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 01/04/2018

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
W 000	INITIAL COMMENTS At the time of investigation 72856-I, a deficiency was cited at W249.	W 000		
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, the facility failed to ensure staff provided supports and services as directed by the individual program plan. This affected 1 of 1 sample client (Clients #1) identified as a result of self-reported incident #72856-I. Finding follows: 1. Record review on 12/18/17 revealed the following: a. An incident report, dated 11/19/17 at 4:00 p.m., documented Treatment Program Manager (TPM) A transferred Client #1 to his/her wheelchair and did not have the straps of the sling crossed between the client's legs. The client slid out of the sling, bumped his/her head on the wall, and was lowered to the floor. TPM A yelled out for help and a nurse was notified. Upon assessment, the nurse noted a large bump to the left side of Client #1's forehead about outer eye	W 249	See attached POC 1/12/18	

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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W 249	Continued From page 1 the size of an egg. No further bruising or redness was noted and no grimacing was noted with movement. Neuro checks were ordered to continue, per protocol. TPM A documented on the incident report as program manager or department head 11/19/17 at 4:28 p.m. TPM A documented, "TPM was transferring (Client #1) into (his/her) wheelchair. The straps of the sling were not crossed between (Client #1's) legs. (Client #1) slipped out of the sling, hit (his/her) head on the wall. TPM caught (him/her) mid-fall and lowered (him/her) to the floor." b. An incident report , dated 11/21/17, documented Client #1 found with a red and swollen right foot with a black and blue spot on his/her big toe. Mobile X-ray was ordered and Client #1 was believed to have a fracture to the right fifth metatarsal. The incident report noted an incident the previous day where Client #1 fell out of a sling and sustained injuries. The nursing assessment noted the top of the right foot warm to touch, reddened and some edema, particularly at the base of the toes. Some bruising noted to the top of the right great toe extended to inner part of the toe between the great toe and second digit. No swelling or warmth noted to that area. Noted purple bruising to the bottom of the right foot measured 5.0 centimeters (cm) x 5.0 cm starting at the base of the great toe. Client #1 appeared to have some swelling with the area of bruising, particularly below the right great toe. The client showed no signs or symptoms of discomfort when the foot was moved. The nurse noted assessments would continue each shift and a message was left on the non-urgent medical line. c. A nursing assessment, completed 11/19/17 at	W 249		

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W 249	Continued From page 2 11:01 p.m. noted, "Right upper lip in the center is a possible 0.3 cm diameter dark red/purple blood blister like area. The assessment summary noted no signs or symptoms of pain. Continued neuro assessments were directed every four hours for 24 hours. Continued record review revealed Client #1's event log included the following: a. Entry from Physician A, dated 11/21/17 at 2:10 p.m., documented results from mobile x-ray of Client #1's right foot and ankle. Findings noted, "... x-ray from today sclerosis in the right fifth distal metatarsal suspicious of an impacted nondisplaced fracture otherwise unremarkable." Interpretation noted, "possible fracture right fifth distal metatarsal after fall yesterday. Versus contusion. Regardless, probably secondary to accidental fall yesterday." Physician A noted Client #1 would see orthopedics that afternoon. b. Entry from Physician A, dated 11/22/17 at 4:07 p.m., documented results from Client #1's orthopedics consultation. Physician A noted a diagnosis of fracture distal right fifth metatarsal. Treatment included a walking boot on Client #1's foot at all times, removed for bathing and orders to return in four weeks. Additional record review revealed appointment report form, dated 12/19/178, from Client #1's four week return to orthopedics. The physician noted the fracture healed. Client #1, 44 years old, had diagnoses including, but not limited to: profound intellectual disability, anemia, iron deficiency, hyponatremia, dystonic cerebral palsy, spastic quadriparesis, joint contractures and osteoporosis.	W 249		

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W 249	Continued From page 3 Record review on 12/18/17 revealed Client #1's physical nutritional management plan (PNMP), dated 11/21/17, Client #1 required EZWay dependent mechanical lift with sling #50341 and a one to two person assist. Additional record review revealed EZWay Smart Lift operator's instructions included direction for use of the medium deluxe sling, used by Client #1 on 11/19/17. According to the instructions, the sling should be centered beneath the patient, then each sling leg placed under the patient's thigh. Excess sling leg should be placed over top of the patients respective thigh. When attaching the sling to the lift, the loops nearest the patients shoulders should be attached to the hanger bar hooks of the lift nearest each shoulder, using the same length and color loop strap on each side. The sling lying over the left leg should be crossed over and attached to the hook of the hanger bar located on the right side of the patient. Next, the sling leg lying over the right leg is crossed over and attached on the hook of the hanger bar located on the left side of the patient using the same length and color of loop strap. When interviewed on 12/18/17 at 4:00 p.m., Treatment Program Manager (TPM) A stated she attempted to completed the transfer to the wheelchair by herself. Client #1 hit the wall and slid out of the EZWay lift. She stated she caught Client #1 as he/she fell, but he/she bumped his/her head and face against the wall while sliding to the floor. She stated she immediately called for assistance and staff came to help get Client #1 back to the wheel chair. TPM A stated she realized she made a mistake by not crossing the leg sling, and this resulted in the fall and	W 249		

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W 249	Continued From page 4 injuries. She stated she wasn't sure why, but she forgot to cross the sling legs. The nursing assessment revealed a bump on the head and later a bump/split lip, but did not reveal the right foot injury. Staff on the night shift noticed a swollen foot that had black and blue marks another nursing assessment was completed and Mobile was ordered STAT. She stated she made a mistake and failed to cross the sling around the legs to secure them which prevents the client from falling/sliding out of the lift. When interviewed on 12/19/17 at 1:00 p.m. Occupational Therapist (OT) A confirmed the expectation that staff should follow training provided for the EZWay lift. OT A explained the leg straps should be crossed when applied to the lift, to prevent the client from falling out.	W 249		

OK 2/7/18

Glenwood Resource Center
Plan of Correction
DIA Investigation #72856-I

W 249 – 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.

On 11/19/17, Treatment Program Manager (TPM) A transferred Client #1 to his/her wheelchair and did not have the straps of the sling crossed between the client's legs. The client slid out of the sling, bumped his/her head on the wall, and was lowered to the floor. Nursing completed an assessment and an incident report was completed.

On 11/21/17, Client #1's right foot appeared swollen with a blue and black spot on his toe. X-rays were taken and initial report revealed Sclerosis in the right 5th distal metatarsal suspicious of an impacted non-displaced fracture. GRC self-reported the suspected fracture to DIA. Out of an abundance of caution, Client#1 was sent for follow up with an Orthopedist.

12/19/17, Client #1's second follow up appointment with Orthopedist found no fracture.

Individual Response

The case was reviewed and considered resolved by Glenwood's Incident Review Committee. TPM A acknowledged and reported the error immediately. TPM A was retrained on GRC's mechanical lifts and sling use/transferring requirements on 12/5/17 prior to DIA's investigation.

GRC will continue to provide competency-based training to employees on mechanical lifts and slings use/transferring requirements and monitor employees to enable them to perform their duties effectively, efficiently, and competently.

Responsible: Treatment Program Administrator
Date Completed: 12/5/17

Systemic Response:

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

GRC will continue to ensure that each GRC client receives 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.

Responsible: Superintendent & Assistant Superintendent
Date Completed: January 12, 2018 and ongoing

EC 2/2/18

✓ 2/2/18

Record of Objection
Glenwood Resource Center (GRC)
Investigation #72856-I

Glenwood Resource Center OBJECTS to the Citation, Fine, and Statement of Deficiencies:

Glenwood complied with the requirements of Iowa Administrative Code 481-64.60(135C).

In response to page 1 in the citation, the statement, "Based on interviews and record reviews, the facility failed to ensure staff provided supports and services as directed by the individual program plan. This affected 1 of 1 sample client (Client #1) identified as a result of self-reported incident.

The State Operations Manual, Appendix J – Guidance to Surveyors, Part 1, Section XII C, states in part, "The threshold at which the frequency of occurrences amounts to a deficiency varies. One occurrence directly related to a life-threatening or fatal outcome can be cited as a deficiency. On the other hand, a few sporadic occurrences may have so slight an impact on delivery of active treatment or quality of life that they do not warrant a deficiency citation."

- Client #1 is transferred via mechanical lift approximately 2,555 each year (minimum of 6-8 transfers per day, 365 days per year). Of Client #1's transfers using a mechanical lift, 99.96% were implemented without incident. The probability of client #1 experiencing this accident was 0.0004. This isolated and extremely rare occurrence was not related to a life-threatening outcome.

- In addition, Glenwood Resource Center implements approximately 130,000 transfers utilizing mechanical lifts each year (51 clients, with a minimum of 6-8 transfers per day, 365 days per year). A review of transfers utilizing mechanical lifts demonstrates that 99.999% of those transfers were implemented without incident, thus demonstrating a near perfect rate of successful transfers using mechanical lifts due to execution of successful supports per the individual program plans.

Fining and Citations, 481 AIC 56.3(4) provides a facility the opportunity to submit a **Self-Identification and Correction Form** prior to the conclusion of the inspection or within two working days of the exit interview. Also, factors for determining the selection of the violation class include the facility's corrective actions after the occurrences (see 481 IAC 56.9(6)). DIA did not provide an exit interview before issuing the citation fine and without an exit, Glenwood Resource Center was not provided the full opportunity to submit a self-identification and correction before the citation fine was issued.