PRINTED: 03/03/2025
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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 01/27/2025

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 impairment: 1 Number of tenants with cognitive impairment: 21 Total census: 22 The following regulatory insufficiencies were cited related the investigation of Complaints #125899-C, #126002-C and the recertification visit to determine compliance with certification for a Dedicated Dementia-Specific Assisted Living Program:	A 000	The Plan of Correction is attached	
A 115	481-67.2(1)b Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: b. An incident report shall be in detail and shall be provided on an incident report form. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to complete incident reports that were detailed. This pertained to 1 of 1 tenants reviewed who was hospitalized in January	A 115		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Karena Mahan TITLE ED (X6) DATE 3/18/202

STATE FORM 6899 25FE11 If continuation sheet 1 of 29

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A 115	Continued From page 1 2025 (Tenant #1). Findings follow: 1. When observed on 1/27/25 at approximately 11:45 a.m. Tenant #1 had discoloration noted under his right eye. 2. Review of Tenant #1's file on 1/22/25 and 1/23/25 revealed Progress Notes indicating on 1/15/25 staff called the nurse and reported Tenant #1 said they were killing people and he pulled his spouse by her shirt. He was hitting staff and could not be redirected or calmed down. Staff was directed to call 911 and he was taken to the hospital. Inpatient Discharge instructions (hospital records) revealed the tenant was seen for COVID-19 and assault. Additional hospital records indicated the chief complaint was the tenant started assaulting staff that evening. There was a bruise noted over the right periorbital area at the scene. He was also combative inside the ambulance and 5 milligrams (mg) of Versed was administered. It indicated he presented from his memory care program after an altercation with another tenant. The history was provided by emergency medical services (EMS) as no one could reach staff at the program. Per the EMS report, he was in an altercation with another tenant and sustained facial trauma in the process. A large bruise was noted around the right eye. A handwritten incident report (other incident reports were provided in the electronic records system) indicated on 1/15/25, Tenant #1 was aggressive and was seeing things. Staff attempted to redirect him. It occurred in an empty apartment. It was noted as a witnessed incident. There were no injuries noted. The tenant refused to have his vitals taken. The report was	A 115		

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A 115	Continued From page 2 completed by Staff A and it indicated Staff B witnessed the incident. Staff called the nurse at 8:15 p.m. and 911 at 8:30 p.m. The report was signed by Staff A dated 1/15/25 at 9:00 p.m. Staff A provided a written statement on the back of the form. 3. When interviewed on 1/22/25 at 3:20 p.m. Staff A said she worked 7:00 p.m. to 7:00 a.m. on 1/15/25. Tenant #1 was challenging to work with that evening. At med pass time, Staff B was looking for the tenant to administer his bedtime medications. She found him in an unoccupied apartment that had furniture in it and had the door cracked. As Staff A approached she heard Staff B in the apartment telling him not to do that. Staff A could see Staff B and Tenant #1 at that time. Then Tenant #1 hit Staff B in the face with a closed fist and she fell to the floor and said Staff A's name. To Staff A it looked like Tenant #1 was going to go after her again. Staff A tried to redirect him, talked to him and told him it was not okay. Staff A said Tenant #1's reality was gone; he started to scream, said they had guns and were in a cult. Tenant #1 tried to run, tripped over his foot, fell and slid on the carpet. He got up and she noticed his cheek area under his eye was red. She could not tell if he hit his head on the bed or the table. She thought he hit it either on the box frame of the bed or the table next to the bed. He got up quickly and independently while she was still trying to talk to him. Staff A opened the door and Tenant #1 took off to the common area. He had a walker; however, it was not with him. Staff called the DON (Director of Nursing) to tell her what was going on and 911 was called. Tenant #1 got his spouse of bed, said she needed to come with him because they were in cult and were leaving. He was "holding her hostage" and he had a shoe and a jacket he was swinging at staff. The	A 115		

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A 115	Continued From page 3	A 115		

police arrived first and he tried to charge at them. He also would not let them into one of the doors in the courtyard. Tenant #1 told police staff had guns and they needed to take the guns. The emergency medical technicians (EMTs) never said anything to staff and they came and picked him up. The only injury to Tenant #1 that she noticed was a red mark in the eye area and that's how she knew he bumped something. Staff A said she noticed his demeanor around 7:15 p.m. to 7:20 p.m. He started getting violent at approximately 7:45 p.m. until between 8:00 to 8:30 p.m. Staff A said she completed the incident report on 1/15/25 at 9:00 p.m. She was not sure if Staff B completed a statement. There were no other injuries noted to Tenant #1.

When interviewed on 1/22/25 at 4:30 p.m. Staff B said she was working on the side of the building that Tenant #1 resided. She was working the 7:00 p.m. to 7:00 a.m. shift with Staff A. When she got there, Tenant #1 was already agitated. Staff A calmed him down and redirected him. He was hallucinating. Staff B went to get his bedtime medications and a tenant in the living room said she thought he was in her apartment. She went to the other tenant's apartment and he was in there. He had taken the rubber stopper off of the wall. Staff B was facing him in the apartment and he hit her in the forehead with a closed fist. Staff A heard Staff B calling for help and Staff A tried to redirect him while he was swinging at staff. She said she blocked her face as she was on the floor and heard Tenant #1 fall. She did not know what happened but thought he fell and hit his face. The room was cluttered and he was on the floor by the bed and dresser. When he got up she saw blood under his eye. Staff A tried to check him over and he took off running. Staff B called the DON and 911 was called. He had his spouse out

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A 115	Continued From page 4 in the dining area and was swinging his shoe at staff. He had his spouse trapped in the dining room and hit Staff C in the head with a shoe. When police arrived, they tried to calm him down. They were eventually able to get him on the gurney. He was agitated. She said he did have a walker but it was left out in the dining room. She had never seen him run before. She did not think she had completed an incident report or witness statement related to the incident. When interviewed on 1/23/25 the DON said the incident took place in an occupied tenant apartment. Staff B called her at 8:20 p.m. and said Tenant #1 had punched her and knocked her to the floor. The DON told her to call 911. She could hear Tenant #1 yelling that people were trying to kill them while on the phone. Tenant #1 was taken to the hospital. She called the hospital the next morning and was told he was admitted for observation. He was discharged from the hospital on 1/22/25. She said the apartment was occupied but no tenants were in the apartment. There were two beds, two dressers and a nightstand. There was also a round table. After she talked to Staff B she called Staff A who said Tenant #1 was running around, saying things about people trying to kill them. Staff A said he was running and fell on the bed and hit his face on something in that apartment. Staff A said his eye was red at that time. She said Staff A completed a paper incident report as it was so chaotic. When she the hospital records on Monday there had been no reports of a physical altercation with another tenant. She assumed his injuries occurred when he fell and hit his face and she had no concerns they happened in any other manner. Staff C was unavailabe for interview.	A 115		

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A 115	Continued From page 5 4. On 1/22/25 review of the Program's policy and procedure related to incident reports indicated staff were to document incidents that involved a tenant, visitor, property or grounds. Staff who witnessed or was first made aware of the incident were to complete and sign an incident report prior to the end of the shift. If staff witnessed or became of aware of damage to the property or injury to tenant, or visitor, staff would notify the executive director. The policy and procedure did not indicate the incident would be recorded in detail on the incident report form as required. 5. The handwritten incident report of the incident as noted above lacked some required information and some information listed was inaccurate. The location on the incident report was noted as an empty apartment. Interviews with Staff B and the DON indicated the incident occurred in an occupied apartment (although the occupant was not present). It was also noted the incident report lacked documentation of any injuries for Tenant #1 despite injuries being observed by Staff A and Staff B. An injury was also reported to the DON. Staff A, Staff B and the DON all indicated Staff B was knocked down to the ground after being struck by Tenant #1. The incident report indicated Tenant #1 struck Staff B; however, did not indicate she had been knocked to the ground. The incident report did not indicate any other staff were involved; however, per interview with Staff B, another staff (Staff C) was hit in the head by a shoe during the incident. 6. When interviewed on 1/27/25 at 2:01 p.m. the DON confirmed all incident reports were provided for the tenants reviewed.	A 115		

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A 125	481-67.2(1)d Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include statements from all staff who witnessed the incident as part of the incident report. This pertained to 1 of 1 tenants reviewed who was hospitalized in January 2025 (Tenant #1). Findings follow: 1. Review of Tenant #1's file on 1/22/25 and 1/23/25 revealed a handwritten incident report indicating on 1/15/25, Tenant #1 was aggressive and was seeing things. Staff attempted to redirect him. It was noted as a witnessed incident. There were no injuries noted. The report was completed by Staff A and it indicated Staff B witnessed the incident. Staff called the nurse at 8:15 p.m. and 911 at 8:30 p.m. The report was signed by Staff A dated 1/15/25 at 9:00 p.m. Staff A provided a written statement on the back of the form. See 67.2 (1)b for more information related to the incident. 2. Review of Staff A's written statement indicated on 1/15/25 at about 8:00 p.m. she tried to redirect	A 125		

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A 125	Continued From page 7 Tenant #1 and told him there was no one there but staff. That caused more agitation and he began to wander around the building as she passed medications. Staff A heard Staff B say to Tenant #1, "No, let's not do this." It was regarding the fact that he had broken the door stopper in an apartment and was digging in the hole to make it bigger. As Staff A approached, Tenant #1 punched Staff B in the face. Staff A tried to intervene and stop the attack. Tenant #1 kept yelling that they had guns and were trying to kill him. Staff A tried to reassure Tenant #1 that he was safe. He tried to run, tripped over his foot and (hit) his face. He got himself up and ran to his apartment. He then dragged his spouse out of bed by her shirt. Staff called the Director of Nursing (DON) and staff was instructed to call 911. He attempted to attack staff and held his spouse "hostage" as he believed they had guns and were in a cult. 3. When interviewed on 1/22/25 at 4:30 p.m. Staff B said she was working on the side of the building that Tenant #1 resided. She was working the 7:00 p.m. to 7:00 a.m. shift with Staff A. When she got there, Tenant #1 was already agitated. Staff A calmed him down and redirected him. He was hallucinating. She went to get his bedtime medications and a tenant in the living room said she thought he was in her apartment. She went to the other tenant's apartment and he was in there. He had taken the rubber stopper off of the wall. Staff B was facing him in the apartment and he hit her in the forehead with a closed fist. Staff A heard Staff B calling for help and Staff A tried to redirect him while he was swinging at staff. She said she blocked her face as she was on the floor and heard Tenant #1 fall. She did not know what happened but thought he fell and hit his face. The room was cluttered and he was on the floor by	A 125		

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A 125	Continued From page 8 the bed and dresser. When he got up she saw blood under his eye. Staff A tried to check him over and he took off running. Staff B called the DON and 911 was called. He had his spouse out in the dining area and was swinging his shoe at staff. He had his spouse trapped in the dining room and hit Staff C in the head with a shoe. When police arrived, they tried to calm him down. They were eventually able to get him on the gurney. He was agitated. She said he did have a walker but it was left out in the dining room. She had never seen him run before. She did not think she had completed an incident report or witness statement related to the incident. Staff C was not available for interview. 4. On 1/22/25 review of the Program's policy and procedure related to incident reports indicated staff were to document incidents that involved a tenant, visitor, property or grounds. Staff who witnessed or was first made aware of the incident were to complete and sign an incident report prior to the end of the shift. If staff witnessed or became of aware of damage to the property or injury to tenant, or visitor, staff would notify the executive director. The policy and procedure did not include a statement related to the requirement of witness statements being included in, or as part of, the incident reports. 5. No witness statements were completed by either staff B or Staff C. 6. When interviewed on 1/27/25 at 2:01 p.m. the DON confirmed all witness statements for this incident were provided.	A 125		

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A 135	Continued From page 9	A 135		
A 135	481-67.2(1)f Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: f. A copy of the completed incident report shall be kept on file on the program's premises for a minimum of three years. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop a policy and procedure related to incident reports that included the timeframe incident reports are required to be retained. Findings follow: 1. On 1/22/25 review of the Program's policy and procedure related to the incident reports indicated all incident reports not related to tenants were kept for 12 months and disposed of. The policy and procedure did not indicate the timeframe for retention of incident reports pertaining to tenants. 2. When interviewed on 1/27/25 at 1:28 p.m. the Executive Director confirmed the policy provided related to the incident reports was the most current policy and procedure.	A 135		
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.	A 150		

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A 150	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policy and procedure related to incident reports. This pertained to 2 of 4 current tenants (Tenant #1 and Tenant #2) and 1 of 2 former tenants (Tenant C1) reviewed. Findings follow: 1. Review of Tenant #1's file on 1/22/25 and 1/23/25 revealed Progress Notes indicating the following: - On 12/8/24 Tenant #1 had hallucinations and delusions, he broke a blind, threw pictures and went into another tenant's apartment. In the morning he continued to have behaviors and was not redirectable. He was taken to the hospital for evaluation. - On 12/9/24 nothing was found to determine the cause of his hallucinations and delusions. An order was received for Seroquel 25 milligrams (mg) at bedtime. It could increase weekly up to 75 mg twice daily. - On 12/17/24 it was noted Tenant #1 had extreme behaviors on 12/15/24. Police were called, he hit staff and staff could not get him to calm down. He was having delusions and could not be redirected. A family member came and got him for a night. He was taken to the primary care provider (PCP) yesterday and new orders were received. His family was going to keep him until Thursday. - On 12/23/24 Tenant #1 continued to see things and people that were not there. The delusions were very real to him and it made it difficult to redirect or distract him. He was throwing things. Family was there and decided to take him and kept him for two nights. - On 1/15/25 staff called the nurse and reported	A 150		

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A 150	Continued From page 11 Tenant #1 said they were killing people and he pulled his spouse by her shirt. He was hitting staff and could not be redirected or calmed down. Staff was directed to call 911 and he was taken to the hospital. Continued record review revealed there was an electronic incident report dated 12/8/24 and a paper incident report dated 1/15/25. There were no incident reports found related to the incidents on 12/15/24 and 12/23/24. 2. Review of Tenant #2's file on 1/27/25 revealed a Progress Notes indicated on 12/9/24 Tenant #2 was noted going through the door while the alarms went off. A physical therapy (PT) staff stayed with her to ensure her safety. Tenant #2's spouse was called and he redirected her into the building. She was agitated for 5 to 10 minutes and then sat down and there were no further issues. Continued review revealed an incident report could not be located related to the incident on 12/9/24 with Tenant #2. 3. Review of Tenant C1's file on 1/22/25 and 1/23/25 revealed he was admitted on 11/22/24 and was discharged on 1/11/25 by his physician. Progress Notes indicated the following: - On 1/3/25 it was noted Tenant C1 broke through the secured door. Staff remained with him when he refused to come back into the building. The nurse arrived and attempted to guide him back into the building. Staff called 911 related to him punching staff and not coming back into the building. He was transported to the emergency department (ED). His family met him at the hospital. Family took him home after he was discharged from the hospital and picked up	A 150		

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A 150	Continued From page 12 his medications as they waited for him to be agreeable to return to the building. There were no incident report located related to the incident on 1/3/25. 4. On 1/22/25 review of the policy and procedure related to incident reports indicated staff would document incidents that involved a tenant, visitor, property or grounds. Staff who witnessed or was first made aware of the incident would complete and sign an incident report prior to the end of the shift. 5. When interviewed on 1/27/25 at 2:01 p.m. the Director of Nursing confirmed all incident reports were provided for the tenants reviewed.	A 150		
A 135	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. This REQUIREMENT is not met as evidenced by:	A 135		

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	80017	A. BUILDING: _____ B. WING _____	C 01/27/2025

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COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

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A 135	Continued From page 13 Based on interview and record review the Program failed to complete evaluations prior to taking occupancy. This pertained to 3 of 4 current tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Review of Tenant #1's file on 1/22/25 and 1/23/25 revealed he was admitted on 10/28/24. A Level of Care and Service Plan document (functional evaluation) was signed on 11/4/24. The functional evaluation was not completed prior to taking occupancy. 2. Review of Tenant #2's file on 1/27/25 revealed she was admitted on 6/17/24. A Comprehensive Observation Tool (health evaluation) was dated 6/18/24. A Level of Care and Service Plan document (functional evaluation) was signed 7/1/24. The health and functional evaluations were not completed prior to taking occupancy. 3. Review of Tenant #3's file on 1/27/25 revealed she was admitted on 7/15/24. A Level of Care and Service Plan document (functional evaluation) was dated 7/16/24. It was not completed prior to taking occupancy. 4. When interviewed on 1/27/25 at 2:01 p.m. the Director of Nursing confirmed all evaluations were provided for the tenants reviewed.	A 135		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via	A 140		

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A 140	Continued From page 14 nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations within 30 days of taking occupancy. This pertained to 4 of 4 current tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file on 1/22/25 and 1/23/25 revealed he was admitted on 10/28/24. A Global Deterioration Scale (GDS) was completed on 12/15/24. A Level of Care and Service Plan document (functional evaluaton) was dated 1/22/25 and it was a 30 day review. Cognitive, health and functional evaluations were not completed within 30 days of taking occupancy. 2. Review of Tenant #2's file on 1/27/25 revealed she was admitted on 6/17/24. A Level of Care and Service Plan document (functional evaluation) was signed on 9/13/24 and 11/22/24. Cognitive, health and functional evaluations were not completed within 30 days of taking occupancy. 3. Review of Tenant #3's file on 1/27/25 revealed she was admitted on 7/15/24. A Level of Care and Service Plan document (functional evaluation) was signed on 9/17/24. Cognitive, health and functional evaluations were not completed within 30 days of taking occupancy. 4. Review of Tenant #4's file on 1/27/25 revealed she was admitted on 9/4/24. A Level of Care and Service Plan document (functional evaluation) was signed 10/2/24. Cognitive and health	A 140		

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A 140	Continued From page 15 evaluations were not completed within 30 days of taking occupancy. 5. When interviewed on 1/27/25 at 2:01 p.m. the Director of Nursing confirmed all evaluations were provided for the tenants reviewed.	A 140		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 4 of 4 current tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file on 1/22/25 and 1/23/25 revealed Progress Notes indicating the following: - On 12/8/24 Tenant #1 had hallucinations and	A 145		

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A 145	Continued From page 16 delusions, he broke a blind, threw pictures and went into another tenant's apartment. In the morning he continued to have behaviors and was not redirectable. He was taken to the hospital for evaluation. - On 12/9/24 nothing was found to determine the cause of his hallucinations and delusions. An order was received for Seroquel 25 milligrams (mg) at bedtime. It could increase weekly up to 75 mg twice daily. - On 12/17/24 it was noted Tenant #1 had extreme behaviors on 12/15/24. Police were called, he hit staff and staff could not get him to calm down. He was having delusions and could not be redirected. A family member came and got him for a night. He was taken to the primary care provider (PCP) yesterday and new orders were received. His family was going to keep him until Thursday. - On 12/23/24 Tenant #1 continued to see things and people that were not there. The delusions were very real to him and it made it difficult to redirect or distract him. He was throwing things. Family was there and decided to take him and kept him for two nights. - On 1/15/25 staff called the nurse and reported Tenant #1 said they were killing people and he pulled his spouse by her shirt. He was hitting staff and could not be redirected or calmed down. Staff was directed to call 911 and he was taken to the hospital. Continued review revealed a Global Deterioration Scale (GDS) was completed on 12/15/24. A Level of Care and Service Plan document (functional evaluation) was completed on 1/22/25. Cognitive, health and functional evaluations were not completed as needed related to the behaviors as noted above.	A 145		

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A 145	Continued From page 17 2. Review of Tenant #2's file on 1/27/25 revealed an order was received to admit to hospice services on 1/23/25. A Comprehensive Observation Tool document (health evaluation) was signed on 1/3/25. A Level of Care and Service Plan document (functional evaluation) was dated 1/25/25. A cognitive evaluation was not completed as needed with Tenant #2's admission to hospice. The most recent health evaluation was completed 20 days prior to the admission to hospice. 3. Review of Tenant #3's file on 1/27/25 revealed an order was received to start hospice services on 1/20/25. A Comprehensive Observation Tool (health evaluation) was last completed dated 12/12/24 (signed on 1/24/25). The Level of Care and Service Plan document (functional evaluation) was last completed on 12/12/24 for increased falls and medication adjustments. It was signed on 12/12/24 and 1/3/25. Evaluations were not completed as needed with significant change related to Tenant #3's admission to hospice. 4. Review of Tenant #4's file on 1/27/25 revealed Progress Notes indicating the following: - On 12/10/24 Tenant #4 was sent to the hospital due to a seizure. Staff reported she was sitting on the couch and yelled. She had stiffened, slid to the floor, had frothy sputum and had bitten her tongue. The nurse called the hospital to give a report on her baseline (as it was new). - On 12/23/24 the PCP was contacted to follow up about getting medications from her hospital stay. Continued review revealed a Level of Care and Service Plan (functional evaluation) was dated 1/6/25. A Comprehensive Observation Tool	A 145		

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A 145	Continued From page 18 (health evaluation) was dated 1/6/25. A GDS was completed dated 12/13/24. Health and functional evaluations were not completed when a change occurred with Tenant #4, with her seizure and hospitalization. 5. When interviewed on 1/27/25 at 2:01 p.m. the Director of Nursing confirmed all evaluations were provided for the tenants reviewed.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to documents nurse's notes by exception. This pertained to 4 of 4 current tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file on 1/22/25 and 1/23/25 revealed Progress Notes indicating the following: - On 1/2/25 (late entry) Tenant #1 tested positive for COVID-19. He was asymptomatic and staff would attempt to have him socially distance and to ensure he was wearing a mask if he was not going to stay in his apartment.	A 290		

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A 290	Continued From page 19 Nurse's notes were not completed related to when he was out of COVID-19 protocols as indicated above. 2. Review of Tenant #2's file on 1/27/25 revealed Progress Notes indicating the following: - On 1/8/25 Tenant #2 tested positive for COVID-19. It was noted she was more tired and weaker than normal. Staff would attempt to have her socially distance and to ensure she was wearing a mask if she was not going to stay in her apartment. Nurse's notes were not completed related to when she was out of COVID-19 protocols and to determine if her symptoms had resolved. Continued review revealed an order was recevied to admit to hospice services on 1/23/25. A nurse's note was not completed related to the order and start of hospice services. 3. On 1/27/25 review review of Tenant #3's file revealed Progress Notes indicating the following: - On 12/27/24 it was noted Tenant #3 had increased falls and her blood pressure had been elevated. Tenant #3 went to the hospital to be evaluated; the hospital indicated the urinanalysis (UA) was negative. The Director of Nursing received the UA results from a UA that was sent out from the Program (which was done prior to the hospital stay). That UA showed growth on the culture. The results were sent to the primary care provider (PCP) and an antibiotic was ordered. - On 12/27/24 it was noted ciprofloxacin HCL 500 milligram (mg), one tablet twice per day was ordered. - On 1/8/25 Tenant #3 tested positive for COVID-19. She was tired and had a decreased	A 290		

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A 290	Continued From page 20 appetite. Staff would attempt to socially distance and ensure she was wearing a mask if she was not willing to stay in her apartment. A nurse's note was not completed with the completion of the antibiotic and to determine if there were further signs and symptoms of a urinary tract infection. A nurse's note was also not completed when she was out of COVID-19 protocols and to determine if her symptoms had resolved. 4. Review of Tenant #4's file on 1/27/25 revealed the following Progress Notes: - On 12/10/24 Tenant #4 was sent to the hospital due to a seizure. Staff reported she was sitting on the couch and yelled. She had stiffened, slid to the floor, had frothy sputum and had bitten her tongue. The nurse called the hospital to give a report on her baseline (as it was new). - On 12/23/24 the PCP was contacted to follow up about getting medications from her hospital stay. - On 1/5/25 (late entry) Tenant #4 tested positive for COVID-19. She was more tired and had less interest in eating. Staff would encourage fluids and food while she was awake. Staff would attempt to socially distance and ensure she was wearing a mask if she was not willing to stay in her apartment. A nurse's note was not completed when Tenant #4 returned to the building post hospital visit. A nurse's note was also not completed when she was out of COVID-19 protocols and to determine if her symptoms had resolved. 5. When interviewed on 1/27/25 at 2:01 p.m. the Director of Nursing confirmed all nurses's notes were provided for the tenants reviewed.	A 290		

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A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans prior to taking occupancy. This pertained to 4 of 4 current tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file on 1/22/25 and 1/23/25 revealed he was admitted on 10/28/24. A Level of Care and Service Plan document (functional evaluation) was dated 10/22/24; however, a signed service plan was not developed prior to taking occupancy. 2. On 1/27/25 review of Tenant #2's file revealed she was admitted on 6/17/24. A Level of Care and Service Plan document (functional evaluation) was signed 7/1/24. A signed service plan was not developed prior to taking occupancy. 3. On 1/27/25 review of Tenant #3's file revealed she was admitted on 7/15/24. A Level of Care and Service Plan document (functional	A 355		

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A 355	Continued From page 22 evaluation) was signed on 8/29/24. A signed service plan was not developed prior to taking occupancy. 4. On 1/27/25 review of Tenant #4's file revealed she was admitted on 9/4/24. A service plan was provided dated 9/9/24, which was after taking occupancy. 5. When interviewed on 1/27/25 at 2:01 p.m. the Director of Nursing confirmed all service plans were provided for the tenants reviewed.	A 355		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days and as needed. This pertained to 3 of 4 current tenants reviewed (Tenants #1, #2 and #4) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. On 1/27/25 review of Tenant #1's file revealed he was admitted on 10/28/24. A Level of Care and Service Plan document (functional evaluation) was dated 1/22/25 and indicated it was for a 30 day review. A service plan document	A 360		

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A 360	Continued From page 23 with a date of 1/22/25 was also provided (labeled when sent as a service plan for 11/18/24). A service plan was not developed within 30 days of taking occupancy. Tenant #1's Progress Notes indicated the following: - On 12/8/24 Tenant #1 had hallucinations and delusions, he broke a blind, threw pictures and went into another tenant's apartment. In the morning he continued to have behaviors and was not redirectable. He was taken to the hospital for evaluation. - On 12/9/24 nothing was found to determine the cause of his hallucinations and delusions. An order was received for Seroquel 25 milligrams (mg) at bedtime. It could increase weekly up to 75 mg twice daily. - On 12/17/24 it was noted Tenant #1 had extreme behaviors on 12/15/24. Police were called, he hit staff and staff could not get him to calm down. He was having delusions and could not be redirected. A family member came and got him for a night. He was taken to the primary care provider (PCP) yesterday and new orders were received. His family was going to keep him until Thursday. - On 12/23/24 Tenant #1 continued to see things and people that were not there. The delusions were very real to him and it made it difficult to redirect or distract him. He was throwing things. Family was there and decided to take him and kept him for two nights. - On 1/15/25 staff called the nurse and reported Tenant #1 said they were killing people and he pulled his spouse by her shirt. He was hitting staff and could not be redirected or calmed down. Staff was directed to call 911 and he was taken to the hospital.	A 360		

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A 360	Continued From page 24 Further review revealed a service plan was signed by Tenant #1's family on 1/23/25. The service plan was not updated with behaviors as noted above when the changes occurred. The service plan signed on 1/23/25 indicated how staff was to manage behavior episodes of aggression related to hallucinations. The service plan did not include throwing items or property destructon. 2. On 1/27/25 review of Tenant #2's file revealed she was admitted on 6/17/24. A Level of Care and Service Plan document (functional evaluation) was dated 9/13/24 and 11/22/24. A service plan was not developed within 30 days of taking occupancy. 3. On 1/27/25 review of Tenant #4's file revealed Progress Notes indicated the following: - On 12/10/24 Tenant #4 was sent to the hospital due to a seizure. Staff reported she was sitting on the couch and yelled. She had stiffened, slid to the floor, had frothy sputum and had bitten her tongue. The nurse called the hospital to give a report on her baseline (as it was new). - On 12/23/24 the PCP was contacted to follow up about getting medications from her hospital stay. Continued review revealed an unsigned service plan with a review date of 1/7/25. The service plan did not reflect the seizure as noted above or any interventions related to seizure activity. 4. Review of Tenant C2's file on 1/22/25 and 1/23/25 revealed he was admitted on 12/12/23. A service plan was provided with a last review date of 1/30/24. A service plan developed within 30 days of taking occupancy could not be located.	A 360		

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	S0017	A. BUILDING: _____ B. WING _____	C 01/27/2025

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 360	Continued From page 25 5. When interviewed on 1/27/25 at 2:01 p.m. the Director of Nursing confirmed all service plans were provided for the tenants reviewed.	A 360		
A 430	481-69.27(1)c Nurse Review 69.27(1) 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: c. 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; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews every 90 days. This pertained to 2 of 2 current tenants reviewed with an applicable 90 day review period (Tenant #2 and Tenant #3). Findings follow: 1. On 1/27/25 review of Tenant #2's file revealed she was admitted on 6/17/24. Tenant #2 received personal and health related care. Tenant #2 did not have a 90 day nurse reviews (health and medication) completed. 2. On 1/27/25 review of Tenant #3's file revealed she was admitted on 7/15/24. Tenant #3 received personal and health related care. Tenant #3 did not have a 90 day nurse reviews (health and medication) completed.	A 430		

PRINTED: 03/03/2025
FORM APPROVED

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 01/27/2025

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 430	Continued From page 26 3. When interviewed on 1/27/25 at 2:01 p.m. the Director of Nursing confirmed all nurse reviews were provided for the tenants reviewed.	A 430		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to have an operating door alarm connected to each exit door. This potentially affected all tenants (census of 22). Findings follow: 1. When observed on 1/21/25 during the initial tour of the building, it was noted there was a front building (100 hallway and 200 hallway) and a back building (300 hallway and 400 hallway). There was a fenced courtyard in between the two buildings. When observed on 1/21/25 at approximatley 4:10 p.m. an exit door in the back building (300 hallway) was observed. The mag lock on the door did not have a red indicator light. It could be not tested as the door could not be opened at the time of the first observation. When observed on 1/22/25 at approximately 3:07 p.m. the door was opened but an alarm did not sound. The door went from the interior of the building to the courtyard. On 1/22/25 at 10:39 a.m. an exit door in the front building (100 hallway) was observed. The mag	A 635		

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	S0017	A. BUILDING: _____ B. WING _____	C 01/27/2025

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

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A 635	Continued From page 27 lock on the door did not have an indicator light. On 1/23/25 at approximatley 1:50 p.m. the door was opened but an alarm did not sound. The door went from the interior of the building to the courtyard. Further observation on 1/22/25 at approximately 3:07 p.m. revealed a door in the back building (400 hallway) had a red light indicator and alarmed when it was opened for a time period. The door did not alarm initially when opened but did alarm after being opened for a time period. When observed on 1/23/25 at approximatley 1:50 p.m. a door in the front building (200 hallway) had a red light indicator and alarmed when observed for a time period. These doors went from the interior of the building to the courtyard 2. Record review revealed the Program had a certificate from the Department for a Dedicated Dementia-Specific Assisted Living Program and currently had 22 tenants and 21 tenants were staged at a four or greater on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Additionally, the Program identified nine tenants that had wandering behavior on the Adult Services Monitoring Entrance Form. 3. When interviewed on 1/27/25 at 12:05 p.m. the Maintenance Coordinator said these four doors were egress doors to the courtyard and the doors could be locked per corporate. He said alarms were placed on 1/27/25 on all four doors. They were after market alarms and would sound when the plane of the door was broken. He said he and the Executive Director had the keys to the doors. Prior to the placement of the door alarms, two of the doors had mag locks and alarms (200 and 400 hallways). He said they were in process	A 635		

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DEPARTMENT OF INSPECTIONS AND APPEALS

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A 635	Continued From page 28 of getting a bid for all new door locks and handles. He confirmed two of the four doors were not alarmed prior to the placement of the door alarms on 1/27/25.	A 635		

Country Manor Memory Care
900 West 46th Street
Davenport, Iowa 52806

Annual Recertification Survey Inspection
Exit Date 01/27/2025
Plan of Corrections:

The facility is committed to ensuring compliance with all regulatory requirements and will continuously monitor these processes to maintain high-quality care for our tenants.
In response to the insufficiencies cited, the following corrective actions will be implemented to ensure compliance with regulatory standards.

A115 Program Policies and Procedures:
Program failed to complete incident reports that were detailed.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- Executive Director and Director of Wellness will review and familiarize themselves with the facility policy and procedure on recording incident reports.
- Caregivers will receive in-service training provided by the Director of Wellness on completing incident reports with all required details to include a description of the incident, individuals involved, the immediate actions taken, and any follow-up interventions.
- The Incident Reporting Policy shall be amended to include "all incidents will be recorded in detail on the incident report." And obtaining witness statements.

Measures taken to ensure the problem does not recur.

- Incident reports will be reviewed 5x week and followed up as needed by the Director of Wellness to ensure these are completed in detail.

How the program plans to monitor performance to ensure compliance.

- ED or designee will conducted random audits monthly to ensure compliance. Results of these audits will be reported to the Quality Assurance Committee for further assessment and review.

Completion date.
March 14, 2025

A125 Program Policies and Procedures
Program failed to include statements from all staff who witnessed the incident as part of the incident report.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- The facility incident reporting policy will be amended to include that statements are to be obtained from all witnessing staff of any incident.

Measures taken to ensure the problem does not recur.

- In-service training will be provided by the Director of Wellness to conclude that staff statements are to be collected pertaining to any witnessed incidents.

How the program plans to monitor performance to ensure compliance.

- The Executive Director and Director of Wellness will audit incident reports daily (5x week) to verify compliance. Results of these audits will be reported to the Quality assurance Committee for further assessment and review.

Completion date.
March 14, 2025

A135 Program Policies and Procedures:
Program failed to develop a policy and procedure related to incident reports that include the timeframe incident reports are required to be retained.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- The facility incident policy and procedure has been amended to include that incident reports are to be kept on file on the program's premises for a minimum of three years.

Measures taken to ensure the problem does not recur.

- The Director of Wellness will provide in-service training on this policy amendment to all staff.

How the program plans to monitor performance to ensure compliance.

- The Executive Director and Director of Wellness will randomly audit incidents to ensure these are maintained on file and on site for a minimum of three years. Results of these audits will be reported to the Quality Assurance Committee for further assessment and review.

Completion date.
March 14, 2025

A150 Program Policies and Procedures:
Program failed to follow its policy and procedure related to incident reports.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- Caregivers will receive in-service training by the Health and Wellness Director on the facility policy pertaining to completion of incident reports.

Measures taken to ensure the problem does not recur.

- The facility Director of Wellness will conduct daily (5x week) compliance audits to ensure adherence with completion of incident reporting.

How the program plans to monitor performance to ensure compliance.

- The Executive Director and Wellness Director will review the results of the monthly audits to verify compliance. Results of these audits will be reported to the Quality Assurance Committee for further assessment and review.

Completion date.
March 14, 2025

A135 Evaluation of Tenant:
Program failed to compete evaluations prior to taking occupancy. Tenant 1, 2, and 3.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- A pre-admission checklist will be implemented requiring evaluations before tenant's take occupancy to include prospective tenant's functional, cognitive and health status. This will be concluded prior to the tenant's signing of the occupancy agreement and taking occupancy of a dwelling unit in addition to determine the tenant's eligibility and appropriateness for the program.
- In-service training will be provided by the Director of Wellness on completion of evaluations prior to admission. The level of care should be completed prior to admission or the day of admission as well as the service plan.

Measures taken to ensure the problem does not recur.

- The director of wellness will be responsible for verification before move in.

How the program plans to monitor performance to ensure compliance.

- ED or designee will conducted random audits monthly to ensure compliance. Results of these pre-admission checklist audits will be reported to the Quality Assurance Committee for further assessment and review.

Completion date.
March 14, 2025

A140 Evaluation of Tenant:
Program failed to complete evaluations within 30 days of taking occupancy.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- The facility utilizes PCC to ensure evaluations are completed within 30 days.
- Comprehensive Observation tool in PCC has been revised to include all elements of the 90-day nurse review requirement.

Measures taken to ensure the problem does not recur.

- A tracking log will be maintained monthly and reviewed by the Executive Director and Director of Wellness.

How the program plans to monitor performance to ensure compliance.

- The Executive Director and Director of Wellness will audit tracking logs and evaluations weekly to verify compliance. Results of these audits will be reported to the Quality Assurance Committee for further assessment and review.

Completion date.
March 14, 2025

A145 Evaluation of Tenant:
Program failed to complete evaluation as needed with significant change.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- Caregiver in-service training will be conducted by the Director of Wellness to recognize significant changes requiring evaluations.

Measures taken to ensure the problem does not recur.

- Director of Wellness will review all evaluations quarterly and those resulting from significant changes to ensure each tenant's functional, cognitive and health status with significant change are updated/addressed.

How the program plans to monitor performance to ensure compliance.

- The Executive Director and Director of Wellness will audit evaluations weekly to verify compliance. Results of these audits will be reported to the Quality Assurance Committee for further assessment and review.

Completion date.
March 14, 2025

A290 Tenant Documents:
Program failed to document nurse's notes by exception.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- Caregivers will receive in-service training on proper documentation using the exception method. The program Director of Wellness will provide this in-service training.

Measures taken to ensure the problem does not recur.

- Documentation consisting of the exception method will be audited weekly by the Director of Wellness to ensure compliance.

How the program plans to monitor performance to ensure compliance.

- The Director of Wellness will report the status of these audits to the facility Executive Director weekly. Results of audits will also be reported to the Quality Assurance Committee for further assessment and review.

Completion date.
March 14, 2025

A355 Service Plans:
Program failed to develop service plans prior to taking occupancy. Tenant 1, 2, 3, 4.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- The pre-admission checklist will include service plan and level of care development prior to occupancy.

Measures taken to ensure the problem does not recur.

- Admission staff will be responsible for verifying auditing service plan completion before move-in, and service plan

How the program plans to monitor performance to ensure compliance.

- Pre-admission checklist and completion of service plans will be reviewed monthly to ensure compliance by the facility administrator.

Completion date.
March 14, 2025

A360 Service Plans:
Program failed to update service plans within 30 days and as needed.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- PCC will track service plan updates, with alerts for required updates within 30 days and as needed and specific to development prior to taking occupancy.
- The facility Director of Wellness will provide caregivers in-service training on the implementation of the tracking system.

Measures taken to ensure the problem does not recur.

- Weekly audits will be conducted to ensure compliance.

How the program plans to monitor performance to ensure compliance.

- The Executive Director and Director of Wellness will review the results of the monthly audits to verify compliance. Results of these audits will be reported to the Quality Assurance Committee for further assessment and review.

Completion date.
March 14, 2025

A430 Nurse Review:
Program failed to complete nurse reviews every 90 days. Tenant 2 and 3

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- PCC will be utilized to remind nursing staff of upcoming 90-day reviews. The Director of Wellness will provide caregivers in-service training to ensure compliance.

Measures taken to ensure the problem does not recur.

- Monthly audits will be completed by the Health and Wellness Director to ensure compliance.

How the program plans to monitor performance to ensure compliance.

- The results of the monthly audits will be reviewed to determine any variable of compliance by the facility Executive Director and Director of Wellness. Results of these audits will be reported to the Quality Assurance Committee for further assessment and review.

Completion date.
March 14, 2025

A635 Life Safety – Emergency Policies/Structure;
Program failed to have an operating door alarm connected to each exit door.

Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.

- The Maintenance Director and all staff will receive in-service training from the facility Administrator on monthly alarm monitoring and reporting.

Measures taken to ensure the problem does not recur.

- The Maintenance Director will inspect and test all door alarms to ensure functionality.
- A log will be maintained monthly for routine checks of all door alarms to ensure functionality.

How the program plans to monitor performance to ensure compliance.

- The results of the routine door alarm checks [log] will be reviewed by the Executive Director. Results of these audits will be reported to the Quality Assurance Committee for further assessment and review.

Completion date.
March 14, 2025