DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0385	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF MARSHALLTOWN ASSISTED LI\	2315 CAMPBELL DRIVE MARSHALLTOWN, IA 50158

(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) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 33 Number of tenants with cognitive disorder: 3 Total Population of Program at time of on-site: 36 There were no deficiencies cited during the onsite infection control survey. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program as well as the investigation of Incident #93201-I and Complaint #94494-C.	A 000		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide appropriate care, treatment, and services to 1 of 1 former tenants reviewed regarding Incident #93201-I (Tenant #C1). Findings follow: Record review on 8-2-21 of Tenant #C1's file	A 160	Plan of Correction is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 160	Continued From page 1 revealed the following: 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. 2. A Service Plan dated 8-6-20 revealed Tenant #C1 required assistance to ambulate long distances and required assistance with transfers. 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. 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	A 160		

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A 160	Continued From page 2 cervical collar was utilized for stabilization and Tenant #C1 was transported to the hospital for treatment. 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 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 he 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. 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.	A 160		

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A 160	Continued From page 3 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. 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. 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.	A 160		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by:	A 140		

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A 140	Continued From page 4 Based on interview and record review the Program failed to evaluate tenant's functional, cognitive, and health status within 30 days of occupancy for 1 of 3 tenants reviewed (Tenant #2). Findings follow: Record review on 8-4-21 of Tenant #2's file revealed she moved in on 3-14-21. No evaluation of Tenant #2's functional, cognitive, and health status within 30 days of occupancy could be located. On 8-12-21 at 9:45 a.m. the Registered Nurse confirmed these findings.	A 140		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop a service plan prior to signing the occupancy agreement and taking occupancy of a dwelling unit for 2 of 3 tenants reviewed (Tenant #1 and Tenant #2). Finding follow:	A 355		

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A 355	Continued From page 5 Record review on 8-4-21 revealed the following: 1. Tenant #1's file revealed a representative for Tenant #1 signed the occupancy agreement on 6-14-21. Further review revealed a service plan dated 6-28-21. No service plan developed prior to signing the occupancy agreement and taking occupancy of the apartment could be located. 2. Tenant #2's file revealed a representative for Tenant #2 signed the occupancy agreement on 3-26-21. Further review revealed a service plan dated 7-16-21. No service plan developed prior to signing the occupancy agreement and taking occupancy of the apartment could be located. On 8-12-21 at 9:45 a.m. the Registered Nurse confirmed these findings.	A 355		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days of occupancy and as needed for significant change in health related care for 1 of 3 tenants reviewed (Tenant #2). Findings follow: Record review on 8-4-21 of Tenant #2's file revealed she moved in on 3-14-21. No service	A 360		

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A 360	Continued From page 6 plan updated within 30 days of occupancy could be located. Continued review revealed an evaluation for a significant change in health services completed 6-24-21. The evaluation documented Tenant #2 no longer required assistance with transfers or ambulation. A service plan dated 7-16-21 failed to be updated as required. On 8-12-21 at 9:45 a.m. the Registered Nurse confirmed these findings.	A 360		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record reveiw the Program failed to develop an individualized service plan that identified needs and preferences for assistance for 1 of 4 discharged tenants reviewed (Tenant #C2). Findings follow: On 8-2-21 review of Tenant #C2's Treatment Administration Records for August through November 2020 revealed she required TED hose to be put on in the morning and taken off at night. The Program failed to develop a service plan to include the use of TED hose. On 8-12-21 at 9:45 a.m. the Registered Nurse confirmed these findings.	A 395		

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A 525	Continued From page 7	A 525		
A 525	481-69.29(3) Staffing 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. This REQUIREMENT is not met as evidenced by: 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: Review on 8-2-21 of Tenant #C1's incident report 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. On 8-3-21 at 9:23 a.m. Staff E confirmed the Program had no formal training on how to load wheelchairs onto the bus. He stated a former staff told 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 and stated all four wheels will be secured along with a seatbelt across the person's chest.	A 525		

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A 525	Continued From page 8 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. 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.	A 525		

The Willows of Marshalltown

To: Iowa Department of Inspections & Appeals

From: Jennifer Stanley

CC: Linda Kellen; Deb Dixon

Date: October 11, 2021

Re: Assisted Living Corrections

A160, A525 During a bus trip a resident was not fully secured properly in the wheelchair and seatbelt constraints.

Date Completed: August 30, 2021- All Directors were properly trained how to secure a wheelchair on a bus. The in-service was completed by the Facilities Director and each Director signed off on the training form. We have a written transportation policy that is available to all staff in the policy binder. This policy has also been discussed with all employees on 8/30/21 during the wheelchair training. If a new employee is hired, The Facilities Director & Maintenance Director will complete the training, which is added in the new hire checklist.

Reason for Finding: This was a self- report.

Persons Responsible: Facilities Director & Maintenance Director

A140 Our nurses are knowledgeable in the 30-day evaluation of tenants, and currently are fully utilizing our EHR/Resident Management software (Point Click Care). The software is configured to remind and prompt the RN staff of all scheduled evaluations.

Date Completed: August 13, 2021

Persons Responsible- Director of Nursing

A355 Service plans will be developed before moving into the facility.

A360 The PCC software updates and flags all 30-day service plans that are due, notifying the Director of Nursing to complete. We will continue to use this same process to be compliant. There is no way the PCC software alerts nursing of the change of condition; therefore, Director of Nursing will complete within 24-48 hours.

A395-Nursing will make sure they meet the residents needs by documenting what they need and how they are cared for in the service plan. This will be a task documented in the plan.

Date Completed: August 13, 2021

Persons Responsible: Director of Nursing

10/29/21