

**Department of Inspections and Appeals**  
**Health Facilities Division**  
**Citation**

Citation Number: 7017		Date: July 25, 2019		
Facility Name: Glenwood Resource Center		Survey Dates: May 6, 13, 14, 15, June 27, 2019		
Facility Address/City/State/Zip 711 So. Vine Glenwood, IA 51534		LK 82603-I, 82574-I, 82722-I		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
64.60  W249	<p><b>481-64.60(135C) Federal regulations adopted - conditions of participation.</b>          Regulations in 42 CFR Part 483, Subpart D, and 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><b>Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.</b>          This rule is intended to implement Iowa Code Section 135C.2(3).</p> <p><b>483.440(d)(1)</b></p> <p><b>As soon as the interdisciplinary team has formulated a client's individual program plan,</b>  <b>each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number</b>  <b>and frequency to support the achievement of the objectives identified in the individual</b></p>	II	\$1,500.00 (trebled \$500.00)	Upon Receipt

Page 1 of 18

Facility Administrator

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	<p><b>program plan.</b></p> <p><b>DESCRIPTION:</b></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 sample client (Client #1) reviewed during investigation #82603-I. Finding follows:</p> <p>Record review revealed Client #1's Incident Report dated 4/7/19, indicated, "I was getting (Client #1's) oral care done right after I got her dressed. She was in her shower chair as I was giving her a shower right before her oral care. I was bringing her back to her bedroom and once we got her in the door way she slid, head first onto the ground. She landed on her right side. Right shoulder and right elbow is pink in color and pinkness is fading."</p> <p>Additional record review revealed the following:</p> <p>a. Facility investigation for Client #1, indicated, "On 4/7/19 (Residential Treatment Worker (RTW) A) reported she didn't fasten (Client #1's) chest and hips supports on her Aquatec shower chair and (Client #1) slipped out of it."</p>			

Page 2 of 18

Facility Administrator

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	<p>On 4/10/19, the investigator documented, "Additional interviews are needed; this report will be amended once all interviews have been completed." The facility amended the investigation on 5/10/19.</p> <p>b. Client #1's diagnosis included profound intellectual disability, epilepsy, osteoporosis, and spastic quadripareisis.</p> <p>c. Client #1's Individual Support Plan (ISP) dated 6/6/18, indicated Client #1 preferred showers and used an AquaTec Ocean shower chair with hip belt and chest support with full assistance from staff. The ISP also indicated Client #1 required two staff to support her dressing.</p> <p>d. Client #1's Physical Nutritional Management Plan (PNMP) dated 3/20/19. The PNMP indicated Client #1 used an "Aquatec Shower Chair (with) hip belt and chest support."</p> <p>e. Client #1's Nursing Assessment on 4/7/19, indicated, "Staff reported client fell out of shower chair. Staff also states client did not hit her head. Staff reports client hit left shoulder on floor and rolled to her side." The assessment also indicated Client #1 had range</p>			

Page 3 of 18

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	<p>of motion within normal limits, a reddened area on the cap of her left shoulder and top of left elbow. The area on the shoulder was slightly warm and both areas were fading over time.</p> <p>When interviewed on 5/14/19 at 12:21 p.m. Residential Treatment Worker (RTW) A reported she was a new staff. She only worked on her own for about a week or two before the incident happened. RTW A reported she gave Client #1 a shower the evening of 4/7/19. She stated after Client #1's shower, RTW A wrapped Client #1 up in her shower chair and pushed Client #1 into her bedroom. RTW A unbuckled Client #1's chest support and lap belt to transfer her into her bed. RTW A remembered she forgot to assist Client #1 to brush her teeth. RTW A stated she forgot to ensure the chest support and lap belt were on Client #1 before moving her into the bathroom. She assisted Client #1 with tooth brushing and moved her back to her bedroom. When they arrived to Client #1's bedroom door, Client #1 leaned forward and fell out of her wheelchair. RTW A believed Client #1 landed on her left side. RTW A did not believe Client #1 sustained injuries, but RTW A was upset after it happened and the nurse took over. RTW A explained Client #1 should have her lap belt</p>			

Page 4 of 18

Facility Administrator

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	<p>and chest support on while in her shower chair. She acknowledged the facility trained her on the proper supports for Client #1.</p> <p>When interviewed on 5/14/19 at 2:15 p.m. the Director of Quality Management acknowledged the facility failed to ensure staff followed Client #1's PNMP.</p>			

**FACILITY RESPONSE:**

Page 5 of 18

Facility Administrator

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Page 6 of 18

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Page 7 of 18

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Page 8 of 18

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Page 9 of 18

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Page 10 of 18

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Page 11 of 18

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Page 12 of 18

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Page 13 of 18

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Page 14 of 18

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Page 15 of 18

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Page 16 of 18

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Page 17 of 18

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