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

Date: March 13, 2023
Program Name: Edencrest at Green Meadows
Address: 6750 Corporate Drive Johnston, IA 50131
Type of Action: Investigations 109237-I, 109191-C, 107724-C, and 106357-C
Date(s) of Action: 11/30/22 – 12/1/22
Citation # 6034

State Rule #	State Rule	Amount of Civil Penalty
IAC 69.33(4)	**481-69.33(231C) Transportation. When transportation services are provided directly or under contract with the program:** **69.33(4) Wheelchairs shall be secured when the vehicle is in motion.** Based on interview and record review the Program failed to properly secure a wheelchair during transport of a tenant. This pertained to 1 of 1 tenant reviewed (Tenant #1) as a result of Incident #109237-I. Findings follow: Record review of Tenant #1's Incident Report dated 11/25/22 revealed her transport chair tipped over to the right-side during transport. She complained of pain to her left shoulder and no other visible injury was noted. The Director called 911. Tenant #1 was transported to the hospital for evaluation. Observation on 11/30/22 at 4:20 p.m. revealed the Director demonstrated where he attached the hooks to the chair belonging to Tenant #1. He stood on the right side of Tenant #1's chair and bent over to attach the hooks on the left side. When interviewed on 11/30/22 at 2:20 p.m. Tenant #1 reported she continued to receive treatment at the hospital following the incident. She confirmed she suffered a fractured neck and collarbone as result of the accident. She reported ongoing pain and rated it 8 out of 10 most of the time. She remembered the Director attach the hooks and seatbelt. She reported the chair did not move much and she had no idea of how it tipped over. Tenant #1's daughter confirmed the injuries Tenant #1 sustained and noted Tenant #1 suffered continued loss of strength due to being bedridden along with history of Parkinson's disease, and required skilled nursing to recover and potentially unable to return to assisted living level of care. On 11/30/22 at 10:00 a.m. the Director stated staff assisted Tenant #1 into a transport chair and he loaded her on the bus. He placed four hooks on the frame by each wheel, placed the seatbelt around her, and jiggled the chair to ensure it was tight. He proceeded to drive towards the destination. He reported after a short distance he looked in the mirror to check on her and all was fine. He drove through two roundabouts and the next time he looked in the mirror	**$3000.00**

	Tenant #1 could not be seen. He pulled over to check on her and observed her on her right side. He noticed seatbelt around her torso, but no longer fastened and the hooks on the left side were no longer attached to the wheelchair. He reported he observed no visible injuries, she moved all extremities, was alert and oriented, and initially declined medical intervention. During further interview on 11/30/22 at 4:00 p.m. the Director stated he could not determine how the wheelchair tipped over.	