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

Date: October 2, 2018
Program Name: Country Manor
Address: 900 West 46th Street, Davenport, IA 52806
Type of Action: Revisit of Investigations #75208-C, 75209-C, 75823-C, and 75340-I and Investigation # 77948-I
Date(s) of Action: August 30, 2018 - September 6, 2018

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	**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.** Based on interview and record review revealed the Program failed to provide care, treatment and services that were adequate and appropriate to a tenant after a fall. This pertained to 1 of 1 tenant reviewed with a fall with fracture (Tenant #4). Findings follow: 1. Record review of Tenant #4's file revealed a diagnosis of neuro cognitive disorder. Tenant #4 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #4 received Hospice services. The service plan dated 7-5-18 reflected Tenant #4 was ambulatory with assistance of one person. Continued record review of a handwritten Incident Report dated 8-15-18 at 6:45 a.m. revealed Tenant #4 was dressed for the day and Staff A walked with her into the medication room to apply her denture. Tenant #4 took a couple of steps and stumbled. She fell in the doorway of the medication room, with her head and chest on the carpet and the rest of her body on the tile floor. She was found lying on the left side. The report indicated Tenant #4 remained at the Program. Areas affected were indicated as the left hand/forearm, left hip and left leg/knee. Vitals were obtained and were as follows: blood pressure was 186/97, pulse was 94, respirations were 23, temperature was 94.3 and oxygen saturation was 95%. The report indicated no major reaction was observed besides a fearful reaction. The report indicated the nurse was not notified. The physician and Tenant #4's family was notified on 8-16-18. The report was signed and dated by Staff A on 8-15-18 at 7:00 a.m. Staff A provided a handwritten entry on the back of the incident report, which indicated on 8-15-18 at about 6:45 a.m. she walked with Tenant #4 into the medication room and they both stood in front of the stink. As Staff A turned to get Tenant #4's denture from the cup, Tenant #4 turned the opposite direction, stepped forward and stumbled and fell. Tenant #4 landed on her left side and did not hit her head or body on anything. Tenant #4 fell straight through the	**$2500.00** **+**

	doorway. Part of her body from the chest up to her head was on the carpet and lower part of her body was on the tiled floor. Tenant #4 did not bump into any objects. Staff A asked if Tenant #4 was okay and she shook her head up and down. Staff D entered the building from the front door about the same time and witnessed Tenant #4's fall. Staff A stood Tenant #4 up and asked Staff D to get Tenant #4's wheelchair. Staff A sat Tenant #4 in the wheelchair and pushed her to the living room and transferred her to the couch. Staff A then took Tenant #4's vitals and completed an incident report. The incident report was put in the Health Care Coordinator's mailbox at the end of shift at 7:00 a.m. An electronic Incident Report indicated on 8-15-18 at 6:45 a.m. (revised on 8-27-18) reflected staff and Tenant #4 were standing in the medication room when staff reached for the denture cup and Tenant #4 turned and took a couple of steps away from her. Tenant#4 stumbled and fell landing on her left side. Staff reported Tenant #4 did not bump anything on her way down and did not hit her head. Tenant #4 was assisted to standing with a two to one assist and was assisted into a wheelchair. Tenant #4 was not taken to the hospital. The injury reflected was a fracture of the left hip. The physician was notified on 8-16-18 at 3:15 p.m. and Tenant #4's family was notified on 8-16-18 at 3:20 p.m. 2. When interviewed on 9-5-18 at 9:54 a.m. Staff A revealed she worked third shift on the day of Tenant #4's fall. Tenant #4 was up and dressed for day and she and Tenant #4 walked to the medication room to assist with her denture. Staff A and Tenant #4 were in the medication room, both facing the sink. It was a normal routine for Tenant #4 to assist with grooming tasks. Staff A turned to get either a washcloth or denture and Tenant #4 turned and fell. Tenant #4 fell straight to the doorway of the medication room. Tenant #4's head and chest was on the carpet and part of her chest and lower body was in the medication room. It was too late to assist Tenant #4 as she turned around. Tenant #4 was wearing shoes when she stumbled. Staff A asked if Tenant #4 was okay and she indicated she was. Tenant #4 landed on her left side and had no complaints of pain. Staff D came in when Tenant #4 fell and got a wheelchair for Tenant #4. Staff A stood her up, she was able to bear weight and there were no complaints of pain. Staff A pushed her to the living room in the wheelchair and she was transferred to the couch. There were no injuries noted and no complaints of pain during the transfer. Staff A took Tenant #4's vitals approximately 15 to 30 minutes after the fall and completed an incident report. The incident report was put in the mailbox for the Health Care Coordinator. The on-call nurse, Health Care Coordinator, Manager or family was not notified of the fall. Staff A said it all happened so fast, she tried to get everything done before she left and there was no signs of anything serious going on with Tenant #4. Staff A thought she said something to one of the staff regarding Tenant #4's fall but could not remember what was said. After the fall with Tenant #4, staff was trained not to touch or move the person before calling the nurse.	

	Staff B worked on first shift on 8-15-18 and worked on the neighborhood Tenant #4 resided. When interviewed on 9-4-18 at 10:13 a.m. Staff B revealed when she arrived to work she had a hard time transferring Tenant #4. The Hospice Nurse was also there that day. The next day when she worked Tenant #4 was still like that and did not respond when asked about pain. The Health Care Coordinator completed an assessment (the day after the fall), an x-ray was completed and Tenant #4 had a hip fracture. On the day of Tenant #4's fall, Staff B was not informed of the fall from the off-going third shift staff, Staff A. Staff B had just noticed Tenant #4 was acting different. Nursing staff was also not aware of Tenant #4's fall. Staff C worked first shift on 8-15-18 in different neighborhood than where Tenant #4 resided; however, did work in the front building. When interviewed on 9-5-18 at 12:40 p.m. Staff C revealed the day after Tenant #4 fell, she worked first shift and assisted with tenants as Staff B passed medications. Tenant #4 was on the couch by the wall. She attempted to assist Tenant #4 and she wasn't standing right. Hospice came in that day and said it was a phase (regarding Tenant #4). Staff C was not aware Tenant #4 had fallen. If a fall occurred staff was supposed to write it on the 24 hour sheet and notify the nurse. At the end of shift staff give report and Staff A did not report the fall to Staff B. Staff D worked third shift on 8-14-18 into 8-15-18 in a different neighborhood than where Tenant #4 resided; however, did work in the front building. When interviewed on 9-5-18 at 3:43 p.m. Staff D revealed at approximately 6:40 a.m. she left to take out the garbage and when she returned she saw Tenant #4 on the floor. Tenant #4 was lying on her side on the floor by the medication room. Staff A asked her to get a wheelchair out of Tenant #4's room and Staff D brought the wheelchair to Staff A. Staff D did not assist with transferring Tenant #4 and did not observe Staff A transfer Tenant #4. Staff E worked second shift on 8-15-18 and worked in the neighborhood Tenant #4 resided. When interviewed on 9-5-18 at 3:16 p.m. Staff E revealed she was not there during the fall with Tenant #4. When she got to work she knew from Staff A that Tenant #4 had fallen. Since the time of the fall, staff repositioned and changed Tenant #4. Continued record review revealed the nurse on-call schedule indicated the Nurse was on-call on 8-15-18 and 8-16-18. When interviewed on 9-5-18 at 8:53 a.m. the Nurse revealed she was on-call on 8-15-18 and she did not receive a call regarding a fall with Tenant #4. She said the Health Care Coordinator called her the next morning and asked if there had been any calls received. The Nurse was made aware of the Tenant #4's fall by the Health Care Coordinator.	

	When interviewed on 9-5-18 at 10:47 a.m. the Hospice Nurse revealed Tenant #4 fell on 8-15-18 and she saw her on that day for her recertification visit. One of the staff reported Tenant #4 was not standing well. She put a gait belt on her and it was obvious she was uncomfortable (grimacing); however, she denied pain when asked. There had been days in the past when Tenant #4 did not want to stand or walk. She told staff she would check back later in the day. Tylenol was administered and Tenant #4 was put into a chair to take a nap. The Hospice Nurse called back later and staff had not weighed her. The next day the Hospice Nurse was not working and supervisory staff assisted in her absence. The Program called for an as needed visit and hospice staff responded and found out Tenant #4 had fallen on 8-15-18. The Hospice Nurse was not notified of the fall on 8-15-18 and Hospice staff did not find out about the fall until 8-16-18. An x-ray was taken and showed a fracture. There was discussion with Tenant #4's family and an election was made not to treat. Tenant #4 was on bed rest and was being repositioned every couple of hours. Staff had been using as needed Morphine and as needed Tylenol and the administration of the medication was inconsistent. She sent a message to the physician to get Tylenol scheduled to get more consistent pain control. The Hospice Nurse said if any falls, medication change or change of condition Hospice was to be notified. When interviewed on 9-4-18 at approximately 2:00 p.m., 9-5-18 at approximately 11:55 a.m. and 9-6-18 at 1:06 p.m. the Health Care Coordinator revealed it was reported that on 8-15-18 at 6:45 a.m. Staff A was at the sink in the medication room with Tenant #4. Staff A reached for the denture cup and Tenant #4 took a couple of steps away and fell. The Nurse was on-call and was not notified of Tenant #4's fall. The Hospice Nurse came in that day; however, she was not made aware of the fall that day. On 8-16-18 one staff reported Tenant #4 had left leg pain. The Health Care Coordinator assessed Tenant #4 and completed ankle, knee and hip range of motion (ROM). Tenant #4 voiced a complaint of pain with the left hip. She checked the communication book and staff on second shift on 8-15-18 had charted Tenant #4 had pain from a fall. Orders were obtained for an x-ray and Hospice and Tenant #4's family were notified of the fall. The x-ray was completed on 8-16-18 (fractured hip) and Hospice spoke with family and family elected not to treat. Staff B, the oncoming staff on 8-15-18, was also not made aware of the fall on 8-15-18. The Health Care Coordinator was not aware of the fall until 8-16-18. Tenant #4's family requested Morphine not be given, it was held for a day or less. The Health Care Coordinator revealed she did not receive the incident report Staff A reported she filled out and placed in her mailbox on 8-15-18. The Health Care Coordinator indicated she was working on 8-15-18 and checked her mailbox every morning on business days. The incident report provided was completed on 8-17-18, when Staff A was interviewed by the Program. When interviewed on 9-5-18 at 11:44 a.m. the Manager revealed the Health Care Coordinator did her assessment of Tenant #4 in the afternoon on 8-16-18 and notified Hospice and family. The Hospice	

	Nurse, the Nurse, the Health Care Coordinator and family were not aware of the fall prior to that time. On 8-24-18 an in-service was held and they went through the incident report policy and reporting of unusual occurrences. The Manager's typed statement indicated on 8-15-18 at approximately 6:45 a.m. Staff A was in the medication room with Tenant #4 to apply her dentures. Tenant #4 faced the sink while Staff A turned around and obtained the dentures. Staff A turned back around and Tenant #4 had turned and taken a step toward the door, stumbled and landed on her left side. Tenant #4 was a GDS of six and was assisted with ambulation per the service plan. Tenant #4 received Hospice services for dementia and encephalopathy. Staff D obtained Tenant #4's wheelchair and assisted Staff A with transferring Tenant #4 into her wheelchair. Vitals were obtained and an incident report was completed. On the afternoon on 8-16-18, the Health Care Coordinator was notified by staff they believed Tenant #4's leg was hurting her. The Health Care Coordinator assessed Tenant #4 and noted pain/discomfort while assessing Tenant #4's left leg. Hospice was notified at 2:52 p.m. A mobile x-ray was scheduled to come to the Program and perform an x-ray. The results were received at 8:04 p.m. The results indicated Tenant #4 sustained a comminuted impacted fracture of the left subcapital femoral neck with intertrochanteric extension. 3. Continued record review revealed 24 hour sheets completed by staff were obtained indicated the following: a. On 8-15-18 (third shift) it was noted Tenant #4's denture was removed and soaked overnight (reapply in the morning). Tenant #4 was soiled at 1:00 a.m. and the protective undergarment was changed and the chux was removed and washed. Upon changing her protective undergarment and turning her on her side, Tenant #4 seemed scared and held on tight to her bedside. b. There was no communication sheet available for first shift on 8-15-18. c. On 8-15-18 (second shift) it was noted staff thought Tenant #4 was in a lot of pain from when she fell. d. There was no communication sheet available for first shift on 8-16-18. e. On 8-16-18 (second and third shifts) it was noted Tylenol administered as directed and noted in the medication administration record (MAR). Instructed by the Health Care Coordinator. No Morphine was to be administered until further notice. Tenant #4 was to remain in bed, her head elevated to 90 degrees with a pillow to separate her feet. Further record review revealed a Patient Report (x-ray report) dated 8-16-18 revealed Tenant #4 had a comminuted left subcapital hip	

	fracture of the left femoral neck with intertrochanteric extension. It was signed electronically on 8-16-18 at 8:15 p.m. 4. Tenant #4's Progress Notes indicated the following: a. On 8-16-18 at 1:52 p.m. it was noted Hospice was notified of Tenant #4 having left hip pain. When left hip ROM was completed Tenant #4 said "No, no, no." Tenant #4 had difficulty with bearing weight. Hospice would be in to assess Tenant #4. b. On 8-16-18 (late entry) it was noted x-ray results were received and Hospice was notified of the findings. The on-call Hospice nurse instructed to call Tenant #4's family and ask what their plan was for treatment. Tenant #4's family was contacted and requested more information on treating at the Program. Hospice was notified and contacted family. Hospice called back and indicated family would call back when a decision was made. Instructions were received from Hospice to keep Tenant #4 in bed on her back with the head of bed slightly elevated and a pillow between her ankles. A return call from received from Tenant #4's family and they did not want Tenant #4 sent out at that time. c. On 8-16-18 (late entry) it was noted Tenant #4 had a yellowing bruise and abrasion noted to the left side of the forehead. The bruise/abrasion was of unknown origin. No swelling, redness and/or bleeding was noted. d. On 8-17-18 it was noted the Health Care Coordinator spoke with Tenant #4's family and Hospice would contact family to set up a time to discuss treatment options. e. On 8-17-18 at 11:12 a.m. it was noted the physician was notified of the fall and hip fracture. The physician was previously notified by Hospice. f. On 8-31-18 it was noted a new order was received for Tylenol 500 milligram (mg) every six hours and as needed Acetaminophen was changed to 500 mg, orally every six hours as needed for pain not to exceed 4 grams in 24 hours. The physician approved for Tenant #4 to be transferred into wheelchair in four weeks from date of fracture (9-15-18). The Program completed a Request for Waiver of Administrative Rule (Health-Care) dated 8-21-18. The request indicated Tenant #4 was bed bound and was an assist of one for all activities of daily living. 5. Continued record review revealed August MARs reflected an order for Acetaminophen 500 mg, two tablets, orally, every six hours as needed (discontinued on 8-31-18). It was documented as given on 8-15-18 at 8:00 a.m. for pain and was documented as effective. It was documented as given on 8-16-18 at 10:00 p.m. for pain and was documented as effective. The August MARs reflected an order	

	for Morphine Sulfate Solution 20 mg/milliliters (ml), 0.25 ml (5 mg) orally, sublingual, every two hours as needed (with an order date of 3-26-18). The first dose was documented as given on 8-17-18 at 12:30 p.m. and was documented as effective. The first dose of Morphine was administered greater than 48 hours after the fall occurred. An order to hold the physician ordered Morphine Sulfate Solution was not found. The MARs reflected an order for Tylenol 500 mg, one tablet, orally every six hours at 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m. with an order date of 8-31-18. The MARs did not reflect any doses documented on 8-31-18. In summary, Tenant #4 a tenant with severe cognitive decline, who received Hospice services, fell on 8-15-18 at 6:45 a.m. Staff present during the fall did not notify the on-call nurse of the fall. Staff reported an incident report was completed related to the fall and was put in the Health Care Coordinator's mailbox. The initial incident report was not found and an incident report was completed by staff on 8-17-18, despite being signed and dated on 8-15-18. On-coming first shift staff, in the neighborhood where Tenant #4 resided, was not made aware of the fall on 8-15-18. It was noted on the 24 hour sheet on 8-15-18 (second shift) that Tenant #4 had a lot of a pain due to a fall. The Hospice Nurse, Health Care Coordinator, Manager and Tenant #4's family was not aware of the fall until 8-16-18. Hospice had a visit with Tenant #4 on 8-15-18 and first shift staff reported she did not want to transfer; however, the Hospice Nurse was not aware of the fall on 8-15-18 at the time of visit and Tenant #4 had times in the past when she did not want to stand or walk. On 8-16-18 at 1:52 p.m. the Health Care Coordinator completed an assessment and notified Hospice of Tenant #4's left hip pain. A mobile x-ray was completed and it was determined Tenant #4 sustained a left hip fracture. An election was made not to treat Tenant #4 post fall with fracture and Tenant #4 was bed bound. August MARs reflected two doses of Acetaminophen were administered, on 8-15-18 and 8-16-18 for pain, including a dose at 8:00 a.m. on 8-15-18. Morphine was held briefly per family request; however, an order was not found related to hold of the physician ordered medication. The first dose of Morphine was given greater than 48 hours from the time of the fall. The Program applied for a waiver to retain Tenant #4 as she exceeded the level of care post fall.	

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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 interview and record review the Program failed to implement the Plan of Correction (POC) effective 5-30-18. This directly pertained to 1 of 4 tenants reviewed (Tenant #4) and potentially affected all tenants (census of 24). Findings follow: Record review of the POC indicated the plan was not implemented or completed by the effective date of 5-30-18 in the area of tenant rights. When interviewed on 9-5-18 at 11:44 a.m. the Manager revealed the POC was followed as indicated.	**$1500.00**

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