Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6691	**Fine amount reduced by 35% to $1,300.00 on November 29, 2017 pursuant to Iowa Code Section 135C.43A**		**Date: November 9, 2017**
Woodward Resource Center		**Survey Dates: October 2-11, 30, 2017**	
1251 334th Street Woodward, Iowa 50276			
	DS		

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, 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 provisions 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**	**$2,000**	**Upon Receipt**
W189	**483.430(e)(1) Standard: Staff training program** W189 (1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. **DESCRIPTION:** Based on interviews and record review the facility failed to ensure effective staff training to ensure staff competently demonstrated the appropriate skills and provided adequate supports to ensure client safety (Client#2).			

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Facility Administrator Date

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	Findings follow: Record review on 10/2/17 revealed the facility's Type 1 Investigation, dated 9/12/17. The investigation documented Client #2 fell from the back seat of the facility van while being transported to the facility Medical Center. As a result of the fall, Client #2 lost a tooth and received scratches. Continued record review revealed an incident report, dated 9/12/17 at 1:00 p.m., documented the incident with Client #2. The report noted, "... staff went to turn into Med Center when I heard a loud noise... staff looked back and observed (Client #2) on the floor of the van, bleeding from (his/her) mouth.... RTW saw another staff walking up to the Med Center and yelled for assistance... assisted (Client #2) into the Med Center trauma room where it was observed that (Client #2) lost a front tooth. (Client #2) also has several scratches from the fall as well. The following scratches were observed: about a two inch mark on the upper left arm, quarter inch scratch on the top of left shoulder, quarter inch scratch on (his/her) left collarbone as well as scratches on (his/her) chin and under (his/her) neck." Record review revealed an assessment, completed 9/12/17 at 1:05 p.m. by Registered			

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	Nurse A, documented, "...bleeding from mouth, staff reports a tooth was knocked out. Also has a red/bluish bruise starting on (his/her) chin, left should bruise 1 1/4 inch, and left clavicle 1/2 inch. Faint reddish linear shaped scrapes on left upper arm. (Client #2) is walking per (his/her) norm, wanting to leave the trauma room area, spitting. No new mark or injuries noted on (his/her) knees. Cool compress applied to (his/her) mouth... bleeding is controlled." Assessment documented: "mouth injury, missing tooth. Neuro check at baseline." Continued record review revealed Client #2 had diagnoses including, but not limited to: autism spectrum disorder, severe intellectual disability, and osteopenia. Record review on 10/2/17 revealed Client #2's Behavior Support Plan, dated 7/18/16. The plan provided information to staff to ensure Client #2's safety including the following: "Vehicles: (She/He) will attempt to PICA items off the floor of the vehicle-keep vehicles (Client #2) rides in as clean as possible. Support staff should sit where they can block PICA. (Client #2) would need an additional staff, besides the driver to ensure PICA safety while in the vehicle." Record review on 10/2/17 revealed Client #2's			

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	Individual Support Plan (ISP), dated 1/10/17. The plan noted **"What we need to know to keep (Client #2) safe**. Vehicles: (She/He) will attempt to PICA items off the floor of the vehicle-keep vehicles (Client #2) rides in as clean as possible. Support staff should sit where they can block PICA. (Client #2) would need an additional staff besides the driver to ensure PICA safety while in the vehicle." The ISP further documented, "(Client #2) needs physical prompts to put on a seatbelt, but will leave it on until reaching the destination." When interviewed on 10/4/17 at 10:00 a.m., Resident Treatment Worker (RTW) G reported she was Client #2's group leader on 9/12/17. The Resident Treatment Supervisor (RTS) A asked RTW G to take Client #2 to the Medical Center to implement his/her dental desensitization program. RTW G reported she asked RTS A if she would be the only staff going, and the RTS said yes. RTW G reported she told RTS A that Client #2 required five minute checks and had pica behavior, so she thought there should be two staff. According to RTW G, RTS A told her Client #2 did require five minute checks, but she had taken the client by herself before and had no issues. RTW G reported she had not taken Client #2 to implement the program before, so she followed the directive of RTS A. RTW G reported			

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	she assisted Client #2 into the van and fastened the seat belt. As they arrived to the Medical Center, RTW G reported she heard a thump and then heard Client #2 scream. RTW G looked back and saw Client #2 on the floor of the van. She stated she immediately got help and Client #2 was taken into the Medical Center for treatment. On 10/2/17 at 2:45 p.m. the RTS A was interviewed and stated she received a call at 1:18 p.m. from RTW G. RTW G informed her that Client #2 had fallen in the van. RTS and the nurse went to the Med Center and Client #2 bleeding from the mouth. RTS stated she thought it was only 2 staff to 1 client when going off campus. The facility investigator stated that according to the ISP plan, there should be 2 staff with a resident that has pica and the RTS stated she was unaware of that and thought only 1 staff person with 1 client on campus. Record review revealed RTW G's statement to the facility, included in the facility's Type 1 investigation. RTW G reported she placed the seat belt around Client #2's chest and snapped it in. When asked by the facility investigator if she heard the belt snap in, RTW G reported she could not be positive, she did not pay attention. Record review revealed Woodward Resource			

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	Center (WRC) Procedures for Transporting Clients, dated 3/5/10. The procedures provided the following guidance: a. Adaptive seating security: Only regular plant operations drivers are not required to apply wheelchair passenger waist and shoulder belts for travel exclusively limited to the WRC campus. All other drivers will apply wheelchair passenger waist/shoulder belts for all on and off campus travel. b. Specific procedures for transporting clients in non-handicapped equipped vehicles: staff should assist clients with using waist/shoulder belts. On 10/30/17, in an email, the Superintendent confirmed staff failed to ensure Client #2 was secured while traveling in the van. **FACILITY RESPONSE:**			

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