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W 000	INITIAL COMMENTS Annual survey completed 2/17/20 to 3/10/20 resulted in deficiencies written at W125, W159, W189, W268, and W289. Investigations #87693-I, #89317-I, #87696-I, #89316-I, #89367-I, #89366-I, #89365-I, #89363-I, #87631-I, #89315-I, #89313-I, #87694-I, #89364-I, #89318-I, #89312-I, #89319-I, #89314-I, #89728-I, #89368-M, and #87692-M were also completed during the survey. Investigation #89317-I resulted in a deficiency written at W339. Investigation #89366-I resulted in a deficiency written at W154. Investigation #89363-I resulted in a deficiency written at W153. Investigation #87631-I resulted in a deficiency written at W249. Investigations #87693-I, #87696-I, #89316-I, #89367-I, #89365-I, #89315-I, #89313-I, #87694-I, #89364-I, #89318-I, #89312-I, #89319-I, #89314-I, #89728-I, #89368-M, and #87692-M resulted in no deficiencies written.	W 000	See Attached POC 7/24/21	
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right	W 125		

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.

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to due process.
This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to obtain consent prior to limiting access to personal possessions (pop). This affected 7 of 8 clients at House 472 with restricted access to pop (Client #9, Client #14, Client #23, Client #24, Client #25, Client #26 and Client #27). Findings follow:

Observation at House 472 on 1/18/20 at 1:15 p.m. revealed Client #14 requested pop. Staff poured her a small cup of pop and placed the bottle back in a locked closet. At 1:20 p.m., Treatment Program Manager (TPM) C confirmed Client #14 bought her own pop but did not have a key to unlock the closet.

Observation on 3/4/20 revealed the names of Clients #9, #23, #24, #25, #26 and #27 on pop in a locked closet in their home.

Record review on 3/4/20 revealed no consent to lock the clients' pop in the closet.

Record review on 3/9/20 revealed the facility Human Rights policy. According to the policy, the facility process to restrict access included "The informed consent of the individual or the individual's parent, guardian, or legal representative."

When interviewed on 3/9/20 at 10:30 a.m., the interim Superintendent confirmed staff should have obtained consent prior to restricting client access to their pop.

W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)	W 153		

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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 interview and record review, the facility staff failed to immediately report allegations of client mistreatment and/or abuse, in accordance with facility policy. This affected 2 of 2 clients (Client #18 and #19) involved in the investigation of incident #89363-I. Finding follows:

Record review on 2/18/20 revealed a Type 1 Investigation Report, initiated 1/17/20. According to the internal investigation, on 1/17/20 Residential Treatment Worker (RTW) I reported to Treatment Program Administrator (TPA) A on 1/16/20 during the p.m. shift at House 360 RTW H was assigned as Client #19's one-on-one staff. RTW I reported RTW H was in the dining room, leaving Client #19 in his bedroom unsupervised. RTW I reported during the shift, Client #19 had been in his bedroom, and RTW H had his feet up blocking Client #19 from leaving his bedroom. RTW I reported he saw this occur approximately seven times in the three to four weeks he worked at House 360. It was also reported, RTW H may not prompt Client #19 to get up to eat supper therefore Client #19 may not receive his meal. RTW I also reported sometime the week prior, RTW H was assigned one-on-one with Client #19. RTW I reported Client #19's bedroom was cold and he observed Client #19's window was open. It was believed the window was opened in

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an effort to get Client #19 to stay in bed. Additionally, RTW I reported on 1/16/20, RTW G was assigned one-on-one to Client #18 and sometime between 7:30 p.m. and 8:00 p.m. RTW G was in the dining room while Client #18 was in his bedroom unsupervised. RTW I reported he witnessed RTW G tapping Client #18's helmet with his ring attempting to agitate him while at the dining room table. RTW I also reported RTW G and RTW H were talking about how they wore rings to hit people in the heads with them, had bragged about hitting clients and stated they would hit people again, and commented about clients throwing feces and they threw it back but never stated any specific client names.

The Surveyor attempted to contact RTW I on 2/19/20 at 5:10 p.m., 2/24/20 at 12:10 p.m., and 2/26/20 at 8:10 a.m. but was unsuccessful. According to the statement RTW I provided to the facility, on 1/16/20 RTW G was assigned Client #18's one-on-one staff and RTW H was assigned as Client #19's 1:1 staff. RTW I reported at approximately 5:15 p.m. RTW H took Client #19's supervision back and they went to the hallway after RTW I had him about ready to eat supper. RTW I reported RTW H put his les up blocking Client #19's doorway and would not put his legs down when Client #19 approached him. RTW I reported he saw RTW H block Client #19 before when Client #19 was in his bedroom, reporting he saw it occur approximately seven time in the three to four weeks he worked in the house. RTW I reported during the meal, he observed RTW G tap Client #18's helmet with a big ring he wore, in an attempt to agitate Client #18. RTW I reported he could tell Client #18 did not like it, so he told Client #18 to take his helmet off since he was seated. RTW I reported at approximately

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7:00 p.m., he observed Client #18 slumped over sleeping and drooling in a chair in the dining room while RTW G sat on the table on his phone. RTW I continued to report at approximately 8:00 p.m., he was in the B side living room, RTW G and RTW H were in the A side dining room and neither Client #18 or Client #19 were in the dining room. RTW I reported throughout the night, RTW G and RTW H had conversations about hitting people that lived at the facility and someone throwing feces and them throwing it back, but reported he did not hear either state client names so was unaware of who they were speaking about. RTW I reported one day approximately a week before, RTW H was Client #19's 1:1 staff. He stated at approximately 8:00 p.m. he went with Client #19's roommate into the bedroom and it was cold, Client #19 was in bed covered up with a sheet and the window on Client #19's side of the bedroom was opened. He stated RTW H was sitting outside of the room with the door closed when he entered and when he asked why the window was open, RTW H said because the room smelled like body odor. RTW I reported there were times he informed RTW H Client #19's supper was ready, but RTW H would say Client #19 was sleeping and did not try to prompt him to eat. RTW I noted he did not report these issues immediately because he was afraid of retaliation and he did not feel it would be taken seriously; and was uncertain of the protocol and reporting process noting "even though they say tell someone it's not that easy."

When interviewed on 2/24/20 at 2:20 p.m., Residential Treatment Supervisor (RTS) A stated he worked on 1/16/20 on the p.m. shift in Pod B, which included House 360. RTS A said he stopped at House 360 after supper, at

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approximately 5:30 p.m., and was at the house for approximately 20 minutes. RTS A explained he stopped back to House 360 around 8:00 p.m. and stayed for approximately an hour. RTS A stated while at the house, he checked in with everyone. RTS A stated RTW I did not report any concerns or allegations to him while he was at House 360.

When interviewed on 2/24/20 at 1:30 p.m., TPA A stated on 1/17/20 at approximately 10:00 a.m., RTW I was not scheduled to work but had gone to the facility to pick up his check. He stated RTW I saw his office door was open and stopped to speak to him. TPA A said RTW I was visually upset and reported RTW G and RTW H left their 1:1 clients unsupervised in their bedrooms on 1/16/20 while they talked in the dining room. TPA A stated RTW I continue to report RTW G and RTW H bragged about hitting clients, throwing feces back at clients; and how they wore big rings and one of them was tapping Client #18's helmet. TPA A stated RTW I reported RTW G and RTW H were making homophobic and sexual remarks but did not indicate if any clients were present when making the remarks. TPA A stated RTW I said he was unsure if he wanted to return to work so he gave him the weekend off to think about it; RTW I resigned the following week. TPA A reported he walked with RTW I to the Director of Quality Managements (DQMs) office and the investigations department took over. TPA A confirmed RTW I failed to immediately report concerns of client mistreatment and/or abuse.

When interviewed on 2/18/20 at 10:45 a.m., the Director of Quality Management confirmed RTW I failed to immediately report allegations of client mistreatment and/or abuse. She stated on

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1/17/20, TPA A walked RTW I to her office and he reported concerns from 1/16/20. She stated RTW I had also reported a concern from the week prior, but he was unable to recall the exact date he had observed Client #19's bedroom window was open.

Review of facility policies revealed the Incident Management Policy, 8/20/19. The policy instructed an employee was to immediately report all incidents, which included alleged abuse, verbally to the direct line supervisor or supervisor on-duty.

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 interviews and record review, the facility failed to conduct thorough investigation into injuries of unknown origin. This affected 1 of 1 client (Client #29) identified as a result of facility self-reported incident #89366-I. Finding follows:

Record review on 2/17/20 revealed an incident report, dated 1/23/20 at 8:00 a..m., documented staff notified a nurse Client #29 "had slight bruising noted to his nose." When the nurse arrive at house Client #29 stated Resident Treatment Worker (RTW) A pinched his nose and put his hand over Client #29's mouth the night before. Night watch staff stated Client #29 did not have the bruising when he got up about 4:00 a.m.

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W 154	Continued From page 7 Continued record review revealed the facility initiated a Type 1 investigation on 1/23/2020. The facility's investigation unsubstantiated allegations of physical abuse; however, the report failed to provide any further investigation into how Client #29 developed bruising to his nose, which became an injury of unknown origin with the facility's unsubstantiated findings regarding the allegation of physical abuse. When interviewed on 2/19/2020 at approximately 3:25 p.m. the Director of Quality Management (DQM) acknowledged the facility's investigation failed to explore the origin of Client #29's bruising to his nose when the allegation of physical abuse was unsubstantiated. When interviewed on 2/20/20 at approximately 12:15 p.m. the Interim Superintendent confirmed the facility failed to conduct a thorough investigation into the origin of Client #29's bruising to his nose.	W 154		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record	W 249		

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W 249	Continued From page 8 review, the facility failed to ensure clients received needed supports and services as outlined in the Individual Support Plan (ISP). This affected 1 of 1 client (Client #19) reviewed during investigation #87631-I. Findings follow: 1. Record review on 2/18/20 revealed a facility Type 1 Investigation Report, initiated on 10/15/19. According to the report, on 10/15/19 RTW G was assigned supervision of Client #19. At approximately 4:00 p.m., RTW G and Client #19 were in the large dayroom of the house when RTW G walked approximately 10 feet away to retrieve Client #19's staff book from the staff desk. RTW G turned around and Client #19 was not present. RTW G went out the front door where another client pointed toward building 358; RTW G saw Client #19 running towards House 355 from 358. RTW G and RTW F returned Client #19 to House 360 at 4:05 p.m. Additional record review revealed Client #19 was 63 years old and resided at the facility since 8/26/63. Client #19 had diagnoses including, but not limited to profound intellectual disabilities, obsessive compulsive disorder, pica (eating inedible items), autism spectrum disorder, and unspecified impulse control disorder. Client #19 had a Behavior Support Plan (BSP), updated 3/25/19 and started 4/1/19, which addressed precursor behaviors of agitation and leaving the assigned area, psychiatric indicators of compulsive behaviors and social isolation, and target behaviors of pica, pica attempts, and aggression. The BSP instructed Client #19 was to receive one-on-one supervision to prevent pica and leaving the assigned area. The one-on-one staff was to remain within two-arm's length of Client #19 to prevent pica and leaving the	W 249		

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assigned area, including when Client #19 was in his bedroom or the bathroom except during the night watch. During the night watch, after Client #19 was in his bedroom and asleep, staff were to complete ten minute checks on him but were to resume one-on-one supervision if he woke up and exited his bedroom. The BSP continued to instruct, if Client #19 attempted to leave his assigned area, staff were to block and redirect him back to the appropriate location.

Review of Client #19's Comprehensive Functional Assessment, signed on 4/11/19, noted identified needs in the areas of: knowing to use crosswalks, looking both directions before crossing the street, waiting for on-coming traffic to clear before crossing the street, being able to travel independently, and notifying others of his location or intended destination.

According to Weather Underground, at 4:00 p.m. on 10/15/19 it was 57 degrees Fahrenheit with an eight mile per hour west wind, no precipitation, and fair conditions in Glenwood, Iowa.

When interviewed on 2/19/20 at 8:50 a.m., RTW F said he was at House 355 on 10/15/19. He stated he was standing in the kitchen at approximately 4:00 p.m. and saw Client #19 running. He said he knew Client #19 had a one-on-one staff so he ran outside to Client #19 and saw RTW G running behind Client #19. RTW F said RTW G got to them within approximately 10 to 15 seconds after he stopped Client #19. RTW F said he though Client #19 was wearing sweatpants, shoes, and a shirt.

When interviewed on 2/26/20 at 10:15 a.m., RTW E said she recalled RTW G was one-on-one with

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Client #19, stating she thought 10/15/19 sounded like the correct date. RTW E reported Client #19 and RTW G were in the large dayroom and she went to do checks on the other side of the house. She said when she walked back she saw RTW G running out of the house so she went to see what was going on. RTW E looked and another client pointed toward House 355. She saw Client #19 running and RTW G running behind him. She stated she continued to watch until they returned to House 360. RTW E stated she was not asked to watch Client #19 and explained she would have signed in and out of his one-on-one zone sheet if she took over his supervision.

When interviewed on 2/26/20 at 3:35 p.m., RTW G said on 10/15/19 he went to House 360 at approximately 3:25 p.m. and took over one-on-one supervision of Client #19. He said Client #19 had been pacing and running around the house and at approximately 4:00 p.m., Client #19 was sitting in the large dayroom, across from an exit door. RTW G said he talked to RTW E, who was in the large dayroom, and said to he was going to grab Client #19's book from the A side living room off of the staff desk. RTW G explained Client #19's zone sheet was in his book so he was going to get the book to complete his documentation. RTW G said he got the book, turned, and saw Client #19 outside through the large dayroom windows. RTW G said it took 15 seconds or less for him to get the book and turn around. RTW G said he ran out of the front door, another client pointed, he saw Client #19 standing by a large tree in the side yard of House 360, and then Client #19 took off running toward House 355. RTW G stated he ran after him and was able to catch up to Client #19 across the street by the CASA House but explained he did not try to turn

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Client #19 around because the ground was sloped and he did not want Client #19 to fall since he had his shoes on the wrong feet. RTW G said Client #19 continue to run when RTW F came out of House 355, ran down the driveway, and they were able to get Client #19 to stop. RTW G reported RTW F walked with him and Client #19 part of the way back to House 360 and turned around when they observed RTW E was outside. RTW G stated he did not observe Client #19 leave the house but assumed he left out of the exit door, which was across from him in the large dayroom. RTW G confirmed he did not specifically ask RTW E to watch Client #19 but reported he said he was going to grab Client #19's book. RTW G said it was common for other staff to assume responsibility if stepping away briefly or for the other staff to go and get the book for the one-on-one staff. He said he could not sign over supervision of Client #19 to RTW E because the zone sheet was in his book on the staff desk, which was what he was going to get. RTW G stated he recalled Client #19 was wearing long pants, a shirt, and shoes.

Review of facility policies revealed the Incident Management Policy, 8/20/19. The policy instructed an employee to immediately report all incidents, which included client elopements, verbally to the direct line supervisor or supervisor on-duty.

Additional review revealed the Habilitation and Safety Policy, last revised 8/18. The policy instructed staff were to know the whereabouts of individuals supported at the facility. The policy continued to instruct, clients with varying levels of supervision outlined in the BSP would be accounted for as specified in their BSP.

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W 249	Continued From page 12 When interviewed on 2/18/20 at 10:45 a.m., the Director of Quality Management (DQM) confirmed RTW G failed to follow Client #19's Behavior Support Plan (BSP) on 10/15/19 when Client #19 eloped from the facility. She explained Client #19 was to be within two-arm's length of staff when awake and RTW G failed to sign Client #19 over to another staff when he stepped away to get his book.	W 249		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure staff engaged clients in activities to promote growth and independence. In addition, the facility failed to ensure staff interactions promoted dignity and respect. This affected 2 of 10 sample clients (Client #1 and Client #9) and 6 clients added to the sample (Client #12, Client #13, Client #14, Client #15, and Client #16. Findings follow: 1. Observations at House 133 on 2/17/20 revealed the following: a. From 4:00 p.m. - 6:10 p.m., Client #12 sat in his wheelchair in a whirlpool tub bathroom (room #57). The room exuded a foul odor and evidence of blood and body fluids existed on the sides of the tub. The hallway outside of the tub room also emitted a sour odor. Client #12 wheeled himself around the area until 6:05 p.m. when Resident	W 268		

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Treatment Worker (RTW) K assisted him to eat his evening meal.

b. At 5:10 p.m., Client #1 sat in an activity chair at the table while RTW L served her evening meal onto her plate. Client #1 picked up her spoon and ate the pureed food. At 5:30 p.m., RTW L served Client #1 fruit. RTW L failed to encourage Client #1 to assist with serving herself food.

2. Observations at House 133 on 2/18/20 revealed:
a. From 7:15 a.m. - 7:25 a.m., Client #13 sat in a chair with a cylindrical toy held up by her left ear and her right hand in her mouth. Treatment Program Manager (TPM) B brought a cloth and wiped her hand. She walked away and offered Client #13 no other activity.

b. From 7:25 a.m. - 8:25 a.m. Client #12 sat in his wheelchair in the whirlpool tub bathroom (Room #57). He propelled around the room, intermittently knocked on a wooden cabinet and smiled at the surveyor when she popped in to check on him. No staff interacted with him. At 8:15 a.m., the surveyor noticed an odor and as Client #12 turned his back to her, saw bowel movement (BM) coming out of his adult brief and resting on the seat of his wheelchair. At 8:25 a.m., RTW M came into the room, asked Client #12 if he was ready for breakfast and started to push him out of the room. The surveyor directed him to look at the seat of the wheelchair and RTW M pushed Client #12 into his bedroom.

c. From 7:30 a.m. Client #13 sat at a table in the dining room and TPM B prompted her to push a voice output switch. Client #13 complied and an automated voice requested a drink please. TPM

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B provided verbal praise, told Client #13 she would get her a drink and walked away. Client #13 hit the switch 20 more times and RTW M told her to "wait her turn" and moved the switch out of her reach. She sat at the table while staff assisted other clients to eat and take drinks. At 7:40 a.m., TPM B told Client #13 staff were preparing her food. Client #13 looked at a pitcher of water on the table and put a cylindrical toy in her mouth, then held it up to her ear. No staff provided Client #13 with a drink until a cup was placed near her plate and staff prompted her to push the switch at 8:04 a.m. Client #13 took the cup, took a drink and then pushed the switch.

3. Observation at House 472 on 2/18/20 at 12:15 p.m. revealed Client #14 came out of the bathroom with her pants down, exposing her buttocks. RTW T told Client #14 to go "finish your job." Client #14 went into the bathroom and came back to the hallway with her pants pulled up. RTW T told her to go sit on the couch and wait for her name to be called for supper.

4. Observation at House 472 on 2/19/20 at 5:25 p.m. revealed Client #9 pushed a cart of bowls filled with food to her table. RTW N served Client #9's food onto her plate without enlisting her help.

5. Observation at House 133 on 2/23/20 at 1:52 p.m. revealed Client #12 alone in the whirlpool tub bathroom until 2:10 p.m. when RTW O came in and played catch with him. Client #14 sat with a cylindrical toy in her ear until 2:05 p.m. when she slid out of her chair and onto the floor. Staff assisted her to stand, noticed a BM odor and walked her to the restroom.

6. Observation at House 472 on 2/23/20 at 5:25

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p.m. revealed Client #14 stood up from her seat in the living room and walked towards the dining room. RTW P stood up and told her to sit down and wait for her name to be called. RTW Ray offered no meaningful interaction or activity to engage Client #14.

7. Observations at House 133 on 2/24/20 at 9:50 a.m., RTW R wheeled Client #12 to the living room area. He hit himself in the chest and returned to the bathroom. Staff intermittently checked on him but offered no activity until 10:45 a.m. At 9:45 a.m., Client #14 sat with a cylindrical toy up by her ear. At 9:50 a.m., she put the toy in her mouth. Staff failed to offer clients meaningful activities/tasks.

8. Observations at House 472 on 2/24/20 at 11:10 a.m. revealed Client #14 walked in the common areas of her home with her buttocks exposed. TPM C prompted her to pull her pants up. Client #14 complied and sat down. At 11:15 a.m., Client #14 again walked with her pants falling down. No staff prompted or assisted her to change into better fitting pants.

9. Observation at House 133 on 2/27/20 at 8:25 a.m. revealed Resident Treatment Supervisor (RTS) B wiped the dining room table after breakfast while Client #1 and Client #14 sat with no activity.

10. Observation at House 472 on 3/2/20 at 1:45 p.m. revealed TPM C folded clothes in the living room while Client #15 sat in her wheelchair with her head down and eyes closed. Client #9 and Client #16 sat on the couch with no activity.

11. Observations at House 133 on 3/2/20 from

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W 268	Continued From page 16 2:50 p.m. - 3:05 p.m. revealed Client #12 sat in his wheelchair in the whirlpool tub bathroom. Evidence of dried bodily excretions existed on the tub. The Surveyor noticed a foul odor and when RTW S came into the area, asked her about the odor. RTW S said Client #12 emitted a bad odor due to a medication he TOOK. TPM B entered the room, noted he resisted oral hygiene and engaged in smearing saliva and nasal secretions on the tub. Staff failed to engage Client #12 in cleaning the tub or in any meaningful activity. When interviewed on 3/4/20 at 4:10 p.m., TPM C confirmed staff should engage clients in meaningful activities and activities of daily living to increase learning experiences and independence. 12. Observations on 2/20/20 at 6:15 p.m. revealed a facility nurse yelled down House 464 hallway and asked staff if Client #31 had a "poop" today. He stated he was going to give him a suppository. Record review on 3/4/20 revealed the facility Philosophy of Services policy. According to the policy, each individual would be treated with respect and dignity. In addition, "All activities must be an opportunity for learning; and any person interacting with another person must be empowered to provide that opportunity". When interviewed on 3/3/20 at 3:35 p.m. the Interim Superintendent confirmed the facility failed to promote growth and independence and failed to provide dignity and respect to clients.	W 268		
W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 289		

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W 289	Continued From page 17 CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure all restrictive measures were incorporated into a program designed to reduce the undesirable target behavior. This affected 1 of 1 sample client in House 470 (Client #8). Finding follows: Observation on 2/19/20 at 9:15 a.m. and 11:10 a.m. and on 2/23/20 at 12:50 p.m. revealed Client #8 had no clothing in her room other than 2-3 pairs of socks and underwear in her chest of drawers. Record review on 2/26/20 revealed Client #8's Behavior Support Plan (BSP) with a target behavior of aggression. The BSP made no reference to restricted access to personal clothing. The written informed consent form included a clothing restriction, with no explanation. "See separate consent letter" was written under the target behavior section of the consent for the clothing restriction. However, no other consent letter was located. Client #8's guardian had signed the written informed consent on 2/14/20. Additional record review revealed Client #8's Individual Implementation Program (IIP) to put	W 289		

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soiled clothing in the hamper/laundry bin and not in the garbage container. The IIP noted nothing of restricting Client #8's access to clothing. Client #8's Individual Support Plan (ISP) dated 10/23/19 noted she liked to change her clothes often throughout the day.

When interviewed on 2/25/20 at 8:45 a.m. Qualified Intellectual Disability Professional (QIDP) A said it was his understanding Client #8's clothes were restricted because she mixed her clean clothes in with her soiled laundry. QIDP A acknowledged the program to put dirty clothes in the laundry bin instead of the garbage container did not address the behavior of mixing clean clothes with dirty clothes. There was also no criteria to reduce the restriction so that Client #8 might regain access to some of her personal clothing.

When interviewed on 3/04/20 at 11:45 a.m. Client #8's guardian stated the staff restricted the client's access to her clothing because she liked to change her clothes multiple times per day and then would mix up the clean clothes with the dirty clothes. The guardian said Client #8 would then put the mixture of clothing in the laundry bin or in the garbage.

When interviewed on 3/05/20 at 8:20 a.m. regarding why Client #8 did not have access to her personal clothing items, the Psychology Assistant (PA) A said Client #8 would mix her clean clothes and dirty laundry together in her room. She noted Client #8 had a program to put her dirty clothes in the hamper instead of the garbage container, but agreed the program didn't address the issue of mixing the clean clothes with dirty laundry.

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W 339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure consistent implementation of nursing care as identified by client needs. This affected 1 of 1 client (Client #2) reviewed during investigation #89317-I. Finding follows: Record review on 2/18/20 revealed a "Type 1 Investigation Report," initiated 10/29/19 after staff noticed a bruised area and swelling on Client #2's inner right thigh. According to the investigation report, on 10/23/19 after Client #2 finished the supper meal she indicated she needed to use the bathroom. Residential Treatment Worker (RTW) B assisted Client #2 to stand. RTW B reported she had one hand holding Client #2's gaitbelt and the other holding Client #2's hand; Client #2 had one foot against the table leg and her other foot was against her chair. RTW B reported as she went to assist Client #2 to walk, the power went out, Client #2 leaned back, and RTW B eased Client #2 to the floor, landing on her buttocks. RTW B and RTW C reported Client #2 did not indicate she was in any pain and had no visible injuries when they assisted her off the floor and to the bathroom. Licensed Practical Nurse (LPN) A arrived to the house and assessed Client #2. LPN A reported Client #2 had no bruising or redness, was able to walk and put her legs out straight, and had no rotation in her hips. LPN A noted Client #2 did not appear to have an injury at the time of her assessment. Later on 10/23/19, RTW	W 339		

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W 339	Continued From page 20 D took over Client #2's supervision and completed a general trigger after Client #2's knees seemed to buckle while ambulating but reported Client #2 never indicated she was in pain and no bruising was present. According to the investigation report, nursing staff continued to assess Client #2's right leg; Physical Therapist (PT) A assessed Client #2 on 10/24/19 and noted her range of motion appeared normal, she did not favor either leg, was able to lean on each foot, and alternated what foot she led with. PT A noted Client #2 did not indicate any pain but noted she did not appear to have the endurance to walk more than 20 foot without her knees trembling and appearing fatigued. PT B completed an additional assessment on 10/25/19 and noted Client #2 did not exhibit any pain, nothing was abnormal when he completed range of motion on her knee and hip, and explained he did not observe any swelling in her knee. X-rays of the knee were taken on 10/27/19 and were negative for fracture or dislocation. On 10/28/19, additional X-rays of Client #2's right femur and hip were completed; the results were negative for fracture. On 10/29/19, Client #2 was sent to the Emergency Room for further evaluation and a CT Scan. The results of the CT Scan revealed Client #2 had a non-displaced right mid femoral diaphysis fracture. Additional record review revealed Client #2 was 58 years old and resided at the facility since 9/23/65. Client #2 had diagnoses including but not limited to profound intellectual disabilities, hypothyroidism, thyroid nodule, diabetes mellitus type II, major motor seizures, orthostatic hypotension, osteoporosis, cervical disk disease, and scoliosis. Client #2 had a Comprehensive Care Plan, implemented 1/22/16, due to being at	W 339		

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W 339	Continued From page 21 risk with osteoporosis and multiple fractures. The plan had a goal for Client #2 not to have any fractures secondary to her osteoporosis. The plan provided triggers, which included back discomfort, hip discomfort, loss of height, any falls, or notable fractures. The plan noted supports, which included but were not limited to reporting any of the triggers to nursing, the nurse was to report to the primary physician any abnormalities, and complete lab/diagnostics as ordered. Record review on 2/19/20 revealed "Glenwood Resource Center Clinical Notes" for Client #2. According to the Clinical Notes, on 10/24/19, Advanced Registered Nurse Practitioner (ARNP) A was notified of the incident on 10/23/19 and ordered rest, ice, elevation, and instructed nursing to continue to assess/monitor Client #2 and report if there was no improvement. On 10/25/19 at 3:47 p.m., Registered Nurse (RN) A documented she completed an assessment of Client #2; noting staff reported Client #2 was able to bear some weight while getting dressed but was unable to ambulate; there was edema to her right knee but no warmth or redness. RN A documented she updated ARNP A and received an order to apply ice to the right knee two times per day and to keep the right leg elevated, documenting she entered the order in the Avatar, part of the facility electronic record. RN A noted an x-ray of the right knee was also ordered. On 10/27/19 at 6:50 a.m., RN D noted, "Order for right knee x-ray placed through Mobilex website this A.M. Requisition and copy of physician's order (from 10/25/19) left on unit." On 10/27/19, Mobilex went to the facility and completed the X-ray of Client #2's knee, two days after ARNP A ordered the right knee X-ray was to be	W 339		

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completed.

Additional record review on 3/2/20 revealed "Client Profile - Order Details". The document revealed ARNP A ordered an X-ray of Client #2's right knee due to swelling on 10/25/19 at 2:25 p.m. The order was valid thru 10/27/19.

When interviewed on 2/24/20 at 1:00 p.m., RN B explained after nursing received a doctor order for an X-ray, if it is during the weekend, the nurses would call and set up Mobilex to come and complete the X-ray. She explained during the week, the Nursing Unit Coordinator (NUC) called and set up the X-ray.

When interviewed on 2/25/20 at 9:50 a.m., RN C explained when an order was entered for an X-ray it should have been noted in the client's record that the referral was made to Mobilex. She explained when an X-ray was ordered STAT, Mobilex responded within a four-hour period; she stated for any X-rays not STAT, Mobilex normally responded within an eight-hour period. RN C stated she did not know why the referral for the X-ray was not completed when the nurse entered the other orders on 10/25/19; she stated that was when the referral would have normally been completed.

When interviewed on 2/25/20 at 10:30 a.m., ARNP A reported on 10/24/19 she was informed Client #2 had been lowered to the ground on 10/23/19 and she was not ambulating per her norm. ARNP A said she was not told of any pain or swelling and was told Physical Therapy had assessed her and reported she was bearing weight on both hips; therefore, she instructed to continue to monitor and let her know if anything

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changed. ARNP A said on 10/25/19 she ordered an X-ray of Client #2 ' s right knee. She explained she did not order the X-ray STAT but said the X-ray should have been completed the same day, or the next day at the latest. ARNP A said the X-ray was completed on 10/27/19 and showed no fracture of the knee. She recalled it was later in the day on 10/25/19 when she ordered the X-ray but said they should have received the results by the end of the following day, at the latest. During a follow-up interview on 3/4/20 at 11:45 a.m., ARNP A said she always entered orders for X-rays with a two-day timeframe, unless it was a STAT order. She explained some clients would refuse initially and if the order was for just the day, another order would have to be entered the following day. She said she did not think Client #2 would refuse but stated again she always entered routine X-ray orders within a two-day timeframe. ARNP A stated her expectation was to have the X-ray completed on 10/25/19, when she entered the order, so if any concerns were identified it could be reported during the Physician Notification.

When interviewed on 2/26/20 at 1:45 p.m., RN A reported she assessed Client #2 and let ARNP A know her findings on 10/25/19. RN A said ARNP A ordered Client #2 was to keep her right leg elevated and was to apply ice to her right knee two times per day; RN A explained she put this order into Avatar. RN A said ARNP A ordered the X-ray. RN A explained the orders were printed to the Nursing Unit Coordinators (NUCs) office and then the NUC completed the referral to Mobilex for the X-ray. She explained the nurse entered everything into Avatar, then printed and took the orders to the house and placed the order in the MAR. She stated on the weekends nursing would

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contact Mobilex to set up an X-ray. RN A said again nurses could complete the referral to Mobilex but stated all orders for labs and referrals, like an X-ray, were printed to the NUC office and the NUC completed the rest, unless it was after hours or on the weekend.

When interviewed on 3/2/20 at 3:55 p.m., the Director of Quality Management (DQM) explained nursing staff were able to complete the referrals to Mobilex for X-rays. She stated the NUC assisted with completing the referrals during the week when she worked from 6 a.m. until 2:30 p.m. but said if it was close to 2:30 p.m., the nurses were responsible to complete the referral to Mobilex. The DQM stated there was no policy or procedure instructing who was responsible to ensure referrals were completed. The DQM confirmed the referral to Mobilex for Client #2's right knee X-ray was not made until two days after ARNP A had ordered it.

When interviewed on 3/4/20 at 11:10 a.m., the NUC reported normally during the week between 6:00 a.m. and 2:30 p.m. she completed the referrals for things such as X-rays. She explained the orders printed to her office so if she was there she would complete the referral. The NUC said the nurses would complete the referrals when she was gone from work. The NUC explained the nurse who took the order was to verify the referral was made by looking in the client's record. The NUC said on 10/25/19 RN A had been in contact with ARNP A and should have ensured the referral to Mobilex for the X-ray was completed. The NUC explained normally after an order was received, the referral was completed right away, even if there was a timeframe to have the x-ray completed within.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G003	A. BUILDING ______ B. WING ______	C 03/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD RESOURCE CENTER	**711 SOUTH VINE STREET GLENWOOD, IA 51534**

(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
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When interviewed on 3/4/20 at 3:30 p.m., the Interim Administrator of Nursing (IAON) explained the NUC would normally complete referrals during the week from 6 a.m. until 2:30 p.m. She stated the order for Client #2's X-ray was entered by ARNP A later in the day than normal on 10/25/19. The IAON stated the expectation was the nurse would follow-up to ensure the referral was made to Mobilex for the X-ray to be completed. She stated it was also the expectation to have the referral, even if not ordered STAT, made the same day it was ordered.

Additional record review on 3/4/20 revealed a Nursing Services Procedure, dated 11/26/18. The purpose of the procedure was to ensure prompt turnaround time of Routine and STAT x-ray orders. According to the document, the application was the RN/LPN, NUC, Nurse Clinician, Nurse Specialist. The procedure instructed after a verbal radiology order or an electronic notification from a GRC Provider was entered, the order was to be verified to ensure the order was routine or STAT. The order was to be called into Mobilex, noting the website could be used to place the order, and the time the order was placed with Mobilex was to be documented in the client record. For routine x-ray orders, five hours after the order was placed, Mobilex was to be called to obtain the status of the pending x-ray and then the provider was to be notified of the status of the pending x-ray and any new orders were to be obtained.

Glenwood Resource Center (GRC)
Standard Level Plan of Correction for DIA Investigation #97262-I, #96453-C, #97258-I, #97196-I, #97277-I, #96103-I, and #97633-I and Annual Survey 2021.

Tag-W158 Facility Staffing - CFR(s) 483.430: The facility must ensure that specific facility staffing requirements are met. (Cross reference W186 & W193)

DIA found the facility failed to comply with the Condition of Participation (COP): Facility Staffing. The facility failed to provide adequate training to ensure staff competently and consistently demonstrated skills and supervision supports to ensure client safety.

Individual Response:

Client # 5's Behavior Support Plan was reviewed and revised on 5/17/2021 to include the statement "For Client # 5, any and all threats to harm herself must be treated as a suicide threat."

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date completed: 5/17/2021

RTW C was retrained on Client #5's revised Behavior Support Plan (BSP) on 5/17/2021.
RTW N was retrained on Client #5's revised Behavior Support Plan (BSP) on 5/18/2021.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 5/18/2021

RTS C will be retrained that if they are working a home as a staff, they are not to leave the home if adequate staffing levels are not met.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date to be completed: 6/25/2021

RTW C will be retrained on the Suicide Watch policy.
RTW N will be retrained on the Suicide Watch policy.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

RTW D is no longer employee at GRC effective 5/12/2021.
RTW E is no longer employee at GRC effective 5/9/2021.
RTW G is no longer employee at GRC effective 4/5/2021.

RTW F was trained that PM breaks will be scheduled and that multiple people should never be on break at the same time on 5/11/2021.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 5/12/2021

Client # 31 no longer resides at GRC as of 6/2/2021.
RTW staff regularly assigned to House 248 will be retrained on the Accountability policy and Levels of Supervision policy.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

RTW A will be retrained on Client #10's Behavior Support Plan.
RTW B will be retrained on Client #10's Behavior Support Plan.
QIDP B will be retrained on Client #13's Behavior Support Plan.
Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Systemic Response:

Area 1 RTSs, House 473 QIDP, House 473 psychology assistant and RTW staff that regularly work with Client #5 were trained on Client #5's revised BSP.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 5/20/2021

Area 1 and Area 2 RTS's will be retrained that if they are working a home as a staff, they are not to leave the home if adequate staffing levels are not met.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date to be completed: 6/25/2021

House 465 RTW staff were trained that PM breaks will be scheduled and that multiple people should never be on break at the same time.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

GRC will retrain all staff who regularly take accountability for individuals on the Accountability and Level of Supervision policies.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Staff that regularly work in House 472 will be retrained on Client # 10's Behavior Support Plan (BSP).

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Staff that regularly work in House 250 will be retrained on Client # 13's Behavior Support Plan (BSP).

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

GRC will continue to provide adequate staffing levels to provide continuous active treatment consisting of needed interventions and services in sufficient number and frequency to support the achievement of objectives identified in the individual program plan. Any changes to adequate staffing levels will be approved by the Treatment Program Administrator.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services

Date to be completed: 7/24/2021, and ongoing

GRC will continue to monitor the implementation of programs through Program Implementation Monitors completed at each house on campus to ensure that each client receives aggressive and continuous training, treatments and supports in accordance with their needs and individual program plan.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021 and on-going
Tag – W159 QIDP – CFR(s): 483.430(a): Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.

DIA found the Qualified Intellectual Disability Professional failed to consistently monitor and provide oversight to client's behavior support programs.

Individual Response:

QIDP A will be retrained on Client #10's Behavior Support Plan.

QIDP A will be trained on the completion of Monthly QIDP Reviews which includes the review of all programs for each individual on their caseload by the 10th working day of the month.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Systemic Response:

QIDPs will be trained on the completion of Monthly QIDP Reviews which includes the review of all programs for each individual on their caseload by the 10th working day of the month.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Tag 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.

DIA found the facility failed to provide sufficient staff to manage and supervise clients as outlined by their individual program plans (IPPs).

Individual Response:

RTW D is no longer employee at GRC effective 5/12/2021.
RTW E is no longer employee at GRC effective 5/9/2021.
RTW G is no longer employee at GRC effective 4/5/2021.
RTW F was trained that PM breaks will be scheduled and that multiple people should never be on break at the same time on 5/11/2021.

Responsible: Assistant Superintendent of Treatment Program Services

Date completed: 5/11//2021

RTS C will be retrained that if they are working a home as a staff, they are not to leave the home if adequate staffing levels are not met.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 6/25/2021

Systemic Response:

House 465 RTW staff were trained that PM breaks will be scheduled and that multiple people should never be on break at the same time.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Area 1 and Area 2 RTS's will be retrained that if they are working a home as a staff, they are not to leave the home if adequate staffing levels are not met.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date to be completed: 6/25/2021

GRC will continue to provide adequate staffing levels to provide continuous active treatment consisting of needed interventions and services in sufficient number and frequency to support the achievement of objectives identified in the individual program plan. Any changes to adequate staffing levels will be approved by the Treatment Program Administrator.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021, and ongoing

Tag-W193 Staff Training Program - CFR(s): 483.430(e)(3): Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

DIA found the facility failed to provide necessary training to implement client behavior support programs (BSP).

Individual Response:

Client # 31 no longer resides at GRC as of 6/2/2021.

RTW staff regularly scheduled in House 248 will be retrained on the Accountability policy and Levels of Supervision policy.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Client # 5's Behavior Support Plan was reviewed and revised on 5/17/2021 to include the statement "For Client # 5, any and all threats to harm herself must be treated as a suicide threat."

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date completed: 5/17/2021

RTW C was retrained on Client #5's revised Behavior Support Plan (BSP) on 5/17/2021.
RTW N was retrained on Client #5's revised Behavior Support Plan (BSP) on 5/18/2021.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date completed: 5/18/2021

RTW C will be retrained on the Suicide Watch policy.
RTW N will be retrained on the Suicide Watch policy.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

RTW A will be retrained on Client #10's Behavior Support Plan.
RTW B will be retrained on Client #10's Behavior Support Plan.
QIDP B will be retrained on Client #13's Behavior Support Plan.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Systemic Response:

GRC will retrain all staff who regularly take accountability for individuals on the Accountability and Level of Supervision policies.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

All Area 1 RTSs, House 473 QIDP, House 473 psychology assistant and RTW staff that regularly work with Client #5 were trained on Client #5's revised BSP.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date completed: 5/20/2021

Staff that regularly work in House 472 will be retrained on Client # 10's Behavior Support Plan (BSP).

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Staff that regularly work in House 250 will be retrained on Client # 13's Behavior Support Plan (BSP).

Responsible: Assistant Superintendent of Treatment Program Services

Date to be completed: 7/24/2021

GRC will continue to monitor the implementation of programs through Program Implementation Monitors completed at each house on campus to ensure that each client receives aggressive and continuous training, treatments and supports in accordance with their needs and individual program plan.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021 and on-going

Tag W-194 Staff Training Program – CRF(s) 483-430(e)(4): Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

DIA found the facility failed to provide training necessary to implement Individual Program Plans (IPPs).

Individual Response:

RTW R was given appropriate Management Action on 5/10/2021.
RTW R will not have accountability for anyone that requires a gait belt until retraining is completed upon return to work.
RTW R will be retrained on Client # 1's PNMP upon return to work.
RTW R was retrained that Client #1 is to wear a gait belt or lift vest at all times during transfers 5/10/21.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 5/10/2021 and upon RTW R's return to work

Systemic Response:

Staff that regularly work with Client # 1 were retrained that Client # 1 is to wear a gait belt or lift vest at all times during transfers.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

GRC will continue to monitor the implementation of programs through Program Implementation Monitors completed at each house on campus to ensure that each client receives aggressive and continuous training, treatments and supports in accordance with their needs and individual program plan.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021 and ongoing

Tag – W234 Individual Program Plan - CFR(s): 483.440(c)(5)(i): Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.

DIA found the facility failed to ensure client Behavior Support Plans (BSP) included clear directions on strategies to be implemented.

Individual Response:

Client #5's Behavior Support Plan was reviewed and revised to include the statement "For Client #5, any and all threats to harm herself must be treated as a suicide threat."

Responsible: Superintendent
Date to be completed: 7/24/2021

RTW C was retrained on Client #5's revised Behavior Support Plan (BSP) on 5/17/2021.
RTW N was retrained on Client #5's revised Behavior Support Plan (BSP) on 5/18/2021.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Systemic Response:

All Area 1 RTSs, House 473 QIDP, House 473 psychology assistant and RTW staff that regularly work with Client #5 were trained on Client #5's revised BSP.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date completed: 5/20/2021

Tag – W249 – Program Implementation – CFR(s): 483-40(d)(1): As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

DIA found the facility failed to ensure clients received needed supports and services as established by the interdisciplinary team and outlined in the Individual Support Plan (ISP).

Individual Response:

QIDP A will be retrained on Client #1's Physical Nutritional Management Plan (PNMP).

RTW H will be retrained on Client #1's Physical Nutritional Management Plan (PNMP).

RTW J will be retrained on Client #2's PERS 2.1.6 Individual Implementation Plan (IIP).

RTW K will be retrained on Client #2's PERS 2.1.6 Individual Implementation Plan (IIP).

RTW N (should be RTW O?) will be retrained on Client #4's Physical Nutritional Management Plan (PNMP).

RTW I will be retrained on Client #7's Physical Nutritional Management Plan (PNMP).

RTW L will be retrained on Client # 29’s Physical Nutritional Management Plan (PNMP).

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Systemic Response:

GRC will continue to provide each client with a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of objectives identified in the individual program plan. GRC will seek opportunities to improve services provided to clients served and modify plans based on identified improvement areas.

GRC will continue to monitor the implementation of programs through Program Implementation Monitors completed at each house on campus to ensure that each client receives aggressive and continuous training, treatments and supports in accordance with their needs and individual program plan.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021 and on-going

Tag-W268 Conduct Toward Client – CFR(s) - 483.450(a)(1)(i): These policies and procedures must promote the growth, development and independence of the client.

DIA found the facility failed to ensure staff engaged clients in activities to promote growth and independence.

Individual Response:

RTS B will be retrained on the Philosophy of Service policy and Individual Support Plan policy.
RTW L will be retrained on the Philosophy of Service policy and Individual Support Plan policy.
RTW P will be retrained on the Philosophy of Service policy and Individual Support Plan policy.
RTS D will be retrained on the Philosophy of Service policy and Individual Support Plan policy.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Systemic Response:

Staff that regularly work in Houses 241, 250, 465, and 472 will be retrained on the Philosophy of Service policy and Individual Support Plan policy.

Responsible: Assistant Superintendent of Treatment Program Services
Date to be completed: 7/24/2021

Tag-W369 Drug Administration – CFR(s) – 483.460(k)(2): The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

DIA found the facility failed to ensure medications were administered according to Physician's Orders.

Individual Response:

CMA A will be retrained on the requirement that medications need to be administered according to a Physician's order.

CMA B will be retrained on the requirement that medications need to be administered according to a Physician's order.

Responsible: Administrator of Nursing
Date to be completed: 7/24/2021

Systemic Response:

GRC will continue to provide annual medication aide update training to all CMAs. Each CMA is monitored quarterly by nursing staff using the Medication Administration Observation Form.

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

Responsible: Administrator of Nursing/Superintendent
Date to be completed: 7/24/2021

Tag-W371 Drug Administration - CFR(s): 483.460(l)(4): The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

DIA found the facility failed to ensure client participation in the drug administration process.

Individual Response:

CMA C will be retrained on providing active treatment during the medication pass process.
CMA E will be retrained on providing active treatment during the medication pass process.
CMA F will be retrained on providing active treatment during the medication pass process.
CMA B will be retrained on providing active treatment during the medication pass process.
CMA D will be retrained on providing active treatment during the medication pass process.

Responsible: Administrator of Nursing
Date to be completed: 7/24/2021

Systemic Response:

Active CMA's will be retrained on providing active treatment during the medication pass process.

Nursing has posted the Self-Administration of Medication Screening (SAMS) form in medication rooms across campus.

Responsible: Administrator of Nursing
Date to be completed: 7/24/2021

Tag-W382 Drug Administration – CFR(s): 483.460(l)(2): The facility must keep all drugs and biologicals locked except when being prepared for administration.

DIA found the facility failed to secure medications until administered.

Individual Response:

CMA F (listed as CMA B) will be retrained on the Medication Variance and Remediation policy.

Responsible: Administrator of Nursing
Date to be completed: 7/24/2021

Systemic Response:

Active CMA's will be retrained on Medication Variance and Remediation policy.

Responsible: Administrator of Nursing
Date to be completed: 7/24/2021

Tag-W445 Evacuation Drills – CFR(s) 483-470(i)(2)(i): The facility must actually evacuate clients during at least one drill each year on each shift.

DIA found the facility failed to ensure clients were evacuated at least once on first and/or second shift each year.

Individual Response:

Assistant Superintendent of Treatment Support Services was retrained that evacuation drills are to be held quarterly for each shift under varied conditions with one full evacuation per shift per year.

Responsible: Superintendent
Date to be completed: 7/24/2021

Systemic Response:

Assistant Superintendent of Treatment Support Services developed a tracker to ensure timely and accurate fire drill information. Individuals inputting data were trained in the usage of the document and expectations for data entry.

A full evacuation drill will be completed at least once every twelve months on each shift. An employee within the GRC Business Office will audit/monitor Environmental Services department's fire drill log and submit to Assistant Superintendent.

Responsible: Superintendent
Date to be completed: 7/24/2021 and ongoing