/16/20 and called DSP B about it.

When interviewed at 3:00 p.m. on 1/06/21, DSP C confirmed she witnessed DSP A drag Client #1 out of the kitchen by his feet/ankles on the afternoon of 3/14/20. DSP C did not report the incident until questioned about it on 3/16/20.

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W 153	Continued From page 2	W 153		

A review of the General Event Report (GER) written by DSP B on 3/16/20 regarding the incident on 3/14/20 revealed a follow-up entry by a facility nurse dated 3/16/20. According to the nursing assessment done 3/16/20, Client #1 had three small bruises in a line along the center of his back.

A review of DSP A's time sheet revealed she worked at the facility from approximately 6:00 a.m. to 2:00 p.m. on 3/14/20 and 3/15/20 and from approximately 6:00 a.m. to 11:26 a.m. on 3/16/20. DSP A was not immediately separated from working with Client #1 because facility management staff didn't learn of the allegation until the morning of 3/16/20.

According to the agency Dependent Adult Abuse policy, staff should immediately report allegations of abuse to the staff person in charge or that person's designated agent.

When interviewed on 1/12/21 at 3:20 p.m. the ICF/ID Director confirmed DSP B and DSP C should have immediately reported the allegation of abuse they witnessed on the afternoon of 3/14/20. She stated a supervisor/manager was always on-call on the weekends and the staff should have notified the on-call supervisor.