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 06/01/2023

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 Investigation #112761-I, conducted from 5/30/23 to 6/1/23, resulted in a deficiency cited at W249.	W 000	See Attached POC 6/13/23	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interviews and record review, facility staff failed to consistently ensure each client received supports and services as outlined in their individual program plan (IPP). This affected 1 of 1 clients (Client #1) involved in investigation 112761-I. Finding follows: Record review on 5/30/23 revealed Client #1's incident report (IR) dated 3/27/23, indicated Client #1 got out of bed around 4:40 a.m., went into the bathroom, fell and hit his head before being discovered by staff. The report further indicated when a nurse arrived a few minutes later, the client was seated in the bathtub naked with blood dripping from a dime sized open wound on the left side of his head. The Registered Nurse (RN) noted the client's left eye started to swell shut during the evaluation/treatment. The report further indicated the Advanced Registered Nurse Practitioner (ARNP) directed the client needed to	W 249		

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 249	Continued From page 1	W 249		

go to hospital. Facility staff called for an ambulance at 4:45 a.m. and Client #1 was treated for his injuries within the hour.

Further record review on 5/31/23 revealed Client #1's nurse's note entered by the ARNP dated 3/27/23, indicted a post discharge evaluation at patient's house confirmed he was clinically stable. The client had three staples noted on the lateral anterior left cephalic region (left side of his head) with mild edema to the injury site and left eyelid. The note added there was no acute deviation to mentation (mental activity) or functional ability.

Additional record review revealed Client #1, a 35 year old male, had diagnoses including profound intellectual disability, autism spectrum disorder, generalized anxiety disorder, KBG Syndrome (genetic disorder characterized by short stature), osteoporosis and stereotypic movement disorder.

Continued record review on 5/30/23 revealed Client #1's Physical Nutritional Management Plan (PNMP) revised 1/31/23, indicated Client #1 needed staff to hold on to his gait belt anytime he ambulated. The document further directed Client #1's bed alarm needed to be reset anytime the client was in bed to alert staff when he got out of bed. Additionally, the client used chair alarms anytime he was seated in a chair to alert staff he was up.

When interviewed on 5/30/23 at 3:33 p.m. Residential Treatment Worker (RTW) A confirmed she worked the overnight (NOC) shift in House 248 on 3/26/23 to 3/27/23 and was assigned to Client #1 and one other client. She indicated the shift typically ran from 10:15 p.m. to 6:15 a.m. She confirmed when she started a shift

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W 249	Continued From page 2 she was supposed to do rounds with a staff from the previous shift and visually see every client she was going to take supervision of. She understood this meant making sure they were dry, breathing and had everything they needed. She admitted she talked with RTW B, but they did not complete rounds into Client #1's bedroom or check to ensure his bed alarm was on/working. She explained they were hesitant to open his door and go into his room because once awake he tended to be loud which had potential to wake up other residents. She confirmed that night she had not entered the room to see Client #1 the entire shift prior to the incident. RTW A reported about 4:30 a.m. she needed to use the restroom and did so thinking neither of the two clients she was assigned to would get up. While in the restroom she heard the door to the bathtub room slam and knew one of her guys went into the bathroom. She got to the bathroom within a couple minutes and found Client #1 trying to put his pants back on with blood coming from his head. She reported she tried to briefly clean him up, put him in the bathtub and left to call for help. Shortly after, a nurse and supervisor arrived and tended to the client. Shortly after the incident RTW C asked her why the alarm never went off she checked in the bedroom and found it to be half plugged in with bent prongs sticking out. She stated she could not bend the prongs to make it work again, but RTW C came into the room and straightened the prongs which allowed it to be plugged in and work properly. She stated she was not sure why it was bent and pulled out of the wall. She thought maybe when he moved, his bed rubbed it and bent the prongs rendering it ineffective. When interviewed on 5/31/23 at 11:25 a.m. RTW	W 249		

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W 249	Continued From page 3	W 249		

B confirmed she worked with Client #1 on the 2:00 p.m. to 10:00 p.m. shift on 3/26/23. She stated she talked with RTW A and other staff at the end of her shift to provide changeover regarding the clients. She reported when she handed supervision of Client #1 over the next shift she stated she was not informed who would be responsible for Client #1. She stated this was the reason she failed to go into client bedrooms together with his new staff and check on him.

When interviewed on 5/30/23 at 2:55 p.m. the Assistant Superintendent (AS) discussed the incident and showed video footage from the hallway and bedroom area from House 248 at the time of the incident. The video revealed Client #1 exited his bedroom at 4:32 a.m. on 3/27/23 and entered the restroom with a shower. One minute later the client left the room and went across the hall to the restroom with a bathtub. Within two minutes the video showed RTW A entered the room with Client #1 and within a couple minutes she was observed outside the restroom making a phone call. Around four minutes later a nurse and a supervisor arrived and entered the restroom with Client #1. The AS reported he watched the video for the shift and the video revealed RTW A never completed her 30 minute checks by Client #1's bedroom all night prior to the incident. The AS confirmed the staff had worked in the home many years, had been trained on both the policy and the client's PNMP and should have checked on him and ensured his alarm was working.

When interviewed on 5/30/23 at 1:20 p.m. the Treatment Program Administrator (TPA) confirmed Client #1 went to the hospital on 3/27/23 and received three staples in his head.

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

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W 249	Continued From page 4 The interview took place in House 248 where the TPA showed Client #1's bed and how it could move if the wheels weren't locked. The TPA also showed how the prongs on the plug in for the bed/alarm had been bent at one time. He confirmed RTW A and RTW B should have completed rounds together at 10:00 p.m. on 3/26/23 and those rounds should have ensured the client's bed alarm was on and working. He stated had the alarm been working staff would have been alerted the client was out of bed and the incident might have been prevented. The TPA further confirmed Client #1 used bed and chair alarms to alert staff to assist him as he walked due to his very unstable gait and a history of falls.	W 249		

Glenwood Resource Center (GRC)
GRC Standard Level Plan of Correction: Investigation #112761-I

TAG-W249 PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1): As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

DIA found facility staff failed to consistently ensure each client received supports and services as outlined in their individual program plan (IPP).

Individual Response:

RTW A was given appropriate management action on 6/13/2023.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 6/13/2023.

RTW B was given appropriate management action on 6/1/2023.

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 6/1/2023.

RTW A & RTW B were retrained on Client #1's Physical Nutritional Management Plan (PNMP) and associated Health Care Data collection (HCD).

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 6/6/2023.

Systemic Response:

All staff regularly assigned to work in House 248 were retrained on Client #1's Physical Nutritional Management Plan (PNMP) and associated Health Care Data collection (HCD).

Responsible: Assistant Superintendent of Treatment Program Services
Date completed: 6/9/2023.

The Resident Treatment Supervisor (RTS) and/or the Qualified Intellectual Disability Professional (QIDP) will routinely monitor the Daily Activity Record (DAR) to ensure that data is entered and initial their review.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date to be completed: 6/9/2023 and ongoing.

GRC will continue to monitor the implementation of Physical Nutritional Management Plans (PNMP) through monthly Program Implementation Monitors. Compliance monitors are completed by Resident Treatment Supervisors (RTS) and the Qualified Intellectual Disability Professionals (QIDP) and clinical monitors are completed by RNs, LPNs, SLPs, OTs, and PTs. The minimum frequency of monitoring is based on the individual's PNM risk level.

Responsible: Superintendent/Assistant Superintendent of Treatment Program Services
Date to be completed: 6/9/2023 and ongoing.