STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000	POC 5/1/21	

At the time of the annual health survey standard-level deficiencies were cited at W159, W352, and 386.

A Focused Infection Control Monitoring Visit was also completed at this time. No deficiencies were cited as a result.

The following investigations were also completed at this time: 94848-I, 92538-I, and 91450-I.

The investigation of 94848- I resulted in a determination of Immediate Jeopardy (IJ). The facility was notified 3/16/21 at approximately 9:30 a.m. The facility implemented a plan, which included discontinuing use of the ultraviolet (UV) lights. The IJ was removed 3/18/21 at approximately 11:30 a.m. A condition-level deficiency was cited at W158 and a standard-level deficiency was cited at W189.

The investigation of 92538-I resulted in a determination of IJ. The facility was notified of the IJ 3/16/21 at approximately 9:30 a.m. The facility implemented a plan, which included revisions to the individual's individual program plan and retraining of staff. The IJ was removed 3/18/21 at approximately 11:30 a.m. A condition-level deficiency was cited at W158 and standard-level deficiencies were cited at W159 and W191

The investigation of 91450-I resulted in standard-level deficiencies cited at W234 and W249.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to maintain minimal compliance with the Condition of Participation - Facility Staffing. The facility failed to ensure staff were adequately trained to demonstrate the appropriately skills to ensure the health and safety of individuals. Cross-reference W159: Based on interview and record review, the Qualified Intellectual Disability Professional (QIDP) failed to effectively integrate, monitor, and coordinate services in order to meet client needs. Cross-reference W189: Based on interviews and record reviews, the facility failed to consistently ensure staff was adequately trained to effectively and competently perform job duties The investigation of 94848- I resulted in a determination of Immediate Jeopardy (IJ). The facility was notified 3/16/21 at approximately 9:30 a.m. The facility implemented a plan, which included discontinuing use of the ultraviolet (UV) lights. The IJ was removed 3/18/21 at approximately 11:30 a.m. Cross-reference W191: Based on observations, interviews and record reviews, the facility failed to consistently ensure staff were trained to meet the behavioral needs of each client.	W 158	Post citation outdoor supervision has been clearly defined on the individual's behavior modification goal with documented re-training of staff completed by 3/19/2021. Systemically, QIDP's will be trained regarding: a. Including the precise definition of supervision outdoors, on any goal addressing elopement. b. Any changes to existing behavior modification goals will require input from, and training of the IDT. Training of the QIDP's will take place no later than 5/1/2021. QIDP is responsible for ongoing monitoring of behavior modification goals through monthly evaluation. Human Rights Committee is responsible for ongoing monitoring of restrictions, for each individual on a quarterly basis.	5/1/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 158	Continued From page 2 The investigation of 92538-I resulted in a determination of IJ. The facility was notified of the IJ 3/16/21 at approximately 9:30 a.m. The facility implemented a plan, which included revisions to the individual's individual program plan and retraining of staff. The IJ was removed 3/18/21 at approximately 11:30 a.m.	W 158		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on interview and record review, the Qualified Intellectual Disability Professional (QIDP) failed to effectively integrate, monitor, and coordinate services in order to meet client needs. This affected 2 of 7 sample clients (Client #5 and #7) and 1 client added to the sample as a result of facility self reported incident #92538-I (Client #19). Findings follow: 1. Review of a facility Injury Incident Report (IIR) dated 7/8/20 revealed Client #19 eloped from the facility around 1:40 p.m. without staff knowledge. The IIR indicated the client received a nursing evaluation at 2:15 p.m. with normal vitals and no injuries within a couple minutes after being found. Review of a Missing Person Report dated 7/8/20 at 2:03 p.m. confirmed the client left campus unsupervised wearing a red t-shirt (interviews revealed he also wore blue jeans and shoes). The state climatologist indicated the weather at the time in Sheldon, Iowa was 90 degrees with wind out of the south at 23 mph and no clouds.	W 159	Post citation outdoor supervision has been clearly defined on the individual's behavior modification goal with documented re-training of staff completed by 3/19/2021. Systemically, QIDP's will be trained regarding: a. Including the precise definition of supervision outdoors, on any goal addressing elopement. b. Any changes to existing behavior modification goals will require input from, and training of the IDT. Training of the QIDP's will take place no later than 5/1/2021. QIDP is responsible for ongoing monitoring of behavior modification goals through monthly evaluation. Human Rights Committee is responsible for ongoing monitoring of restrictions, for each individual on a quarterly basis.	5/1/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 3 Review of a facility investigation document provided a timeline of events using witness testimony and phone logs. The summary revealed the Residential Leader (RL) saw Client #19 seated on a swing chair in front of House 354 shortly after 1:40 p.m. When she checked again a few minutes later he was gone. At 2:03 p.m. staff from another home found the client a 1/2 mile northwest of the facility on a walking trail and returned him to campus. The investigation also indicated the client last eloped from the facility five years ago but continued to have a program addressing leaving assigned areas. The goal focused on teaching the client to notify staff prior to leaving the residence by pushing a button. The client was also provided a CareTrac tracking device in his shoe to help locate him in the event of elopement. Review of a Program Procedure for Client #19 dated 5/20/20 revealed a goal for the client to "Refrain from leaving designated areas." The program indicated the desired behavior for the client was to learn to ring a doorbell installed inside the house to let staff know he wanted to go outside. The program tracked the number of times the client left an assigned area with or without staff supervision. In the first month of the program staff documented two incidents of leaving the area with supervision. The program failed to provide any information regarding the client's supervision level. Review of the Individual Comprehensive Plan (ICP) in place at the time of the elopement (10/19) and the new ICP (10/20) after the elopement found one brief sentence regarding supervision. The statement in both ICPs read	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 4	W 159		

"Client #19 tends to wander and needs supervision. Client #19 has a tracking device called a CareTrak, which allows staff to track him if he should wander away from his home."

Review of Client #19's current physician order dated 12/31/20 revealed the client diagnosed with but not limited to intellectual disability, seizure disorder, pervasive developmental disorder, depression, schizophrenia, insomnia, autism and, dementia.

Review of Client #19's Comprehensive Functional Assessment dated 9/2019 (for the time of the incident) revealed he would not inform staff when leaving the home and did not understand street safety which involved traffic or traffic lights. Review of Client #19's Risk Assessment dated 10/2019 and in place for the 7/8/20 incident revealed many situations which presented a risk for the client. Some of the risks listed among many others were busy streets, intersections, sidewalks, uneven terrain, walkways, eating inedible foods, and being alone in any environment presented risk for the client.

Observations on 3/2/21 and review of a map of the area in Sheldon, Iowa revealed Client #19 crossed at least one street alone during the elopement on 7/8/20. Based on where Client #19 was discovered he crossed Monroe Avenue which was a 25 mph zone. Client #19 may have also walked down Pine Street and Rainbow Drive. Both streets are 25 mph zones and do have sidewalks the client may have used.

Interviews were conducted on 3/2/21 and 3/3/21 with 7 of 8 staff who worked in the home on 7/8/20 (Residential Skills Trainer (RST) D, RST I,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 5	W 159		

RST J, the former Residential Leader (RL), Life Skills Teacher (LST), Coordinator of Therapy Services and Exercise and Sports Development Staff). Of the 7 staff interviewed who worked on 7/8/20, 4 of the 7 indicated Client #19 needed staff with him to be outside the home. 3 of the 7 staff indicated the client could be outside alone if watched out the window or indicated they did not know his supervision level for being outside.

When interviewed on 3/3/21 at 12:00 p.m. Residential Advocate (RA) confirmed she worked in the home for over two years. When asked if Client #19 were allowed to be outside alone while staff watched from the window she indicated that wasn't encouraged, but allowed. She stated they encouraged staff to go outside with him, but sometimes it worked better to watch him out the window.

When interviewed on 3/3/21 at 11:40 a.m. the current Residential Leader (RL) A confirmed she did not work at the facility at the time of Client #19's elopement. When asked, RL A stated she did not know for sure whether Client #19 could be alone outside without staff present. She also did not know whether staff could watch him from inside the house through a window. She indicated she started employment about a month prior to the interview. She also confirmed being the Residential Leader was in a supervisory role in the home.

When interviewed on 3/3/21 at 11:43 a.m. the Qualified Intellectual Disabilities Professional (QIDP) A confirmed she remembered the incident from 7/8/20. She stated prior to the elopement on 7/8/20 staff was allowed to watch Client #19 when he was outside from a window inside the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 6 house. She indicated after the incident staff was no longer allowed to watch from inside and must be outside with him. When asked where the change was documented, she indicated it was changed in the "leaving the area" program. After she looked at the program she confirmed she failed to document the change after the elopement. When interviewed together on 3/3/21 at 12:15 p.m. the Director of Health Services (DOHS) and QIDP A indicated they were concerned half the direct care staff and supervisory staff did not know Client #19's supervision level. Both agreed all staff needed to know each client's supervision level to ensure safety. The DOHS indicated one small sentence in the ICP regarding supervision was not enough clear direction for staff, especially for a client who needed a tracking device in his shoe due to potential elopement. Both agreed the information needed to be spelled out specifically in programming and trained to all relevant staff. The investigation of 92538-I resulted in a determination of IJ. The facility was notified of the IJ 3/16/21 at apporoximately 9:30 a.m. The facility implemented a plan, which included revisions to the individual's individual program plan and retraining of staff. The IJ was removed 3/18/21 at approximately 11:30 a.m. 2. Observations at 8 a.m. on 3/2/21 revealed Client #7 sitting at a dining table during the morning meal. Client #7 sat at the table feeding himself while in his wheelchair. Client #7's glasses were off his face and not covering his eyes. Client #7's adaptive equipment included a	W 159	QIDP's will be trained regarding implementation of, and consistent use of mechanical supports as per documented recommendations. Training will be completed by May 1, 2021	5/1/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 7 deep-dish plate, heavy-handled silverware, straw and dycem mat to aide in independence. He leaned heavily to his right side and Client #7's head turned to the right and down. Client #7 had difficulty in keeping the food in his mouth when he would take a bite. Observations at 11:55 a.m. on 3/2/21 revealed Client #7 eating lunch. Residential Skills Trainer A (RST A) assisted with the meal and attempted to apply a hard plastic neck collar. She stated they used the soft collar in the morning however it did not support the head. She placed the correct neck collar on Client #7 and stated the Occupational Therapist took the soft collar used previously that morning. Record review revealed the following: a. Client #7's Occupational Therapy (OT) Brace Protocol, dated 2/16/21, documented: "Rationale: Client #7 has been having a difficult time holding head up at meals causing food to fall out of mouth. The brace should help support Client #7's head neck to in a more upright position allowing ease with eating. Wear Schedule: Client #7 is to wear neck brace during meal times. He may wear brace throughout the day outside of meal times as desired. Please clean brace with soap and water or disinfectant wipe after each meal." b. Client #7's Individual Support Plan (ISP), dated 2/4/21, included Nutritional Services: Client #7 eats independently, but with supervision at meals. Client #7 is able to adequately chew and swallow his foods. He does sometimes take large bites of foods and his staff prompts him to take smaller bites. In order to help Client #7 sit up straight at meals, he wears a neck collar to keep him from	W 159	Coordinator of Therapeutic Services or designee will survey appropriate use of therapeutic devices on a rotational monthly basis, ensuring each ICF/ID home's use of those devices is surveyed at least twice per year. This will be in addition to the review of mechanical supports completed annually at the time of the ICP. This will be initiated no later than May 1, 2021.	5/1/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 8	W 159		

leaning over to the right. Client #7's meal intake is usually 100%. The ISP included a list of Mechanical Supports/Assistive Devices, which included a Neck Collar to assist with head/neck positioning while eating due to poor posture.

When interviewed on 3/2/21 at 1:12 p.m. the Qualified Intellectual Disability Professional (QIDP) stated Client #7 had broken his lateral support bracket on his wheelchair. It is unclear when this happened but most likely in the last couple of days. This allowed Client #7 to lean heavily to the right side without support. The QIDP stated this causes his head to tilt even more to the right. She said the OT has recently been to the facility and had given the facility a OT protocol for the neck brace. She said staff should follow the recommendations of the OT at all times.

When interviewed on 3/2/21 at 4:30 p.m. the Occupational Therapist stated she completed a Brace Protocol for Client #7. She said he should wear the hard plastic brace as it provided support and kept the head upright. She further stated staff should follow the protocol at all meal times.

When interviewed on 3/2/21 at 12:05 p.m. RST A stated they had multiple neck collars and just started to use the hard plastic collar. She confirmed they used the soft collar earlier in the day for breakfast. She also said it did not support the head as well. RST A also confirmed the lateral guard on the wheelchair had broken.

When interviewed on 3/3/21 at 2:00 p.m. the ICF/ID Director confirmed the facility failed to follow the recommendation of the Occupational Therapist dated 2/16/21. The facility also failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 9 follow the Individual Support Plan. 3. Record review at revealed Client #5's dental exam dated 7/29/19 indicated Client #5 had general anesthesia for a dental cleaning and a cavity filled. A dental desensitization program could not be located. When interviewed on 3/3/21 at 2:20 p.m. the Residential Advocate (RA) A confirmed the facility failed to ensure Client #5 had a desensitization program.	W 159	Dental desensitization goal has been implemented, no additional occurrences have been identified. QIDP and nursing teams will be trained regarding necessity of dental desensitization goals on anyone utilizing sedation dentistry by May 1, 2021. QIDP is responsible for ongoing monitoring of behavior modification goals through monthly evaluation. Human Rights Committee is responsible for ongoing monitoring of restrictions, for each individual on a quarterly basis.	5/1/2021
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to consistently ensure staff was adequately trained to effectively and competently perform job duties. This affected 1 of 1 client involved in incident 94848-I (Client #18). Findings follow: Review of a facility Injury Incident Report (IIR) dated 11/20/20 revealed a UV light designed to kill bacteria was discovered in Client #18's bedroom about 1:00 a.m. by Residential Skills Trainer (RST) C. The document indicated RST C entered Client #18 room at 1:00 a.m. after he saw	W--189	UV Lights were removed from all ICF/ID homes, use discontinued 3/17/2021. Documentation of training on use of potentially harmful equipment will be completed prior to use, with introduction of any new equipment.	3/17/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 10	W 189		

a light on in the room. He noted the client appeared asleep, so he turned off the light and removed it from the power source. The IIR also indicated the client received a nursing assessment which revealed "bilateral red eyelids, increased watery eyes, would not open eyes at this time to assess sclera. No other areas noted of redness. Slight swelling noted to the upper eyelids, skin intact". Nursing provided the client with a cold washcloth, sunglasses and, Visine drops.

Review of a Physician's Order dated 12/31/20 revealed Client #18 was 48 years old. The client was diagnosed with severe intellectual disability, history of seizures, adjustment disorder, psychosis, asthma, and bilateral keratoconus (eyes). The document further indicated the client needed training in areas such as getting dressed, shaving, shutting the door while changing clothes, and making his bed.

Review of the facility investigation completed shortly after the incident revealed the UV light was placed in Client #18's room on 11/19/20 during the day shift. The investigation further revealed the light was not removed from the room until 1:00 a.m. on 11/20/20 and Client #18 turned the light during the night. The investigation revealed the purpose of the UV light was to reduce the spread of infection by killing bacteria and was only to be used in empty rooms due to the harmful effects of the lights. The investigation noted the light appeared to be functioning and can be set to run for 15, 30, or 60 minutes. If the light were just turned on and no additional buttons were hit the light would run for 15 minutes and shut itself off. If another button was hit the light could be extended to 30 or 60 minutes and would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 11 shut itself off when the cycle completed. Review of a facility document for Ultra-Violet Disinfection Lamp Use revealed in capitalized letters "NO ONE CAN BE IN THE ROOM WHEN THE LIGHT IS BEING USED-DO NOT USE IN OPEN ROOMS WHERE DOORS CANNOT BE CLOSED OFF. UV LIGHT IS HARMFUL TO EYES AND SKIN." The document indicated when staff used the machine it needed to be placed in the center of the room about 3 to 4 feet off the ground and run for 30 minutes. The document further described cleaning of the device upon completion but failed to instruct staff to remove it from the room and where to put it. After the incident on 11/20/20, the procedure was revised and included staff needed to remove the machine from rooms after use and return it to storage immediately. Review of a physician order from 11/20/20 revealed Client #18 was exposed to UV light during the overnight hours on 11/19/20. The physician ordered the client receive Visine drops in both eyes 6 to 8 times a day through the weekend and he needed to be seen on 11/23/20 if symptoms were not improved. Review of Nurses notes dated 11/22/20 and 11/23/20 revealed the symptoms resolved and no further medical attention was necessary. Review of the manufacturer's directions for the UV Light machine revealed warnings. The document indicated people should not look directly into the light and the device should be used in the absence of people, animals, and plants due to potential for rash, conjunctival irritation, fatigue etc. The warnings further indicated long-term exposure to UV light has the	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 12	W 189		

potential hazard of skin and eye burning and long-term inhalation of ozone can damage the respiratory tract.

When interviewed on 3/2/21 at 2:10 p.m. RST D confirmed she worked on day shift 11/19/20. RST D believed she put the light in Client #18's room and ran it for 30 minutes as they were trained to do sometime before noon. After the light ran for 30 minutes she asked RST E to put the light away and remembered RST D stated she would. She found out the next day the light never got put away as it should have. RST D stated the light was placed on a footstool at the end of Client #18's bed which was about 3 feet straight inside the doorway. She was not sure why no other staff saw it until 1:00 a.m. the next morning as somebody should have noticed it when they helped the client in his room. She indicated Client #18 couldn't talk for a conversation but was capable of turning lights on and off.

When interviewed on 3/2/21 at 4:00 p.m. RST E indicated she could not remember whether she or RST D put the light in Client #18's room on 11/19/20, but remembered it being placed in the room. She did not remember being asked by RST D to put the light away after it ran its cycle. She indicated she knew it should be put away and was not sure why they didn't do it. She mentioned it may have been a busy day and got overlooked.

When interviewed on 3/3/21 at 12:40 a.m. RST F confirmed he found the light on in Client #18's room at 1:00 a.m. on 11/20/20. He mentioned when he walked by the room he saw light inside so he looked in and saw the blue light on. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 13 stated the client appeared asleep, so he turned off the light, unplugged it, and removed it to the supervisor's office. When interviewed separately on 3/3/21 between 4:45 p.m. and 5:00 p.m. RST F, RST G and RST H all confirmed they were familiar with Client #18's evening routine. All 3 staff indicted they needed to go into Client #18's bedroom at least once if not more often each evening on the afternoon/p.m. shift (approximately 2:00 p.m. to 10:30 p.m.). They noted at a minimum staff would make sure the client dressed appropriately and got into bed okay usually between 8:00 p.m. and 8:30 p.m. Staff also confirmed they usually checked on him at least once after he went to bed at approximately 8:30 p.m. and before their shift ended at approximately 10:30 p.m. They indicated this needed to be done every evening therefore a UV light 3 or 4 feet inside the door would likely be noticed. When interviewed on 3/2/21 and 3/3/21 the Director of Health Services (DOHS) confirmed the client suffered some injuries as a result of the UV light left in his room on 11/19/20. She indicated the swollen eyelids, watery eyes, and light sensitivity resolved within a couple of days. She reported they put the UV lights into use on 9/14/20 with the procedure for use. She stated staff was trained in how to use the lights and on the procedure, but they did not have documentation of the initial training. She also confirmed the policy was amended the day after the incident which directed staff to put the UV light away in the supervisor office immediately after use. The DOHS also confirmed she was aware the UV light could be potentially dangerous to humans. The DOHS believed staff knew to put	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 14 the light away immediately after use after the first training and felt they just miscommunicated in this particular case. The investigation of 94848- I resulted in a determination of Immediate Jeopardy (IJ). The facility was notified 3/16/21 at approximately 9:30 a.m. The facility implemented a plan, which included discontinuing use of the ultraviolet (UV) lights. The IJ was removed 3/18/21 at appromimately 11:30 a.m. A condition-level deficiency was cited at W158 and a standard-level deficiency was cited at W189.	W 189		
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to consistently ensure staff were trained to meet the behavioral needs of each client. This affected 1 of 1 clients involved in 92538-I (Client #19). Findings follow: Review of a facility Injury Incident Report (IIR) dated 7/8/20 revealed Client #19 eloped from the facility around 1:40 p.m. without staff knowledge. The IIR indicated the client received a nursing evaluation at 2:15 p.m. with normal vitals and no injuries. Review of a Missing Person Report dated 7/8/20 at 2:03 p.m. confirmed the client left campus unsupervised wearing a red tee-shirt (interviews	W 191	Post citation, outdoor supervision was clearly defined on the individual's behavior modification goal with documented re-training of staff completed by 3/19/2021. Systemically, QIDP's will be trained regarding: a. Including the precise definition of supervision outdoors, on any goal addressing elopement. b. Any changes to existing behavior modification goals will require input from, and training of the IDT. Training of the QIDP's will take place no later than 5/1/2021. QIDP is responsible for ongoing monitoring of behavior modification goals through monthly evaluation. Human Rights Committee is responsible for ongoing monitoring of restrictions, for each individual on a quarterly basis.	5/1/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 191	Continued From page 15 revealed he also wore blue jeans and shoes). The state climatologist reported the weather at the time in Sheldon, Iowa was 90 degrees with wind out of the south at 23 mph and no clouds. Review of a facility investigation document provided a timeline of events using witness testimony and phone logs. The summary revealed the Residential Leader (RL) saw Client #19 seated on a swing chair in front of House 354 shortly after 1:40 p.m. When she checked again a few minutes later he was gone. At 2:03 p.m. staff from another home found the client a 1/2 mile northwest of the facility and returned him to campus. The investigation also indicated the client last eloped from the facility 5 years ago but continued to have a program addressing leaving assigned areas. The goal focused on teaching the client to notify staff prior to leaving the residence by pushing a button. The client was also provided a CareTrac tracking device in his shoe to help locate him in the event of elopement. Review of a Program Procedure for Client #19 dated 5/20/20 revealed a goal for the client to "Refrain from leaving designated areas". The program indicated the desired behavior for the client was to learn to ring a doorbell installed inside the house to let staff know he wanted to go outside. The program tracked the number of times the client left an assigned area with or without staff supervision. In the first month of the program staff documented 2 incidents of leaving the area with supervision. The program failed to provide any information regarding the client's supervision level. Review of the Individual Comprehensive Plan (ICP) in place at the time of the elopement	W 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 191	Continued From page 16	W 191		

(10/19) and the new ICP (10/20) after the elopement found one brief sentence regarding supervision on page 4. The statement in both ICP"s read "Client #19 tends to wander and needs supervision. Client #19 has a tracking device called a CareTrak, which allows staff to track him if he should wander away from his home".

Review of Client #19's current physician order dated 12/31/20 revealed the client diagnosed with but not limited to intellectual disability, seizure disorder, pervasive developmental disorder, depression, schizophrenia, insomnia, autism and, dementia.

Review of Client #19's Comprehensive Functional Assessment dated 9/2019 (for the time of the incident) revealed he would not inform staff when leaving the home and did not understand street safety which involved traffic or traffic lights. Review of Client #19's Risk Assessment dated 10/2019 and in place for the 7/8/20 incident revealed many situations which presented a risk for the client. Some of the risks listed among many others were busy streets, intersections, sidewalks, uneven terrain, walkways, eating inedible foods, and being alone in any environment presented risk for the client.

Observations on 3/2/21 and a review of a map of the area in Sheldon, Iowa revealed Client #19 crossed at least one street alone during the elopement on 7/8/20. Based on where Client #19 was discovered he crossed Monroe Avenue which is a 25 mph zone. Client #19 may have also walked down Pine Street and Rainbow Drive. Both streets are 25 mph zones and do have sidewalks the client may have used.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 191	Continued From page 17 When interviewed on 3/2/21 at 2:20 p.m. Residential Skills Trainer (RST) D revealed she worked the day of the elopement as well as 7 other staff in House 354. She indicated she was 1 of 3 RST's assigned to House 354 on 7/8/20 as well as 4 staff from "The Center" assigned full-time to the home Monday to Friday since March 2020 due to Covid-19. She also indicated the Residential Leader (House Supervisor) was present at the time of the incident. RST D remembered at the time of the elopement (between 1:30 p.m. and 2:00 p.m., she estimated) all the clients (8) were in the backyard doing a water (slip and slide) activity with all the staff except the Residential Leader (no longer employed) who cleaned the kitchen inside the home. She could not remember which staff told the Residential Leader (RL) when Client #19 left the activity and entered the house, but she was sure someone told her. A while later the RL walked out to the backyard activity and asked if anyone knew where Client #19 was and noted she last saw him in the front yard seated in a chair. RST D indicated they searched the house and quickly made relevant notifications the client was missing. She indicated she was aware Client #19 had a tracking device and could not be outside alone unsupervised due to a history of elopement. When interviewed on 3/3/21 at 10:40 a.m. RST I told almost the same story as RST D except she indicated RST J (brand new employee) was also inside with the RL. She remembered Client #19 went inside during the slip and slide activity because he does not like water. She, like RST D, could not remember who told the RL Client #19 went inside, but knew someone told her. She	W 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 191	Continued From page 18	W 191		

remembered the RL coming outside asking if anyone knew where Client #19 was as he was no longer in the front yard on the swing chair. When asked about Client #19's supervision level, RST I indicated the client could be alone outside on the swing without staff with him. She indicated she often just watched him from inside the house outside a window. She revealed she and others often did this as he liked to be outside in nice weather. She indicated a couple of times he wandered from the swing while she was inside, but she went right out walked with him. She noted you can watch him from inside the house, but you can't take your eyes off of him or he might leave.

When interviewed on 3/3/21 at 11:10 a.m. RST J confirmed she was the third RST on duty that day. She also revealed she had only been employed about a week or two at the time of the incident. She confirmed she was inside the house at the time of the elopement documenting on the computer. The RST stated she was unaware Client #19 came in the house and knew nothing about the incident until someone came and told her the client was missing. She indicated the client should never be left alone outside and staff were not allowed to watch him from the window as far as she knew.

When interviewed on 3/2/21 at 5:00 p.m. the former RL (no longer employed) remembered she worked the day of Client #19's elopement. The RL apologized and stated she couldn't remember much from the incident except he was missing and they found him. She remembered seeing Client #19 outside in the front chair swing but does not remember if anyone ever asked her to supervise him. She thought maybe he left the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 191	Continued From page 19	W 191		

backyard activity and walked around to the front without coming inside the house. She also could not remember if she was the one who discovered him missing. She did know he was an elopement risk and needed supervision.

When interviewed on 3/3/21 at 11:43 a.m. the Qualified Intellectual Disabilities Professional (QIDP) A confirmed she remembered the incident from 7/8/20. She stated staff was allowed to watch Client #19 when he was outside from a window inside the house prior to the 7/8/20 incident. She indicated after the incident staff was no longer allowed to watch from inside and must be outside with him. When asked if the change was updated in his ICP or his "leaving the area" program she initially said yes, but after looking she confirmed she failed to document the change.

When interviewed on 3/3/21 at 12:00 p.m. Residential Advocate (RA) confirmed she worked in the home for 2.5 years. When asked if Client #19 were allowed to be outside alone while staff watched from the window she indicated that wasn't encouraged, but allowed. She stated they encouraged staff to go outside with him, but sometimes it worked better to watch him out the window.

When interviewed on 3/3/21 at 11:40 a.m. the current Residential Leader (RL) A confirmed she did not work at the facility at the time of Client #19's elopement. When asked, RL A stated she did not know for sure whether Client #19 could be alone outside without staff present as she hadn't been trained on that yet. She also did not know whether staff could watch him from inside the house through a window. She indicated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 191	Continued From page 20 began employment about a month prior to the interview. Interviews on 3/3/21 with three additional staff (Life Skills Teacher, Coordinator of Therapy Services and Exercise and Sports Development Staff) assigned to the home since March 2020 due to Covid 19 all confirmed they were present on 7/8/20 when Client #19 eloped. On 7/8/20 all three staff reported they were outside with the group doing a water activity. They all three remembered Client #19 went inside the house and someone told the RL who was inside, but no one knew who told her. Eventually, the RL came out and asked if anyone knew where Client #19 was and they all began a search. All three stated they were somewhat familiar with the clients in House 354 even before March 2020 as they helped with lunch 2 days a week. They were not sure if they were ever trained on Client programs once they became full-time house staff in March of 2020. When asked if Client #19 could be outside alone without staff present 2 of the 3 indicated they were not sure (Coordinator of Therapy Services and Exercise and Sports Development) and the other reported staff must be with him outside. When interviewed together on 3/3/21 at 12:15 p.m. the Director of Health Services (DOHS) and QIDP A conceded with half the staff saying the client could be outside alone and the other half saying he couldn't, there was a staff training problem. Both agreed staff needed to be trained to the extent they all know client supervision levels and can consistently provide the required levels. The DOHS indicated one small sentence in the ICP regarding supervision was not enough clear direction for staff, especially for a client who	W 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 191	Continued From page 21 needed a tracking device in his shoe due to potential elopement. The investigation of 92538-I resulted in a determination of IJ. The facility was notified of the IJ 3/16/21 at approximately 9:30 a.m. The facility implemented a plan, which included revisions to the individual's individual program plan and retraining of staff. The IJ was removed 3/18/21 at approximately 11:30 a.m.	W 191		
W 234	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. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure behavioral intervention programs designed to support individuals with behavioral challenges and keep individuals safe provided all the relevant information needed by staff to apply intervention methods consistently and effectively. This affected at least 4 clients in House 366 involved in investigation 91450-I (Client #13, Client #14, Client #15, and Client #16). Findings follow: Review of Client #14's record revealed a behavioral log that involved Client #13 dated 3/13/20. The log revealed Client #13 hit Client #14 on the arm at 4:00 p.m. An Injury/Incident Report (IIR) dated 3/13/20 revealed five minutes later at 4:05 p.m. Client #13 pushed Client #14	W 234	QIDP's will be trained by May 1, 2021 on the following: a. Including identification of precursor (predictive) behaviors when known, and precise staff response to same on behavior modification goals addressing aggression. b. Including precise definition of staff response when targeted behaviors occur, on behavior modification goals addressing aggression. c. Necessity of seeking IDT input on behavior modification goal changes, and re-training of IDT with any significant change to behavior modification goals. QIDP is responsible for ongoing monitoring of behavior modification goals through monthly evaluation. Human Rights Committee is responsible for ongoing monitoring of restrictions, for each individual on a quarterly basis.	5/1/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 22	W 234		

(while using his walker) to the ground. The IIR indicated Client #14 sustained a 10 cm by 4 cm red abrasion to the right side of his back. The report noted staff was supposed to be in a position to block these types of behavior as Client #13 often targeted Client #14. Another IIR dated 3/23/20 at 6:50 p.m. revealed Client #13 pushed Client #14 to the ground as he walked with his walker. Client #14 sustained an abrasion 2.5 cm by 2 cm to the left rear elbow/arm. The client complained of soreness when he attempted to move it. An IIR dated 3/24/20 at 6:50 a.m. revealed Client #13 hit Client #14 in the face leaving a .7 cm laceration to the outside of the eyebrow and a .5 cm laceration to the bridge of his nose. Client #13's behavior log noted he hit another (unidentified) peer in the face five minutes later at 6:55 a.m. that morning.

Review of a facility investigation dated 5/8/20 revealed Client #13 assaulted at least two peers on multiple occasions between 6:00 a.m. and 6:54 a.m. The report revealed at approximately 6:00 a.m. Client #13 attempted to hit Client #15 several times, but Residential Skills Trainer (RST) A blocked him. Shortly after this, RST A attempted to complete shift documentation and turned his back to Client #13 and Client #15. Client #13 then hit Client #15. RST A became aware of the assault when Client #15 called out for his help. At 6:35 a.m. Client #13 was given PRN medication to help calm him down. Between 6:42 a.m. and 6:46 a.m. Client #13 again hit Client #15 across the face and laughed. At 6:52 a.m. Client #13 chased Client #15 and hit him on the back of the head before he headed toward East Home. At 6:54 a.m. RST A was in the kitchen, RST B and the RN were in the medication room when Client #13 approached

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 23	W 234		

Client #16 in his wheelchair and pushed him out the front door and dumped him onto the landscaping rock, resulting in multiple abrasions. The report indicated staff was alerted when the front door alarm went off. When interviewed on 2/24/21 at 12:45 p.m. RST B confirmed no one supervised Client #13 on 5/8/20 when he pushed Client #16 outside of the home into the landscaping rock. She remembered she first noticed Client #13 pushing Client #16 out the door when Client #16 yelled "He's got me." She confirmed Client #13 should have been supervised based on his behavior patterns that morning.

Review of Client #15's record revealed an IIR dated 6/2/20 at 3:47 p.m. The IIR indicated Client #13 hit Client #15 on the right arm and tried to push him off his chair. The report indicated Client #15 sustained a 3 cm by 2 cm bruise to his right forearm. Review of Client #13's behavioral logs revealed at least twenty-two separate assaults against peers from 3/13/20 to 6/2/20.

Review of Client #13's record revealed a behavioral program updated in February 2020, March 2020, and June 2020. The program revealed several preventative measures which instructed staff on how to speak with Client #13 and being prompted to engage in preferred activities.
A section of the program titled "Methods to use when targeted behavior occurs" indicated steps staff should take if it appeared Client #13 was going to be aggressive. The target behaviors listed in the program included verbal aggression defined as "any voiced threats of hurting someone else, making repetitive statements" such as shut up, sit down, that's bullshit or be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 24	W 234		

quiet. The other target behavior listed was physical aggression defined as hitting, kicking, making contact with others or their assistive devices (walkers & wheelchairs, etc.).

The plan indicated if staff heard one of the statements of verbal aggression or after he already engaged in physical aggression towards someone else staff needed to do the following: "Actively attend where Client #13 is, whom he is walking by and be ready to intervene". The program further stated staff would use body positioning to walk by Client #13 in an attempt to make it harder to hit peers. Additionally, the program indicated after Client #13 was aggressive he received a PRN medication and staff needed to maintain a visual of him until the medication went into effect or until he has had de-escalated.

Review of a facility investigation document completed (after the 6/2/20 assault) by the Director of Health Services (DHOS) revealed the following "There is no strong antecedecent pattern to Client #13's aggression. There is no behavioral chain prior to aggression. Client #13's mood is not a predictor of aggression. The absence of behavioral predictors makes behavioral prevention difficult. There were no consistent, precipitating events to the aggression, that would indicate that there was staff culpability related to preventing the occurrence".

When interviewed on 2/25/21 at 11:50 a.m. the Qualified Intellectual Disabilities Professional (QIDP) confirmed there were not always indicators of Client #13's aggression. She also confirmed the program failed to include in the program all the potential indicators of aggression

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 25	W 234		

they were aware of such as wringing of the hands, pacing fast, grunting, and pacing between the two sides of the home. She also confirmed the program should have indicated the client often aggressed without warning. When asked why these indicators were never added to the program she indicated she wasn't sure but admitted they should have been included. She also confirmed 1 to 1 supervision was put in effect in March 2020, but never outlined in the program. She also noted she could see where staff might have been confused about Client #13's supervision once the PRN medication was given and just kept a visual of him rather than walking beside him to protect others. She confirmed numerous residents received injuries as a result of Client #13's aggression.

When interviewed on 2/25/21 and 3/2/21 the DOHS confirmed she wrote the June 2020 investigation summary which indicated Client #13's aggression often came without warning and made it hard to predict. She also confirmed despite several program revisions there was no mention Client #13's aggression often occurred without any warning. She confirmed this documentation in the program could have been very important in protecting other residents. She also confirmed all behavior that may have alerted staff to possible aggression such as wringing hands, pacing, grunting, etc should have been included in the program and taught to staff. The DOHS confirmed with the danger posed by Client #13's aggression, supervision needed to be clearly spelled out in the behavior plan. She confirmed the program might have been confusing for staff in regards to supervision. The program called for staff to walk between Client #13 and his peers if they perceived he might be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 26 aggressive or had been aggressive. The program also indicated the client received a PRN medication after he became aggressive. Once the PRN medication was given the program noted staff needed only to maintain visual supervision of the client until he deescalated. She agreed this could have given staff the idea they no longer needed to walk between the client and his peers but only keep him in their field of vision. She also confirmed the program failed to define what being "deescalated" looked like for Client #13 leaving it up to individual staff to decide. The DOHS also confirmed in March of 2020 Client #13 received 1 to 1 supervision with staff on occasion, but the behavior program failed to provide direction for staff when 1 to 1 took place.	W 234		
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 interviews and record reviews, facility staff failed to consistently implement behavioral intervention programs designed to support individuals with behavioral needs and provide safety to all residents in the home. This affected at least at least 4 individuals in House 366 involved in investigation 91450-I (Client #13,	W 249	QIDP's will be trained by May 1, 2021 on the following: a. Including identification of precursor (predictive) behaviors when known, and precise staff response to same on behavior modification goals addressing aggression. b. Including precise definition of staff response when targeted behaviors occur, on behavior modification goals addressing aggression. c. Necessity of seeking IDT input on behavior modification goal changes, and re-training of IDT with any significant change to behavior modification goals.	5/1/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 27 Client #14, Client #15 & Client #16). Findings follow: Review of Client #14's record revealed a behavioral log that involved Client #13 dated 3/13/20. The log revealed Client #13 hit Client #14 on the arm at 4:00 p.m.#14 An Injury/Incident Report (IIR) dated 3/13/20 revealed five minutes later at 4:05 p.m. Client #13 pushed Client #14 (while using his walker) to the ground. The IIR indicated Client sustained a 10 cm by 4 cm red abrasion to the right side of his back. The report noted staff was supposed to be in a position to block these types of behavior as Client #13 often targeted Client #14. Another IIR dated 3/23/20 at 6:50 p.m. revealed Client #13 pushed Client #14 to the ground as he walked with his walker. Client #14 sustained an abrasion 2.5 cm by 2 cm to the left rear elbow/arm. The client complained of soreness when he attempted to move it. An IIR dated 3/24/20 at 6:50 a.m. revealed Client #13 hit Client #14 in the face leaving a .7 cm laceration to the outside of the eyebrow and a .5 cm laceration to the bridge of his nose. Client #13's behavior log noted he hit another (unidentified) peer in the face five minutes later at 6:55 a.m. that morning. Review of a facility investigation dated 5/8/20 revealed Client #13 assaulted at least two peers on multiple occasions between 6:00 a.m. and 6:54 a.m. The report revealed at approximately 6:00 a.m. Client #13 attempted to hit Client #15 several times, but Residential Skills Trainer (RST) A blocked him. Shortly after this, RST A attempted to complete shift documentation and turned his back to Client #13 and Client #15. Client #13 then hit Client #15. RST A became	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 28	W 249		

aware of the assault when Client #15 called out for his help. At 6:35 a.m. Client #13 was given PRN medication to help calm him down. Between 6:42 a.m. and 6:46 a.m. Client #13 again hit Client #15 across the face and laughed. At 6:52 a.m. Client #13 chased Client #15 and hit him on the back of the head before he headed toward East Home. At 6:54 a.m. RST A was in the kitchen, RST B and the RN were in the medication room when Client #13 approached Client #16 in his wheelchair and pushed him out the front door, and dumped him onto the landscaping rock, resulting in multiple abrasions. The report indicated staff was alerted when the front door alarm went off.

When interviewed on 2/24/21 at 12:45 p.m. RST B confirmed no one supervised Client #13 on 5/8/20 when he pushed Client #16 outside of the home into the landscaping rock. She remembered she first noticed Client #13 pushing Client #16 out the door when Client #16 yelled "He's got me". She confirmed Client #13 should have been supervised once he became aggressive that morning as written in his program.

Review of Client #15's record revealed an IIR dated 6/2/20 at 3:47 p.m. The IIR indicated Client #13 hit Client #15 on the right arm and tried to push him off his chair. The report indicated Client #15 sustained a 3 cm by 2 cm bruise to his right forearm. Review of Client #13's behavioral logs revealed at least twenty-two separate assaults against peers from 3/13/20 to 6/2/20.

Review of Client #13's record revealed a behavioral program updated in February 2020, March 2020, and June 2020. The program

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 29	W 249		

revealed several preventative measures such as how to speak with Client #13 and being prompted to engage in preferred activities. A section of the program titled "Methods to use when targeted behavior occurs" indicated steps staff should take if it appeared Client #13 was going to be aggressive. The plan indicated staff needed to "Actively attend where Client #13 is, whom he is walking by and be ready to intervene." The program further stated staff needed to use body positioning and walk by Client #13 to make it harder to hit his peers. The program further noted when Client #13 received a PRN medication staff needed to maintain a visual of him until the medication went into effect or until he deescalated.

When interviewed on 2/25/21 at 11:50 a.m. the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff failed to follow Client #13's behavioral program which resulted in the numerous assaults over several months. She provided the example of 5/8/20 and confirmed numerous assaults took place that morning when staff should have been supervising Client #7. She found staff failed to communicate supervision responsibility for Client #13 which resulted in each staff thinking someone else supervised Client #13. This left no staff supervising the client and resulted in numerous assaults. She confirmed repeated assaults should not have happened once staff was aware of aggressive or verbally aggressive behavior as the program outlined. Once staff became aware of these behaviors they needed to provide close supervision by walking with Client #13 ready to intervene with body positioning in the event of aggression. Program revisions were made in February 2020 and again after the three assaults

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 30 with injury in March 2020. She confirmed the program remained the same once aggression occurred, staff should have been ready to block and protect. When interviewed on 2/24/21 at 2:30 p.m. the Director of Health Services (DOHS) also reported she was very troubled by the amount of assaults Client #13 engaged in against his peers. She also referred to 5/8/20 specifically as an example of a day when staff failed to follow the behavior program which resulted in several assaults and Client #16 being pushed into the rocks and tipped over in his wheelchair. She indicated sometimes the behavior seemed to have no antecedent and staff found it difficult to know when aggression might occur, but once it did staff needed to respond according to the program. She confirmed the program failed to provide much-needed information and detail, but felt with what was in the program staff should have known to protect other residents once they saw or heard aggression from Client #13.	W 249		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on interviews and reviews, the facility failed to ensure clients received an annual dental exam. This affected 1 of 6 sample clients (Client #5). Finding follows:	W 352	QIDP and nursing staff will be re-trained by May 1, 2021, regarding the minimal requirement of annual dental exams. QIDP's are responsible for monitoring frequency of dental exams, to ensure compliance.	5/1/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 352	Continued From page 31 Record review revealed Client #5's dental exam, dated 7/29/19, indicated Client #5 received general anesthesia for a dental cleaning and a cavity filled. Additional record review revealed Client #5's nursing notes, dated 7/29/19, indicated Client #5 should see his local dentist in a year and should return to general anesthesia in two years. No current dental exam could be located. When interviewed on 3/3/21 at 2:20 p.m. the Director of ICF/ID confirmed the facility failed to ensure Client #5 had a yearly dental exam. She stated his local dentist refused to see Client #5 for a yearly exam and suggested he just had exams under general anesthesia every two years.	W 352		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to secure medications until administered. This potentially affected all clients living in the home (Client #4, Client #8, Client #9, Client #10, Client #11, and Client #12). Finding follows: Observations on 3/2/21 at 7:00 a.m. revealed Certified Medication Aide (CMA) A prepared medication in the medication room. He placed the medication in a medication cup and sat the	W 382	CMA's and nursing staff will be retrained regarding avoiding leaving medications unattended, and unlocked at any time by May 1, 2021.	5/1/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G006	A. BUILDING _____ B. WING _____	C 03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 382	Continued From page 32 cup on the counter. CMA A walked out of the medication room and left the medication on the counter with the medication room door open. CMA A walked to the living room, assisted Client #10 stand up and walk to the medication room. CMA A administered medications to Client #10 in the medication room. Record review revealed the facility Medication Administration policy, indicated, "The medication cupboard, or medication cart will be kept locked at all times, unless in use. Medication cart keys will be stored in a locked, designated area, when not in use. The nurse, CMA, or CMM (Certified Medication Manager) will keep medication cart keys (while in use), or medication cupboard keys on their person." The policy also indicated, "Administer medication or assist individual as needed. Do not leave until medicine has been taken." When interviewed on 3/3/21 at 1:35 p.m. the Director of ICF/ID confirmed the facility failed to secure medications until administered.	W 382		