

**Iowa Department of Inspections and Appeals  
Health Facilities Division  
Adult Services Civil Penalty Citation**

<b>Date:</b> September 27, 2021
<b>Program Name:</b> Willows of Marshalltown AL
<b>Address:</b> 2315 Campbell Drive Marshalltown, IA 50158
<b>Type of Action:</b> 93201-I
<b>Date(s) of Action:</b> 8/2/21 – 8/12/21

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	<p><b>481-67.3 Tenant rights.</b> All tenants have the following rights:  <u>67.3(2) To receive care, treatment and services which are adequate and appropriate.</u></p> <p>Record review on 8-2-21 of Tenant #C1's file revealed the following:</p> <ol style="list-style-type: none"> <li>1. An Incident Report dated 8-13-20 revealed he participated on a bus trip to view storm damage in the area. Staff E (Facility Director) loaded and secured his wheelchair on the bus. Staff E drove the bus and slowly turned a corner. He heard a noise, looked in the back, and observed Tenant #C1 on his right side with his head against the side of the wheelchair ramp at approximately a 45 degree angle. He immediately called 911. The paramedics removed Tenant #C1 from the bus and transported him to the hospital.</li> <li>2. A Service Plan dated 8-6-20 revealed Tenant #C1 required assistance to ambulate long distances and required assistance with transfers.</li> <li>3. Progress Notes dated 9-3-20 revealed Tenant #C1 transferred to a nursing facility after he was discharged from the hospital. He later transferred to hospice care and passed away.</li> </ol> <p>Review on 8-9-21 of UnityPoint Health Marshalltown Ambulance Encounter Narrative revealed upon entry into the bus Tenant #C1 was found lying on his right side with the wheelchair on top of him and observed tissue and blood on the grate of the wheelchair lift. Tenant #C1's head was positioned out of anatomical alignment, kinked with the left ear almost touching his left shoulder and right side of the head on the grate of the lift. Tenant #C1 was noted to be groaning in pain. The securement straps located to the front and rear right wheels of the wheelchair to the van floor were removed. Tenant #C1's cervical spine was manually stabilized and the wheelchair was removed. The left ear was noted to be avulsed (pulled away) from his head with minimal connection and bleeding was controlled. A cervical collar was utilized for stabilization and Tenant #C1 was transported to the hospital for treatment.</p> <p>Review on 8-5-21 of UnityPoint Health Emergency Department documentation revealed an admission diagnosis of an unspecified injury of the ear. The final diagnoses were traumatic subdural hemorrhage with loss of consciousness of unspecified duration and</p>	<b>\$10,000.00</b>

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	<p>nondisplaced type II dens fracture-initial encounter for closed fracture (neck fracture) due to a fall from a non-moving wheelchair in a transport vehicle. Further review revealed imaging results indicated a fracture of the C2 vertebral body extending through the base of the dens and into the left lateral mass of C2 along the vertebral foramina and transverse process. Computed Tomography (CT) scan of his head indicated a subdural hematoma on the left side measuring 1.2 centimeters (cm) in diameter and a subdural hematoma on the right side measuring 1.0 cm in diameter. An X-ray of his pelvis indicated a possible minimally displaced fracture. Provider notes documented Tenant #C1 was at immediate threat to life-threatening deterioration including subdural hematoma and cervical fracture. Counseling was provided to family and discussed plan of care for the diagnoses and prognoses.</p> <p>Review on 8-5-21 of Iowa River Hospice documentation revealed Tenant #C1 was admitted on 8-27-20 with diagnoses of traumatic subdural hemorrhage with loss of consciousness, displaced fracture of second cervical vertebra, and unspecified dementia. The subdural hemorrhage was documented as the terminal diagnosis. Further review revealed he passed away on 8-27-20.</p> <p>On 8-3-21 at 9:23 a.m. the Staff E confirmed the Program had no formal training on how to load and secure wheelchairs on the bus. He stated a former staff informed him to secure two wheels with straps, one in the front and then go diagonally to the wheel in the back. He stated after this incident he went online and found a video on how to secure a wheelchair. He stated all four wheels are now secured along with a seatbelt placed across the person's chest.</p> <p>On 8-3-21 at 10:54 a.m. Staff E stated he had no knowledge if the Program had a formal written policy for transportation at the time of the accident. He created one after this incident.</p> <p>On 8-3-21 the Executive Director provided a copy of the Program's Transportation policy and confirmed staff had no formal training on how to secure wheelchairs in a vehicle at the time of the incident. Review of the Transportation Policy stated vehicles shall have adequate seat belts and securing devices for ambulatory and wheelchair using passengers. Wheelchairs shall be secured when the vehicle is in motion.</p>	
<p><b>69.29(3)</b></p>	<p><b><u>481—69.29(231C) Staffing</u></b>  <u>69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population.</u></p> <p>Based on interview and record review the Program failed to ensure all personnel received appropriate training on how to secure a wheelchair during transportation for 1 of 1 discharged tenants regarding Incident #93201-I (Tenant #C1). Findings follow:</p>	

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