Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **9033**			**Date:** **December 4, 2020**
Facility Name: **Glenwood Resource Center**		**Survey Dates: September 14, 2020 – November 17, 2020**	
Facility Address/City/State/Zip **711 So. Vine** **Glenwood, IA 51534**			
	LK	**92297-M**	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
64.60	**481-64.60(135C) Federal regulations adopted - conditions of participation. 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. 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. This rule is intended to implement Iowa Code Section 135C.2(3).** **DESCRIPTION**	**I**	**$4,500.00**	**Upon receipt**
W318	**The facility must ensure that specific health care services requirements are met.** Based on interviews and record reviews, the facility failed to provide clients with nursing services in accordance with identified needs. See W331.			

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W331	On 10/30/20 at 4:20 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to provide nursing care as identified by client needs. The facility developed a plan to remove the IJ, which included retraining on emesis assessments and who can call 911. On 11/4/20 at 3:47 p.m., the IJ was removed from the facility. **The facility must provide clients with nursing services in accordance with their needs.** Based on interviews and record reviews, the facility failed to provide clients with nursing services in accordance with identified needs. This affected 1 of 1 client (Client #23) reviewed during investigation #92297-M. Findings follow: Record review revealed the following:			

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	a. Type 1 Incident Investigation dated 6/13/20, indicated, "Client #23 left the unit at 9:41 p.m. by 911. While at the hospital Client #23 had another emesis and coded. The hospital staff could not revive." b. Client #23, at the time of the incident, was a 65-year old man with a diagnosis of Profound ID, Autism Spectrum Disorder, Rumination Disorder, pica, Slow Transit Constipation, Dysphagia, and Hyperthermia. He also had a history of bowel obstruction and aspiration pneumonia. c. Client #23's Individual Support Plan (ISP) dated 4/2/20, indicated the facility provided Client #23 with a one-to-one staff because of his history to eat inedible items. He was at risk of hyperthermia and the facility took his temperature rectally three times a shift. His diet was a texture puree consistency. He independently fed himself unless too fatigued. d. Client #23's Autopsy Report dated 7/15/20 indicated the cause of death to be artherosclerotic cardiovascular disease.			

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	e. Client #23's nursing assessment completed on 6/13/20 at 7:00 p.m. by LPN B, included vital signs and indicated his blood pressure was 126/81, his pulse was 97, his respirations were 18, his oxygen was 90%, and a rectal temperature was 97.8. The nursing assessment also indicated, "Client awakens while sleeping but actually more drowsy... S: Staff report client had an emesis. Staff also state that client is just not acting himself. O: Witnessed yellowish thick emesis with remnants of undigested food from supper possibly. No odor noted. Moist pharyngeal sounds noted bilat (bilateral) - as if client needs to cough. A: Emesis assessment. P: Continue per protocol. Staff to notify nursing with any concerns." f. Client #23's nursing assessment completed on 6/13/20 at 9:25 p.m. by LPN B indicated his oxygen was 81% and they tried to give Client #23 oxygen via nasal cannula but he would not leave it on. The nursing assessment also indicated, "S: Staff called stating that client was having more emesis. O: Received call from staff at 9:20 p.m. that client was still having emesis. Called (RN A) before arriving at 9:25 p.m. at 465. Client was having an emesis upon			

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	arrival that was thick yellow with food particles and had a "chicken" aroma. Informed (Medical On Duty) at 9:27 p.m. that client had had 13 emesis since supper and she gave an order to send the client out 911 and to notify her where the ambulance was going to go so she could call up before he got there. Client was then placed on O2 via concentrator with NC d/t O2 at 81% RA, however, he would not leave it on even with staff assisting him. Client left via 911 on a stretcher. Ambulance staff informed that the client would engage in pica and will grab anything and everything to place in his mouth. (Medical ON Duty) informed that he was going to JEMH and she stated she would call and give them a head's up. A: Transfer to hospital/possible aspiration. P: Will f/u with hospital with diagnosis." g. House 465 call log included a call received at 7:01 p.m. from the clinical wing, at 7:55 p.m. from LPN B's desk, at 8:09 p.m. from LPN B's desk, and at 9:16 p.m. from LPN B's desk. h. RTW/CMA DD's notes from 6/13/20 indicated Client #23 had an emesis at 6:30 p.m., 6:45 p.m., 7:03 p.m., 7:19 p.m., 7:24 p.m., 7:44 p.m., 7:53 p.m., 8:00 p.m., 8:10 p.m., 8:18			

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	p.m., 8:45 p.m., 8:57 p.m., 9:10 p.m., 9:24 p.m., and at 9:30 p.m. i. Assessment/Reassessment guidelines indicated after notification of an emesis, the nurse should do a physical assessment upon notification and notify the RN for clinical oversight. A client is reassessed after an emesis every shift for 24 hours and then twice daily for 48 hours. If another emesis occurs, the nurse should complete another physical assessment upon notification. j. Nursing Services Procedure dated 3/4/19, indicated, "1. First Employee discovering a medical emergency will assume the role of "First responder... 2. The First responder will activate the Emergency Response System by dialing *9-911 and: a. Notify via radio, telephone (overhead page:83-555), or unit staff that there is a medical emergency 'Nurse Stat' or 'Code Blue,' repeating twice (include location of event) and request the AED..." When interviewed on 9/23/20 at 2:45 p.m. RTW/CMA DD reported he worked the morning shift on 6/13/20 and Client #23 was good. Client #23 finished dinner at			

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	approximately 5:00 p.m. He was the first one done eating. He had pureed chicken, but did not eat much. RTW/CMA DD stated Client #23 was normal until about 5:30 p.m. At approximately 5:30 p.m., RTW EE took Client #23 to the bathroom. During transfer to the toilet, Client #23 let go of the stand. RTW EE yelled for help and they decided to take him to his bed because that was a safer option. RTW EE changed Client #23 and he stayed in bed for approximately 30 minutes. RTW/CMA DD took over Client #23's one-to-one supervision from 6:00 p.m. to 6:30 p.m. while RTW EE went to break. Took two people to transfer him out of bed and back into his wheelchair for 7:00 p.m. medication. At 6:30 p.m., RTW/CMA DD got ready to administer medication to clients and RTW EE was Client #23's one-to-one staff when Client #23 had his first emesis. RTW/CMA DD called LPN B and did not get a response before Client #23 had another emesis. RTW/CMA DD wrote down the exact times Client #23 had an emesis and the exact time LPN B showed up to complete an assessment. RTW/CMA DD asked the surveyor to refer to his timeline he gave the facility investigator for the times as he could not remember. RTW/CMA DD stated he documented the exact time everything			

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	happened. According to RTW/CMA DD, he called LPN B after each emesis. RTW/CMA DD did say he did not believe the first two pages went through, but he continued to page to make sure LPN B received them. Client #23 had vomited three to four times and RTW/CMA DD completed a set of vitals for LPN B before he arrived at the home the first time. RTW/CMA DD gave LPN B the vitals. RTW/CMA DD observed LPN B with the stethoscope but did not see him do any assessments. RTW/CMA DD could not report if LPN B completed the assessment as he was in and out of the room administering medications to other clients. RTS K also came to the house around the same time LPN B was there. Before LPN B left the home, RTW/CMA DD asked if he should still administer medication to Client #23. LPN B told him yes and to let him know if there were problems. RTW/CMA DD told LPN B he would wait to administer his medications last so Client #23 had RTW/CMA DD's full attention. RTW/CMA DD administered Client #23's medication and they came right back up. RTW/CMA DD paged LPN B again and did not hear anything until closer to 8:00 p.m. LPN B told RTW/CMA DD to monitor Client #23 and report changes. RTW/CMA DD took over			

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	Client #23's one-to-one supervision to monitor him. Client #23 continued to have emesis and RTW/CMA DD continued to try to get a hold of LPN B. He would not return his page. RTW/CMA DD called his supervisor and asked her if he should call the nursing supervisor because LPN B was not responding. RTS K stated she would be right over. LPN B and RN A arrived before RTS K after 9:00 p.m. They called 911 and Client #23 left in the ambulance with RTW EE. RTW/CMA DD stated the EMT's (Emergency Medical Technicians) placed Client #23 on his back on the stretcher. He did not understand why they would place him on his back when he was vomiting. RTW/CMA DD described Client #23's appearance and actions. He said he was pale, but always had a ghostly look. He did not seem happy and he was limp. Client #23 was not opening his mouth the emesis was just coming out of his mouth. RTW/CMA DD stated Client #23 is usually active grabbing at items to pica. He did not have pica and could not click his wheelchair belt. When you looked into his eyes, he seemed like he was still there. Client #23's emesis was more mucus and at the end of the night, it was clear. It seemed like a lot of built up drool. RTW/CMA DD reported LPN B was not responding to RTW/CMA DD's			

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	calls. The nurse in charge of the house was not their normal nurse. Their normal nurse would come right out when he called her. RTW/CMA DD felt like he could not talk to LPN B. When he did talk to him, RTW/CMA DD felt like he was bugging him. When LPN B did respond, he would just inform RTW/CMA DD to keep an eye on Client #23 and let him know. RTW/CMA DD told LPN B he was concerned. RTW/CMA DD felt like LPN B shrugged it off as if it was a normal thing. RTW/CMA DD stated he never hounded nurses, but he felt like he needed to call about Client #23. Brandon also stated he understood it could be nothing, but clients that had less of a medical issue had more assessments completed. RTW/CMA DD felt sad for Client #23 that he was not getting the response and medical attention that he was paying for. He understood people were busy but he felt ignored. RTW/CMA DD reported staff can call 911, but some staff told him he had to wait for a nurse and others told him to call. RTW/CMA DD believes Client #23 would have been more comfortable at the hospital as they may have been able to do something for him.			

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	When interviewed on 10/30/20 at 12:37 p.m., RTW E reported he was Client #23's one-to-one supervision. Client #23 started vomiting and continued to vomit. RTW/CMA DD called LPN B after every emesis. According to RTW E, LPN B did not come to the home as soon as RTW/CMA DD called him. RTW E believes it was approximately 7:00 p.m., when LPN B came to the house, but he could not remember. When LPN B came into the home, Client #23 was vomiting. RTW E stated LPN B stood behind Client #23 and did not see him complete an assessment. He did not remember LPN B using a stethoscope on Client #23. RTW EE stated LPN B could not have completed an assessment without him witnessing it. He was Client #23's one-to-one and was right next to Client #23. RTW EE stated RTW/CMA DD completed vital signs on Client #23 before LPN B arrived. Before LPN B left the home, he told staff to keep an eye on Client #23 and let him know of any changes. RTW EE reported Client #23 continued to vomit and RTW/CMA DD called LPN B after each emesis. RTW EE stated RTW/CMA DD called so he did not see how he called the nurse, if it was by phone or radio. According to RTW EE, RTW/CMA DD called the nurse more than three or four			

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	times. He stated RTW/CMA DD called six or seven times at a minimum. RTW EE stated Client #23 had no problems before he started to vomit. His vomit was yellow and did not have food particles or anything in it. Client #23 was up in his wheelchair. RTW EE stated Client #23 had a pica diagnosis, but did not get a hold of anything when he was supervising him. As Client #23 continued to vomit, his breathing got deeper. LPN B and another nurse came out to the house. They said to call 911. RTW EE rode with Client #23 to the hospital. The doctor told RTW EE, Client #23 aspirated on his vomit and his heart was not strong enough to continue. In RTW EE's opinion, LPN B was not a good nurse. When they had their regular nurse, she came to the house when they called. When LPN B came to the house, he did not do anything. When interviewed on 9/23/20 at 10:00 a.m. RTW CC reported Client #23 was in RTW EE or RTW/CMA DD's care constantly. Client #23 usually ate on his own, but RTW EE fed him most of his meal. She stated early in the evening she assisted Client #23 into his stander. He tried to slide through. She stated they had him in the stander correctly, but she			

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	believed he was weak. He had a couple of large bowel movements and she retrieved rags to help. Client #23 started vomiting after supper. RTW/CMA DD called the nurse after each emesis. According to RTW CC, RTW/CMA DD called LPN B five times before he arrived at the home. She stated he did not complete an assessment, just stared at the back of Client #23's head. RTW CC remembered LPN B was at the home for approximately five minutes. After LPN B left, staff took Client #23 to his bedroom. She took clothing protectors to his bedroom. When they brought him back out to the living area, Client #23 continued to vomit. RTW CC remembered Client #23 had labored breathing. According to RTW CC, his coloring did not look good. She thought he had a gray complexion. He looked tired and not real alert. They discussed calling someone. RTW/CMA DD called the supervisor. RTW CC stated Client #23 vomited approximately 13 times. LPN B came out to the home with another nurse. They called the doctor and she told them to call 911. He was still breathing when they took him out. She could not remember times at which things took place. RTW CC stated she talked to an overnight staff and they told her his ankles looked swollen overnight, but a regular staff			

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	stated it was normal swelling in his legs. RTW CC did not know RTWs could call 911. When interviewed on 9/28/20 at 3:00 p.m. RTW FF reported she came in at 2:00 p.m. that day and did not notice anything different with Client #23 until after dinner, but she was new and had not dealt with him that much. She had not worked with him because she had not been trained on him yet. She did not know of any pre-existing conditions, but knew he had pica. After dinner, Client #23 had emesis after emesis. She knew RTW/CMA DD called LPN B a few times before he came to the home. When LPN B arrived, he stood behind Client #23 watching him. RTW FF stated she was right there when LPN B came in giving new bibs to staff after each episode. She did not remember LPN B using a stethoscope on Client #23. She believes he just said to observe him and then left. Client #23 continued to vomit and RTW/CMA DD continued to call the nurse. Client #23 sounded "gurgly." His vomit looked like a thicker yellow/golden colored fluid. She stated there his vomit did not have chunks. A nurse arrived at the home at approximately 9:20 p.m. to 9:30 p.m., before they called 911 and the ambulance took him to			

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	the hospital. She was unsure if the nurse completed an assessment at that time. RTW FF remembered there was an issue of the nurse not responding in a timely manner. She felt the nurse should have been there sooner. She believed they did not call 911 beforehand because RTW/CMA DD tried to get a hold of someone. When interviewed on 9/28/20 at 2:35 p.m. RTS K reported she stopped at House 465 at approximately 7:00 p.m. She witnessed Client #23 have two emesis. RTS K stated there was not any bulky stuff in his emesis. She believed LPN B was there when she arrived and wanted them to monitor him. She could not remember if LPN B completed an assessment. She remembered LPN B thought Client #23 had a cold because he had raspy breathing. LPN B stated it sounded like he needed to clear his throat. LPN B also thought his food might not be agreeing with his tummy. RTS K thought LPN B must have completed an assessment since he suggested a cold. RTS K left the house after they changed his clothing protector. She suggested taking him somewhere more comfortable, such as his bedroom to watch T.V. Client #23 had			

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	hyperthermia and his bedroom was warmer than other parts of the home. RTS K stated Client #23 did not look pale. Client #23 was not his usual self, he was not trying to grab. According to RTS K, Client #23 had not been as active since they put him on one-to-one supervision. RTS K stated RTW/CMA DD called her after he administered Client #23's medication, at approximately 8:00 p.m. He did not think LPN B was responding in a timely manner. Client #23 did not take the medication and RTW/CMA DD was concerned. RTS K instructed RTW/CMA DD to page LPN B again and they sent Client #23 out a little bit later. She also instructed RTW/CMA DD to page the nursing supervisor if he still did not get a response. According to RTS K, she did not think RTW/CMA DD called after every apparent episode. They are to call the nurse and the supervisor after each episode. They do not document the time they receive calls. The supervisor would include the time on each apparent episode form. They did not notify her after every emesis. RTW/CMA DD notified her one time before rounds and then again after RTW/CMA DD administered medications. They should have notified her more than that, but they get busy with supper and getting change of position completed with clients. They ask			

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	that the staff notify the supervisors as soon as possible or within 30 minutes of an apparent episode. RTS K believed the staff did what they were supposed to do. She is hoping LPN B also did what he was supposed to do. If the nurse does not respond, they can call the nursing supervisor. If they still do not get a response, they call the AOD (Administrator on Duty). They did not think Client #23 would pass that night. Andy thought it was a bug, but should have gotten outside help. When interviewed on 10/12/20 at 10:45 p.m. RN A reported she worked on 6/13/20 and had house 465. She always had houses on the hill, 465 is one of her regular houses. She heard approximately three pages for 465. It could be possible there were more pages that she did not hear, but unlikely. If anyone heard 16 pages or several pages for 465, one of the RN's would have shown up at the house. All of the nurses hear the pages over the radio; when you call for a nurse, it does not just go to one radio. LPN B called her at approximately 9:30 p.m. and requested she went to the house with him. When she arrived, Client #23 sat in the dining room with staff around him. He had an emesis and staff			

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	informed her he had multiple. Client #23's respirations were audible. He was struggling. RN A asked if vitals were completed, and they said yes. RN A put on the pulse oximeter and then directed staff to get vitals. RN A told LPN B to call the doctor and asked staff to get the oxygen. They sent out within minutes. RN A stated Client #23 was hypothermic, so they always kept him warm. He had one-to-one supervision because of pica diagnosis. RN A felt like someone should have notified her sooner. If staff cannot get a hold of the LPN, they can get a hold of the RN. RN A did not see LPN B's original assessment. She stated everything was gone by the time she tried to look at it. She stated the RN's oversee the LPN's. There are some assessments that only RN's can complete, such as after a chemical injection. The LPN's can complete an emesis assessment. The LPN's notify the RN's of anything happening in the houses. As medical issues come up during the shift, they document on a spreadsheet for the triage nurse to call the physician on-call at 9:00 p.m. The triage nurse reads right off of the spreadsheet. She stated they could call the physician anytime; they do not have to wait until 9:00 p.m. She worked with LPN B before and			

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	had no problem with him. She believed he was a great worker. When interviewed on 9/29/20 at 1:00 p.m. the Interim AON reported she was on campus for a few hours on the evening of 6/13/20. Within a few hours, she heard at least two pages early in the evening. She had another house and could not state if she heard another page. When someone calls for a nurse, you can use the house phone or a radio, both come through the nurse radio. Maintenance is on a different frequency. The nurses hear all the calls, as long as their knobs are on the right frequency. The Interim AON talked to LPN B at approximately 7:30 p.m. to 8:00 p.m. He went to her office and asked how he should document Client #23's level of consciousness. The drop down boxes on the nurse assessment did not reflect what he wanted to say. He told her Client #23 had an emesis and was not alert, but was not lethargic. She told him to mark non-responsive. The Interim AON stated Client #23 could be like that with medications. He reflected that in his assessment. He also told her he had stuff in his throat and needed to cough. She agreed with him that Client #23 is			

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	sometimes like that. The Interim AON explained some of Client #23's history. She stated he did not have a strong history of emesis. He did have a history of gastrointestinal issues. He wore oxygen at night while in bed; she believed he had sleep apnea. They also have to monitor his oxygen after a seizure. Anything less than 90%, he needed oxygen. She did look at his past oxygen levels to determine what was normal for him. The Interim AON stated they originally assumed 91% was normal for him. After she reviewed his past oxygen levels, his normal was in the middle 90's. His lowest oxygen level was at 92% on one occasion. After her review, she determined 91% to be low for him. They are usually OK with 88% for most people. The Interim AON stated when a client has an emesis their assessment would include, at a minimum, vitals, lung sounds, bowel sounds, and level of consciousness. After you complete the assessment, you need to make sure you document. After every emesis, a nurse should assess the client. The Interim AON stated there was no timelines on how long the LPN had to notify an RN of an emesis. They are trying to work on getting that on the guidelines, but it would vary from client to client. She believed the LPN should notify an RN after a			

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	client had a couple of emesis, but it would depend on the assessment. They should notify the RN just to give a heads up or get a second opinion. The Interim AON could not say if the LPN notified the RN appropriately. The Interim AON could not say if the LPN notified the RN appropriately. She stated he could have documented the number of times Client #23 had an emesis. If the medical issue is an emergency, the site nurse can call the provider. If it is a non-emergency, they put it on the call log, just for information. At 9:00 p.m., the triage nurse calls the on-call physician and reads the document. If the on-call physician has questions, they may ask to clarify. The physicians not necessarily notified for an emesis, especially if it is one emesis during a meal. The Interim AON confirmed an LPN could give permission to administer medications after an emesis. It does not have to come from the speech therapist. She stated it was important that he received his medications, even if they have had an emesis. The Interim AON reported the autopsy report indicated Client #23 passed away from a heart attack. She stated the ambulance hook up did not bring up cardiac issues. She is unsure if the hospital would have caught it. The Interim AON stated LPN B was one of the			

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	nurses picked to provide treatment in a COVID-19 home. She is unsure why he did not appear attentive, but she questioned why he responded so quickly to the last call. She stated RTWs do not always complete vitals, but the CMAs could do some of the vitals. Some of the nurses ask staff to get the vitals, but you really do not know if they completed them. When the Interim AON does an assessment, she completes the vitals herself. The Interim AON stated if Client #23 would have had one emesis, he should have completed another assessment within four hours. Even if he just took his oxygen level, especially if it sounded like he needed to cough. When interviewed on 9/29/20 at 3:35 p.m. RN B reported she worked the evening of 6/13/20. RN B and RN A were at the infirmary and she believed she heard three pages for house 465. They heard each page answered. After the third call, they both thought something must be going on and then LPN B called RN A. RN A left for house 465. According to RN B, she did not hear the pager 16 times. She stated she would respond if any house paged 16 times. She thought			

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	three pages was a lot. The only time she would not have heard a page is if she had her stethoscope in her ears. She does not believe she missed any of the pages. There could possibly be a time when the radio would cut someone out, if another house paged at the same time. RN B did know of a time this has happened. She said sometimes there is static and you only hear part of it. RN B stated the staff could call the nurse's desk, but they usually use the radio. After a nurse receives a page over the radio, they will call the house number. RN B is curious why there was not a nurse stat call from the staff at the house. They sent Client #23 out as soon as RN A saw him. RN B stated the nurse could complete the vital signs during their assessment or ask the CMA do them, it depended on the situation. If she were unfamiliar with a client, she would ask staff. The RTWs are well versed in the clients. They know when clients are not acting like themselves and can provide information when completing assessments or treatments. RN B explained an RN's duty. She stated the RNs have their own assignments and cover the LPN's if there are issues. The LPN's report incidents and changes of condition to the RN. They can also ask for second opinions or if they are concerned with			

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	anything. RN B stated there is not much difference between an LPN and an RN. There are certain assessments only an RN can complete. A couple of the assessments only an RN can complete include suicidal threats or attempts and sexual assaults. LPN's can do an emesis assessment, but they should report anything concerning to the RN. Not all LPN's would report an emesis to an RN, unless it is a significant change. They should also notify the physician. The triage nurse calls the physician on-call at 9:00 p.m. and informs them of any non-emergency medical issues. The triage nurse puts in any orders from the physician. If you believe a client needs an order for something, then you can call the physician and get the order. You do not have to wait until 9:00 p.m. to notify or receive an order from the physician. When interviewed on 9/29/20 at 3:24 p.m. LPN D reported she worked the evening of 6/13/20. She stated when she hears a page on the radio she makes sure a nurse responds with a "10-4." She believed she heard between three and four pages for house 465, but she cannot be sure. She thought the pages were after supper, between 6:00 p.m. and 8:00			

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	p.m. She also believed she heard a "10-4" with every page. She knew they had an emergency call at another house after the last 465 page. She did not hear 16 pages for house 465 and the last she heard Client #23 had a small emesis. LPN D explained the difference in duties between an LPN and an RN. She stated the LPN's could not do some assessments, such as initial assessments and suicidal assessments. LPN's could do most of the other assessments. LPN's are able to implement their nursing judgement. The LPNs had to notify RN's of incident reports and change of conditions. LPN D believed the LPNs had 30 minutes to notify the RN's of non-emergency issues. If it is an emergency, they should notify RN's right away. She stated when RN B is her RN, RN B documents when LPN D informs her of medical issues. If she is unfamiliar with a client, she looks at the client's ID sheet and recent and/or past assessments. LPN D will also ask RTWs about the client or any other familiar nurse. When LPN D completes an emesis assessment, she asks what size and color the emesis was. She also listens to lung and bowel sounds. RTWs and CMA's usually help. LPN D notifies the physician if the client is stable and starts the emesis protocol. She stated if a client has more than one emesis, she			

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	goes back to the home and reassess. LPN D documents the number of emesis in the S portion of the SOAP (Subjective, Objective, Assessment, and Plan) note. It depended on how spaced out the emesis are and if vitals were different if she documented a new assessment. She would monitor the vital signs. They document the vital signs on a separate log on the computer. LPN D stated she would stay at the home and monitor the client if they are vomiting continuously. She also stated she could get an order for Zofran from the physician. According to LPN D, Client #23 is pica so she would want to listen for a bowel obstruction in case he ate something he should not. When interviewed on 9/29/20 at 3:00 p.m. LPN C reported he worked the evening of 6/13/20. The LPNs usually have three houses during a shift. He was the triage nurse for the evening. He gave the 9:00 p.m. report to the physician on-call. Nurses write their concerns or questions on an excel document for the 9:00 p.m. report. LPN C calls the physician on-call and reads from the document. Sometimes the physician gives orders, but most of the time it is just information relayed to the physician. If a			

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	nurse needs an order, they call the physician themselves. They would not wait for the 9:00 p.m. report for an order. It is possible there was a page and he did not hear it. According to LPN C, between 6:00 p.m. and 8:00 p.m., LPN C heard three pages for house 465. He stated he heard the pages answered with a "10-4". Another nurse would have offered to help if the nurses heard more pages. LPN C did not know what was going on at 465. He stated they sent another client to the hospital around the same time they sent Client #23. LPN C stated RN's have to do certain assessments, such as admissions, chemical injections, and restraint assessments. LPN C explained when an LPN should notify the RN's of medical issues. He stated if the issue is an emergency deal with it first and then the LPN notifies the RN. For other concerns or conditions, the LPN can notify the RN at the end of the shift. If a client has an emesis, the nurse should assess within 20 minutes and notify physician if fever or possible aspiration. The nurse can notify the physician within 24 hours if it is not extreme. Per protocol, they should reassess the client every shift for 24 hours after an emesis then twice daily for 48 hours. If the client has another emesis, the protocol starts over. According to LPN C, if the client has			

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	more than one emesis in a short amount of time, they can compile them into one assessment. If the emesis is 20 minutes apart, enter as one assessment. The process starts over unless close together. Notify the RN depending on the condition. LPN C would try to be at the home while the client had an emesis and would not leave the home until the client was stable. The RTW/CMA could do the vital signs, but with this situation, he would do it himself. If the RTW/CMA completed the vital signs, LPN C would redo them. LPN C would also listen to the lung sounds and take temperature right away. If there is a low-grade temperature, it could indicate aspiration. If LPN C did not know the client, he would ask his supervisor or other nurses that have worked with the client before. He may also look at progress notes. LPN C believed LPN B was a solid nurse and he could rely on him. When interviewed on 11/4/20 at 1:30 p.m. LPN B reported his main houses are 133 and 241. Those are the houses he completes quarterly nursing assessments and other exams on a regular basis. The facility assigns different houses during his shift. The evening of 6/13/20, his assignment included house 465			

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	and 2 or three other houses. On 6/13/20 at approximately 7:00 p.m., LPN B received a page via the radio that Client #23 had an emesis. He needed to go over to 465 to do catheter irrigation, so he went right away. Staff completed vitals before he arrived. He stated it was ideal for staff to complete vitals, but it was not always the case. When he arrived at the home, Client #23 and staff sat in the dining room. LPN B believed he had another emesis while he was there. LPN B completed an assessment and vitals. He listened to his lungs and there was nothing unusual. He did not know why anyone would say he did not complete an assessment. He stated he used the stethoscope at the house, the one they keep on their vitals stand. He checked the client's blood pressure and pulse oxygen. Vitals were within normal limits. Surveyor read LPN B his documented assessment and he agreed with the documentation. The assessment only indicated one emesis, because LPN B only remembered Client #23 had one emesis before he arrived at the home. He stated the incident was five months ago. He listened to his lungs and bowel sounds, they do not put vitals in the assessment. They document on a different log on the computer. If he completed the vitals, he			

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	would have documented them on the log. LPN B believed he told facility staff if there were problems to call. LPN B believed the next phone call from house 465 was at 8:30 p.m., but someone told him that was not one of the times. The surveyor told LPN B from the facility call log there was a phone call from his desk at 7:55 p.m. and 8:09 p.m. He stated the page he believed happened at 8:30 p.m. must have been at 8:09 p.m. He explained the staff usually used the radio to page the nurses, but could use the overhead. The staff told him at that time Client #23 had another emesis. LPN B told the staff that he let the physician know and would call them after 9:00 p.m. with any order from the physician. LPN B did not think there would be an order from the physician, but he could tell staff the physician was aware or going to keep an eye on him. LPN B explained how information passed on to the physician on-call. He stated they document on a spreadsheet for the triage nurse to read to the physician at 9:00 p.m. LPN B would hear from the triage nurse if there they prescribed an order. LPN B reported the documentation on the assessment was different from the spreadsheet for the physician on-call because some physicians did not want a lot of information. LPN B heard the triage nurse call			

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	in the information. According to LPN B, staff did not indicate it was an emergency, until the final page. He believed the page came at 9:16 p.m. He stated he could hear it in their voices that something was not right the last time he talked to them. LPN B asked why the staff did not call 911 or a nurse stat if they thought it was an emergency. LPN B notified RN A to meet him over at the house because he felt something was wrong. He arrived about the same time as RN A. Client #23 was still in his wheelchair next to the break room. LPN B stated Client #23's face did not look bad, but he could hear audible lung sounds. LPN B went to the medication room to call the physician. RN A attempted to get vitals. LPN B asked the physician if they could send Client #23 out, as he sounded in distress. The physician gave approval. LPN B did not know what went on in the home while he was in the medication room. He stated he wasted a lot of time getting on the computer and trying to find the house printer on the computer. LPN B did not remember a certain number of emesis; he believed Client #23 had two to three. He did not consider two or three to be excessive. He did not recall there being that many emesis, if there had been a large amount he would have been worried. He stated he would have been			

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	worried because of his history of bowel obstruction and aspiration pneumonia. He knew of his history from working there so long. Client #23's lungs and bowel sounds were normal, so he knew he did not have an obstruction. LPN B just got back to his office to chart on Client #23 and received a nurse stat at another house. LPN B thought he received pages at 7:00 p.m., 8:30 p.m., and 9:15 p.m. He did not remember the calls at 7:55 p.m. and 8:09 p.m., but he remembered he responded every time the CMA called. LPN B stated staff claimed they notified him after each emesis, but if that were the case, another nurse would have responded. He explained the evening nurses have an understanding and someone would have called him to see if he needed help. He saw other nurses and they did not say anything to him. According to LPN B, there are times someone tries to use the radio and it does not go through. LPN B reported there were so many policies, but he believed they are to go back and check a client after an hour if there is an emesis. He thought he had an hour after the page to complete an assessment. He would have gone out to the house after the 8:30 p.m. page, but wanted to wait to find out if the physician gave an order. He stated they notify the RN of what			

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	goes on during the shift if out of the normal. They use their nursing judgement on when to notify the RN, but let them know at some point during the shift what is going on. He did not feel it was an emergency that night until the final call from staff. He called the RN right after that last page. LPN B stated if he had more schooling in heart attacks, he would have known Client #23 was having one. He could not tell he was in pain. LPN B does not feel he did anything wrong. He does not put a lot of stock in the staff that worked. He saw their charting the next day and felt like they were coached on what to document. The documentation was too medical for a staff to write, unless they walked around with a notebook writing down times. He did not know many nurses that did that. Other nurses have had clients pass away and they were not suspended. The Interim AON was right next door at 463. If she heard several pages, she would have gone over to the house. LPN B asked why the staff did not have RTS K, the operator, or another nurse get a hold of him. He also asked why the staff did not call 911.			

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Facility Administrator Date

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Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **9033**			**Date:** **December 4, 2020**
Facility Name: **Glenwood Resource Center**		**Survey Dates: September 14, 2020 – November 17, 2020**	
Facility Address/City/State/Zip **711 So. Vine** **Glenwood, IA 51534**			
	LK	**92297-M**	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	When interviewed on 9/29/20 at 4:05 p.m. the Interim Medical Director (MD) reported he reviewed Client #23's case. His first concern was aspiration, but the autopsy indicated Client #23's lungs were clear. The autopsy indicated Client #23 died of a heart attack. He believed the delay in Client #23's care was problematic. He stated LPN B should have notified RN A of what was happening sooner than he did. After LPN B notified RN A, she did the right thing and sent him to the emergency room. In the Interim MD's opinion, if there is a delay in responding to a heart attack the person has a less chance of survival. He stated if LPN B responded two hours earlier the outcome could have potentially been reversible. The delay did not make things easier. Timeliness is of the essence when someone is having a heart attack. The client could not communicate chest pains, but some people vomit when they are in pain. Vomiting is also a symptom of a heart attack. The Interim MD stated it did not seem right that the CMA could not get a hold of LPN B and his assessment lacked information. The assessments did not give detail on what was going on, such as the number of emesis. LPN B also completed only two assessments. He did not feel LPN B had an attentive response and he did not understand the delay of sharing			

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	information. He stated the easiest thing to do is tell someone. When interviewed on 10/30/20 at 4:20 p.m. the Superintendent confirmed the facility failed to provide nursing services to Client #23's needs. On 10/30/20 at 4:20 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to provide nursing care as identified by client needs. The facility developed a plan to remove the IJ, which included retraining on emesis assessments and who can call 911. On 11/4/20 at 3:47 p.m., the IJ was removed from the facility. **FACILITY RESPONSE:**			

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