DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0017	A. BUILDING: _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 19 TOTAL Census of Assisted Living Program for People with Dementia : 20 No regulatory insufficiencies were cited during the investigation of Complaint # 100368-C, Complaint # 100369-C, Complaint # 100403-C, Incident # 103873-I, and Complaint # 102661-C. The following regulatory insufficiencies were cited during the investigation of Complaint # 106548-C, Incident # 102385-I, Incident # 102453-I.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to follow all established policies for 2 out of 7 tenants reviewed (Tenant #2 and #4). Findings include: 1. A review of Tenant #2's record on 8/9/22 revealed an admission date of 6/8/22. Tenant #2 had a diagnosis of dementia, hearing loss, paroxysmal atrial fibrillation, chronic obstructive pulmonary disease (COPD), cellulitis, urinary tract infections, benign prostatic hyperplasia with lower	A 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0017	A. BUILDING: _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 1	A 150		

urinary tract symptoms, and a personal history of pneumonia. Tenant #2 had an activated DNR status. Tenant #2's record contained an on-call nurse's note dated 7/31/22 regarding a call received from staff. The call revealed Tenant #2 had increased shortness of breath after administering the tenant's PRN inhaler, breathing treatment, and PRN oxygen. A call was placed to the tenant's wife who requested him to be assessed at the emergency room. The staff contacted 911 for a transport to the hospital.

On 8/3/22 at 1:00 pm, the on-call Jaybird RN stated she had given the go-ahead to contact non-emergency 911 to have Tenant #2 assessed. The on-call Jaybird RN indicated the paramedics did want a physical copy of the iPost which she stated she obviously could not provide and staff indicated they could not either. The on-call Jaybird RN later received a call from the hospital indicating Tenant #2 was COVID-19 positive and was admitted to the hospital.

On 8/8/22 at 9:00 am, Staff A stated she worked until 7:00 p.m. on 7/31/22. Staff A first noted Tenant #2's difficulty with breathing and anxiety. Staff A stated his O2 level was at 91 which was somewhat low for him as he normally ran a 92 or 93 level due to his COPD. Staff A had Tenant lie down and use his PRN oxygen to assist with is breathing. Once on his oxygen, his anxiety went down and his O2 had gone back up. During the 7 pm shift change with Staff C, Staff A reviewed Tenant #2's concerns with her.

On 8/8/22 at 9:36 am, Staff C stated she worked after 7:00 p.m. with Tenant #2 on 7/31/22. Staff C continued to notice further breathing issues after administering breathing treatments per his orders. Staff C contacted the on-call nurse and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0017	A. BUILDING: _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 2	A 150		

received instructions to call 911 for a transport to the hospital for assessment. Staff C made the call and stayed on the line with the on-call nurse until paramedics took Tenant #2. When the paramedics arrived, Staff C stated the paramedics wanted an actual copy of the tenant's DNR wishes which Staff C stated she did not have, but could give the paramedics the information verbally as she had that on her iPad. The on-call Jaybird RN which was also on the phone stated she had no way to print them as she was not close to the facility. The paramedics indicated to Staff C that they would have to treat Resident C as full-treatment until they received information otherwise.

On 8/8/22 a review of the Personal Care Services policy was reviewed. The Personal Care Services policy revealed the following:
"Emergency Transfer: If a resident becomes acutely ill and needs an immediate emergency transfer, the nurse or staff will arrange for transfer via ambulance to the hospital indicated on the transfer/move out report. All transfers are coordinated with the input of the Designated Responsible Person as to the time and location of transfer. "
"Emergency Care Information Packet: "Each resident has a Face/Profile Sheet with written medical emergency information readily available to the staff person on duty, as well as emergency personnel. The emergency information includes the residents: name, date of birth, phone numbers of persons to contact in case of an emergency, such as physician, designated responsible person or other family member, allergies, list of current medications, and advance directives."

On 8/9/22 at 1:30 p.m., the Clinical Risk and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0017	A. BUILDING: _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 3	A 150		

Assessment Director along with the Manager confirmed Staff C did not follow the Personal Care Policy on 7/31/22. All staff were retrained on the Emergency Care Information Binders on 8/5/22.

2. A review of Tenant 4's record on 8/9/22 revealed an admission date of 8/7/20. Tenant #4 had a diagnosis of frontotemporal dementia, edema, urinary tract infections, major depressive disorder, anxiety disorder, essential hypertension, gastro-esophagel reflux disease, osteoarthritis, and toxic encophalopathy. Tenant #4 has an order dated 12/2/21 for Hydrocodone/Acetaminophen 5-325 mg, one tablet to be taken twice daily for pain. Tenant #4's record revealed an incident report dated 2/26/22, Staff F, the Program registered nurse and Staff H counted the narcotics during a 2:00 a.m. staff switch over and discovered Tenant #4 was missing Hydrocodone tablets. Tenant #4 had two separate cards of tablets, one for day and one for night. The PM card of Hydrocodone tablets should have counted to 25, but only contained 16 tablets. The AM card of Hydrocodone should have contained 26 tablets but only contained 18. A police report was filed.

On 8/4/22 at 2:20 p.m., Staff F, the Program's registered nurse, stated after she discovered the missing medications, she looked back on the narcotic count sheet to see when the last time all of the medications were accounted for. The previous change over of staff occurred at 3 pm on 2/25/22 at 3:00 p.m. by Staff H and Staff J. The count that was written on the form was correct, but Staff F noted Staff H wrote a red "error" across her initials. Staff F stated she asked Staff H about this and Staff H stated she noticed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0017	A. BUILDING: _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 4	A 150		

count was off then. Staff F asked Staff H why she didn't report it then and Staff H felt Staff H's response was confusing, but that she indicated she text Staff F. Staff F stated she did not receive any text that day before from Staff H. Staff F stated Staff H said nothing about the missing narcotics for Tenant #4 until she was questioned about it. Staff H was terminated for not reporting the missing narcotics sooner to Staff F who was the Program registered nurse.

On 8/8/22 at 10:49 a.m., Staff H stated on 2/25/22 at the 3 pm staff change over, her and Staff J were counting the narcotics. Staff H stated that every time Staff J seemed to be working the narcotics would end up missing. Staff H stated on this day Staff J was trying to hurry Staff H into the counting the narcotics. Staff H stated then the activity staff came in wanting something and distracted her. Staff J quickly finished the count and Staff H signed off with her. At the 7 pm medication pass, Staff H noticed some of Tenant #4's Hydrocodone missing, so she wrote error on the narcotic count sheet and stated she text Staff H about it.

A further review of Tenant #4's record revealed an incident report dated 2/28/22 completed by Staff F. On 2/28/22, two staff discovered Tenant #4's card of 18 Hydrocodone tablets was missing from the narcotic lock box. Staff also discovered the narcotic count sheet was missing. Staff F was immediately contacted. Staff F instructed all staff to search for the card of Hydrocodone. The missing narcotic sheet was eventually discovered but the card of Hydrocodone tablets were not discovered.

On 8/4/22 at 2:20 p.m., Staff F stated during her internal investigation of Tenant #4's missing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0017	A. BUILDING: _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 5 Hydrocodone, she interviewed Staff J if she had seen the Hydrocodone when she counted the narcotics. Staff J reported that she counted the narcotics on 7/26/22 at 11 pm and they were accounted for but when she left her shift at 3 pm on 7/27/22, she noticed a missing pack of narcotics for Tenant #4. Staff J did not report this to the registered nurse, Staff F. Staff F stated Staff J was terminated due to not reporting the missing medications. A review of the Program's Medication Policy revealed the following guideline: "Perhaps the most important concept about the Six Rights is that a violation of any right constitutes a medication administration error. Thus, if any mistake is made, it should be reported immediately to the RN so counter measures to solve any resulting problems can be taken. A medication error report form must also be completed and submitted to the RN." On 8/8/22 at 2:20 p.m., the Clinical Risk and Assessment Director along with the Manager confirmed both Staff H and Staff J discovered missing narcotics for Tenant #4 and did not report them immediately per policy standards.	A 150		
A 290	481-67.5(2)g Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: g. Narcotics protocol, including destruction and reconciliation, shall be determined by the program's registered nurse. This REQUIREMENT is not met as evidenced	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0017	A. BUILDING: _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 6 by: Based on interviews and record reviews, the Program failed to follow the established policy for narcotic protocols for 1 of 7 tenants reviewed (Tenant #4). Findings include: 1. A review of Tenant 4's record on 8/9/22 revealed an admission date of 8/7/20. Tenant #4 had a diagnosis of frontotemporal dementia, edema, urinary tract infections, major depressive disorder, anxiety disorder, essential hypertension, gastro-esophageal reflux disease, osteoarthritis, and toxic encophalopathy. Tenant #4 has an order dated 12/2/21 for Hydrocodone/Acetaminophen 5-325 mg, one tablet to be taken twice daily for pain. On 8/4/22 at 2:20 p.m., Staff F the Program registered nurse, stated narcotic counts were completed at the beginning of every shift with two staff members present. Staff F stated when she looked back over the narcotic count sheets during her investigations, she discovered staff had not completed them consistently. An incident report for Tenant #4 dated 2/9/22, revealed staff discovered one card of 29 Hydrocodone tablets were missing from the narcotic lock box during the 7 am narcotic count on 2/9/22. On 8/8/22 during a review of the narcotic count sheets used in the internal investigation of the missing Hydrocodone on 2/9/22, the following was noted: On 2/8/22 at the 11:00 p.m. shift change, no narcotic count was completed. An incident report for Tenant #4 dated 2/12/22, revealed staff discovered one card of 29 Hydrocodone tablets were missing from the	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0017	A. BUILDING: _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 290	Continued From page 7 narcotic lock box during the 7 am narcotic count on 2/12/22. On 8/8/22 during a review of the narcotic count sheets used in the internal investigation of the missing Hydrocodone on 2/12/22, the following was noted: On 2/11/22 at the 11:00 p.m. shift change, no narcotic count was completed. An incident report for Tenant #4 dated 2/26/22, revealed staff discovered Tenant #4's AM card for Hydrocodone was missing 8 tablets during the 7 am narcotic count on 2/12/22. The PM card for Hydrocodone was missing 9 tablets. On 8/8/22 during a review of the narcotic count sheets used in the internal investigation of the missing Hydrocodone on 2/26/22, the following was noted: On 2/25/22 at the 7:00 am shift change, no narcotic count was completed. On 2/25/22 at the 11:00 p.m. shift change, no narcotic count was completed. On 8/8/22 at 2:20 p.m., the Clinical Risk and Assessment Director along with the Manager confirmed the narcotic counts were not completed consistently around the times of the missing medications.	A 290		