DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 04/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A deficiency was cited at W322 regarding the investigation of #87699-I. No deficiencies were cited related to the investigation of #87700-I.	W 000		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to provide appropriate health care and assessment for a client who displayed ongoing symptoms of possible illness. This affected 1 of 1 client identified during the investigation of #87699-I (Client #1). Finding follows: 1. Record review on 1/08/20 revealed Client #1 was a 64 year old woman with a diagnosis including Severe Intellectual Disability, Hypothyroidism, Osteopenia, Dyphagia, Anemia, Bilateral Blindness, Hearing Loss, Kyphosis, Osteoarthritis, Peripheral Vascular Disease, Thrombocytapenia, Pancytopenia and Hyperprolactemia. Client #1 began having episodes of gagging, emesis and meal refusals on 10/06/19. The Primary Care Provider (PCP) ordered lab work on 10/07/19, which was reportedly within normal limits for Client #1. Client #1 continued to have ongoing episodes of gagging, emesis and decreased food intake during the rest of the month, but she had a prior	W 322	See attached POC 4/20/20	

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 322	Continued From page 1 history of periods of gagging,emesis and meal refusals. Nursing staff did regular assessments, which did not reveal anything unusual. Staff documented on 10/20/19 that Client #1 was more lethargic, needed increase assistance to transfer and was not communicating like she usually did. Client #1 continued to need increased staff assistance due to weakness and lethargy over the next several days. Client #1 was assessed by agency nurses, physical therapy (PT), occupational therapy (OT) and speech therapy, but not by the PCP or any physician. The PCP ordered lab work on 10/27/19, which was collected on 10/28/19 and received on 10/29/19. The PCP assessed Client #1 on 10/29/19. According to the PCP, the results of the blood work revealed a lower platelet count than usual, a high white blood count and acute renal injury (renal failure). The PCP sent Client #1 to the hospital emergency department on 10/29/19 and Client #1 was subsequently admitted to the hospital. The diagnosis upon admission was at urinary tract infection (UTI) and sepsis. The hospital administered IV antibiotics to Client #1. The hospital diagnosis on 10/30/19 was a UTI, urosepsis and possible pneumonia. The facility PCP spoke with the hospital physician on 11/03/19 and learned further testing revealed Client #1 had cancer, with metastasis to the liver, lung and probable lesion in the cecum. Client #1 was then provided with comfort care and died at the hospital on 11/05/19. 2. Additional record review of nursing/clinical notes and staff notes revealed the following: 10/06/19: Client #1 refused supper, but drank a supplement. She later vomited the supplement. Given Tylenol for temperature of 100.3, but	W 322		

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vomited after that. Nurses started emesis and hyperthermia protocol.

10/07/19: No further emesis or fever. No staff concerns. Lab work done on 10/07/19 for CBC and CPMP. Interpretations: normocytic normochromatic anemia, elevated alk phos and AST. History of cholecystectomy, normal bilirubin levels. Recommendations: Monitor for signs of blood loss, ordered FOBT x 3 specimens; repeat CBC CMP in 1 month for follow anemia and elevated Alk Phos and AST. (The Fecal Occult Blood Tests were done 10/16/19 and 10/17/19 and were negative.)

No further concerns until 10/14/19: Client #1 was shaking after supper and had a temp of 100.8, per staff. Nurse checked her and noted the client wore heavy pajamas and a blanket over her. Nursing will continue to assess for elevated temperature.

10/15/19: A staff person documented Client #1 has not been herself: not wanting to eat and had been gagging. Client #1 refused breakfast, but drank liquids. She then vomiting the liquids. Emesis protocol put into place.

10/17/19: Staff noted gagging at meal times.

10/18/19: AM staff noted meal refusals and gagging. Staff noted Client #1 seemed to be in a good mood. She didn't take AM medication. Client #1 went out for a medical appointment-annual mammogram. Findings were negative.

10/19/19: Emesis after lunch and supper. Speech therapist and physician/ARNP notified. Staff noted Client #1 didn't seem to be feeling well.

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W 322	Continued From page 3 Emesis protocol initiated. Vitals WNL (within normal limits). 10/20/19: Overnight staff noted Client #1 was very weak and lethargic when he got her up for toileting at 1:35 a.m. Temp was 100.7. Client #1 seemed to have no strength in legs, arms, hands. She needed additional staff assistance to stand and have brief changed. Also less verbal. Staff notified nurse, who did assessment. Nurse assessment at 8:10 am revealed no fever and vital signs WNL. Refused lunch, but drank liquids. Emesis after drinking liquids. AM staff noted two staff needed for some of her transfers. 10/21/19: Registered Nurse (RN) A noted she did an assessment on Client #1. Lung sounds clear. Client #1 only drank liquids that morning and afternoon. Refused to eat. RN A documented she talked with PCP about continuing emesis and gagging. 10/22/19: Overnight staff noted Client #1 continued to need two-person assistance during transitioning and standing. Client #1 dropped to floor when standing with staff assistance in the bathroom, assisted to the floor with staff holding gait belt. AM staff noted Client #1 ate most of her breakfast and lunch, with some gagging. AM staff noted it took 2-3 staff to transfer her and she didn't want to stand. PT assessed Client #1 at her home that afternoon, due to reports of decreased endurance with ambulation. Staff stated it took 2-3 staff to complete a transfer. The PT noted that illness had been circulating through the household which might explain the increased lethargy and diminished functional mobility. The PT recommended to perform Client #1's hygiene cares in bed versus using toilet and grab bar until	W 322		

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W 322	Continued From page 4 further notice. PM staff noted Client #1 refused supper and was very quiet. 10/23/19: PT again visited the house to assess Client #1. She was able to stand with 2 staff assistance for only a few seconds. PT recommended to continue to provide hygiene cares in bed and to continue to offer stand-pivot manual transfers. OT also assessed Client #1 on 10/23 regarding transfers and toileting. OT reviewed with staff how best to transfer Client #1. No nursing concerns on this date. 10/24/19: OT again assessed Client #1 and made recommendations regarding transfers and toileting, due to decreased endurance. OT noted Client #1 wasn't feeling well and was expected to return to baseline. Client #1 gagged repeatedly at breakfast. She refused breakfast and lunch, but did have a supplement and milk. Client #1 refused supper, but drank milk and juice and then had an emesis. Nurse assessed. 10/25/19: Nursing assessment in AM, with vital signs WNL. No signs or symptoms of distress. PT assessed Client #1 again and tried a type of standing mechanical lift, which was not successful. Client #1 had an emesis after supper. Nursing assessment was unremarkable. 10/26/19: Client #1 ate very little breakfast and had emesis after drinking juice. Nursing assessment unremarkable. Client #1 ate a few bites of lunch and refused supplements. Client #1 was still having problems standing without staff assistance. 10/27/19: Staff noted Client #1 did not assist with personal cares and acted like she had no	W 322		

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strength to put her arms through her sleeves when dressing. Staff fed her breakfast and Client #1 had trouble lifting the cup at times, using both hands. She ate a few bites for lunch and drank her liquids. RN A noted Client #1 appeared tired. RN A documented that she sent an email to the PCP about concerns of frequent emesis and being weak. (The PCP ordered blood draw/labs, which were done on 10/28/19.)

10/28/19: PT again assessed Client #1. She was able to stand with assistance from two staff, but refused to attempt to ambulate with her walker. Endurance for standing was 3-5 seconds. Client #1 ate a few bites of supper and vomited.

10/29/19: Client #1 was seen at the facility clinic by her PCP for assessment due to emesis and poor appetite. The CPC noted staff reported for the past few days Client #1 had no interest in her favorite items, did not call for favorite staff and had been seen drinking from the faucet. She also had decreased food intake and more meal refusals than usual, in addition to gagging episodes and emesis. Labs drawn on 10/28/19. After reviewing the lab results and assessing Client #1, the PCP ordered an immediate transfer to ER. The PCP noted Client #1 had episodes of gagging and emesis over multiple years. Vital signs taken during the exam were WNL, with regular heart rate, clear lung sounds and normal active bowel sounds. Client #1 was awake and alert, but not vocalizing or crying per her baseline. Staff reported weakness, requiring 2-3 staff assistance with transfers. Doctor noted AKI (Acute Kidney Injury) and Leukocytosis/possible UTI, based on the lab results. Client #1 went to the ER/hospital on 10/29/19 and was admitted.

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W 322	Continued From page 6 11/03/19: The facility PCP documented she talked with a hospital doctor who informed her a CT scan of Client 1's abdomen and chest showed metastasis to the liver, lung and a probable lesion in cecum. The location of the primary cancer was unknown. 11/05/19: The facility PCP documented she talked with a hospital nurse who informed her Client #1 had a Do Not Resuscitate (DNR) order in place, with comfort cares. The only medication she was receiving was IV seizure medications and IV pain medications. Client #1 died at the hospital on the evening of 11/05/19. 3. When interviewed on 1/08/20 at 10:45 a.m. the PCP acknowledged Client #1 had symptoms of gagging, emesis, decreased food intake and increased weakness around mid-October 2019. OT and PT had been assessing Client #1's decrease in mobility. The PCP had ordered routine labs on 10/07/19, which were within normal limits for Client #1. The PCP ordered blood work again on 10/27/19 and got the results on 10/29/19. The blood work revealed renal function was decreased, which was new for Client #1, indicating possible dehydration or sepsis. The white blood cell count was increased, indicating a possible infection. Client #1 had Thrombocytapenia, but the platelet count was lower than usual for her. The PCP examined Client #1 on 10/29/19 and decided to send her to the emergency room due to the results of the blood work. When asked why she didn't examine Client #1 prior to 10/29/19 or order labs prior to the 10/27/19, the PCP stated she was aware of Client #1's status and getting regular updates from the facility nurses. Client #1's condition didn't appear to be overly serious. She had a past	W 322		

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W 322	Continued From page 7 history of going through periods of gagging. Her vital signs and weight were stable. Client #1 had limited communication skills. It was not unusual for her to making crying and whining sounds. The CPC said she had no idea Client #1 was seriously ill until she reviewed the lab results. Client #1's cancer diagnosis was a shock. 4. When interviewed on 1/27/20 at 11:30 a.m. Registered Nurse (RN) A stated she was Client #1's primary nurse at the facility and had worked with her for approximately five years. RN A said Client #1 had a history of going through episodes of gagging and emesis, which lasted about one month. These episodes happened about every two years. By the latter part of October, Client #1 was having more incidents of gagging and emesis than she had in the past. The lethargy/weakness and decreased communication Client #1 exhibited were not typical for her. RN A said she kept the PCP updated regarding Client #1. RN A stated she thought the PCP should have seen Client #1 when she became more lethargic. RN A said she told the PCP that Client #1 should be seen. Client #1 became weaker around the middle of October. RN A stated sometimes when she notified a facility ARNP (Advanced Registered Practical Nurse) or Physician about a concern about a resident, she didn't get a response. During a follow-up interview on 3/03/20 at 9:15 a.m. RN A said Client #1 became weak and needed increased staff assistance, which was not typical. RN A said she asked the PCP to see Client #1 around the time she became weak/lethargic. The PCP told RN A to keep monitoring Client #1. RN A said it could be difficult to get vital signs and do a thorough	W 322		

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assessment on Client #1, because she resisted. RN A said it was not unusual for Client #1 to sleep for much of the day. She had a history of sometimes refusing to eat, but in the past she would always drink. During the latter part of October, Client #1's eating and drinking were minimal. Client #1 needed two staff to transfer her and needed assistance to dress, which was unusual. RN A reviewed the nursing notes from October and noted that she talked with the PCP on 10/21/19 about the continued emesis and gagging. RN A didn't recall if she told the PCP on that date that she thought the PCP should see Client #1. RN A didn't recall what date she told the PCP that Client #1 should be seen. RN A documented she sent an email to the PCP on 10/27/19 regarding Client #1's weakness and ongoing emesis. The PCP ordered a blood draw/labs on 10/27/19. RN A said in last the week or so at the facility, Client #1 didn't present as being in pain, but was weak, not eating or drinking much, sleeping a lot and seemed to be ill. RN A said she had concerns regarding the PCP's lack of timely follow-up. RN A said she had concerns that the ARNPs and physicians at the facility sometimes didn't follow up in a timely manner or see clients as soon as they should.

5. When interviewed on 1/27/10 at 2:50 p.m. the facility Medical Director said the PCP had been in touch with the nursing staff regarding Client #1's status, which did not appear to be significantly out of the norm. Nurses also documented information on the physician notification line, which a facility nurse reviewed with the physicians/ARNPs three times per day. The Medical Director said there had been ongoing communication back and forth between RN A and the PCP regarding Client #1. He said typically if a

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W 322	Continued From page 9 nurse requested the PCP to see a client, then the client would be seen, or there would be an explanation regarding why the PCP didn't think it was necessary to see the client. The Medical Director said if Client #1 was exhibiting new (not historically typical) symptoms of lethargy, increase assistance with transfers and not helping with dressing, then she should have been seen by her PCP. 6. When interviewed on 1/09/20 at 10:20 a.m. the Resident Treatment Supervisor (RTS) stated prior to roughly mid-October, Client #1 needed the assistance of one staff person and a gait belt for transfers. He said Client #1 had a history of sometimes refusing to eat. She also had a history of periods of gagging and emesis, but it was more pronounced during October. It was beyond what had been typical in the past. The RTS said Client #1 didn't appear to be seriously ill during the month of October, but she didn't seem to be her usual self. She didn't show signs of being in pain. The facility nurses were doing regular assessments. 7. When interviewed on 3/03/20 at 11:20 a.m. Resident Treatment Worker (RTW) A said she was a long term employee at the facility. She said when Client #1 initially refused to eat it was not overly concerning because she had refused to eat in the past. It became more concerning when Client #1 got weaker and needed 2 staff to transfer her. RN A was frequently checking on Client #1. The Speech Therapist was also there, assessing Client #1 regarding the episodes of gagging and emesis. RTW A said she thought there must be something wrong with Client #1 when she got so weak and needed 2 staff to assist her.	W 322		

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8. When interviewed on 3/03/20 at 1:30 p.m. RTW B said she had worked at Client #1's house for about 10 years. She said Client #1 had gone through phases in the past when she had some gagging, vomiting and refusal to eat, but in October it was ongoing. RTW B was concerned because Client #1 wasn't herself. She was less social and engaged with others. Client #1 had previously been able to easily transfer with one staff person assisting her, but she became a 2-person transfer. RTW B said Client #1 didn't necessarily seem sick, but was not her usual self. Nursing staff, speech therapy, OT and PT all came to assess Client #1. There were no indications that Client #1 was in pain, but she kept getting worse.

9. When interviewed on 3/03/20 at 4:00 p.m. RTW C stated she had worked at Client #1's house since May, 2019. She said Client #1 had been able to transfer with one staff person assisting her, but by mid-October she required two staff to assist her. RTW C recalled that during October, Client #1 had episodes of gagging, emesis, refusing to eat and weakness. Client #1 also lost interest in things she had enjoyed and she didn't interact as much with others. Her personality changed. RTW C thought the PCP should have seen Client #1 sooner, due to her weakness and not eating.
10. When interviewed on 3/03/20 at 3:20 p.m. the Speech Therapist (ST) said she went to the house to assess Client #1 several times (in October) due to ongoing gagging, emesis and refusing to eat. The ST said she thought something was very wrong with Client #1. She requested an EGD (esophagogastroduodenoscopy) be done to

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W 322	Continued From page 11 check Client #1's esophagus, but either the PCP or the Medical Director said it wasn't necessary. Client #1 had a full gastrointestinal work up several years earlier. The ST said she didn't recall if she requested to have Client #1 assessed by the PCP. The ST said she thinks the PCP should have seen Client #1 sooner. Client #1's increased frequency of the emesis, gagging and meal refusals were not normal for her. The ST stated Client #1's quality of life might have been better if she had been diagnosed sooner.	W 322		

ok 7/14/20

Glenwood Resource Center
Standard Level Plan of Correction for DIA #87699-I

W 322- 483.460(a)(3) Physician Services – The facility must provide or obtain preventative and general medical care.

Individual Response:
Medical Providers have been trained on the Medical Care Protocol (rev.6/9/20), which includes medical provider guidance to ensure the following aspects of medical care; admission diagnostic and evaluation, routine medical care, use of medical consultants and specialties and urgent/emergent medical care.

Responsible: Interim Medical Director & Interim Superintendent
Date completed: 6/9/2020

Systemic Response:
The Interim Medical Director participates in the M-F morning medical provider meetings, evaluates provider response, and reviews IPR documentation and initiates situation resolution per standards of practice.

Responsible: Interim Medical Director & Interim Superintendent
Date completed: 4/28/20