Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6024			**Date:** March 7, 2023
Facility Name: Glenwood Resource Center		**Survey Dates:** 1/19/23 – 2/7/23	
Facility Address/City/State/Zip 711 S Vine St Glenwood, IA 51534	**CC**	**The fine may be reduced by 35 percent pursuant to Iowa Code section 135C.43A and subrule 56.3(6)**	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
IAC 481 - 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).**	**I**	**$5250.00**	**UPON RECEIPT**
W102	**GOVERNING BODY** The facility must ensure that specific governing body and management requirements are met. Based on interviews and record review, the facility failed to maintain minimal compliance with the			

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	Condition of Participation (COP) - Governing Body. Finding follows: Cross-reference W104: Based on interviews and record reviews, the facility failed to ensure and monitor client safety when using mechanical lifts. These finding resulted in the determination of Immediate Jeopardy (IJ) on 2/2/23 at 3:53 p.m., based on the facility's failure to develop policy and/or procedures to ensure and monitor client safety when using mechanical lifts. The facility developed, trained and implemented a Dependent Mechanical Lift procedure, which included retraining the use of a mechanical lift with assistance from a second staff. The IJ was removed on 2/6/23 at 2:53 p.m.			
W104	**The governing body must exercise general policy, budget, and operating direction over the facility.** Based on interviews and record reviews, the facility failed to ensure and monitor client safety when using mechanical lifts. This affected 1 of 1 clients who utilized a mechanical lift (Client #1). Finding follows:			

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	Record review on 1/31/23 revealed Client #1's incident report documented by Residential Treatment Worker (RTW) A dated 1/29/23, indicated, "I was in the process of getting (Client #1) up for the evening activities and supper. I had hooked all (four) corners up onto the lift pivoted to put him in his chair. As I was turning, I saw the right side of the sling slip off the lift then I reached out to grab it but he slipped out fast. I started screaming before he hit the ground. When he landed, he first landed on his left hip then his head hit on the left side. I screamed for help and yelled for the others to call the nurse." The facility called 911 and paramedics took Client #1 to the Emergency Room (ER). Record review on 2/1/23 revealed Client #1's hospital report dated 1/31/23, indicated Client #1 sustained a subarachnoid hemorrhage at the right frontal region and left frontal scalp laceration, closed with staples. Client #1 stayed in intensive care for two days before discharged back to the facility. Clinical notes dated 1/31/23, indicated Client #1's injuries included a large abrasion to his left arm and reddened areas on his left knee.			

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	Continued record review revealed facility training dated 5/2021, indicated, "All individuals who use a dependent mechanical lift to transfer must be assisted by (two) people." A facility procedure for use of mechanical lifts could not be located. When interviewed on 2/6/23 at 10:53 a.m. RTW A reported house 462 as her normal house. She stated she normally worked four-hour increments at different houses during the day, wherever the need was. On 1/29/23, RTW A worked at house 462 all day. She took over Client #1's group at 2:00 p.m. She remembered she went in his bedroom to transfer Client #1 from his bed to his wheelchair. She completed personal cares, dressed him, and placed the sling for the Hoyer lift under him. After she connected the sling to the Hoyer lift, she lifted Client #1 up over the bed to ensure all connections were good. RTW A then put the bedrail down, holding onto his feet as his head was up by her chest. RTW A turned Client #1 off his bed and he fell out of the sling. She said she tried to reach for him, but it happened fast. RTW A stated Client #1 fell onto his left "bum" then his head. She screamed for help and another staff called the nurse. Nobody moved Client #1, although RTW D moved his clothing protector off his			

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	face so he could breath. Staff stood over Client #1 until the nurse arrived. According to RTW A, the facility trained her to use a second staff when using the Hoyer lift to transfer clients. She did not know why she did not get a second staff to help her because they had plenty of staff. RTW A admitted on two prior occasions she completed Hoyer transfers without a second staff. One time the house had three staff, one staff with a one-to-one client, another staff as the medication administrator, and RTW A left to transfer clients. She stated she called a supervisor for help, but they could not get help to the house until 9:00 p.m. The other time happened during a COVID outbreak. The facility left her with three clients at the house while everyone else moved over to the COVID house. She called a supervisor for help with the transfers and the supervisor told her they did not have enough staff and she had to do the best she could. RTW A denied witnessing anyone using a Hoyer lift without a second staff and usually assisted others as the second staff. She believed if the facility left her in a position she had to complete Hoyer lift transfers without a second staff, she is sure other staff completed them without a second staff.			

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	When interviewed on 1/31/23 at 4:26 p.m. RTW B reported on 1/29/23 he had a one-to-one client in the client's bedroom. He heard a scream and heard RTW C ask if they wanted her to call a code blue. He believed they called the nurse, but he did not witness anything. He could not remember how many staff they had on-duty that day. RTW B stated staff should use a second staff during all mechanical Hoyer lifts. He explained one staff holds onto the client and one maneuvers the lift. One staff is able to assist during a standing transfer. RTW B denied using a Hoyer lift without a second staff or witnessing anyone else using a Hoyer lift without a second staff. He stated if other staff were busy, they needed to wait until someone was available to assist with the lift. Additional interview on 2/2/23 at 12:36 p.m. RTW B called the Surveyor and stated he was sorry, but he was dishonest during his first interview. During the morning shift on 1/29/23, he believed he had three clients in his group who used a Hoyer lift to transfer. RTW B stated he did not use a second staff to assist him with the Hoyer lift transfers. He did not know why he did not ask another staff to assist him. He stated he was busy and just completed the transfers alone. He also did not remember how many staff			

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	worked on the morning of 1/29/23. RTW B admitted he completed Hoyer transfers without a second staff on a routine basis and especially when they are short staff. When interviewed on 2/1/23 at 3:45 p.m. the Director of Quality Management explained staff were trained to use mechanical lifts and demonstrate competency when they are hired. During an additional interview with the Director of Quality Management on 1/31/23 at 3:30 p.m. she confirmed the facility failed to provide a policy and/or procedure to ensure and monitor the safety of clients using a mechanical lift.			

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IAC 481-Chapter 56.1	**56.6(1) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor**	**I**	**$3500.00 x 3 (trebeled) = $10,500.00**	**UPON RECEIPT**
IAC 481-Chapter 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.**			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	This rule is intended to implement Iowa Code Section 135C.2(3).			
W368	Based on interviews and record reviews, facility staff failed to consistently ensure medications were administered as ordered by the prescribing physician. This affected 2 of 2 clients (Client #2 and Client #3) involved in incidents #110000-I and 109790-I. Findings follow: 1. Record review on 1/31/23 revealed the facility investigation documented on 12/6/22, during the evening (HS) medication administration, Residential Treatment Worker (RTW) D administered Client #2 another client's medication. The report noted Client #2 was never provided with his own medications that evening, just the medications of another client discharged to another facility earlier in the day. The report further indicated the error was not discovered until the next morning when RTW E noticed the client didn't seem to be acting right. RTW E checked Client #2's medications and found his medications from HS on 12/6/22 were still in the pack although signed off, but his discharged peer's medications were not in their pack. RTW E suspected Client #2 had been			

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	provided the wrong medications the night before on 12/6/22, and notified the nurse. The Advanced Registered Nurse Practitioner (ARNP) was contacted and labs were drawn and sent to the hospital. Around 4:00 p.m. Client #2's lab results showed high levels of Valproic Acid and the presence of Lithium in his system. The facility contacted Poison Control, who recommended Client #2 go to the hospital for observations. The facility sent Client #2 to the hospital. The facility investigation indicated Client #2 received the following medications on 12/6/22 that belonged to another client: Divalproex 2250 mg, Lithium 750 mg, Lorazepam 2 mg, Reguloid 1.04 mg, Stimuland 8.6mg-50mg Senna Docusate. Record review of Client #2's file revealed he was 22 years old, ambulatory and had been at Glenwood Resource Center (GRC) around 14 years. The client was diagnosed with severe intellectual disability, autism spectrum disorder, attention deficit hyperactivity disorder (ADHD) and had seizures. Client #2's Behavior Support Plan (BSP) revealed behaviors of aggression, self-injurious behavior (SIB), property destruction and leaving assigned areas.			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	Review of Client #2's Medication Administration Record (MAR) for 11/2022 revealed he should have received the following medications on 12/6/22 and they were marked off as received: Atropine Solution 2 drops, Calcium Carbonate, Divalproex Sodium 600 mg, Guanfacine 1 mg, Daily Multivitamin 2 gummies, Risperidone 2 mg and Vitamin D3 25 mgs. The MAR also indicated the client received his 8:00 a.m. medications the next morning on 12/7/22 which included: Atropine Solution 2 drops, Divalproex Sodium 600 mg, Risperidone 2 mg and Poly Glycol 17 grams. Record review revealed labs results for Client #2, completed 12/7/22, identified his Lithium level as 0.4 millimoles per liter (mmol/L) with a reference range of 0.4 - 1.3 mmol/L and his valproic acid level to be 176 micrograms per milliliter (ug/mL) with a reference range of 40-100 ug/mL. The level was identified as "critical ' . Additional record review revealed the facility medication administration policy revised 8/8/22, listed the 8 rights of medication administration: right patient, right medication, right dosage, right route, right time, right documentation, right reason and right			

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	response. The policy also provided such directives to medications administrators as staying focused/avoiding distractions, assure proper identification of the individual about to receive medications, perform three label checks and match the bubble pack against the MAR. Further record review revealed the facility procedure about medication disposal revised 6/4/21, documented proper destruction of medications. The policy did not include procedures for medication disposal after a client moved from the facility. When interviewed on 2/2/23 at 11:15 a.m., RTW E reported on 12/7/22 he was responsible for Client #2 on the am.m. shift. Client #2 appeared "groggy and stumbly." RTW E reported this was not totally abnormal for Client #2, but he appeared to have difficulty tracking and appeared "intoxicated," as his appeared lethargic and weak while ambulating. RTW E reported his concerns to the nurse and checked Client #2's medications. At that time he discovered Client #2's p.m. medications were still available. He noted a discharged individuals medications were still in the cart, checked the cassette, and identified that client's p.m. medications were not there, despite him			

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	not being at the facility. Labs were ordered for Client #2 and he ended up being transported to the hospital. While at the hospital RTW E heard discussion regarding the presence of Lithium, which only the discharged client had taken in that home. The physician at the hospital also noted Client #2's levels of valproic acid were "dangerous" and gave him a liter of fluids by IV. When interviewed on 1/30/23 at 1:45 p.m. RTW D confirmed she passed Client #2 the wrong medications on 12/6/22. She admitted she was distracted by things at her personal residence and by clients who stayed in the room and doorway with her after they received their medications. She stated she asked another staff to get Client #2 and bring him to the medication room. She stated she already popped out what she thought were his medications, but later found out they belonged to another client who moved. She remembered when Client #2 failed to show up after a few minutes she took the cup of meds down his room and administered them to him there. She returned and signed off the MAR that she gave him his medications although the meds he received weren't his. She confirmed she failed to follow many of the facets of facility policy regarding medication			

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	administration on 12/6/22 despite being trained on several occasions. When interviewed on 1/31/23 at 11:30 a.m. the ARNP confirmed she was contacted the morning of 12/7/22 regarding a possible medication error from the night before on 12/6/22 for Client #2. The ARNP remembered after she was told Client #2 received another client's medications on 12/6/22 at hour of sleep (HS) and then received his own regular medications on the morning of 12/7/22, she looked over the medications for any potential problems. She stated she was mostly concerned about the amount of Valporic Acid (VA) potentially in his system. She ordered labs to be completed and around 4:00 p.m. the lab results returned with high levels of VA. The ARNP stated she called Poison Control and was advised to have the client go to the Emergency Room (ER) for observation. She stated she followed the recommendation and sent Client #2 for observation. Client #2 received an IV and observation and was sent home. The ARNP recommended the client stay at the ER all night, but the physician in the ER disagreed and sent him home. She remembered the next morning when they did labs again and the client was no longer at a concerning level of VA. She indicated the only			

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	client in the house who received Lithium was discharged on 12/6/22 which further cemented her belief they had discovered the medication variance. 2. Record review on 1/31/23 revealed the facility investigation indicated on 12/24/22 Qualified Intellectual Disabilities Professional (QIDP) A provided Client #3 an extra 100 mg of Clozapine at the 12:00 p.m. medication administration. The report further detailed the QIDP recognized her error right after she passed the medications, when she counted the medication. She notified supervisory staff, the Superintendent was contacted and the client was sent to the hospital by ambulance. At the hospital Client #3 ate lunch, acted normal and maintained vitals within normal limits. The client was sent home around 2:30 p.m. on 12/24/22 after a brief stay. The attending physician ordered the client to be monitored for dizziness and sedation for the next four hours starting at 12:55 p.m. Further record review of Client #3's file revealed diagnoses including moderate intellectual disability and autism spectrum disorder (ASD). The client is ambulatory and had a behavior support plan to			

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	address behaviors of aggression, self-injurious behavior (SIB), disruptive behavior and periods of uncontrollable crying. The client also used a picture board to communicate with staff. Record review of Client #3's MAR confirmed she was prescribed 100 mg of Clozapine at 12:00 p.m. medication pass on 12/24/22. Review of the count sheet revealed QIDP A counted the medications after administration as she was supposed to and identified she provided two 100 mg tabs of Clozapine instead of one. Record review revealed the facility medication administration policy last revised 8/8/22, listed the 8 rights of medication administration: right patient, right medication, right dosage, right route, right time, right documentation, right reason and right response. The policy also provided directives such as staying focused/avoiding distractions, assure proper identification of the individual about to receive medications, perform three label checks and match the bubble pack against the MAR. When interviewed on 1/30/23 at 2:25 p.m. QIDP A confirmed she passed medications to Client #3 on			

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	12/24/22. She indicated in her job she doesn't pass medications often, but was trained to pass them and knows how to pass them. She indicated on 12/24/22 she's not sure what happened, but instead of popping out 1x100mg tablet of Clozapine as ordered and then popping out the 20 mg of Propranolol from another bubble pack, she popped out another Clozapine from the pack she just popped one out of. She stated the medication she popped out and provided the client was the one scheduled for the next day (12/25/22). She stated she allowed herself to be distracted, taking phone calls and attending to other matters while she passed the meds which she knew violated the facility's medication policy. When interviewed on 1/31/23 at 11:45 a.m. the ARNP confirmed she was made aware of the situation on 12/24/22. She stated once she was told what happened she decided the best decision was to just cut back on the 200 mg of Clozapine Client #3 was scheduled to receive later in the day to 100 mg. The client then received only 100 mg instead of 200 mg in the evening which would ensure at the end of the day the client still received the same total she was prescribed. The ARNP stated Client #3 was never in any distress and she wouldn't have sent her to the			

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6024			**Date:** March 7, 2023
Facility Name: Glenwood Resource Center		**Survey Dates:** 1/19/23 – 2/7/23	
Facility Address/City/State/Zip 711 S Vine St Glenwood, IA 51534	**CC**	**The fine may be reduced by 35 percent pursuant to Iowa Code section 135C.43A and subrule 56.3(6)**	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	hospital, but the decision had already been made before she had a chance to assess the situation completely. When interviewed on 2/2/23 at 11:30 a.m. the Director of Quality Management (DQM) confirmed in both cases staff failed to follow the policy and training provided, which resulted in clients receiving the wrong medications.			

_____ _____

Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).