IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 38608-C

June 1, 2012

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

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

Dear Ms. Will:

Enclosed is the **Final Complaint/Incident 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/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

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

Complaint/Incident Intake #: 38608-C

Date of Complaint/Incident Investigation:

April 25, 2012

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	20
Total Population of Program at time of on-site	22
TOTAL census of Assisted Living Program	22

Program History – The program received regulatory insufficiencies in the areas of: Policy and Procedure, Medications, Food Service, and Life Safety during the Recertification visit of March 6, 2012.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Policies and Procedures

Complaint/Incident Allegation: It was alleged the Program did not have a policy on pets and a pet had lived at the Program. It was alleged the pet that lived at the Program was not cared for by the tenant who owned the pet or by staff.

- Monitoring Observation: A Pet Policy indicated for those tenants that requested to keep a pet at the Program they had to obtain permission from management. The tenant was responsible for the daily care of the pet. Pets were required to be up to date on all shots and vaccinations and be in good health. The care of the pet would be addressed upon coming to the Program and what disposition was to be made in the case of an emergency with the tenant. While in the common areas the pet would be on a leash and in command of the tenant. An Addendum dated 8-27-11 indicated tenants' pets would be kept in the premises of the tenants' apartments at all times unless being taken by leash outside to use the bathroom.

  In addition to the Pet Policy, the Occupancy Agreement (OA) had a section on Pet Deposit and Policy. The OA reiterated the Pet Policy and also indicated there was a $500.00 non-refundable pet deposit that must be paid prior to admission.

  The Director identified Tenant #1 as the only tenant in the past year to have a pet at the Program.

  Tenant #1, a 72 year old, was admitted on 6-13-11 and diagnoses include: Hypertension (HTN), Type II Diabetes Mellitus, Hypercholecterolemia, Paroxysmal

Atrial Flutter and Frontotemperal Dementia. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline.

Tenant #1's OA included a Pet Deposit and Policy section. Vaccination records were provided for the pet, which indicated four vaccines were given on 5-27-11.

A statement signed by the Director and dated 4-25-12, stated Tenant #1 owned a dog. The dog moved into the Program on 6-10-11 and resided there until the dog passed away in November 2011. Tenant #1 took full care of all of the dog's needs including feeding, toileting and walking. Tenant #1's family ensured the dog was seen at all veterinary appointments. Additionally, the dog was always on a leash and at Tenant #1's side.

Staff #1 said Tenant #1 had a dog, provided care for the dog and always kept the dog on a leash. Staff #2 stated Tenant #1 had a dog and took care of the dog all the time. The dog was on a leash most of the time. Sometimes the dog came out of Tenant #1's apartment if the door was left open. She would take the dog back to the apartment and shut the door. She said after Tenant #4 fell, Tenant #1 was required to always hold onto the leash when the dog was out of the apartment.

The Director said there was enough staff to meet the needs of the tenants and there was adequate supervision of tenants by direct care and administrative staff. Staff #1, #2, #3 and #4 said there was enough staff to meet the needs of the tenants.

The Program provided a Pet Policy and the OA had a section on Pet Deposit and Policy. Per staff interviews and a statement from the Director, Tenant #1 provided care for the pet and the pet was on a leash.

There were no pets at the Program at the time of the investigation.

- Regulatory Insufficiency: None noted.

B. Nurse Review

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

Monitoring Observation: Tenant #4, an 82 year old, was admitted on 8-28-10 and diagnoses include: Dementia, HTN, Diabetes and Hyperlipidemia. Tenant #4 was staged at a six on the GDS, which indicated severe cognitive decline. Tenant #4 was discharged on 8-31-11. According to an Incident/Accident Report dated 8-27-11 at 5:45 p.m., Tenant #4 was trying to walk into the great room and he/she tried walking over another tenant's dog. Tenant #4 tripped and landed on his/her left side. Tenant #4 did not hit his/her head, range of motion was within normal limits and there were no injuries noted. The incident was witnessed by Staff #2. A nurse and family were notified. Nurse's Notes dated 8-29-11 indicated Tenant #4 had a witnessed fall on 8-27-11 at 5:45 p.m. Tenant #4 denied pain at the time of the incident. There were no skin tears or bruising noted and there was no change in ambulation or issues moving extremities.

The Fall Investigation Checklist indicated the next morning Tenant #4's foot was bruised and he/she was limping. Tenant #4 was evaluated in the Emergency Room (ER) and the results indicated it was a sprain. Discharge instructions from the ER were dated 8-28-11 at 11:22 a.m. The instructions included: to apply ice to the injury 10 to 20 minutes, 3 to 4 times a day, an elastic wrap could be used to keep swelling down, keep foot elevated to reduce swelling and discomfort and to try to avoid standing or walking while the foot was painful The orders were not noted and were not transcribed to a treatment record to ensure health care professionals' orders were current. A nurse review was not completed when Tenant #4 returned from the ER to determine if there were any changes in Tenant #4's health status.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, 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 licensed practical nurse via nurse delegation: To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program. (IAC r. 481-69.27(2))

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

C. Structural Requirements

Complaint/Incident Allegation: It was alleged a tenant fell and sustained an injury.

- Monitoring Observation: Four tenant files were reviewed including two current tenant files and two discharged tenant files. Tenants #2, #3 and #4 had Incident/Accident Reports regarding falls.

  Tenant #2, a 91 year old, was admitted on 7-14-11 and diagnoses include: Duodenal Ulcer with Gastrointestinal Bleed, History of HTN, Peripheral Neuropathy, Hyperlipidemia, Adrenal Insufficiency, Osteoarthritis and Alzheimer's. Tenant #2 was staged at a six and seven on the GDS, which indicated severe to very severe cognitive decline. According to an Incident/Accident Report dated 7-31-11 at 4:40 a.m., Tenant #2 tried to get off the toilet and fell on the bathroom floor causing an abrasion and swelling to the right side of the forehead and a very small abrasion to the right knee. Vital signs were taken, ice was applied to the forehead and range of motion was completed. A nurse and a family member were notified. An incident report was found related to the fall and the incident did not require notification to the Department for a significant injury.

  Tenant #3, a 64 year old, was admitted on 5-2-11 and diagnoses include: Gastroesophageal Reflux Disease, B12 Deficiency, Melanoma, Scoliosis with Chronic Back Pain and Recurrent Deep Vein Thrombosis. Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. According to an Incident/Accident Report dated 3-13-12 at 2:30 a.m., Tenant #3 was in bed and got

twisted in the comforter and ended up falling flat on his/her back and hit back of his/her head. Ice was applied to the back of the head and Tenant #3 had a small bump on the back of his/her head. The report indicated the injury was a hematoma on the back of the head. According to another Accident/Incident Report dated 3-21-12 at 5:05 a.m., Tenant #3 got up to go to the bathroom and staff heard a noise. Tenant #3 was at the door without his/her walker and when staff tried to grab his/her arm, he/she fell back and hit the right side of the head. Tenant #3 had a hematoma and a small tear on the right elbow. Staff witnessed the incident and a nurse was notified. Incident reports were found related to the falls and the incidents did not require notification to the Department for a significant injury.

Tenant #4's file was reviewed. According to an Incident/Accident Report dated 8-27-11 at 5:45 p.m., Tenant #4 was trying to walk into the great room and he/she tried walking over another tenant's dog. Tenant #4 tripped and landed on his/her left side. Tenant #4 did not hit his/her head, range of motion was within normal limits and there were no injuries noted. The incident was witnessed by Staff #2. A nurse and family were notified. The Fall Investigation Checklist indicated another tenant's dog was lying on the floor and the area was well lit. Nurse's Notes dated 8-29-11 indicated Tenant #4 had a witnessed fall on 8-27-11 at 5:45 p.m. Tenant #4 denied pain at the time of the incident. There were no skin tears or bruising noted. There was no change in ambulation or issues moving extremities.

Staff #2 said she believed Tenant #4 was trying to move out of the way for someone when Tenant #4 tripped over another tenant's dog's leash. She said the dog was lying in front of a book shelf, wearing a leash which was lying on the floor about four to five feet in length. Staff #2 witnessed what occurred and checked on Tenant #4 who was holding the bottom of his/her leg and complained of pain. She took Tenant #4's vitals and called a nurse.

The Fall Investigation Checklist indicated the next morning Tenant #4's foot was bruised and he/she was limping. Tenant #4 was evaluated in the ER and the results indicated it was a sprain. According to an Incident/Accident Report dated 8-28-11 at 1:25 p.m., Tenant #4 got up out of the chair, he/she was reclined with an ice pack. Tenant #4 un-reclined the chair and tried to walk and then fell to the right side. Another tenant witnessed the incident and it was not witnessed by staff. Left hip pain was noted and a nurse was notified. The medic and family were notified, according to Nurse's Notes. It was determined Tenant #4 had a fractured hip. According to a Fall Investigation Checklist, the area was clear of trip hazards, was well lit and there had been no recent changes in furniture.

Staff #1 said Tenant #4 was still ambulatory and complained of foot pain when he/she returned from the ER. She didn't recall any assistive devices or wraps on Tenant #4's feet. Staff #1 said she assisted Tenant #4 into a recliner and extended the foot rest in order to prop the foot up and applied ice to the foot.

The incident on 8-28-11 did not require notification to the Department as Tenant #4 attempted to ambulate independently and there was no documentation in the file regarding a change in ambulatory status that indicated he/she required assistance. There were no trip hazards identified on the Fall Investigation Checklist related to the incident on 8-28-11.

The incident on 8-27-11 did not require notification to the Department as Tenant #4 did not sustain a significant injury and he/she ambulated independently.

- Regulatory Insufficiency: None noted.