

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6952		Date: April 15, 2019
Facility Name: Glenwood Resource Center		Survey Dates: February 8 – March 13, 2019
Facility Address/City/State/Zip		
711 S Vine Street Glenwood, IA 51534	MW	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
64.60(135C)	<p>481—64.60 (135C) Federal regulations adopted—conditions of participation. Regulations in 42 CFR Part 483, Subpart D, Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.</p> <p>Classification of violations is I, II, and III, determined by the division using the provisions in 481—Chapter 56, “Fining and Citations,” to enforce a fine to cite a facility.</p> <p>This rule is intended to implement Iowa Code section 135C.2(3).</p>	I	\$3500	UPON RECEIPT
W249	<p>W249 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)</p> <p>§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.</p>			

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	<p>DESCRIPTION:</p> <p>Based on interviews and record reviews, 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 #21) reviewed during investigation #80823-I and 1 of 1 Client (Client #12) reviewed during investigation #81670-I Finding follows:</p> <p>1. Record review on 2/8/19 revealed an incident report dated 1/31/19 at 5:20 p.m., completed by Administrator on Duty (AOD) B, documented Client #21 stated she got a screw from a broken fan and swallowed it. Client #21 showed similar screws in the bottom of the fan. Client #21 called 911 and an ambulance crew arrived, but the doctor determined it was not needed. Client #21 was later transported to the hospital due to complaints of pain and blood in her sputum from possibly swallowing a screw. Nurse A documented the following on the incident report: "...When entering house 240, there were many EMS (emergency medical services), Sheriff personnel present in the house along with (AOD A and AOD B). No RTW staff were present at the time. Client #21 met me in the hallway of the unit and told me she needed to go to the hospital because she had swallowed a screw. When</p>			

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	asking about the possibility of her swallowing a screw, she stated that it came from a broken fan that they had since put in the closet. (Client #21) was yelling/screaming demanding to go to the hospital this nurse placed a call to the OD (on duty physician), for orders regarding transport and x-ray. Orders received to have EMS/Sheriff leave the unit and that we would wait on Mobilex (mobile x-ray) until morning with the PCP (primary care physician) would be available. If client became symptomatic, the to call her back and we would go from there. (Client #21) is still screaming and gesticulating. Multiple attempts to assess client, with frequent verbal abuse and threats of violence to this nurse... An additional offer to complete an assessment was made, with clear refusal from (Client #21). This nurse removed herself from the unit. Two more calls were received from (AOD B) (6:12PM) and (AOD A), requiring the presence of this nurse, last of which, (8:05PM) (AOD A) informed me that she was bleeding. When re-entering the house, (Client #21) was 'hacking', like she was clearing her throat and spitting into a cup. There was a small amount of blood tinged saliva and mucous present in the cup. At the time, (Client #21) allows this nurse to do an assessment and findings are stated above. However, she did refuse a peri-area visual assessment. When			

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	<p>asked to point to where it hurt, she pointed to the low end of the left side of her throat.</p> <p>Additional record review revealed dictation from Client #21's emergency department visit indicated she arrived on 1/31/19 at 9:02 p.m. The report documented, "Patient presents emergency department by squad from Glenwood Resource center. The patient told staff that she swallowed a screw. Patient is complaining of throat and abdominal pain. Patient states she swallowed the screw today. Patient has a history of swallowing foreign bodies. Nothing makes patient's symptoms better or worse." Diagnostic Radiology noted, "Single metallic screw foreign body within the right mid abdomen." The dictation further documented Client #21 underwent endoscopy to remove the foreign body. Client #21 was discharged from the emergency department on 2/1/19 at 12:50 a.m.</p> <p>Client #21, 16 years old, had diagnoses including bipolar II disorder with recurrent depression, anxiety disorder, cluster B personality traits, reactive attachment disorder, and mild intellectual disability. Client #21's behavior support plan addressed the following target behaviors: aggression, smearing (bodily fluids/excrements), self-injurious behavior, property destruction, suicide attempts, suicide threats, leaving</p>			

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	assigned areas, pica (ingestion of inedible), and pica attempts. When interviewed on 2/13/19 at 2:15 p.m., Resident Treatment Worker (RTW) A confirmed she worked with Client #21 on the evening of 1/31/19. RTW A reported she was with the client at school that afternoon, along with RTW B. When they returned from school, Client #21 asked if she could redeem her pop cans and wanted to bring them to her Wildly Important Goals (WIG) meeting. RTW A reported she was sure Client #21 wanted to cash in her cans to buy junk food. RTW A and RTW B accompanied Client #21 to her meeting at Psychologist A's office. Client #21 darted for Psychologist A's desk and began to touch everything. During the WIG meeting, Client #21 requested to have two female staff and became agitated when told that was not possible. Client #21 asked if she could take her cans to cash them in for snacks and was told it was ok. RTW A reported she communicated she wanted to check with Treatment Program Administrator (TPA) A and Treatment Program Manager (TPM) B first. Client #21 again became agitated and began yelling and cursing, using vulgar language. The temperature that day was six degrees Fahrenheit with ice and snow and there was a travel ban on campus. Client #21 became more agitated and			

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	Psychologist A said he would look into it. RTW A spoke up and said she was sorry, but did not feel comfortable traveling off campus with the weather. The last question of the WIG meeting was, "What else do you want?" RTW B spoke up and reminded Client #21 she said she wanted a fan. The Superintendent said he would look into it and RTW A told the group the storehouse would have fans. Client #21 got up and began touching everything in Psychologist A's office. RTW A redirected her and told her they needed to go find her a fan. They left Psychologist A's office and went to the storehouse, but it was closed and no one was available to assist them. RTW A, RTW B, and Client #21 then went to house 359, where the supervisors' offices are. Client #21 walked into the office, saw RTS A and yelled, "(RTS A) raped me!" RTW A and RTW B (also present in house 359), were currently separated from Client #21 based on allegations of abuse she made. RTW A and RTW B closed the doors to their offices. Client #21 went to Administrator On Duty (AOD) A's office, grabbed a pair of pliers from his desk and ran towards the door, threatening to leave the area. Client #21 gave AOD A the pliers when he asked for them and said he would meet them at the storeroom. When they arrived at the storeroom, Client #21 chose a tower fan in a box and they returned to Client #21's home. When they arrived home, Client #21 ate dinner at her			

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	<p>table in the hallway. RTW A sat across from her. RTW B opened the box the fan came in in the hallway, and realized the fan needed to be put together. The pieces of the fan were in bags RTW B said he could put it together and contacted someone to get a tool. RTW B was told they didn't have any. RTW continued to remove it from the box and begin to put it together as RTW A and Client #21 watched. RTW B handed the screws, she believed there were six, to RTW A and she handed them to him one at a time as he worked. RTW B was finished putting the fan together, when Client #21 jumped up suddenly and said she was calling 911 because RTS A raped her. RTW B stood the fan up and quickly put it in the closet, with Client #21 following him to the closet. Client #21 was upset and yelled at RTW B when he told her she could not have the fan right now. Client #21 called 911 and reported she had been raped and beaten. When the police arrived, she told them RTS A raped her and she swallowed a screw. Client #21 paced the area and said she didn't swallow a screw, as RTW A followed her. AOD B arrived to the home shortly after EMS arrived and told RTW A and RTW B to go to break. RTW A reported she did not see Client #21 obtain a screw and did not see her ingest one. RTW A wondered if a screw fell out of the fan when RTW B stood it up. RTW A confirmed she was trained</p>			

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	<p>on Client #21's behavior support plan (BSP). RTW A stated Client #21's BSP directed Client #21 should have nothing small enough to go through a toilet paper roll. RTW A confirmed the pieces of the fan were small enough to fit through a toilet paper roll. RTW A stated the fan should have just been put away when they realized it needed to be put together.</p> <p>When interviewed on 2/14/19 at 9:50 a.m., RTW B reported he worked with Client #21 on 1/31/19, along with RTW A. He reported they were with Client #21 at school and returned to campus for her WIG meeting. Client #21 was upset with RTS A at the WIG meeting. RTW B and RTW A took Client #21 to house 359 to find AOD A to gain access to the storeroom to get a fan. While at 359, Client #21 made an allegation of abuse against RTS A. AOD A took them to the storeroom, where Client #21 picked out a tower fan. When they returned to the house, he pulled the fan from the box and parts fell out. RTW B thought it would be ok to put the fan together. He gave RTW A the screws and she handed them to him. Client #21 suddenly went to the restroom and became agitated. She said she had been raped and wanted to call 911. RTW B put the fan into a closet and locked the closet. They called RTS B and decided to unlock the phone to let Client #21 call 911. When she called 911 she</p>			

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	<p>reported RTS A hit and raped her and told them to also send an ambulance because she swallowed a screw.</p> <p>RTW B reported there were four little black screws and six bigger silver screws with the fan. He put all of the screws in the fan. He tightened the silver screws all the way down and tightened the black screws the best he could. RTW B reported he tried to get a screwdriver. RTW B confirmed Client #21's BSP indicated she should have nothing smaller than toilet paper tube in her environment.</p> <p>Record review on 2/13/19 revealed Client #21's Behavior Support Plan (BSP), active 1/28/19, included pica as a target behavior. The BSP indicated environmental sweeps should be conducted whenever the client went to another room/location. The BSP further directed Client #21 should not have access to items small than would fit through a toilet paper tube (this includes potentially removable pieces attached to larger items or things that can be broken into smaller pieces) unless otherwise approved by the IDT.</p> <p>When interviewed on 2/13/19 at 5:00 p.m., AOD B stated staff should've never had screws out where Client #21 could get them.</p>			

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	<p>When interviewed on 2/13/19 at 5:45 p.m., AOD A stated he received a call to report Client #21 called 911 and also reported she swallowed a screw. When he arrived to the home, AOD A asked Client #21 to show him where she got the screw. She told him from the fan in the closet and pointed to the bottom of the fan. AOD A confirmed staff should not have had loose screws around Client #21. AOD A stated staff never communicated or expressed concern that the fan was in pieces and needed put together.</p> <p>When interviewed on 2/14/19 at 2:30 p.m., RTS B reported RTW B called the office and asked for a screwdriver. She told him they did not have a screwdriver. When she asked RTW B why he needed one, he told her for loose screws, but did not recall him saying he was putting a fan together. RTS B stated staff should have put the fan away when they realized it was in pieces.</p> <p>2. Record review on 3/6/19 revealed an incident report dated 2/9/19 documented, "Staff was assisting (Client #12) for his shower and sitting him up in his bed. (Client #12) fell head first out of bed and onto the floor. (Written on 2/9/19 8:01AM). Response: Staff called nurse and supervisor on duty." The incident report further noted, "(TPM C) saw (Client #12) at 7:45AM</p>			

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	<p>Client #1 was lying on his back, in bed with a washcloth on his forehead. The cut on his left eyebrow was deep. (Client #12) did not lose consciousness. (Client #12) was transferred by non-emergency ambulance to JEMH ER (Jennie Ed Methodist Hospital) for evaluation. Phone call from staff stated a (CAT) scan had been completed on (Client #12's) head, an x-ray of his shoulder was done and the wound was closed with staples. If the results are within normal limits, (Client #12) will return later today."</p> <p>The Facility's investigation noted Client #12 left the Facility for the ER (Emergency Room) at 8:15 a.m. and returned from the hospital at 11:30 a.m. The hospital discharged the client with the following diagnosis, "... 1. Fall 2. Closed head injury 3. Facial laceration." When Client #12 returned from the hospital, he ate his lunch and liquids at 1:33 p.m., with no issues. He was reported to be resting in his recliner.</p> <p>Client #12, 61 years old, had diagnoses including profound intellectual disability; hypothyroidism; epilepsy, complex partial, treatment resistant; osteoporosis.</p> <p>Continued record review revealed Client #12's Individual Support Plan (ISP) dated 6/14/18 specified, "Dressing: "Supportive siting (i.e.</p>			

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	<p>wheelchair, shower chair with hip belt toilet when lift is in front of him, seated edge of bed with hands on assistance)." The ISP further directed, "(Client #12) requires hand on assistance when seated edge of bed due to decreased seated balance and poor righting reaction/protective responses." The ISP further noted, "Know that (Client #12) has osteoporosis. He takes medication for this. Use caution when assisting him with personal cares."</p> <p>According to Client #12's Physical Nutritional Management Plan, revised 1/22/19, he required supporting sitting during dressing.</p> <p>When interviewed on 3/6/19 at 9:30 a.m., Residential Treatment Worker (RTW) C stated on 2/9/19 she got Client #12 ready for a shower. She described Client #12 sat on the edge of his bed, as she reached for the standing mechanical lift to transfer him from the bed to the lift. She recalled she turned away from Client #12 and reached for the lift with both of her hands. She explained she turned away from Client #12 for "three or four seconds" and did not have one hand on him for support. Client #12 fell to the floor and she yelled to RTW D for assistance. She indicated RTW D grabbed a washcloth and applied pressure on the laceration to his left eye. RTW C stated she called the on-call Nurse while</p>			

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	<p>RTW D and another staff lifted Client #12 to his bed. RTW C noted the RN assessed Client #12 before he left for the hospital. Client #12 returned from the hospital at approximately 12:00 p.m., with staples above his eye. RTW C stated she was familiar working with Client #12 as she had worked with him for at least three years and received training on his PNMP. She pointed out she had never had an accident with him and Client #12 usually fell back into his bed when he sat on the edge of his bed. She added perhaps he might have been too close to the edge of the bed. RTW C acknowledged she did not have one hand on Client #12 when he was on the edge of his bed. She said she felt awful about the accident. She stated she might have been too comfortable with transferring Client #12 and let her "guard down." RTW C stated, "It was my fault."</p> <p>When interviewed on 3/6/19 at 9:00 a.m., RTW D stated on the day of the incident she was not in Client #12's room. She worked in an area next to his bedroom. She described she heard a "thud" and RTW C called for her assistance. She said she went into Client #12's room, saw him on the floor, grabbed a nearby washcloth and applied pressure to a wound above his eye. She reported RTW C called the on-call nurse while she and another RTW lifted Client #12 to his bed. RTW D</p>			

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	<p>noted the nurse arrived and assessed the Client. RTW D pointed out in the 15 years she worked with Client #12, she never witnessed him being involved in an accident. She explained Client #12 usually fell backwards or to his side when on the edge of his bed. RTW D offered they worked short staff the day of the incident; however since it was a Saturday the routine was more relaxed, they were not in a hurry and there was nothing out of the ordinary that day.</p> <p>When interviewed on 3/6/19 at 10:00 a.m., TPM C stated according to Client #12's PNMP, he required a one-hand assist when on the edge of his bed. She acknowledged Client #12 might have been too close to the edge of the bed; however, she was not present at the time of the incident. TPM C noted RTW C received training on Client #12's PNMP. TPM C also stated RTW C was a dependable staff and might have gotten too comfortable with transferring Client #12.</p> <p>FACILITY RESPONSE:</p>			

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