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 02/15/2023

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. General Population Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 17 TOTAL Census of Assisted Living Program for People with Dementia : 20 No regulatory insufficiencies were cited during the investigation into Complaint #109854-C, Complaint #110767-C and Incident #110283-I. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with recertification for an Assisted Living Program for People with Dementia as well as the investigation into Complaint #107888-C, 107954-C, 109955-C and 110978-C.	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 interview and record review, the program failed to follow the Program's policies for 2 of 7 current tenants and 1 of 4 discharged tenants reviewed (Tenant #6, Tenant #7 and Tenant #C3). Findings follow: 1) Record review on 2/8/23 revealed Tenant #6 was diagnosed with Parkinson's disease, anxiety	A 150		

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disorder and a mild cognitive impairment. The program conducted a cognitive test on 1/26/23 and Tenant #6 scored a 6 on the Global Deterioration Scale indicating Severe Cognitive Decline.

Tenant #6 had a service plan dated 1/26/23. According to the service plan, Tenant #6 had a history of preferring the company of male tenants. Staff were to redirect Tenant #6 to privacy when she was engaged in intimate activities with a male tenant (Tenant #4). They were to ensure the safety and consent of both tenants. Tenant #6 preferred to have sexual contact with a male tenant. The sexual contact included kissing, fondling, oral and vaginal intercourse. The family and provider were aware of the sexual activity and were agreeable to Tenant #6's desires in this area. Safety and dignity were to be preserved by staff. Tenant #4's service plan reflected similar language.

When interviewed on 2/8/23 at 7:38 PM, Tenant #6's son and designated power of attorney (DPOA) reported the last time he heard about a relationship between his mother and another tenant (Tenant #4) was about a year ago. He heard about his mother's involvement with one tenant but not with two men. The DPOA was surprised by this information. He said he could not imagine his mother, prior to her dementia diagnosis, sexually involved with two men and thought this behavior was a product of her cognitive impairment.

Record review of Tenant #7's file revealed Tenant #7 moved to the program on 6/8/22. Tenant #7 scored a 6 on the Global Deterioration Scale indicating Severe Cognitive Decline on 1/12/23. Tenant #7's service plan, dated 1/12/23, indicated

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he was diagnosed with unspecified dementia. Tenant #7 had a history of groping staff in an inappropriate manner. Tenant #7's service plan made no mention of a sexual involvement with another tenant.

When interviewed on 2/13/23 at 11:10 a.m., Staff B reported she witnessed Tenant #6 touch Tenant #7 in a sexual manner. Staff B sat in the living room and and observed Tenant #7 reach under Tenant #6's shirt and under her pants. Tenant #7 unbuckled his pants when Tenant #6 was around. Tenant #7 was married and his wife reportedly preferred Tenant #6 not sit near her husband. Tenant #7 did not act in a sexual manner toward other female tenants. Tenant #7 followed Tenant #6 to her room but staff redirected him out of the room before anything sexual occurred. This occurred quite a few times and Staff B was unable to provide a number of times they interacted in an intimate manner. Staff B never documented these interactions. She told the other caregivers, but not the nurse or Director.

When interviewed on 2/13/23 at 3:06 p.m., Staff J said about two to three times a month she saw either Tenant #6 and Tenant #7 or Tenant #6 and Tenant #4 engage in sexual acts. Tenant #6 initiated the behavior but they are all willing partners. It usually started on the couch in the front room or in Tenant #4's apartment. She walked in and saw Tenant #6 and Tenant #7 engaging in sexual relations in his apartment. Staff J reported the information about Tenant #7 and Tenant #6 acting in a sexual manner together to the Director.

When interviewed on 2/13/23 at 4:25 p.m. Staff A stated Tenant #6 and Tenant #7 touched each others genitals under their clothes daily. Staff A

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provided frequent redirection to the tenants. In the past month, Tenant #6's health declined and this reduced the amount of sexual activity.

When interviewed on 2/13/23 at 4:50 p.m., Staff K reported she was told she could not tell the three tenants what to do when they engaged in sexual behavior. One day she came in and Tenant #7 was touching Tenant #6 on the couch. A co-worker said it had been going on for an hour. The co-worker informed her Tenant #7's wife did not want the activity going on.

During a meeting on 2/8/23 at 4:45 p.m., the Director, the Director of Resident Engagement and the Clinical Risk and Compliance Manager stated they talked with Tenant #6's son and he approved her relationship with both men. He understood Tenant #6's dementia and was comfortable with her sexual relationships with two male tenants. They had not spoken to Tenant #7's wife. The Director later denied awareness of the relationship between Tenant #6 and Tenant #7.

Record review revealed the Program's Sexuality in Dementia policy noted the Registered Nurse (RN) and team will engage the tenant and activated DPOA (designated power of attorney) in a diaglogue regarding intimacy, sexual expression and their own belief system. The spouse/partner, activated DPOA should be involved [in discussions] about the resident's sexually expressive behavior only if the resident is unable to make these decisions for her/himself in this regard; and the resident's expressed wishes and possible risks to well-being, being taken into account when developing a service plan that addresses the tenant's needs.

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When interviewed on 2/15/23 at 4:15 p.m. The Director of Resident Engagement and Clinical Risk and Compliance Manager confirmed the program did not follow the program's Sexuality in Dementia policy.

2) Record review of Tenant C3's incident report dated 12/19/22 at 2:30 a.m. identified a Resident Assistant (RA) called the former RN and notified her Tenant C3 was observed on the floor next to her bed. Tenant C3 was last seen 40 minutes prior in her bed sleeping. Tenant C3 was assessed and noted with a scant bleed to her forehead. Tenant C3 was loudly verbalizing pain to her left shoulder. The former RN directed the RA to call the medics to transport Tenant C3 to the emergency department. The incident report noted, POA and Hospice notified with a call to Dr., but no response from the doctor. The incident report form noted the POA, Hospice and doctor were all notified on 12/19/22 at 8:00 a.m.

When interviewed on 2/15/23 at 2:20 p.m., Tenant C3's POA reported she recieved notification about her mother's fall when the hospital informed her Tenant C3 needed a ride home. Tenant C3's mother was on hospice and the POA was not sure she would have approved a transfer out of the building for treatment.

Record review revealed the program's policy on Emergency Transfers indicated if a resident became acutely ill and needed an immediate emergency transfer, the nurse or staff arranged for transfer via ambulance to the hospital indicated on the transfer/move out report. The program policy directed all transfers were coordinated with the input of the designated responsible person as to the time and location of

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A 150	Continued From page 5 transfer. Record review failed to reveal evidence the program attempted to make contact with Tenant #C3's designated responsible person regarding the time and location of the transfer prior to Tenant #C3's transfer. When interviewed on 2/15/23 at 4:15 PM, the Clinical Risk and Compliance Manager reported she believed emails documented notification of Tenant #C3's power of attorney prior to the transfer. The program failed to provide emails or documention regarding the notification.	A 150		
A 160	481-67.3(2) Tenant Rights 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide the proper care to 1 of 4 discharged tenants reviewed (Tenant #C4). Finding follows: Record review on 2/13/23 revealed Tenant #C4 moved to the program on 11/30/22. His initial service plan was completed on 11/29/22. Tenant #C4's service plan noted incontinence but made no note of a history of urinary tract infections (UTIs). No behavior issues were identified on his	A 160		

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service plan. The Registered Nurse (RN) updated Tenant #C4's service plan on 12/23/22. Tenant #C4's updated service plan noted Tenant #C4 refused assistance with activities of daily living at times and might need redirection. The updated plan documented Tenant #C4's history of urinary tract infections (UTIs). The plan directed Staff to monitor him for signs and symptoms of UTIs such as pain, frequency, urgency, incontinence, dizziness, weakness or confusion and to report any changes to the nurse. Staff should encourage Tenant #C4 to drink fluids.

The program nurse contacted Tenant #C4's doctor on 1/5/23 via fax and notified him the tenant was displaying more aggressive and sexually inappropriate behaviors. The program requested a urinalysis (UA) and a medication review. The doctor responded with an order for a UA on 1/6/23. The doctor did not make any changes to Tenant #C4's medication regime. The RN directed staff via a communication log on 1/6/23 to obtain a UA from the tenant. The Director explained many staff tried to get the urine sample without luck until 1/10/23. Tenant #C4 started an antibiotic, Levaquin, on 1/10/23. Tenant #1's Leaquin order directed one pill daily for ten days. Tenant #C4 took a total of four doses Levaquin and refused six doses of Levaquin.

According to incident reports dated 1/12/23 at 2:58 AM, the alarm to the locked memory care unit activated and Tenant #C4 walked outside to the enclosed courtyard. When two staff members attempted to redirect him, he swung at one of them. He kicked the other staff member and punched her in the stomach. They got him back inside and increased his supervision level from hourly checks to 30 minute checks.

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A 160	Continued From page 7 Later the same evening at 8:05 PM, when staff attempted to assist Tenant #C4 to the toilet, he grabbed Staff A and punched her in the face, grabbed her shirt and then punched her six additional times. Two other staff members attempted to intervene but Tenant #C4 continued to aggress Staff A. Tenant #C4 wouldn't let go of Staff A's shirt and ripped off her bra. He started to charge after another resident so Staff A got in his way, which continued the attack. He struck her in the chest and face again. Staff called 911 and medics transported Tenant #C4 to the emergency room. Tenant #C4 had a small skin tear to the dorsum of the right hand about the size of a pea with no active bleeding or skin flap present. There were three small linear scratches/abrasions to the dorsum of the right hand. There was a small avulsion type laceration to the left forefinger with no active bleeding. Tenant #C4 had full extension and flexion of all fingers on both hands. No other signs of injury aside from the skin injuries were noted. On 1/14/23, Tenant #C4 waled outside to the secured courtyard with appropriate clothing and a coat. He did this multiple times but when staff redirected him inside, he physically assaulted staff by swinging at them and hitting them. He was sent to the Emergency Department for medication management for his urinary tract infection and behaviors. The program nurse documented she spoke with the Emergency Department (ED) Dr. about Tenant #C4's behaviors and non-compliance with taking his Levaquin. The program arranged for a 1:1 sitter to stay with Tenant #C4, at his wife's expense, upon his return from the hospital.	A 160		

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Tenant #C4, his wife and a hospice nurse met to discuss his admission to hospice. They reviewed his urinary tract infection and refusal at times to take his prescribed medication. According to the hospice plan, the hospice nurse would, "identify the urinary infection, develop plan of treatment, monitor for side effects, and assess patient for response to treatment."

On 1/16/23, the program nurse received a call from the team informing her Tenant #C4 was banging on other tenant's doors. He was also having exit-seeking behaviors and setting off the alarms. When given an oral PRN he spit it on staff twice. His wife and hospice were notified of this behavior.

The covering nurse reminded staff Tenant #C4's antibiotic was prescribed daily. She directed staff to try to give it to him throughout the day if he refused the first time. Staff should also encourage fluids.

Tenant #C4's Primary Care Physcian (PCP) was notified of the tenant's behavioral issues on 1/17/23, but not Tenant #C4's refusal to consistiently take his antibiotic to treat his UTI.

A note from the nurse on 1/19/23 indicated Tenant #C4 refused all of his medications after several attempts, including his antibiotic. She encouraged staff to continue to attempt to administer the antibiotic.

It took the program four days to get a urine sample from Tenant #C4. Tenant #C4 took four of ten doses of his antibiotic. The program did not communicate with the tenant's physician about these concerns as his confusion and

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A 160	Continued From page 9 increased behaviors escalated. During an interview with Tenant #C4's physician on 2/15/23 at 8:35 AM, he stated the program should have notified him Tenant #C4 was not taking his antibiotic to treat the UTI. On 2/15/23 at 4:15 PM, the Clinical Risk and Compliance Manager reported she believed the fill-in nurses at the facility were directed to report information to the doctor but did not provide documentation of this.	A 160		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to have a sufficient number of trained staff available to fully meet the needs of 3 of 3 tenants reviewed (Tenant #1, #4 and #6). Findings follow: Record review revealed the documentation survey report from September 2022, indicated Tenant #1 recieved visual checks eight times per shift during an eight hour shift. She did not receive the proper visual checks on the following nights: - No checks from 6:32 PM 9/17/22 - 8:50 AM 9/18/22 - No checks from 10:00 PM 9/18/22 - 7:41 AM 9/19/22 - No checks from 2:59 PM 9/20/22 - 11:42 PM	A 325		

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A 325	Continued From page 10 9/20/22 The documentation survey report for the month of September 2022, indicated Tenant #4 received visual checks eight times per shift, or hourly. The checks increased to every 30 minutes on 9/17/22 when Tenant #4 was in bed, including naps and at night. Tenant #4 did not receive the proper supervision on the following dates: - The 11:00 PM shift on 9/9/22 - 7:31 AM on 9/10/22 (no visual checks) - He received four of eight visual checks on the 3:00 PM - 11:00 PM shift on 9/13/22 - No visual checks from 6:00 PM on 9/13/22 - 7:36 AM on 9/14/22 - Four of eight visual checks from 3:00 PM - 11:00 PM on 9/18/22. - No visual checks from 7:00 PM on 9/16/22 to 8:25 AM on 9/17/22 - No visual checks from 11:00 PM on 9/19/22 to 6:00 AM on 9/20/22 - No visual checks from 6:44 PM on 9/20/22 to 7:34 PM on 9/20/22 - No visual checks from 6:37 PM on 9/21/22 to 7:18 PM on 9/21/22 The documentation survey report for the month of September 2022, noted Tenant #6 received visual checks eight times per shift during an eight hour shift. Tenant #6 did not receive the proper supervision on the following dates: - No visual checks from 10:00 PM on 9/9/22 - 7:31 AM on 9/10/22 - No visual checks from 5:37 PM on 9/13/22 - 7:37 AM on 9/14/22 - No visual checks from 6:53 PM on 9/16/22 - 7:24 AM on 9/17 22 - No visual checks from 10:20 PM on 9/19/22 - 7:27 AM on 9/20/22 - No visual checks from 6:44 PM on 9/20/22 -	A 325		

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A 325	Continued From page 11 7:33 AM on 9/21/22 - No visual checks from 6:38 PM on 9/21/22 - 7:17 AM on 9/22/22 On 2/15/23 at 11:00 AM the Director of Resident Engagement stated one staff worked the overnight shift on 9/17/22 and 9/22/22. The program consistrf of two buildings with a courtyard in between the two. If only one person was working, when the staff was in Building A, no one would be in Building B to supervise the tenants. The Clinical Risk and Compliance Manager and Director of Resident Engagement confirmed the tenants did not receive the proper supervision on 2/15/23 at 4:15 PM.	A 325		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to train 5 of 6 employees, hired within the past three months, reviewed within 30 days of hire (Staff D, Staff E, Staff F, Staff I and Staff H). Findings follow: Record review on 2/8/23 revealed Staff D was	A 345		

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A 345	Continued From page 12 hired on 11/16/22. Staff D's personnel record contained no delegations. Staff E was hired on 11/28/22. Staff E's personnel record contained no delegations. Staff F was hired on 12/26/22. Staff F's personnel record contained no delegations. Staff I was hired on 11/16/22. The nurse completed training with Staff I on 2/8/23, more than 30 days after Staff I's date of hire. Staff H was hired on 10/31/22. The nurse completed her training on 12/29/22, more than 30 days after Staff H's date of hire. The Director confirmed this information on 2/9/23 at 1:10 PM.	A 345		
A 410	481-67.19(3)b Record Checks 67.19(3)b Conducting a background check. The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person's maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete a background check	A 410		

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(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 410	Continued From page 13 prior to the date of hire for 3 of 7 employees reviewed (Staff G, Staff H and Staff I). Findings follow: Record review on 2/8/23 revealed Staff G's hire date of 2/1/22. The program completed her background check over a year later, on 2/8/23. Continued record review revealed Staff H's hire date of 11/16/22. The program completed her background check on 11/22/22, six days after her hire date. Additional record review revealed Staff I's hire date of 10/31/22. The program did not complete a background check for Staff I. The Director confirmed these findings on 2/9/23 at 1:10 PM.	A 410		
A 395	481-69.26(4)a 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 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to identify the needs of 1 of 7 current tenants (Tenant #7) and 1 of 4 discharged tenants (Tenant C4) on the service plan. Findings follow: 1) Record review on 2/8/23 revealed Tenant #7 moved to the program on 6/8/22. Tenant #7	A 395		

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 02/15/2023

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A 395	Continued From page 14	A 395		

scored a 6 on the Global Deterioration Scale indicating a Severe Cognitive Decline on 1/12/23. Tenant #7's service plan, dated 1/12/23, indicated he was diagnosed with unspecified dementia. Tenant #7 had a history of groping staff in an inappropriate manner. Tenant #7's service plan made no mention of a sexual involvement with another tenant.

When interviewed on 2/13/23 at 11:10 AM, Staff B reported she witnessed Tenant #6 touch Tenant #7 in a sexual manner. Staff B sat in the living room and Tenant #7 reached under Tenant #6's shirt and under her pants. Tenant #7 unbuckled his pants when Tenant #6 was around. Tenant #7 was married and his wife reportedly preferred Tenant #6 not sit near her husband. Tenant #7 did not act in a sexual manner toward other female tenants. Tenant #7 followed Tenant #6 to her room but staff redirected him out of the room before anything sexual occurred. This occurred quite a few times and Staff B was unable to provide a number of times they interacted in an intimate manner. Staff B never documented these interactions. She told the other caregivers, but not the nurse or Director.

When interviewed on 2/13/23 at 3:06, Staff J said about two to three times a month she saw Tenant #6 and Tenant #7 engage in sexual acts. Tenant #6 initiated the behavior but Tenant #7 was a willing partner. It usually started on the couch in the front room. She walked in and saw Tenant #6 and Tenant #7 engaging in sexual relations in his apartment. Staff J reported the information about Tenant #7 and Tenant #6 acting in a sexual manner together to the Director.

When interviewed on 2/13/23 at 4:25 PM Staff A stated Tenant #6 and Tenant #7 touched each

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A 395	Continued From page 15	A 395		

others genitals under their clothes daily. Staff A provided frequent redirection to the tenants.

When interviewed on 2/13/23 at 4:50 PM, Staff K reported she was told she could not tell the tenants what to do when they engaged in sexual behavior. One day she came in and Tenant #7 was touching Tenant #6 on the couch. A co-worker said it had been going on for an hour. The co-worker informed her Tenant #7's wife did not want the activity going on.

2) Record review of Tenant C4's file revealed Tenant C4 moved to the program on 11/30/22. The former Health Care Coordinator wrote a progress note on 12/20/22, relaying Tenant C4 was urinating in places such as the floor. Re-directive attempts were successful.

Tenant C4's service plan dated 12/23/22, identified Tenant C4 was incontinent of bladder and bowel. He used incontinence products which staff were to dispose of every shift.

The plan made no mention of Tenant C4's urination in inappropriate places.

On 2/20/23 at 1:41 PM, the Clinical Risk and Compliance Manager confirmed the service plans did not address the tenants' needs.