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

Date: July 21, 2021
Program Name: Country Meadow Place
Address: 17396 Kingbird Ave, Mason City, IA 50401
Type of Action: Investigations #97246-C, 97390-C, 95084-C, 97326-C, 97465-C
Date(s) of Action: 5/17/21 – 6/21/21

State Rule #	State Rule	Amount of Civil Penalty
481-67.3(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 provide adequate and appropriate care, treatment, and services to 1 of 5 tenants reviewed (Tenant #1). Findings follow: Review of Incident Report dated 5-2-21 documented two unwitnessed falls during the overnight shift. Tenant #1 complained of leg pain. The report documented the nurse became aware of the tenant's leg pain at 7:30 a.m. She documented, "...reports her leg "hurts a whole lot" Resident's typical level of mobility is up independently with walker, but with current pain level, resident is not willing to ambulate. Resident given acetaminophen, and ice applied to leg. After this failed to bring pain relief, resident was sent to ER for evaluation." Continued record review revealed a progress note, dated 5/4/21, documented "... resident had a fractured hip that was surgically repaired with a rod and screws placed. The plan is for resident to discharge... for a skilled care stay for rehabilitation." Additional review of progress notes revealed the following: a. On 5/2/21 at 7:30 a.m. the Health Care Coordinator documented she received a call from staff regarding Tenant #1's leg pain. It was further documented, "...states it "hurts a whole lot" when pressing on leg, resident indicates the leg hurts on	**$3000.00**

	top of the thigh near the knee. Resident currently lying in bed and does not want to get out of bed or ambulate due to leg pain. Instructed (staff) to apply ice and given acetaminophen and call back if not effective." b. On 5/2/21 at 8:30 a.m. the HCC noted a call received informing her the interventions were not effective against Tenant #1's leg pain. She further noted, "... refusing to move it and doesn't want to attempt to ambulate on it. Instructed (staff) to call EMS for transport to ER to have resident evaluated. At this time resident still reporting pain on anterior thigh near the knee. c. On 5/2/21 at 8:47 a.m. the HCC documented: "Call received from a 2nd day shift (staff) reporting that resident had been taken by EMS. It was at this time that writer was made aware that night shift had reported to 2nd day shift (staff) that resident had two falls in the night, the first was an unwitnessed fall with resident stating she just "sat down" in hallway, resident was assisted back up to standing with 2 assist per report, and shortly thereafter, wen resident was back in her room, she had an unwitnessed fall next to her bed. She was assisted up and back into her bed by (staff) and (complained of) leg pain at that time, which was 0145." Record review on 5-27-21 of Tenant #1's Service Plan dated 4-2-21 revealed she resided in the locked memory care unit and required a 4-wheeled walker for ambulation and a wheelchair for longer distances. Further review revealed she had a recent history of falls. Tenant #1's diagnoses included: unspecified dementia with behavioral disturbance, age-related osteoporosis without current pathological fracture. Record review of In-Service training for Staff Notification to Nurse revealed staff must notify the nurse when a resident has fallen, staff must contact the nurse prior to getting the resident up, and staff must notify the nurse anytime they complete an incident report. Staff A and Staff B attended the training on 12-11-2020. When interviewed on 6-2-21 at 3:04 p.m. Staff A stated on 5-2-21 Tenant #1 lowered herself to the floor and when asked if she fell, Tenant #1 stated she did not. Staff A stated she assumed Tenant #1 stated a fact and appeared to have not injuries. Staff A stated she called Staff B for assistance and they	

	assisted her from the floor. Staff A stated she left to assist another tenant and a few minutes later Staff B joined her to assist. She stated she heard a crash and Staff B left to check it out. Staff A stated Staff B told her he found Tenant #1 on the floor and complained of some pain and was in bed. Staff A asked Staff B if he called the nurse and he informed her he had not and she failed to follow up to ensure the nurse was notified. Staff A stated she continued to check on Tenant #1 and found her sleeping and appeared comfortable. Staff A stated she informed the next shift Tenant #1 needed pain medication because she told Staff B earlier she was hurting. Staff A stated she could not explain why she assumed pain medication would be needed if Tenant #1 was sleeping and stated no further complaints. Staff A confirmed she attended the training on 12-11-2020 on when to contact the nurse and confirmed she failed to ensure the nurse was notified of Tenant #1's falls. When interviewed on 6-2-21 at 1:27 p.m. Staff C stated Staff A asked her to check on Tenant #1 because she fell twice in the night and had complained of pain. Staff C stated she observed Tenant #1 and she appeared to be in pain and had trouble moving. Staff C stated she asked Staff A if she contacted the nurse and Staff A stated no because they were not bad falls. Staff C contacted the nurse and was told to apply ice and administer Tylenol. Staff C stated Tenant #1 continued to be in pain and contacted the nurse to let her know. Tenant #1 was sent to the hospital for further evaluation. When interviewed on 5-20-21 at 9:37 a.m. Staff B stated Staff A called him for assistance. He stated he finished assisting another tenant before going to the memory care side approximately 15 minutes later. He stated he observed Tenant #1 on the floor of her bathroom doorway. He stated Tenant #1 stood up and refused assistance and would not go back to her bed. He stated he and Staff A left her to assist another tenant and later walked by Tenant #1's room and observed her on the floor by her dresser. He stated he and Staff A assisted her to her knees and up into her bed. He stated he did not take vitals and did not know if Staff A completed them either time. He stated he assumed Staff A completed an incident report and contacted the nurse since she was assigned to the memory care unit. When interviewed on 6-2-21 at 1:17 p.m. the Director confirmed Tenant #1 suffered a hip fracture after her falls. He confirmed Staff A and Staff C attended the in-service on 12-11-	

	20202 that included when staff are to notify the nurse and when to to write an incident report. He stated both staff received a final written warning for failing to follow the policy as trained. He confirmed both staff are no longer employed by the Program.	

481-67.13(4)	**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 interviews and record review, the Program failed to adequately implement plans of correction to ensure on-going compliance. Finding follows: Record review revealed a regulatory insufficiency cited at Iowa Administrative Code (IAC) 481 Chapter 69.3(2) on 12/31/20 due to failure to provide tenants adequate and appropriate care; specifically, failure to notify the nurse in a timely manner of change in tenant condition. The Program submitted a plan of correction indicating the deficient practice would be corrected by 4/2/21. A revisit completed 6/21/21 resulted in a deficiency cited at IAC 481-67.3(2) due to failure to tenants adequate and appropriate care; specifically, staff failed to notify the nurse in a timely manner following a significant incident per Program policy.	**$1000.00**