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

Date: September 28, 2017
Program Name: Country Manor
Address: 900 W 46th Street Davenport, IA 52806
Type of Action: 2nd Revisit on Investigation #64658-I & Investigations #68237-I, 70048-I, and 70171-C
Date(s) of Action: 8/15/17 – 9/12/17

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 6-1-17. Findings follow: A review of the Plan of Correction indicated the plan was not implemented or completed by effective date of 6-1-17 in the areas of program policies and procedures and service plans. Please see 67.2(1)(d) and 69.26 (4)(a) for additional information.	**$3000.00**
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 observation, interview and record review the Program failed to develop service plans to reflect identified needs of tenants. This pertained to 2 of 5 tenants reviewed (Tenants #6 and #7). Findings follow:	

	1. Observation on 8-22-17 at 3:30 p.m. revealed Staff B transferred Tenant #6 from the wheelchair to his/her bed. Tenant #6 did not bear weight or participate with the transfer. Tenant #6's legs were contracted when lifted by staff, and remained contracted once placed on the bed. Staff B prepared to check Tenant #6's protective undergarment in bed and did not take Tenant #6 to the bathroom. Staff B verbalized the protective undergarment was not wet and Tenant #6 was not changed. Staff B transferred Tenant #6 back from the bed to the wheelchair and Tenant #6 did not bear any weight and was cradled to transfer back into the wheelchair. Tenant #6's legs were again contracted. Record review revealed Tenant #6's service plan indicated he/she needed to be taken to the bathroom every two hours while awake for bladder incontinence and taken once in the night. The service plan reflected Tenant #6 was a one person transfer and required assistance from bed to chair and vice versa. An interview with Staff B on 8-21-17 at 4:44 p.m. revealed Tenant #6 could not do anything himself/herself, except eat. Toileting was completed in bed as Tenant #6 could not stand and staff rolled him/her in bed. Tenant #6 did not help with toileting. An interview with Staff F on 8-21-17 at 5:55 p.m. revealed Tenant #6's protective undergarment was usually changed in bed and Tenant #6 did not go on the toilet or commode. An interview with Staff G on 8-22-17 at 2:02 p.m. revealed Tenant #6 was usually changed in bed and no staff took him/her to the toilet. Tenant #6 would not hold the bar and did not help with toileting. Further review of Tenant #6's service plan revealed it did not reflect staff changed Tenant #6 in bed for toileting needs and also did not accurately reflect the transfer process for Tenant #6. b. Continued record review revealed a 90 day nurse review, dated 5-5-17, indicated Tenant #6 was on a turn schedule at night related to bony structure and wore hip pads at night. Review of the service plan revealed failure reflect the need for repositioning at night or the hip pads worn at night. c. Further record review indicated wound clinic documentation indicated orders including: to increase the nutritional	

	supplement to two to three times per day, mattress overlay/specialty bed or mattress and wheelchair cushion. Review of the service plan revealed failure to reflect the nutritional supplement, mattress overlay or wheelchair cushion. The service plan did not reflect the identified needs of Tenant #6. 2. Record review of Tenant #7's file revealed his/her nurses notes indicated the following: a. On 6-1-17 it was noted Tenant #7 encouraged tenants of the opposite sex to sit next to him/her. He/She would hold their hands and eventually put their hand down his/her pants. Nurse's Notes indicated it was a "constant task" to keep him/her from luring tenants of the opposite sex to the sofa or to his/her apartment. b. On 6-7-17 Tenant #7 had his/her hands inside another tenant's protective undergarments. The other tenant was removed and Tenant #7 taken to bathroom. It was noted Tenant #7's behavior was occurring more frequently. c. On 8-4-17 at 9:30 a.m. Tenant #7 touched himself/herself in front of another tenant. Tenant #7 was removed from the area. d. On 8-4-17 at 10:30 a.m. Tenant #7 had his/her hands inside another tenant's pants. The other tenant was removed from the area and Tenant #7 was told his/her actions were inappropriate. Tenant #7 became angry and combative. An ambulance was called. Tenant #7 refused to go with paramedics and permission was given by the legal representative to have Tenant #7 sedated. Tenant #7 was transferred to the hospital. Tenant #7's legal representative called and said Tenant #7 would be returning to the program with an order to treat a urinary tract infection (UTI). A call was received from the hospital which indicated Tenant #7 would be returned to the Program and the hospital was told the Program was unable to take Tenant #7 back due to danger to other tenants. A call was made to corporate and the corporate nurse instructed the Program not to take Tenant #7 back. Nurse's Notes indicated Tenant #7's legal representative "insisted" Tenant #7 return to the Program. Tenant #7 returned on 8-4-17 with new orders for Alprazolam and an antibiotic. Staff were instructed to make rounds every 15 minutes during the night to ensure Tenant #7 slept. e. On 8-12-17 Tenant #7 acted out sexually towards another	

	tenant. The other tenant was removed from the area and Tenant #7 became aggressive towards staff. Tenant #7 stated he/she would break the staff's arm and chased staff down the hall yelling profanities at staff, who escaped out the door. f. On 8-19-17 Tenant #7 became very angry with the Nurse when she removed tenants of the opposite sex from the living area. Tenant #7 became combative and tried to hit and push her to the floor. The Nurse left the building and as needed medication was administered. Continued record review revealed Tenant #7's service plan indicated Tenant #7 had tendencies of inappropriate behavior toward certain vulnerable tenants. Tenant #7 would hold their hands and try to persuade the tenants to touch him/her inappropriately. The Service Plan directed staff to be aware of the tenants he/she tended to seek out and to monitor the whereabouts of Tenant #7. Tenant #7 should not to sit with the tenants of the opposite sex at meals and the tenants of the opposite sex were to not be kept in the hall that Tenant #7 resided. Tenant #7's service plan failed to reflect the combative behavior that resulted at times when Tenant #7 was redirected and the other tenants were removed and interventions related to the behavior.	

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

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 the Program failed to provide adequate and appropriate care, treatment and services. Findings follow: 1. Record review revealed incident reports completed by Staff A, on 8-9-17 at 6:30 p.m. Tenant #5 got out of his/her wheelchair and tried to walk. As the alarm went staff ran to grab him/her and Tenant #5 hit the floor before staff could catch him/her. Tenant #5 landed on his/her right leg and held his/her knee. Staff A further documented she and a co-worker got Tenant #5 back in his/her chair and to the dining room table. Staff A took his/her vitals (temperature was 97.3, respirations were 18, pulse was 65 and blood pressure was 144/85) and a pain medication was given. Tenant #5 began reading a book and calmed down. Staff checked the length of Tenant #5's legs and made sure his/her hip was in place, which it was. At that time he/she started saying he/she was in pain so staff took him/her to bed so that he/she could relax. About 10:30 p.m. his/her alarm went off. Tenant #5 was in pain and staff tried to elevate his/her legs but Tenant #5 did not want the pillow placed. Staff A went and got a co-worker because the way Tenant #5 was laying seemed strange. Tenant #5 screamed, "like in more pain." Staff waited for the Nurse to get there before assisting further to verify the position of the legs. When the Nurse arrived Staff A told her Tenant #5 should be sent out because he/she could not take the pain and Tenant #5 was sent out. According to the incident report, staff initially notified the nurse of the fall on 8-9-17 at 6:37 p.m. An incident reported completed by Staff B dated 8-9-17 indicated at about 6:40 p.m. Staff B responded to assist Staff A with lifting Tenant #5 from lying on the floor. Tenant #5 was able to sit in the wheelchair. At about 7:30 p.m. Staff A requested to put Tenant #5 in bed. Both of Tenant #5's legs were stretched out. At 11:06 p.m. Staff A told Staff B that Tenant #5 was in pain and his/her leg "bends." Additional record review revealed Nurse's Notes, dated 8-17-17 (late entry), indicated staff called the Nurse on 8-9-17 at 6:30 p.m. and reported Tenant #5 fell to the floor in the living room. Staff was instructed to check for leg length and if the legs were even. Staff was to check range of motion and if there were any complaints of pain with movement. Tenant #5's family was called and said not to send to the emergency room (ER). Staff was instructed to stand Tenant #5 and to place in the wheelchair following hip precautions. Staff stated Tenant #5 transferred without incident or complaints of pain. Staff was instructed the Nurse would be in the building at 12:45 a.m. to work the night shift and to call if further complaints of pain. At 12:00 a.m. staff called the Nurse and stated Tenant #5 complained of pain and staff was instructed to give a pain pill and the Nurse was on her way to the	**$750.00**

	program. At 12:45 a.m. the Nurse arrived at the building and assessed Tenant #5. The right leg was twisted under Tenant #5 and the left leg was pulled up to the chest. Staff was instructed to call an ambulance. Paramedics arrived and transferred Tenant #5 to the ER and Tenant #5's family was called again without success. At 2:00 a.m. a call was received from the hospital which indicated Tenant #5's femur was broken. According to a PRN Medication Information document, the following was ordered: Hydrocodone/Acetaminophen 5/325 milligram (mg), one tablet, every four hours as needed for pain and Lorazepam 0.5 mg, one tablet, every four hours as needed for agitation. On 8-9-17 at 6:30 p.m. one tablet of Lorazepam was administered and the result as of 7:30 p.m. was effective. On 8-9-17 at 6:40 p.m. one tablet of Hydrocodone/Acetaminophen was administered for pain and the result as of 7:20 p.m. was not effective. On 8-9-17 at 10:30 p.m. one tablet of Hydrocodone/Acetaminophen was administered for pain and the result as of 1:00 a.m. was not effective. Emergency medical services records indicated the call was received on 8-10-17 at 12:53 a.m. and medics arrived at the building at 1:02 a.m. Medics were dispatched for a fall with hip pain. Staff reported Tenant #5 fell that afternoon on his/her hip. At that time Tenant #5 had not expressed any complaints and staff put Tenant #5 back into the wheelchair and later to bed. Staff reported after Tenant #5 was in bed he/she started having complaints of pain and they found him/her with a deformed right leg. It was noted Tenant #5 had an obvious deformity to the right hip and right leg and swelling to the same areas. The right leg was externally rotated and Tenant #5 had his/her leg bent at the knee. The left knee was drawn up and there were complaints of pain when that leg was straightened out. Tenant #5 was given Fentanyl intravenous push with improvement in his/her complaints of pain. Tenant #5 was transported to the hospital. Hospital records indicated Tenant #5 was seen on 8-10-17 at 1:55 a.m. Records documented Tenant #5 sustained a fall the day prior while getting out of wheelchair, was to put to bed and woke up screaming with an obvious deformity to the right hip with shortening and rotation. Symptoms included: pain, swelling and loss of mobility and the degree at present was severe. Diagnostic Radiology records indicated the impression was an acute fracture of the right femoral diaphysis with displacement/angulation. The discharge summary indicated the date of admission was 8-10-17 to 8-16-17. Admission diagnosis included a right hip fracture. Discharge diagnosis indicated closed femur fracture, status/post open reduction and internal fixation of a closed periprosthetic femur fracture from a fall. Tenant #5 could not bear weight for eight weeks post-surgery. The discharge summary indicated Tenant #5 was seated in a chair, tried to get up and suddenly fell. He/she was helped back to the chair but leg deformity was noted. Tenant #5 was brought to the hospital where Tenant #5 was diagnosed with a right hip fracture. Family decided to have surgical repair and Tenant #5 had an open reduction and internal fixation of the right femoral shaft fracture with bone grafting for the right periprosthetic closed femur fracture.	

	Record review of Tenant #5's file revealed his/her diagnoses included: dementia, osteoporosis, degenerative joint disease and status/post compression fracture (thoracic). Tenant #5 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The service plan reflected Tenant #5 had a chair alarm when in the chair and under him/her when in bed. Tenant #5 was independently mobile inside the building by propelling his/her wheelchair, but was dependent outside of the building. Tenant #5 had physical therapy (PT); however, it was discontinued on 8-9-17. Nurse's Notes dated 6-5-17 to 7-10-17 indicated Tenant #5 was admitted to the hospital for a broken hip. Tenant #5 underwent surgical repair of the hip, went to a skilled facility and returned to the Program on 7-10-17. An interview with Staff A on 8-21-17 at approximately 2:25 p.m. revealed Tenant #5's family brought him/her to the living room and asked Staff A to let the family member out of the building. Staff A was going to get Staff B and Tenant #5's alarm went off and Staff A responded. Tenant #5 was laying on his/her right side in the living room. Staff A called the Nurse and Staff B stayed with Tenant #5. The Nurse instructed staff to check vital signs and to ensure Tenant #5's legs were even. Tenant #5 complained of knee pain and Staff A administered an as needed pain pill. There was nothing abnormal with vitals and Staff A and Staff B transferred Tenant #5 off the ground to the wheelchair. Tenant #5's family was notified and declined to send Tenant #5 out to the hospital. Once in the chair staff observed his/her legs and there were no other complaints voiced. Staff A and Staff B helped get Tenant #5 get dressed and ready for bed. Tenant #5 was relieved to lie down. The bed alarm would go off and Tenant #5 was close to the edge of the bed and was moved using the under pad. Staff A completed rounds and pulled back the covers and noticed the right leg looked funny and Tenant #5 grimaced. There was a dramatic change at 10:00 p.m./10:30 p.m. Staff A went and got Staff B as the leg did not look normal. The Nurse was called; she was coming in and directed them to give Tenant #5 another pain pill until she got there. Tenant #5 seemed like he/she was in pain. As soon as the Nurse arrived the non-emergency ambulance was called. An interview with Staff B on 8-21-17 at 4:44 p.m. Staff B cleaned up after supper and Tenant #5 was in the living room. Staff A was the caregiver for the area where Tenant #5 resided. Staff A had just come in the dining room and sat down and Tenant #5's chair alarm went off. Staff A got up and Tenant #5 was on the floor. Tenant #5's family had just left. Tenant #5 was laying on the floor on his/her right side. There was no response when asked if there was any pain. Tenant #5 was picked up and put into the wheelchair. Staff A pushed Tenant #5 into the dining room and gave him/her a magazine. Tenant #5 could stand up when he/she was placed in the wheelchair and voiced no complaints of pain. Staff A and Staff B changed Tenant #5 into pajamas. Tenant #5 stood up when staff assisted Tenant #5 with getting changed for bed around 7:00 p.m. to 8:00 p.m. When Staff A and Staff B put Tenant #5 into bed his/her legs were straight. Close to 11:00 p.m. Tenant #5 was in pain and Staff A asked Staff B to look at	

	Tenant #5's leg. It was different, the leg was bent in the opposite direction, and it looked "like something out of the Exorcist." Tenant #5's leg was not like that before. As soon at the Nurse arrived she went in to check Tenant #5. Interviews with the Nurse on 8-21-17 at 3:04 p.m. and 8-22-17 at 4:15 p.m. revealed she worked on the floor the day of Tenant #5's fall. She received a telephone call from Staff A at 6:30 p.m. Staff A reported Tenant #5's family had just left and Staff A had gone into the other room and heard the chair alarm. Tenant #5 fell on his/her hip on the right side. There were no issues with shortening of legs and no complaints of pain. Staff B assisted Staff A with picking Tenant #5 up off the ground. Tenant #5 was weight bearing and had no complaints. Tenant #5 sat in the wheelchair in the dining room. Staff A and Staff B said Tenant #5's legs were straight. Something happened in bed and during rounds staff heard Tenant #5 moaning. Around 11:45 p.m. to 12:00 a.m. she received a telephone call from staff regarding Tenant #5 and she was on her way into the building. When the Nurse arrived Staff A asked her to check Tenant #5's legs. Tenant #5's leg was twisted and a non-emergency ambulance was called. Tenant #5 was diagnosed with a femur fracture and needed surgery. A nurse at the hospital asked how Tenant #5 was left in that condition. The Nurse explained range of motion was completed and the leg was not deformed until 11:00 p.m. rounds. She was not informed the leg looked different until she arrived; staff had called the second time to administer a pain pill. A written statement from the Executive Director dated 8-10-17 indicated she arrived at the Program at 4:50 a.m. on 8-10-17 and received a report from the Nurse that Tenant #5 was sent to the hospital with a possible fracture. She called and spoke with Staff A, who reported Tenant #5 had been seated in the wheelchair and had spent time with his/her family in the living area. The family member had just left the building and Staff A walked into the dining room, a few feet from where Tenant #5 was located and she heard Tenant #5's chair alarm going off. Staff A ran towards Tenant #5, who was already falling to the floor. Staff A called the Nurse and gave a verbal report which indicated the fall occurred on the right side. Staff A verbalized Tenant #5's legs were even. There was no evidence of pain, other than Tenant #5's knee hurt a little bit. Staff A and Staff B assisted Tenant #5 back into the wheelchair and Staff A assisted Tenant #5 into the dining room to read books and magazines. Staff A called Tenant #5's family member regarding the fall and the family member declined to send Tenant #5 to the hospital. Staff A received permission from the Nurse to give Tenant #5 a Hydrocodone, per doctor's orders. Staff A got Tenant #5 ready for bed and checked in at 8:30 p.m. and Tenant #5 was asleep. About 10:30 p.m. Staff A heard Tenant #5's bed alarm and went to check on him/her. Tenant #5 was in pain and she tried to elevate his/her legs to make him/her more comfortable. Tenant #5 verbalized he/she did not want to move them. Another Hydrocodone was given at 10:30 p.m. Staff A checked on Tenant #5 again at 11:30 p.m. and Tenant #5 was asleep. The Nurse arrived at 1:00 a.m. for work and she checked on Tenant #5 who then complained of pain. The Nurse sent Tenant #5 into the ER and it was	

	determined Tenant #5 sustained a fractured right femur. An ER nurse questioned why it took so long to bring Tenant #5 into the ER and the Nurse explained the series of events. Corrective action for Staff A and Staff B on 8-10-17 included: how to assess for pain and a discussion of checking on tenants more frequently post fall (30 minute checks were advised). Tenant #5 fell on 8-9-17 at approximately 6:30 p.m. and was transferred to the ER on 8-10-17 after 1:00 a.m. Tenant #5 was found to have a fractured femur. Post fall on 8-9-17, Tenant #5 had two pain medications administered without effective results, had complaints of pain, an abnormal presentation of the leg and was not assessed by licensed nursing staff and sent to the ER in a timely manner. Tenant #5 did not receive appropriate assessment, pain management or a prompt transfer to the ER post fall on 8-9-17. Tenant #5 did not receive services that were adequate and appropriate.	

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