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
	S0017	A. BUILDING _____ B. WING _____	C 12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR	900 W 46TH ST DAVENPORT, IA 52806

(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	481-67 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. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 31 Total Population of Program at time of on-site: 34 TOTAL census of Assisted Living Program: 34 At the time of the investigation of Incident #64658-I, a regulatory insufficiency was cited.	A 000	See attached POC 3/1/17	
A 089	481-69.26(4)a Service Plans 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 This REQUIREMENT is not met as evidenced by: Based on record review the Program failed to develop service plans to reflect identified needs of tenants, specifically interventions to address elopement. This pertained to 2 of 2 tenant files reviewed (Tenants #1 and #2). Findings follow: 1. Record review revealed an incident report, dated 12-8-16, documented Tenant #1 seen at	A 089		

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

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A 089	Continued From page 1 6:45 p.m. by Staff A. Staff A documented she had a conversation with the tenant about him/her leaving the building with her keys, to find his/her car. Staff A informed Tenant #1 she didn't have his/her car keys and his/her car was in the shop. An additional incident report, dated 12-8-16, documented Tenant #1 taken to the emergency room (ER) post elopement. The tenant received stitches to the #4 digit on the left hand. Vital signs were taken and were as follows: temperature 97.6 degrees, pulse 84, respirations 16 and blood pressure 118/64. Additional record review of Tenant #1's file revealed the following: a. Tenant #1, admitted on 11-1-16, had a diagnosis of dementia and was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. b. An Elopement Risk Evaluation and Interventions document, completed on 11-1-16, 12-1-16 and 12-9-16, identified Tenant #1 as a high elopement risk. c. Tenant #1's service plans, dated 10-31-16 and 12-1-16. Neither plan identified elopement concerns or interventions. The service plan dated 12-1-16 identified Tenant #1 had Alzheimer's dementia and had sundowning confusion. The service plan indicated Tenant #1 did well daily; however, around 4:00 p.m. to 5:00 p.m. he/she started to have sundowning behaviors. Redirection was most necessary in the evening hours. Further record review revealed Tenant #1's service plan updated on 12-9-16 (post	A 089		

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A 089	Continued From page 2	A 089		

elopement) reflected general information regarding chronic confusion; however, the service plan failed to provide specific interventions related to Tenant #1.

d. According to fax communication document to the physician dated 10-31-16, prior to admission to the Program Tenant #1 was picked up on the side of a road by a sheriff. Family was concerned about Tenant #1 having an accident or harming someone while driving. It was not the first time family had been alarmed and woken up in the early morning hours from police calling about Tenant #1.

Fax communication documents to the physician dated 11-10-16 indicated Tenant #1 had been at the Program for 10 days, had not been sleeping at night, continued to pack bags and wanted to leave at 1:00 a.m. in the morning. Tylenol PM was not effective. Tenant #1 was very agitated, had not been sleeping, wanted to leave and was pacing.

A fax communication document to the physician dated 11-28-16 indicated Tenant #1 was packing and wanting to leave. The tenant took Seroquel 25 milligrams (mg) twice daily. A medication for anxiety was requested.

According to a Nurse Review document dated 12-1-16 new medications were obtained including: Seroquel 25 mg, one tablet by mouth twice daily on 11-14-16 and Ativan 0.5 mg, one tablet by mouth twice daily on 11-29-16.

When interviewed on 12-14-16 at 9:44 a.m. Staff A revealed Tenant #1 wanted to find car keys and leave. Tenant #1 was last seen at 6:45 p.m. going to the C section of the building. She was

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A 089	Continued From page 3 notified to complete a head count and it was determined Tenant #1 was not found. Regarding Tenant #1's elopement there were no audible alarms and the windows were not alarmed. Tenants were checked on every 15 to 20 minutes. Observations on 12-14-16 at approximately 10:55 a.m. revealed the following: a. The Program was dementia-specific by dedication and had secured exit doors. The building had four sections A, B, C and D. The front of the building had sections A and B and back of the building had sections C and D. The front and the back of the building was separated by a courtyard. The courtyard was enclosed by a metal fencing and had two secured gates. The windows were not alarmed; however, the window observed (in the C section) had a window stopper to prevent the window from opening fully. b. Although Tenant #1's elopement was not observed the following was a presumed route based on the footprints tracked by the Director and Nurse on 12-9-16 and shown to the monitors on 12-14-16. The window in the apartment on the C section of the building (which was not the section where Tenant #1 resided) was observed and window stopper was present in the window. The window exited to the courtyard. Tenant #1 presumably exited the building through the window, climbed the fenced (bushes were flattened near the fence), traveled off of the Program's property into the alley behind the building, across a yard of a private residence, across a field of a private residence, crossed Northwest Blvd, which was a two lane city street with a posted speed limit of 35 miles per hour (mph) and went to private residence for assistance. The Director and Nurse estimated	A 089		

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A 089	Continued From page 4 the distance traveled was 331 yards. According to the State Climatologist the weather conditions at the local airport on 12-8-16 at 6:52 p.m. were as follows: 23 degrees Fahrenheit (F), winds from the west at 13 mph, with a wind chill of 11 degrees F. The skies were cloudy and very light snow had ended at 5:23 p.m. with a trace amount accumulated. According to the staffing and training policy, the Program would not utilize a personal emergency response system for tenants due to serving tenants with memory loss. Instead staff would be in the approximate area of the tenants and routinely check on the tenants. When interviewed on 12-14-16 at 1:52 p.m. the Nurse revealed Tenant #1 sustained a cut that required six sutures, had two spots where there were skin flaps that were clipped back, was given a tetanus shot and new order for antibiotic in the hospital after the elopement. Upon return from the hospital she assisted him with bedtime cares and noted a spot on the knee, which was described as a old scab. Regarding tenant checks staff knew where the tenants were at, staff was with them all the time and there was no specific times (for checks). At night the tenants were checked every one to two hours. When interviewed on 12-14-16 at 1:15 p.m. the Director confirmed Client #1's history of elopement. With this particular incident, Tenant #1 was gone approximately 15 minutes. He/she ambulated independently without assistive devices. The windows were not alarmed; however had window stoppers in place. Regarding tenant checks it was expected staff knew where tenants were. At bedtime checks	A 089		

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A 089	Continued From page 5 were completed every two hours and while tenants were awake staff was expected to know their whereabouts. The Director acknowledged the tenant's service plan failed to address elopement behavior. 2. Record review of Tenant #2's file revealed the following: a. Tenant #2, admitted on 11-12-16, had a diagnosis of dementia and was staged at a five on the GDS, which indicated moderately severe cognitive decline. b. Elopement Risk Evaluation and Interventions documents completed 11-10-16, 11-21-16, 11-28-16 and 12-9-16 identified Tenant #2 as a high elopement risk. c. Nurse's Notes dated 11-28-16 documented the Nurse was called several times that weekend due to Tenant #2 trying to crawl out of the bedroom window and wanting to leave. Tenant #2 received a skin tear on the right forearm and it was cleaned and dressed. Additional record review revealed Tenant #2's service plan, dated 11-10-16, did not address any elopement concerns or interventions. Further record review revealed Tenant #2's service plan dated 11-21-16 identified Tenant #2 as an elopement risk. General information about chronic confusion was added to the service plan; however, specific interventions related to Tenant #2 were not provided on the service plan.	A 089		

COUNTRY MANOR
MEMORY CARE

900 West 46th Street | Davenport, Iowa | p: 563-391-1111 | f: 563-391-6267

January 19, 2017

Complaint/Incident Intake #64658-I

Iowa Department of Inspection & Appeals
Linda Kellen
Bureau Chief
Adult Services/ Special Services
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

HEALTH FACILITIES
JAN 24 2017

Dear Mrs. Kellen,

Please consider this our plan of correction for the regulatory insufficiencies cited on December 14, 2016 with the **Final Complaint/ Incident Investigation, Country Manor, Davenport, IA** completed by the Department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 231C and Iowa Administrative Code, chapters 481-67 and 481-69, pertaining to regulatory insufficiency in the areas service plans.

Service Plans
481-69.26(4)a: The service plans shall be individualized and shall indicate, at a minimum a) the tenants identified needs and preferences for assistance.

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. The Wellness Director, Registered Nurse will ensure that service plans on each tenant are individualized and identify needs and preferences for assistance; including interventions to address elopement and redirection if that is an identified need.

2. What measures will be taken to ensure the problem does not recur?
    a. The Wellness Director, Registered Nurse will complete service plans on each tenant as outlined in the State of Iowa regulations and each service plan will be individualized and identify needs and preferences; including interventions to address elopement and redirection if that is an identified area of need.

3. How the program plans to monitor performance to ensure compliance.
    a. The Wellness Director, Registered Nurse or designee will complete a quarterly audit of all service plans to ensure the problem does not recur therefore we will be in compliance

4. Date by which the regulatory insufficiency will be corrected?
    a. All tenants service plans will be updated if need be, to identify needs and preferences for assistance; including interventions for elopement and redirection by March 1, 2017.

Thank you for your consideration and please do not hesitate to contact me at 563-391-1111 if any further information is required. Further, we are aware that we have a civil penalty to pay. That will be paid within the time frame outlined of 30 days.

Sincerely,

Nichole Will

Nichole Will, BSW
Executive Director