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

Date: April 14, 2017
Program Name: Country Manor
Address: 900 W 46th Street Davenport, IA 52806
Type of Action: Revisit on Investigation #64658-I
Date(s) of Action: 3/30/17

State Rule #	State Rule	Amount of Civil Penalty
67.13(4) **+**	**481-67.13(17A,231C,85GA,SF394) Exit interview, final report, plan of correction.** **67.13(4) Monitoring revisit. The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance.** Based on record review the Program failed to implement the Plan of Correction effective 3-1-17. Findings follow: A review of the Plan of Correction indicated the plan was not implemented or completed by the effective date of 3-1-17 in the area of service plans. Please see 69.26(4)a for additional information.	**$1000.00**
69.26(4)a	**481-69.26(231C) 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** Based on interview and record review the Program failed to develop service plans that reflected the identified needs of the tenants for two of three tenant files reviewed (Tenants #2 and #3). Findings follow: 1. Record review revealed Nurse's Notes,dated 3-1-17, indicated Tenant #2 went into another tenant's room and started shouting to get out of his/her room. Tenant #2 grabbed the other tenant over his/her mouth and the other tenant fought	

	back and bit Tenant #2's hand. Tenant #2 punched the other tenant in the right rib cage. Tenant #2 sustained a skin tear, which was treated. Nurse's Notes, dated 3-2-17, indicated the Nurse was notified at approximately 7:09 p.m. the previous evening Tenant #2 had an inappropriate sexual behavior. Staff redirected Tenant #2 and Alprazolam was given. The Nurse was notified early that morning Tenant #2 went into another tenant's apartment and wanted to start a confrontation with the other tenant. Tenant #2 thought the other tenant was in his/her home. Tenant #2 was redirected; however, it took two staff and took longer than normal. Nurse's Notes, dated 3-16-17, indicated the Nurse was called the previous night regarding aggressive behaviors. Staff attempted to redirect Tenant #2; staff received two hits to her face and Tenant #2 received a skin tear to the wrist area and scratches to watch area. Nurse's Notes, dated 3-27-17, indicated the Nurse received several calls over the previous weekend regarding exit seeking and sexual behaviors with two different tenants of the opposite sex. Tenant #2 would "lure" the tenants into his/her room and staff would redirect and remove them from the room. Tenant #2 pounded on different tenant rooms. Redirection seemed to be getting more challenging. Further record review revealed Tenant #2's service plan, dated 11-21-16, (current service plan) reflected Tenant #2 as an elopement risk and indicated Tenant #2 had aggressive behaviors. General information regarding chronic confusion and aggression was indicated on the service plan; however, specific interventions for Tenant #2 related to exit seeking/elopement and aggressive behaviors were not provided. The service plan was not updated to reflect behavior including: going into other tenants' apartments and confrontations, aggression towards staff, exit seeking and sexual behaviors and interventions related to the behaviors. The service plan failed to reflect the identified needs of Tenant #2. Interview with the Nurse on 3-30-17 at 12:01 p.m. revealed Tenant #2 had confrontations with two different tenants, one of which resulted in an injury. Tenant #2 had a confrontation with staff and Tenant #2 hit staff in the jaw. Tenant #2 had sexually inappropriate behavior, which included attempts to lift up other tenants' shirts, patted staff and other tenants on the buttocks and he/she lured tenants of the opposite sex into Tenant #2's room. Tenant #2's exit seeking behavior consisted of going to	

	the exit door. Interview with the Director on 3-30-17 at 12:48 p.m. revealed Tenant #2 had confrontations with two different tenants, one of which resulted in an injury. Tenant #2 had a confrontation with staff and Tenant #2 hit staff twice in the face. Tenant #2 had tried to lift up a tenant's shirt, patted staff and other tenants on the buttocks and tried to take tenants of the opposite sex towards his/her apartment. Regarding exit seeking behavior, Tenant #2 was at the door. 2. Record review of Tenant #3's file revealed a diagnosis of dementia. Tenant #3 was staged at a six on the GDS, which indicated severe cognitive decline. According to the ALP Monitoring Entrance Form, Tenant #3 was identified as a tenant who wandered throughout the Program. A 90 day nurse review document, dated 1-29-17, indicated Tenant #3 wandered throughout the back building. An annual nurse review document, dated 10-28-16, indicated Tenant #3 wandered in the back building. Interview with the Nurse on 3-30-17 at 12:01 p.m. revealed Tenant #3 wandered between two sections of the building and did not exit seek. Interventions for Tenant #3's redirection included: table tasks and programming. Interview with the Director on 3-30-17 at 12:48 p.m. revealed Tenant #3 walked between two sections of the building. Further record review revealed Tenant #3's service plan dated 10-28-16 (current service plan) identified Tenant #3 was prone to wandering; however, did not provide any specific interventions related to the wandering behavior. The service plan did not reflect the identified needs of Tenant #3.	