

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

Date: August 15, 2019
Program Name: Prairie Hills at Clinton
Address: 1701 13 th Ave. North Clinton, IA 52732
Type of Action: complaint 84025
Date(s) of Action: 7/1/19 to 7/8/19

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	<p>481-67.3 Tenant rights. All tenants have the following rights: <u>67.3(2) To receive care, treatment and services which are adequate and appropriate.</u></p> <p>Based on interview and record review, the Program failed to ensure adequate and appropriate care was provided to 2 of 6 tenants reviewed (Tenant #1, #4). Findings follow:</p> <p>1. Review on 7/3/19 of a Documentation Survey Report for Tenant #1 revealed she was to be checked by staff sixteen times per shift (once every thirty minutes). There was no documentation of checks being conducted for Tenant #1 at the following times: 5/13/19 from 3:00 AM - 7:00 AM, 5/15/19 from 1:00 AM - 4:00 AM and 5/24/19 from 12:00 AM - 6:00 AM. There were 1-2 hour gaps in checks on 5/1/19, 5/3/19, 5/6/19, 5/11/19, 5/12/19, 5/16/19, 5/18/19, 5/22/19, 5/26/19 and 5/31/19.</p> <p>On 5/26/19, the Documentation Survey Report reflected Tenant #1 was checked at 5:00 AM but not again until 6:55 AM at which time a Progress Note reflected she was heard yelling and found on the floor by her sink with an abrasion to her right elbow.</p> <p>2. Record review on 7/3/19 revealed Tenant #4 was admitted to the program on 2/21/19. He was diagnosed with Lewy Body Dementia. A note from Tenant #4's physician dated 2/27/19 noted Tenant #4 had worsened over the past month. There were several days when Tenant #4 was barely able to function. The doctor noted Tenant #4 was having more difficulty walking and was shaky. The Health Care Coordinator sent a fax to Tenant #4's doctor on 3/1/19 notifying him Tenant #4 had three falls since admission and seemed somewhat weaker.</p> <p>A service plan dated 3/21/19 noted Tenant #4 was at risk for falls due to his history and was to receive safety checks for falls 16 times per shift (every 30 minutes).</p> <p>A progress note dated 4/3/19 reflected Tenant #4 fell at 2:50 AM without injury. Tenant #4 suffered another fall on 4/3/19 at 5:50 PM during which time he was transported to the hospital by EMTs. He returned to the Program on 4/4/19 with no new orders. Tenant #4 fell on 4/5/19 at 12:40 AM without apparent injury. The Health Care Coordinator noted "staff to check on him every 30 minutes during the remainder of the shift." Tenant #4 fell on 4/6/18 at 4:00 AM and had</p>	\$2500.00 total

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67.9(1)	<p>pain in his hip. He was transported to the emergency room. According to a note from the Emergency Department Tenant #4 was diagnosed with an accidental fall, hematoma and confusion. He returned to the Program later in the day. On 4/7/19 at 4:45 AM, staff heard a loud sound and found Tenant #4 sitting on the floor with fresh blood on his shirt. An open area was noted on the top of his head. Tenant #4 was transferred to the emergency room. The Health Care Coordinator spoke with the ER nurse who informed her Tenant #4 had a brain bleed. Tenant #4 was admitted to the hospital. A nurse at the hospital informed the Health Care Coordinator Tenant #4 was essentially unresponsive with a poor prognosis. Tenant #4 returned to the program on 4/8/19 on hospice and was noted to be unresponsive to touch or verbal stimuli. Tenant #4 passed on 4/15/19.</p> <p>A review of Documentation Survey reports for April 2019 identified Tenant #4 was to have visual checks every 30 minutes. Tenant #4 received no documented safety checks until 4/8/19 at 4:30 PM.</p> <p>The Health Care Coordinator confirmed checks were not documented until 4/8/19. She reported staff were frequently in Tenant #4's apartment but there was no documentation to reflect this.</p> <p><u>481-67.9(231B,231C,231D) Staffing.</u> <u>67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.</u> Based on interview and record review, the Program failed to provide adequate staffing on the locked memory care unit, potentially affecting all 16 tenants. Findings follow:</p> <p>Record review on 7/3/19 of a Documentation Survey Report for Tenant #1 revealed she was to be checked on by staff sixteen times per shift (once every thirty minutes). There was no documentation of checks being conducted for Tenant #1 at the following times: 5/13/19 from 3:00 AM - 7:00 AM, 5/15/19 from 1:00 AM - 4:00 AM and on 5/24/19 from 12:00 AM - 6:00 AM. There were 1-2 hour gaps in checks on 5/1/19, 5/3/19, 5/6/19, 5/11/19, 5/12/19, 5/16/19, 5/18/19, 5/22/19, 5/26/19, 5/31/19.</p> <p>On 5/26/19, the Documentation Survey Report reflected Tenant #1 was checked on at 5:00 AM but not again until 6:55 AM at which time a Progress Note reflected she was heard yelling and found on the floor by her sink with an abrasion to her right elbow.</p> <p>On 7/2/19 at 4:25 PM Staff C reported more often than not there were two staff members working second shift in the memory care unit during the week, however there was usually one staff person working second shift on the weekend. Staff C identified seven tenants who required 1:1 assistance with ambulation. She stated she could not keep up with checking on tenants every 30 minutes when she was working by herself.</p> <p>On 7/2/19 at 1:40 PM, Staff D reported there often was only one staff working on the unit. She felt she was unable to quickly respond to</p>
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<p>69.26(4)a</p>	<p>tenant pages when she was there by herself. Staff D reported it was difficult to care for the tenants when she was also responsible for doing things such as serving meals, responding to pages, caring for tenants' needs and providing supervision.</p> <p>When interviewed on 7/2/19 at 1:58 PM. Staff E reported first shift staff members on the memory care unit were responsible for doing laundry, meals, administering medication and getting tenants up in the morning. She felt it was not safe for the tenants to only have one staff working first shift.</p> <p>An interview with Staff B on 7/2/19 at 2:25 PM revealed she did not think tenant needs could be met with only one person working. Staff B said there was no way to respond to a tenant when showering another tenant. Staff B had come to the memory care unit and found tenants with soiled briefs. She said one person could not do it all.</p> <p>On 7/2/19 at 4:00 PM Staff F reported most of the time there were two people working on the memory care unit, except on weekends. She felt there were a lot of falls on the memory care unit due to a lack of staff. She said one person could not do it all.</p> <p>On 7/3/19 at 12:35 PM the Manager stated she had never worked in an assisted living program in which there had been so many people falling. The Manager had worked on the memory care unit for one week from 3:00 PM - 6:00 PM during the month of April. She said she realized at that time having one staff member working on that unit was not enough. They attempted to schedule two staff in the memory care unit but it was not always possible due to staffing issues.</p> <p><u>481-69.26(231C) Service plans.</u> <u>69.26(4) The service plan shall be individualized and shall indicate, at a minimum:</u> <u>a. The tenant's identified needs and preferences for assistance</u></p> <p>Based on interview and record review, the Program failed to ensure service plans addressed identified needs for 5 of 6 tenants reviewed (Tenant #1, #2, #3, #4 and #6). Findings follow:</p> <p>1. Record review on 7/2/19 revealed Tenant #1 had a service plan dated 4/15/19. According to the service plan, Tenant #1 had a history of falls. Tenant #1 was to receive escorts to/from activities or the dining room, use a wheeled walker and call for assistance.</p> <p>A review of Progress Notes and Incident Reports revealed Tenant #1 experienced a fall on 5/16/19 which resulted in a transfer to the ED (Emergency Department). She fell twice on 5/22/19. On 5/24/19, Tenant #1 fell in her apartment and had a laceration to her head resulting in three staples in her head at the ED. Tenant #1 had a fall on 5/26/19, resulting in an abrasion to her right elbow. Tenant #1 fell on 5/28/19, cut the back of her head and was transferred to the ED where she received staples to her head. Tenant #1 fell again on</p>	
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	<p>6/4/19 resulting in a transfer to the ED for blood found on her head.</p> <p>Tenant #1's service plan was not updated until 6/4/19 to put in new interventions to address her falls.</p> <p>2. Record review on 7/3/19 revealed Tenant #2 had a service plan dated 6/14/19. The service plan identified Tenant #2 required assistance with ordering her medication and wished it to be administered safely according to doctor's orders.</p> <p>A comprehensive assessment dated 6/14/19 noted Tenant #2 preferred to have her medication crushed and given to her in applesauce. A progress note dated 6/26/19 documented Tenant #2 was consistently refusing meds, while the program was using different approaches and different staff. The Health Care Coordinator notified Tenant #2's POA (power of attorney) who reported Tenant #2 had refused medication frequently when she was temporarily in a skilled nursing facility from 5/8/19 to 6/13/19. A progress note dated 7/1/19 noted Tenant #2 continued to refuse medication at times.</p> <p>The tenant's service plan did not list interventions to address Tenant #2's medication refusals.</p> <p>3. Review of a 90 Day Nurse Review for Tenant #3 dated 2/10/19 revealed a 90-minute family meeting was held on 12/12/18. On 7/8/19 at 11:45 AM the Health Care Coordinator confirmed she attended this meeting. She stated during the December meeting, the family reported they did not think Tenant #3 was being bathed regularly. They questioned some clothing choices the tenant was making. They also didn't want Tenant #3 just sitting in the dining room following a meal. The Health Care Coordinator did not believe any of these requests required a change to Tenant #3's service plan.</p> <p>An email was received from a family member of Tenant #3 on 7/14/19. This family member reported taking notes at the meetings. She reported at the December 2018 meeting, the family expressed concern with Tenant #3 losing weight. They requested that caregivers ask Tenant #3 if she needed food cut up and to also divide up her food onto different plates so she was not overwhelmed with the amount. They asked Tenant #3 to receive escorts to and from the dining room. The family was worried they had found Tenant #3 sitting in soiled undergarments when they arrived at her apartment due to increased incontinence of bowel and bladder and wondered if she could be checked on more frequently.</p> <p>The tenant's service plan dated 11/12/18 was not updated to reflect these requested services.</p> <p>In addition, a comprehensive assessment dated 11/12/18 indicated Tenant #3 preferred staff to stand by during transfers. The tenant was to communicate this request to staff as needed. The comprehensive assessment also noted Tenant #3 needed an escort to/from activities and the dining room. According to the 11/12/18 service plan, Tenant #3 was independent with ambulation and not identified as a fall risk.</p>	
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	<p>According to a 90 day review dated 2/10/19, Tenant #3 had falls on 11/10/18 and 11/11/18. She also received Physical Therapy and Occupational Therapy from 11/11/18 to 12/12/18. A 90 day review dated 5/10/19 noted Tenant #3 fell on 2/24/19 and 4/22/19.</p> <p>The tenant's service plan was not updated to reflect the falls, assistance with transfers and escorts, or the therapies she received.</p> <p>4. Record review on 7/3/19 revealed Tenant #4 was admitted to the program on 2/21/19. He was diagnosed with Lewy Body Dementia. A note from Tenant #4's physician dated 2/27/19 noted Tenant #3 had worsened over the past month. There were several days when Tenant #4 was barely able to function. The doctor noted Tenant #4 was having more difficulty walking and was shaky. The Health Care Coordinator sent a fax to Tenant #4's doctor on 3/1/19 notifying him Tenant #4 had three falls since admission and seemed somewhat weaker.</p> <p>A progress note dated 4/3/19 reflected Tenant #4 fell at 2:50 AM without injury. Tenant #4 suffered another fall on 4/3/19 at 5:50 PM during which time he was transported to the hospital by EMTs. He returned to program on 4/4/19 with no new orders. Tenant #4 fell on 4/5/19 at 12:40 AM without apparent injury. The Health Care Coordinator noted "staff to check on him every 30 minutes during the remainder of the shift". Tenant #4 fell on 4/6/18 at 4:00 AM and had pain in his hip. He was transported to the emergency room.</p> <p>According to a note from the ED Tenant #4 was diagnosed with an accidental fall, hematoma and confusion. He returned to the program later in the day. On 4/7/19 at 4:45 AM, staff heard a loud sound and found Tenant #4 sitting on the floor with fresh blood on his shirt. An open area was noted on the top of his head. Tenant #4 was transferred to the emergency room. The Health Care Coordinator spoke with the ER nurse who informed her Tenant #4 had a brain bleed. Tenant #4 was admitted to the hospital. A nurse at the hospital informed the Health Care Coordinator Tenant #4 was essentially unresponsive with a poor prognosis. Tenant #4 returned to the program on 4/8/19 on hospice and was noted to be unresponsive to touch or verbal stimuli. Tenant #4 passed away on 4/15/19.</p> <p>A service plan dated 3/21/19 noted Tenant #4 was at risk for falls due to his history. He was identified as independent with ambulation but needed to use an assistive device. The tenant's service plan was not updated to provide interventions related to his falls until 4/9/19.</p> <p>5. Record review revealed Tenant #6 had a service plan dated 4/30/19. Tenant #6's service plan identified she was independent with ambulation but may need reminders to slow down her pace while walking. Tenant #6 was to be reminded to call for assistance and to wait after standing to ensure she was not light headed before she started walking.</p> <p>A review of Incident Reports revealed Tenant #6 fell on 3/19/19 and 3/20/19. On 6/10/19, she was found sleeping on the floor at the foot of</p>	
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	<p>her bed. She expressed no pain and was helped to bed. On 6/11/19, a progress note indicated Tenant #6 reported pain in her left shoulder while dressing and had limited range of motion. Tenant #6's husband took her to the Emergency Room where she was treated for a closed fracture of the distal clavicle and dehydration. Tenant #6 received home care instructions which included wearing a splint. A progress note dated 6/13/19 identified Tenant #6 did not want the sling on and was taking it off independently. A progress note dated 6/18/19 documented Tenant #6 was found on her bathroom floor on her back. She complained of hip pain and right shoulder pain. Tenant #6 was transferred to the emergency room via ambulance. She returned on 6/19/19 without a fracture but did have a closed head injury.</p> <p>Tenant #6's service plan was not updated to reflect her falls or interventions put in place to assist her to wear her splint.</p> <p>6. On 7/8/19 at 11:45 AM the Health Care Coordinator confirmed service plans were not updated as needed.</p>	
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