IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 32900-C

April 8, 2011

Nichole Will, Director
Country Manor
900 W 46th Street
Davenport, IA 52806

RE: Final Complaint Investigation Report, Country Manor, Davenport, Iowa

Dear Ms. Will:

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 32900-C**

Nichole Will, Director
Country Manor
900 W 46th St
Davenport, IA 52806

Date of Investigation:

March 8, 2011

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations. IAC r. 481-67.10(5). The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 481 IAC chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Country Manor on March 8, 2011. In preparing this report, the following information was considered:

Current Program Census:

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	24
Total Census of ALP:	24

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Program History – There were no substantiated Regulatory Insufficiencies this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Nurse Review

During the course of the investigation, the following information was obtained.

- Monitoring Observation: Tenant #2, an 87 year old, was admitted on 8-2-10 and diagnoses include: Allergies, Brain Cancer, Constipation, Dementia, Hyperlipidemia and Osteoarthritis. The tenant was staged a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline.

  The tenant had an order for Tylenol 325 mg tablet two tablets every six hours as needed. The tenant received the Tylenol on 2-10-11 at 8:00 p.m. and it was documented as effective. It was given on 2-11-11 at 12:30 a.m. and it was documented as effective. The second dose was given four and one half hours from the previous dose. The medication was not administered consistent with physician order. The tenant was diagnosed with a hip fracture, had surgery and at the time of the investigation was at nursing facility. The medication was administered consistent with the physician order.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care or health-related, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r. 481-69.27(1))

B. Staffing

Complaint Allegation: It was alleged there was not appropriate nurse follow up related to an incident.

- Monitoring Observation: Eight tenant files were reviewed.

  Tenant #1, an 87 year old, was admitted on 4-30-10 and diagnoses include: Dementia, Congestive Heart Failure (CHF) and Osteoarthritis. The tenant was staged at a six on GDS, which indicated severe cognitive decline.

  According to an Incident/Accident Report, on 2-24-11 at 5:30 p.m. the tenant was found on the outside laying down in the courtyard and it was a possible fall. The tenant had a lump on his/her head, abrasions on his/her nose and forehead and a swollen knuckle. The nurse was notified at 5:35 p.m.

  Staff #5 completed the incident report. She stated she was called up front by other staff to look at the tenant. She observed the tenant's finger and the tenant could not move the middle finger. It looked like the tenant needed to go to the emergency room (ER), according to Staff #5. The nurse was called and told staff to let the tenant go

and see how the tenant was in the morning. Staff #5 called the family and family opted to take the tenant to the hospital. The tenant returned on the same day and was diagnosed with bruises and two fractured fingers.

The nurse stated she was notified the tenant was found outside. Staff told her the tenant had a bump on his/her forehead and swollen fingers. She had staff take vitals and contact the family and recommended the tenant be seen. She stated family came in and took the tenant to the hospital. The nurse called the hospital later and found the tenant had a Urinary Tract Infection (UTI) and two fractured fingers. The tenant returned that night. The nurse stated she told staff the tenant should have been seen.

Tenant #2's file was reviewed. According to an Incident/Accident report, on 2-10-11 at 7:55 p.m. staff found the tenant lying on his/her back on the floor. The tenant stated he/she had tripped and fell on his/her knee and just laid on his/her back. The tenant complained of pain on his/her right knee when staff moved the tenant. Tylenol was given and the knee was ice packed. The nurse was notified at 8:00 p.m. and responded at 8:00 p.m. The tenant's family was notified at 8:02 p.m.

Staff #6 provided a written statement and was interviewed. At approximately 7:55 p.m. another tenant ran over to her and she responded. She found Tenant #2 on his/her back. She asked if the tenant was hurt anywhere and the tenant reported his/her knee hurt. She took the tenant's vitals, tried to get the tenant up and when barely moved the tenant complained of pain. She did not move the tenant from the waist down and moved the tenant's upper back. She laid the tenant back down and called the nurse. She told the nurse what happened. The nurse instructed her to take vitals every four hours for twenty four hours. The nurse asked if she had moved the tenant and she told her yes but the tenant hurt so she let the tenant stay on the ground. The nurse instructed her to get another staff to help get the tenant up into a chair and try to move the tenant's leg to see if the tenant could move it. The nurse told her to contact family and inform family of what happened. She said if still in pain in the morning family should come in and take the tenant to the hospital. She stated she was not instructed to call if pain increased. She stated she called the tenant's family and he/she asked if there was a doctor at the program. She told him/her there was not a doctor and family decided not to send the tenant out for evaluation. She had another staff assist and they transferred the tenant to bed. The tenant hurt, according to the statement. She put an icepack on the tenant's knee and gave the tenant Tylenol. She stated she gave report to third shift. She checked on the tenant approximately every 20 minutes and the tenant was asleep.

Staff #7 provided a written statement and was interviewed. She arrived on third shift on 2-10-11 and been informed from second shift the tenant had fallen. She indicated the tenant complained of pain in the right knee and right hip. The tenant could not move at all or sit up in bed. She stated the tenant needed to use the toilet and the tenant could not bear weight on the right leg and the right knee was swollen. Three staff assisted the tenant to the bathroom. In the early morning she gave the tenant Tylenol for pain and it helped; however, the tenant was still in pain. She checked on the tenant and the tenant felt a little better; however, had pain when the leg was moved. She took the tenant's vitals and they were fairly normal, except the pulse was high. She informed first shift of the tenant's pain. She indicated it was obvious the tenant was in a lot of pain.

Staff #8, a licensed practical nurse (LPN), provided a written statement and was interviewed. She came in on 2-11-11 and the tenant was non weight bearing to the right leg and was in "excruciating pain." The right leg appeared to be externally rotated and the tenant was unable to perform range of motion (ROM) at that time. She stated the tenant could not verbalize a pain level; however, the tenant complained of pain in the knee. She notified the tenant's legal representative and told him/her the tenant needed further evaluation from a doctor. She gave the legal representative the option of an ambulance or family transfer. The legal representative chose to take the tenant to the physician's office for an x-ray. The tenant was diagnosed with a right hip fracture and was transported from the physician's office to the hospital.

The nurse provided a statement and was interviewed. She was notified by Staff #6 via telephone at 8:00 p.m. that she found the tenant on the floor. Staff #6 told her the tenant had fallen to his/her knees and could not get up so the tenant laid down. The tenant complained of his/her knee hurting. She instructed Staff #6 to get another staff and to get the tenant up from the floor, elevate the knee, put ice on the knee and give Tylenol for discomfort. She indicated she stated to call if the Tylenol was not effective. She reminded Staff #6 to take vitals every four hours for 24 hours. She told Staff #6 to call the tenant's family and inform him/her of the situation and give the choice of having the tenant sent out to the hospital or have the tenant assessed in the morning by a nurse. She indicated she did not receive another phone call from staff, which lead her to believe the Tylenol was effective and no other issues needed to be addressed.

The tenant had an order for Tylenol 325 mg tablet two tablets every six hours as needed. The tenant received the Tylenol on 2-10-11 at 8:00 p.m. and it was documented as effective. It was given on 2-11-11 at 12:30 a.m. (not six hours from previous dose as prescribed) and it was documented effective. The tenant was diagnosed with a hip fracture, had surgery and at the time of the investigation was at nursing facility. Prior to the hip fracture the tenant ambulated independently. Hospital records indicated the tenant was comfortable with it in the supine position unless it was moved.

Tenant#3, an 83 year old, admitted on 12-2-10, with diagnoses of: Anemia, Anxiety, Coronary Artery Disease (CAD) and Dementia. The tenant was staged at a five on the GDS, which indicated moderately severe cognitive impairment. On 12-22-10, the tenant was transported to the hospital due to complaints of chest pain, resolved by Nitroglycerin, but continued decreased responsiveness and shortness of breath. Nitroglycerin 0.4 mg tab sublingual was administered with effective results. A letter signed by two of the tenant's Power of Attorneys (POA's), dated 12-23-10, stated "Please do not rush into expediting emergency treatment for medical conditions, but assess … and wait to see if conditions pass."

Staff #8, an LPN, stated the tenant complained of chest pain. Staff paged the nurse who was present in the building and the nurse did not answer. The nurse was paged again and did not respond. Staff #8 stated she then responded.

The nurse stated she had not heard the first page due to a loud fan and did not hear the second page due to personal reasons. Staff #8, an LPN, gave the Nitroglycerin and

the tenant was sent out by ambulance. The tenant returned and there were no new orders. The nurse stated Staff #8 was capable of responding to the issue.

The Director indicated from January 2011, the nurse had been the only nurse on call.

A meeting was scheduled for 3-9-11 and one of the agenda items was clarification of on call nursing.

- Regulatory Insufficiency: Any nursing services shall be provided in accordance with Iowa Code chapter 152 and 655-Chapter 6. (IAC r. 481-67.9(5))

During the course of the investigation, the following information was obtained.

- Monitoring Observation: Four staff files were reviewed.

  Three tenants had been diagnosed with Scabies. Staff#1, #2, #3, and #4 did not have evidence of nurse delegation in regards to Universal Precautions.

  Staff #3 had transcribed a new medication order for Tenant #4 on the Medication Administration Record (MAR). Staff#3 did not have evidence of nurse delegation training for this task. The Director had transcribed a new medication order for Tenant#5 on the MAR. She did not have evidence of nurse delegation training for this task.

  Staff did not have appropriate nurse delegation training.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

Dated this 8th day of April, 2011.