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 03/15/2021

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: 5 Number of tenants with cognitive disorder: 20 TOTAL Census of Assisted Living Program for People with Dementia: 25 The investigation of Complaints #93240-C, #93988-C and #94640-C was completed. An onsite infection control survey and the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program was also completed from 12/1/20 to 3/15/21. The following regulatory insufficiencies were identified:	A 000	See Attached POC 5/20/21	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced	A 003		

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A 003	Continued From page 1 by: Based on observation, interview and record review the Program failed to follow established policy and procedures. This potentially affected all tenants (census of 25). Findings follow: When interviewed on 12-2-20 at 2:15 p.m. the Director identified one tenant received nebulizer treatments. The tenant was COVID-19 positive and staff wore gowns and surgical masks when they assisted the tenant with the nebulizer treatment. Record review of Tenant #5's file indicated Tenant #5 had an order for Albuterol Sulfate Nebulized Solution 3 milliliters (ml) to inhale orally via nebulizer one time per day at 8:00 a.m., started on 3-23-20 and discontinued on 12-4-20. The November 2020 medication administration records (MARs) reflected it was documented as administered daily in November. December 2020 MARs indicated it was documented as administered from 12-1-20 to 12-4-20. Tenant #5 tested positive for COVID-19 on 11-24-20 (date of test). The MARs reflected the nebulizer treatment was administered while Tenant #5 was COVID-19 positive. When interviewed on 12-22-20 at 1:42 p.m. the Director said the nebulizer was changed to an inhaler for Tenant #5. Continued record review revealed the Program had a COVID-19 outbreak with 24 tenants having positive COVID-19 test results between 11-2-20 and 12-10-20 (date of tests). There were also eight staff that tested positive in that timeframe. Further record review of the Program's policy and procedure for aerosol treatments indicated the	A 003		

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program would request a physician's order to discontinue the treatment or staff would wear N95 masks during the treatment.

2. Observation on 12-15-20 at approximately 11:30 a.m. Staff F served plated meals to three tenants on the A side of the building. The food was dished up and served on disposable dishware (uncovered) and transported to the apartments via a cart. Staff A took the cart in the hallway to deliver the meals. When observed she delivered meals into three tenant apartments, provided the plate, disposable silverware, put salad dressing on the salads and delivered the dessert. Staff A had on gloves; however, she entered the three tenant apartments to deliver meals and she did not doff gloves, complete hand hygiene and don new gloves between each apartment.

Continued record review revealed the Hand Washing Technique delegation indicated prior to leaving a tenant apartment, if gloves were worn, to remove the gloves and wash hands with soap and water. The Gloving delegation indicated prior to leaving an apartment to wash hands with soap and water.

Record review revealed the Program had a COVID-19 outbreak with 24 tenants that had positive COVID-19 test results between 11-2-20 and 12-10-20 (date of tests). There were also eight staff that tested positive in that timeframe.

When interviewed on 12-21-20 at 3:08 p.m. the Clinical Care Specialist said if staff wore gloves in an apartment, staff was to remove gloves and use hand sanitizer. If it was a tenant with

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A 003	Continued From page 3 COVID-19, staff would complete hand washing after glove removal.	A 003		
A 007	481-67.2(1)d Program Policies and Procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. 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 observation, interview and record review the Program failed to ensure incident reports included witness statements from individuals who witnessed incidents. This pertained to incidents with three tenants (Tenants #1, #2 and #3). Findings follow: 1. Record review of an Incident Report (handwritten) dated 11-23-20 at 11:25 a.m. indicated when Staff B went into Tenant #1's room, she was seated on the floor. Staff B indicated she asked Tenant #1 if she was okay and if she wanted to get up and Tenant #1 said	A 007		

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no, that she was fine. Staff B asked multiple times and Tenant #1 "cussed" at her so she left her alone. Then Staff B and a few staff members got her up (mechanical lift). When staff got her up they saw her injuries. Tenant #1 was transferred to the hospital. It was noted there were wounds to both feet. Vitals were as follows: blood pressure was 93/44, pulse was 91, respirations were 18, temperature was 97 and oxygen saturation was 97%. The report indicated the physician and family were notified.

Continued record review of the electronic Incident Report dated 11-23-20 at 11:25 a.m. indicated upon coming into the Program staff notified the Former Healthcare Coordinator a tenant (Tenant #1) needed to be assessed and "her feet do not look right." When she went to the room Tenant #1 was seated on the edge of the bed with both feet open to air. The right top of the foot had an abrasion that measured 1.5 inches (in) by 3 in. The skin looked like it was "scraped." The top of the left foot had an abrasion about the same size. Tendons were visible through the skin. No active bleeding was noted to either foot. On the bilateral lower extremities (BLE), multiple blisters were noted up to the knees. The wounds were cleansed, covered with Telfa and gauze and Tenant #1 denied pain with cleansing. She asked Tenant #1 if she fell and she said yes; however, could not explain further. Staff reported Tenant #1 denied falling when asked several times. Staff were instructed to watch Tenant #1 to ensure she did not ambulate prior to being transported to the hospital. The report indicated Tenant #1 was alert and ambulated without assistance. The report indicated Tenant #1 was barefoot and the shoes were on the other side of the room. The report indicated Predisposing Situation Factors included improper footwear and Predisposing

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Physiological Factors were confusion, impaired memory and recent illness. Predisposing Environmental Factors indicated furniture.

See 67.3(2) for additional information related to the incident.

A written statement from Staff D was provided dated 11-25-20 (two days after the incident). A written statement from Staff B (undated) was provided. Staff E and Staff F did not provide statements related to their involvement with the incident with Tenant #1.

2. Record review revealed an Incident Report dated 9-6-20 indicated staff let Tenant #2 outside to walk around. Staff went outside to check on Tenant #2, he was not found and had eloped. Police and emergency medical services were notified to assist in bringing Tenant #2 back to the building. Tenant #2 returned to the building with no injuries.

See 69.35(1) for additional information related to the incident.

Staff K, the staff who worked at the time of Tenant #2's elopement (no longer an employee of the program) completed an incident report; however, did not complete a witness statement related to the incident.

3. When observed on 12-15-20 at approximately 11:45 a.m. Tenant #3 ambulated with a shuffled gait and his neck rested on his chest.

Record review of Tenant #3's file revealed a handwritten Incident Report indicated on 9-27-20

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at 9:02 a.m. Tenant #3 was very weak and he could not walk on his own. Staff helped him to the dining room and he ate. As staff was cleaning up, Tenant #3 took two steps and fell face forward. Tenant #3 had a knot on the left side of the forehead and vitals were as follows: blood pressure was 137/92, pulse was 120, respirations were 19, temperature was 98.2 and oxygen saturation was 97%. Staff L signed the incident report and timed it at 9:21 a.m. It indicated Nurse #1 was notified. The Nurse Section of the incident report was not completed, including documentation of family notification, physician notification, date and time entered into the electronic records and progress notes. The section on the incident report for Action Taken/Outcome was not completed, which would have included if Tenant #3 was taken to a hospital or remained at the Program. An electronic incident report related to the incident was also not completed.

Continued review on 12-10-20 to 12-16-20 of Tenant #3's file revealed Tenant #3 received hospice services. ED Physician Notes (hospital records) indicated Tenant #3 was seen in the ER 9-27-20 at 10:46 a.m. Tenant #3 arrived via ambulance after a "mechanical fall resulting in a hematoma to the left forehead."

When interviewed on 12-17-20 at 1:40 p.m. Staff L said Tenant #3 was weak and sat in the chair between the living room and dining room. She was cleaning up in the dining room and Tenant #3 fell face forward. He had a lump on his forehead. She said he took steps, had not gone far and fell forward. She called Nurse #1 and took his vitals. She did not know if Tenant #3 was sent out but believed he was sent out for it.

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A 007	Continued From page 7 Staff L did not complete a witness statement related to the incident with Tenant #3 and the incident report that was completed did not reflect all needed information, including that Tenant #3 was sent to the hospital via ambulance. 4. Further record review of the Program's incident report policy indicated staff should notify the nurse or director when a tenant fell or an unusual event occurred. An incident form was completed by the nurse or director. The director or nurse indicated a person in charge to complete the incident report in their absence. The incident report would be turned into the nurse as soon as possible. The nurse reviewed reportable incidents and entered them into the electronic system. The handwritten forms were kept for three years and the electronic forms were kept indefinitely. The incident report policy provided did not address witness statements, by those who witnessed the incident. The Program provided an Investigations and Notifications document. The document indicated to obtain written and signed statements from all involved; however, obtaining witness statements was not included in the incident report policy. 5. When interviewed on 3-15-21 at 11:30 a.m. the Director said all incident reports and witness statements requested were provided.	A 007		
A 013	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.	A 013		

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A 013	Continued From page 8 This REQUIREMENT is not met as evidenced by: 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. Based on interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate. This pertained to 1 of 1 tenant reviewed that was hospitalized in the last three months (Tenant #1). Findings follow: Record review revealed a handwritten incident report dated 11-23-20 at 11:25 a.m. which indicated when Staff B went into Tenant #1's room, she was seated on the floor. Staff B indicated she asked Tenant #1 if she was okay and if she wanted to get up and Tenant #1 said no, that she was fine. Staff B asked multiple times and Tenant #1 "cussed" at her so she left her alone. Then Staff B and a few staff members got her up (mechanical lift). When staff got her up they saw her injuries. Tenant #1 was transferred to the hospital. It was noted there were wounds to both feet. Vitals were as follows: blood pressure was 93/44, pulse was 91, respirations were 18, temperature was 97 and oxygen saturation was 97%. The report indicated the physician and family were notified. Continued record review of the electronic Incident Report dated 11-23-20 at 11:25 a.m. indicated	A 013		

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upon coming into the Program staff notified the Former Healthcare Coordinator a tenant (Tenant #1) needed to be assessed and "her feet do not look right." When she went to the room Tenant #1 sat on the edge of the bed with both feet open to air. The right top of the foot had an abrasion that measured 1.5 inches (in) by 3 in. The skin looked like it was "scraped." The top of the left foot had an abrasion that was about the same size. Tendons were visible through the skin. No active bleeding was noted to either foot. On the bilateral lower extremities (BLE), multiple blisters were noted up to the knees. The wounds were cleansed, covered with telfa and gauze and Tenant #1 denied pain with cleansing. She asked Tenant #1 if she fell and she said yes; however, could not explain further. Staff reported Tenant#1 denied falling when asked several times. Staff were instructed to watch Tenant #1 to ensure she did not ambulate prior to being transported to the hospital. The report indicated Tenant #1 was alert and ambulated without assistance. The report indicated Tenant #1 was barefoot and her shoes were on the other side of the room. The report indicated Predisposing Situation Factors included improper footwear and Predisposing Physiological Factors were confusion, impaired memory and recent illness. Predisposing Environmental Factors indicated furniture.

Record review on 12-7-20 through 12-16-20 of Tenant #1's file revealed Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #1 diagnoses included: frontotemporal dementia. A Comprehensive Assessment dated 10-28-20 provided a weight of 230 pounds for Tenant #1 on 7-15-20. The service plan dated 10-28-20 reflected Tenant #1 ambulated independently. The service plan also indicated Tenant #1

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preferred assistance with decision making.

Record review of Hospital #1 records indicated Tenant #1 was seen on 11-23-20 at 1:51 p.m. and was brought to the ER status post fall. She was found on the floor that morning and was confused. She was "last seen well 14 hours ago." Tenant #1 tested positive for COVID-19 three days prior. The records indicated diagnoses included: COVID-19, severe sepsis, rhabdomyolysis and acute kidney injury. Records further indicated "labs showed an acute kidney injury, lactate elevation of 8.5, metabolic acidosis, leukocytosis." Tenant #1 had pressure sores on her lower extremities. "Those are suspected related to down time ... She was found in her room, on her knees with her knees flexed, calves contacting the posterior thighs on the carpet and the patient was attempting to get up. It is suspected that this position caused the abrasions of her bilateral dorsal feet, as well as the rhabdomyolysis from pressure from the patient's calves and thighs." Tenant #1 would be transferred to another hospital by ground as a bed became available. Tenant #1 transferred on 11-23-20 at 8:20 p.m.

Continued record review of Hospital #2 records indicated Tenant was admitted to the ER on 11-23-20 and admitted to the hospital on 11-24-20. Diagnoses included: fall, rhabdomyolysis, acute kidney injury, hyperkalemia, COVID-19, increased anion gap metabolic acidosis, deep tissue injury and hyperphosphatemia. She was found on the floor with multiple pressure wounds and an exposed tendon on the dorsum of the left foot. It would require major surgery with a free flap reconstruction. She was found in the prone position with an estimated time down of 14 hours.

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Hospital #2 records indicated the following regarding Tenant #1's wounds:

a. The left dorsal foot had suspected deep tissue injury, approximately 10 x 4 centimeters (cm). There was skin loss "with maroon dry wound base, exposed tendon." The periwound skin was "Non-blanchable violaceous skin extending up to dorsal aspect of great toe."

b. The posterior left leg had a "Suspected deep tissue injury vs compartment syndrome." It extended from the posterior thigh to the calf. The description of the wound indicated "Violaceous skin and blanchable erythema with serous filled intact bulla."

c. The right dorsal foot had a suspected deep tissue injury that was approximately 8 x 3 cm and was described as "Mixed: 90% purple non blanchable skin with some blistering 10% skin loss with dried exudate." There was "violacous non-blanchable intact skin also present on the dorsal aspects of the right toes and right heel, suspect these are deep tissue pressure injuries."

d. The left posterior leg had a "Suspected deep tissue injury vs compartment syndrome." It extended from the posterior thigh and calf. The wound was described as " Mixed: Violacous intact skin, blanchable erythema, and intact and deroofed serous bulla." There was a small amount of serous drainage noted.

e. There were wounds on the sacrum/coccyx, bilateral buttocks, perineal skin and posterior thighs. It was suspected as a deep tissue injury with "moisture component, suspected cutaneous fungal infection." The wound was described as "Mixed: Violacous intact skin, white non-viable

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tissue present on inferior buttocks/perianal skin, blanchable erythema with satellite lesions."

f. It also noted diaphoresis and intertrigo as the suspected etiology for the abdominal skin folds and groin skin folds.

Record review of the Certificate of Death indicated Tenant #1 died on 12-10-20 at a hospice
facility. The manner of death was listed as an accident and the date and time of injury were listed as 11-23-20 at midnight. The location of the injury was listed at the Program's address and the description on the injury indicated a ground level fall. The immediate cause of death was sepsis and rhabomyolysis and due to or consequence of the wounds of the lower extremities and ground level fall. Other significant conditions indicated dementia.

When interviewed on 12-7-20 at 1:15 p.m. Tenant #1's friend said she had time between appointments, knew Tenant #1 had COVID-19 and stopped to see her through the window. She peaked in the window and she saw her right away. It appeared at first that she was waving but she realized it was a tremor in her right arm. Tenant #1 was sitting on the floor; her head was above the bed and she faced the window. The friend could not see her legs but had the impression her legs were under the bed as she could not be sitting on them due to her weight. The friend said it was very upsetting and there was no attempt to move her shoulder and Tenant #1 had a blank stare. Tenant #1 wore a light-colored t-shirt and she could only see her from the shoulders up. She knocked on the door to the Program (inside the double door) and no

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staff answered. There was a tenant laying on the couch and another tenant came to the door but she did not want her to set off the alarms. The friend left the door and called the spouse of Tenant #1's power of attorney (POA). She told her Tenant #1 was on the floor, had a tremor and had a blank stare. The POA's spouse contacted the Director. The friend said the bed was not made and there was a bag on top of the bed. Tenant #1 did not have a mask on and the door was open.

When interviewed on 1-12-21 at 1:00 p.m. the spouse of Tenant #1's POA indicated on 11-23-20 they received a text from Tenant #1's friend at 10:26 a.m. indicating she had called the Program three times on Sunday (day prior) and could not get through. They called Tenant #1's friend at 10:28 a.m. and the friend was going to stop by and peak in through the window. At 10:45 a.m. the friend called her back and said Tenant #1 was seated on the floor and she did not try to get up. Tenant #1 was kind of waving and had a blank stare/look. The POA's spouse told her that they did not think Tenant #1 could get up. The friend went back to the building and knocked on the door and no one answered. The POA's spouse called the Program and there was no answer. At 10:54 a.m. they texted the Director and told the Director they could not get through and a friend had stopped by and saw Tenant #1 on the floor. She asked the Director to text why Tenant #1 was on the floor and when she was up. At 10:56 a.m. the Director texted back and said Tenant #1 was physically doing okay and had struggled with quarantine (similar message to what the POA had received earlier that morning). It also indicated she would check to see why she was on the floor. At 11:39 a.m. she received a text message from

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the Director that indicated Tenant #1 said she did not fall and then said she did fall. It would be treated as a fall. She would have the Former Healthcare Coordinator handle it. At 11:43 a.m. they received a voicemail from the Former Healthcare Coordinator and then called the Program back at 11:53 a.m. They spoke with the Former Healthcare Coordinator at 11:55 a.m. and was told she wasn't there that morning and had just walked into the situation. The Former Healthcare Coordinator said Tenant #1 had a wound on her foot, the tendon was showing and she needed to get permission to get a medic. Tenant #1 had been moved off of the floor to the bed and the Former Healthcare Coordinator cleaned the wound. Tenant #1 did not react to the wound being cleansed. She wanted the POA to talk to the Former Healthcare Coordinator. The POA was in a meeting, but called the Program approximately 20 minutes later and gave permission to have her sent out. The POA's spouse indicated every tenant at the Program had dementia. They left Tenant #1 there and let her make that judgement despite the fact the tenants were there because they could not make their own judgements. A medic or a call to the POA was not made to get her off the floor. She had never seen her sit on the ground and she said Tenant #1 weighed about 280 pounds and was not agile. She was not someone that would ever sit on the floor. There was no contact regarding falls previously.

When interviewed on 12-7-20 at 10:10 a.m. and 1-12-21 at 10:00 a.m. Tenant #1's POA said he received a text message at 8:30 a.m. on 11-23-20 from the Director who indicated Tenant #1 was doing fine and was struggling with quarantine. There were no other updates or communication

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provided by the Program that morning. At 10:30 a.m. Tenant #1's friend was near the Program and went to her window. Tenant #1 was on the floor and did not appear right. The friend went to the Program's door and no one answered. The friend called the POA's spouse who called the Program and received no answer. The POA's spouse then texted the Director. He spoke with the Former Healthcare Coordinator via phone at 12:00 p.m. and was told Tenant #1 had a wound on her foot. The Former Healthcare Coordinator said she had dressed the wound with a tendon exposed. Tenant #1 did not have any complaints of pain and vitals were normal. Tenant #1 was transported to a local hospital. He was informed Tenant #1 had developed rhabdomyolysis and had low blood pressure and would be admitted to the intensive care unit (ICU). Due to a shortage of ICU beds in the region and Tenant #1 was transferred to another hospital out of the area. Tenant #1 transferred to a hospice house on 12-7-20 and died on 12-10-20. Tenant #1 ' s POA said the Director called him regarding the Program's investigation. She reported staff saw Tenant #1 at 5:30 a.m. as she sat on the edge of her bed putting on her shoes. She must have fallen and at 7:30 a.m. did not want to get up. Her breakfast was served to her on the floor. She was checked again at 9:00 a.m. and did not want to get up. Tenant #1 was observed on the floor by her friend at 10:30 a.m. Tenant #1 ' s POA stated he had not been contacted or updated by anyone from the building on Saturday or Sunday when Tenant #1 was COVID-19 positive. He called the Program three times on Saturday (two days prior) and there was no answer. He called on Sunday (one day prior) and was told she was resting. The next update came at 8:30 a.m. on 11-23-20 via text from the Director, which indicated Tenant #1 was doing

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fine. Regarding the time Tenant #1 was on the floor, Tenant #1's POA said the medical records indicated 14 hours; however, he was not sure how it was determined. His impression was that she had been on the floor for a significant amount of time, due to the extent of her skin injuries and rhabdomyolysis. He said he did not feel she would have gotten up off the floor if they had not intervened and that staff fed her on the floor. He said it was not normal for Tenant #1 to sit on the floor and that she had gained weight with dementia. He had not been contacted for any falls prior or for her being on the floor. He said he was told the vitals were normal but Tenant #1 was hypotensive at the emergency room (ER). It was shocking to him how ill she was based on what he was told that morning. He said there was a lack of closer monitoring with Tenant #1 being COVID-19 positive.

When interviewed on 12-14-20 at 1:43 p.m. Staff D said she worked second and third shifts. She was not assigned to Tenant #1's area of the building on the second shift (evening of 11-22-20). Staff J was assigned the area on the second shift but Staff D helped and was a "hands on" person. Staff D was the only staff on the third shift for the back building on the overnight shift (11-22-20 into 11-23-20). On 11-22-20 at approximately 8:00 p.m. she asked Tenant #1 if she was ready for bed and Staff D and Staff J helped her to her room, got her into her pajamas, changed her protective undergarment and changed her bedding. Tenant #1 did not eat the evening meal and wasn't feeling well. She had saved a plate and asked her if she was hungry. She was provided a dinner plate in her room. Staff laid her down and she was "pretty much" asleep. Checks were done by either Staff D or Staff J, although she believed it was Staff J. On

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the third shift there were three staff in the building, two staff in the front building and one staff in the back building. She said normally Tenant #1 would get up throughout the night. That night she did not get up throughout the night. When she completed checks for tenants she would observe them inhale and exhale three times. The first check for tenants on the third shift was done at shift change. She could not say exactly when the first check was for Tenant #1; but it was done when it switched to third shift. She checked Tenant #1 throughout the shift (hourly checks) and she was asleep in bed at all of the checks. She never heard her get up. She said earlier that day Staff J administered as needed medications. Between 5:15 a.m. and 5:20 a.m. she went to Tenant #1's room and she was up and she believed she had gotten herself dressed. She was seated on the left side of her bed and was trying to put on her shoes. She asked her how she felt and told her she would be back to help her put on her shoes and walk her up. Tenant #1 was not wearing socks when she saw her that's why she told her she would come back. Staff D assisted another tenant and did not make it back. At approximately 6:00 a.m. (time last seen) Staff D had assisted another tenant a door away and walked by and saw Tenant #1 sitting on the edge of the bed. She completed a narcotic count but it was not completed together as on-coming staff were late. She gave a verbal update to Staff E; however, did not complete rounds with her. She did not complete report or rounds with Staff B (on-coming staff). Staff D reported she had never seen Tenant #1 with a continuous positive airway pressure machine (it is indicated on Tenant #1's service plan). She did not provide toileting assistance during the night shift for Tenant #1 and said Tenant #1 was more independent and staff provided reminders and

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direction.
Staff D also worked one or two days before and said Tenant #1 sweat badly. She tried to sit on the toilet and she caught her and lowered her to the down. She called the nurse on-call. Vitals were taken and were normal. Another staff assisted and Tenant #1 was put back to bed and given Gatorade.

A handwritten statement from Staff D was provided dated 11-25-20 (two days after the incident). It indicated on Saturday (11-21-20) morning Tenant #1 was sweating "ferociously." She called the nurse on-call and was told to check her vitals, ensure she was not hurt and then put her into bed. She asked for assistance from another co-worker to lift her and put her into bed. Tenant #1's vitals were normal. On Sunday (11-22-20) evening when Staff D worked she saw Tenant #1 walking around and sitting on the couch. She asked her if she was okay and Tenant #1 said she was fine. She let her stay on the couch and Tenant #1 refused dinner. She kept a plate for her to ensure she ate that day. At 8:00 p.m. she asked her if she was ready for bed and she "implied" she was ready. Staff D and another staff walked with her to her room, helped her get cleaned up and changed into her night clothes and offered her a plate. She ate dinner and went to bed. During the third shift Staff D checked on her and she was asleep. Staff D noted she went into each tenants' apartment to ensure they were breathing. At 5:15 a.m. to 5:20 a.m. she got her up and asked her if she needed to use the restroom and to assist with changing her protective undergarment. When she came into the room she was already trying to put on her shoes and come out of her room. She told her as soon as she was done helping other tenants she would be back to help her get up and walking.

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Tenant #1 said okay. When Staff D saw Tenant #1 last she was "fine and responsive." She did not have time to go back as she was helping another tenant.

When interviewed on 12-8-20 at 3:30 p.m. Staff B reported she worked first shift (7:00 a.m. - 3:00 p.m. on 11-23-20 on the D side of the building. Staff E also worked in the back building on the C side. Staff D had worked the overnight shift. Staff B got there late at approximately 7:30 a.m./7:40 a.m. and she did not talk to Staff D (off-going staff). Staff B did her medication count and started rounds for the tenants. When she did her rounds, she saw Tenant #1 on the floor. Tenant #1's feet were under her buttocks and she was sitting on top of them. She was near her bed and was close enough to pull herself up. Staff B said Tenant #1 had sweatpants and a sweatshirt but had no socks or shoes. The first time she saw her was probably around 8:00 a.m. She asked Tenant #1 if she was okay and why she was on the floor. She did not say why she was on the floor. She left her room and less than five minutes later brought her breakfast. She asked her if she wanted to get up and eat at her table or in bed and Tenant #1 said no. Tenant #1 remained in the same position. The next time she went to her room was approximately 8:30 a.m. to pick up breakfast plates. Tenant #1 was done with breakfast and requested more for breakfast. Tenant #1 remained in the same position and Staff B asked her if she wanted to get up. Tenant #1 said no. At 9:00 a.m. rounds were completed and Tenant #1 remained in the same position on the floor. She asked her if she wanted to get up and she said no. At 10:00 a.m. rounds were completed and when checked on, Tenant #1 remained in the same position. Staff B tried to

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help Tenant #1 up and she "cussed" at her. She was asked if she wanted staff to help her into bed and she said no. Staff E also came in to help and a gait belt was used to try to lift her, but she wouldn't let staff. At 11:00 a.m. staff including: Staff B, Staff E, Staff F and Staff G tried to use a lift to get her up. The lift went up a little bit and staff helped her into bed still in the sling. When she was lifted into bed staff noticed the wounds to her feet. It appeared the skin was peeled back and her tendon was visible. Staff took off Tenant #1 ' s pants and there were boils on her legs (calf) on both legs. The Former Healthcare Coordinator was in the building and staff went to get her. The Former Healthcare Coordinator was not notified prior. The Former Healthcare Coordinator cleaned both wounds and wrapped them. An ambulance arrived and Tenant #1 was sent out. Staff B said she administered medications to Tenant #1 and provided her breakfast. Regarding toileting services, she said Tenant #1 usually went by herself. When staff got her up she wanted to go to the bathroom but staff did not think it was a good idea to walk. Her protective undergarment was changed. She said she saw Tenant #1 sit in that position a few times before, where she sat by the bed to lift herself up and that's why she did not think much of it. It was not frequent but she had seen her do it previously. She said Tenant #1 was able to get herself up.
Staff B stated the documentation of the last checks were late, but the first two were on time.

When interviewed on 12-8-20 at 1:17 p.m. Staff E reported she worked first shift in the back building on the C side on 11-23-20. She came in and did rounds with Staff D (off-going third shift staff). Staff D did not report anything unusual with

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Tenant #1. She did not recall if Staff B completed rounds. Staff E went to the C side and started disinfecting, getting ready for breakfast and passing medications. The Director texted and asked for an update on the COVID-19 positive tenants. She told her how Tenant #1 had been over the weekend but she had not checked on her that day. She also gave updates on other tenants. At 10:30 a.m. the Director texted her to check on Tenant #1 as her family did a window visit and saw her on the floor. Staff E and Staff B went to her room and saw Tenant #1 on the ground. Tenant #1 was seated on her feet, the top of her feet and legs were on the floor. She was near her bed and was in day clothes. She was asked if she was okay and she said yes. Staff asked if she wanted to get up and she said no. She was asked if she fell and she said no. Staff F was called to help with the Hoyer lift. Staff B, E and F got Tenant #1 up and into bed and there were no complaints of pain. When up in bed staff noticed the wounds on the tops of both feet. There were no other injuries noted. Tenant #1 was assisted up off the floor at approximately 10:45 a.m. The Former Healthcare Coordinator was called and she came to the building about 10 minutes later. She wrapped Tenant #1 ' s legs and called Tenant#1's family and an ambulance. Staff E had not seen Tenant #1 prior to that time and Staff B had not told her she was on the floor prior to that time. After she was found on the floor, Staff B told her she on the floor when came to work on first shift and Tenant #1 had not wanted to get up.

When interviewed on 12-14-20 at 1:22 p.m. Staff F reported she worked first shift on 11-23-20 and was assigned to the front building (A side). She arrived for work, completed the screening, punched in, got report from the third shift and

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completed a medication count. Staff from the back building, (Staff B and Staff E) contacted her to bring back the Hoyer lift to get Tenant #1 up off the floor. She arrived at her room and Tenant #1 was on the floor on her knees (tops of feet on the floor). Tenant #1 was responsive, "cussing" at staff and telling them to leave her alone. Tenant #1 was COVID-19 positive and appeared pale. She was dressed in a sweatshirt and jeans and had no socks or shoes on. Tenant #1 was right in front of her bed. Staff B, E and F positioned the lift, leaned her back and pulled her feet out in front of her and she was lifted and placed into bed. The tops of her feet looked almost "raw" but not bleeding. The print of the carpet was on them. There were no other injuries noted and no complaints of pain from Tenant #1. Tenant #1 was not able to say what happened. She did not aid with any other cares for Tenant #1 and she brought the lift back to the front building. She believed the Former Healthcare Coordinator and Director were notified by one of the staff in that building.

When interviewed on 12-17-20 at 11:51 a.m. Staff J reported she worked both Saturday and Sunday on the second shift in the back building. Tenant #1 was COVID-19 positive and on Saturday she was not herself, she did not look right and she had lost color in her face. She looked extremely tired and very lethargic. She was between her room and the living area and they tried to keep everyone quarantined. She did not have an appetite and the meal was brought to her room and she ate. On Sunday, Tenant #1 was about the same as the day before and she was sent to the hospital on Monday. On Saturday she worked with Staff D and visual checks were completed for Tenant #1. She did not notice any injuries. She

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did not call the on-call nurse. She heard (regarding the incident with Tenant #1) that third shift did visual checks and first shift staff was late to work. Tenant #1 was not checked on until 11:00 a.m. almost 12:00 p.m. That was when Tenant #1 was found on the floor and staff called the nurse. She said it did not go together, regarding the injuries and what staff said.

When interviewed on 12-10-20 at 10:02 a.m. the Former Healthcare Coordinator said she contacted the Director and told her that she would be in the building around 11:00 a.m. and to let the staff know. When she arrived at the building at 11:00 a.m. staff said she needed to look at Tenant #1's feet and she immediately went to her room. She had not been notified by staff prior to coming into the building and had not been contacted by the Director prior to coming into the building. When she went to Tenant #1 ' s room she observed Tenant #1 seated on the edge of the bed with the sling (from the lift) under her. She wore long pants and a long-sleeved shirt. She did not wear socks or shoes. She looked at Tenant#1 ' s feet; the left foot appeared worse than the right foot. Both tops of her feet were open but did not actively bleed. The wounds had the appearance of a clear dressing over her tendons and ligaments; however, there wasn't a dressing on the feet and the skin was sheared. Tenant #1 said she had fallen and when asked questions about the fall was unable to give appropriate answers. She asked staff and it was the first time Tenant #1 had reported she had fallen. She rinsed her legs with saline and wrapped them. Tenant #1 had no complaints of pain when the feet were wrapped. She was alert and knew the Former Healthcare Coordinator, but

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seemed more tired. Vitals were taken and Tenant #1's blood pressure was a little low but the vitals were not outside of her baseline. She called Tenant #1's family members and left a message. She contacted the Clinical Care Specialist and indicated if she did not get a response from family she was going to send Tenant #1 out. She spoke to a family member of Tenant #1 and sent her to the emergency room via ambulance. She estimated it was an hour from the time she saw Tenant #1 until she was sent out. They changed her as the ambulance arrived, as she was incontinent of bladder and bowel, which was her baseline. Paramedics arrived and her pants were up on the legs and she observed blisters mid-calf to right behind the knees on both legs. The next day she called the local hospital and was told Tenant #1 was discharged and not transferred. She called Tenant #1's family member and was told she was transferred to a hospital out of the area and had rhabdomyolysis. The Former Healthcare Coordinator reported staff working on the first shift did not complete rounds with off-going staff from the third shift. At 8:00 a.m. rounds Tenant #1 was on the floor and was not uncomfortable. She did sit on the floor at times, she had seen her do it and it was not abnormal for her. She thought staff would have tried to get her up before 11:00 a.m. Staff did not notify her that Tenant #1 was on the floor. If rounds were completed at shift change staff would have known if it happened on the third shift. There was discussion of re-education of staff for notification of the nurse, completion of hourly rounds not just documentation of hourly rounds and what to report to the nurse. Tenant #1 could get herself up sometimes, but she was COVID-19 positive at that time. When asked what she thought happened with Tenant #1, she said she didn't know as nothing was reported to her but said

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maybe she had her feet under bed and she skinned the top of her feet. Or she was seated on her knees with her feet behind her; however, she verbalized no pain.

When interviewed on 12-17-20 at 2:30 p.m. Nurse #1 (on-call nurse) said she was not contacted by staff the weekend prior to the incident with Tenant #1. She was not involved or contacted regarding the incident on 11-23-20 with Tenant #1.

When interviewed on 12-21-20 at 3:08 p.m. the Clinical Care Specialist said she was not contacted by the staff regarding Tenant #1. She was contacted by the Former Healthcare Coordinator after the incident regarding Tenant #1's feet.

Record review of the Documentation Survey Report for November 2020 indicated Staff D documented hourly visual checks completed at 3:00 p.m., 4:00 p.m., 5:00 p.m., 6:00 p.m., 7:00 p.m., 8:00 p.m., 9:00p.m. and 10:00 p.m. The 11:00 a.m. was not documented on the sheet. The 11-23-20 12:00 a.m. check was documented as completed by Staff I and it indicated Tenant #1 was unavailable (per staff interview Staff I was not working at that time). Staff D documented visual checks for Tenant #1 at 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m. and 6:00 a.m. for Tenant #1. Staff B documented visual checks from 7:00 a.m., 8:00 a.m., 9:00 a.m., 10:00 a.m. and 11:00 a.m. The 12:00 p.m. visual check was documented by Staff B was Tenant #1 was unavailable.

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A 013	Continued From page 26 The time stamped Documentation Survey Report for November 2020 indicated visual checks were documented as completed by Staff D on 11-22-20 at the following times: the 3:00 p.m. and 4:00 p.m. check were documented at 3:39 p.m., the 5:00 p.m. was documented at 6:09 p.m., the 6:00 p.m. and 7:00 p.m. checks were documented at 6:39 p.m., the 8:00 p.m. was documented at 8:12 p.m., the 9:00 p.m. and 10:00 p.m. checks were documented at 9:41 p.m., the 11:00 p.m. and 12:00 a.m. (on 11-23-20) were documented at 12:27 a.m. Staff D documented visual checks completed on 11-23-20 at the following times: the 12:00 a.m. check was documented at 12:27 a.m. (as indicated above with the 11:00 p.m. check), the 1:00 a.m. and 2:00 a.m. checks were documented at 1:34 a.m., the 3:00 a.m. check was documented at 3:07 a.m., the 4:00 a.m. and 5:00 a.m. checks were documented at 4:36 a.m., the 6:00 a.m. check was documented at 6:00 a.m. (per written statement Staff D said she saw her last at 5:15 a.m./5:20 a.m.) Visual checks were documented as completed by Staff B on 11-23-20 at the following times: the 7:00 a.m., 8:00 a.m., 9:00 a.m. and 10:00 a.m. check were documented at 11:57 a.m. and 11:58 a.m. The 11:00 a.m. check was documented at 12:51 p.m. The task sheet indicated to provide reminders/cue to use the toilet and to show Tenant #1 where the bathroom was located. It indicated to provide reminders four times per shift while awake. Staff D documented toileting assistance on	A 013		

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11-22-20 at 3:00 p.m., 5:00 p.m. and 7:00 p.m. At the 9:00 p.m. check it was documented as NA. The 11:00 p.m. check was not documented. On 11-23-20 the 1:00 a.m., 3:00 a.m. and 5:00 a.m. checks were documented as NA.
Staff B documented toileting assistance at 7:00 a.m. and 9:00 a.m. check and that Tenant #1 was continent, there was no bowel movement and the check was completed. The 7:00 a.m. was documented at 11:57 a.m. and the 9:00 a.m. check was documented at 11:58 a.m. The 11:00 a.m. check was recorded as NA.

The task sheet indicated to assist with dressing/undressing, hands on assistance and to assist with clothing selection on first and second shifts. It was documented as completed on 11-22-20 by Staff D at 8:41 p.m. and by Staff B on 11-23-20 at 2:58 p.m.

The task sheet reflected a COVID-19 screening on each shift. It was documented as completed on 11- 23-20 at 11:57 a.m.

When interviewed on 12-22-20 at 1:42 p.m. the Director said she was not in the building on 11-23-20 She reached out to staff at 8:00 a.m. regarding the COVID-19 positive tenants and provided family updates. Staff E told her Tenant #1 was okay for the most part and was "cussing" at staff and as needed medication was used. She told staff to update the Former Healthcare Coordinator when she came into the building. Tenant #1's POA was updated via text message. At approximately 11:00 a.m. she received a text message from the spouse of Tenant #1's POA. The message indicated a friend had stopped for a window visit and Tenant #1 was on the floor and was concerned she could not get up. She

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reached out to Staff E and asked her to check on Tenant #1. At some point after speaking with the staff she was told Tenant #1 had been on the floor all morning and had refused assistance. She told Staff E to call the Former Healthcare Coordinator, who did not answer. She then instructed staff to take Tenant #1's vitals and use the Hoyer lift to get her up. At 11:30 a.m. the Former Healthcare Coordinator arrived at the building and completed a visual assessment. Staff was calling her and she was in the process of walking in. She updated the Director on the wounds on Tenant #1's feet and said she needed to be seen at the ER. The Former Healthcare Coordinator said it looked like a tendon was showing. The Director told her to update the family and get permission. Tenant #1 was sent out of the building at 12:30 p.m. She notified management company staff and started an investigation. It was determined that Staff D documented a check was last completed at 6:00 a.m. and she last saw Tenant #1 at 5:20 a.m. At that time, she was seated on the edge of the bed. Staff B first saw her at 7:45 a.m. Staff E had not seen her that morning. Between 5:20 a.m. and 7:45 a.m. she ended up on the floor and it was not determined how she got on the floor. In Staff B's statement she said she had checked on her at 7:40 a.m. and at 8:00 a.m. brought her breakfast and medications and Tenant #1 did not want to get up. Tenant #1 had more breakfast and was checked on at 9:00 a.m. and Tenant #1 cursed at her. Staff B left her to calm down. Staff B arrived late for work that day at 7:40 a.m. Staff D would have stayed until Staff B arrived. To provide the best care she expected staff to receive a verbal report and complete a quick walk through of the area. She did not remember being contacted by staff regarding Tenant #1. The expectation for nurse notification was that if staff

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did not see the incident, it would be considered a fall and the nurse should be notified right away. Staff did not notify the nurse when Tenant #1 was observed on the floor.

The Director also provided a typed statement and summary of the incident. The statement indicated the Director learned through the investigative process Staff D last documented a visual check at 6:00 a.m. and said the last time she saw Tenant #1 was about 5:20 a.m. when Tenant #1 was seated on the edge of her bed, putting on her shoes. Staff B, Tenant #1 ' s assigned staff, saw Tenant #1 about 7:45 a.m. and Tenant #1 was on the floor next to her bed, seated on her knees with her legs under her. Staff B said Tenant #1 refused assistance multiple times that morning. Staff E had not visualized Tenant #1 until the Director called about Tenant #1 being on the floor at 11:00 a.m. despite asking for a morning update. Staff B was counseled for failure to call the nurse for an incident and failure to properly give report and complete rounds with the incoming employee. Staff D was counseled for failure to complete a "true" 6:00 a.m. visual check and failure to properly give report and completed rounds with an incoming employee. Staff E was counseled for insubordination. The statement further noted on 11-24-20 contact was made with Tenant #1's family member regarding an update on Tenant #1 as the Program was informed Tenant #1 was not a patient at the local hospital. The family member said Tenant #1 was at another hospital due to lack of ICU beds and that Tenant #1 had rhabdomyolysis. On 11-25-20 she received a call from a hospital social worker who asked if Tenant #1 had eaten breakfast that morning. The Director said Tenant #1 had eaten breakfast while she sat on the floor.

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In summary, Tenant #1 who was COVID-19 positive was seen on the ground by a friend who stopped by her window. The friend attempted to notify staff at the building without success and notified Tenant #1's family. A family member called the building without success and then texted the Director. Tenant #1 was assisted off the ground by a Hoyer lift and three staff and injuries were noted to her feet. Tenant #1 was assessed by a nurse and blisters were also noted to the BLE. Tenant #1 was sent to a local hospital and then transferred to a hospital out of the area. Hospital #1 records indicated estimated Tenant #1 was last seen well 14 hours prior and her injuries on her feet were due to the time down. Hospital #2 records indicated diagnoses included: fall, rhabdomyolysis, acute kidney injury, hyperkalemia, COVID-19, deep tissue injury, increased anion gap metabolic acidosis and hyperphosphatemia. She was found on the floor with multiple pressure wounds and an exposed tendon on the dorsum of the left foot. It would require major surgery with a free flap reconstruction. She was found in the prone position with an estimated time down of 14 hours. Tenant #1 was discharged from the hospital on 12-7-20 to a hospice house for end of life care and died on 12-10-20. Visual checks were not documented as completed at the scheduled times on three shifts before Tenant #1 was assisted from the ground on 11-23-20. Staff interviews and statements indicated Tenant #1 was seen putting on her shoes at the end of her bed at 5:20 a.m. and was on the floor when staff completed the first check on the first shift. The incident report date and time was 11-23-20 at 11:25 a.m. Staff did not complete report with off-going and on-coming staff and failed to notify the nurse of

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A 013	Continued From page 31 an incident. Staff interview indicated Tenant #1 declined assistance to get up off the floor. The nurse was not notified of Tenant #1 on the floor and interventions were not provided related to her safety and well-being. On Saturday before the incident Tenant #1, who was COVID-19 positive was diaphoretic, was not herself, had a loss of appetite and had to be lowered to the ground by staff. The nurses denied notification of the incident. Tenant #1 was not assessed by a nurse for the condition change over the weekend. Tenant #1's family was not notified of Tenant #1's condition in the days prior to the incident on 11-23-20. Family and a friend of Tenant #1 had attempted multiple times to contact the building in the days prior to the incident, mostly without success. Tenant #1's family was informed on 11-23-20 at 8:30 a.m. that Tenant #1 was fine despite Tenant #1 being on the floor when the text message was sent. The nurse assessment completed on 11-23-20 indicated Tenant #1 had no complaints of pain when the wounds were dressed, despite exposed tendon and vitals were indicated as normal. Tenant #1 was noted as hypotensive at the hospital. Tenant #1, who had severe cognitive deficit, who's service plan reflected she needed assistance with decision making and was COVID-19 positive, was not assisted up off the floor for hours, nor was assessed by a nurse until Tenant #1's family notified the Program that Tenant #1 was seen on the floor by a friend that stopped by her window. Tenant #1 did not receive services that were adequate and appropriate.	A 013		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number	A 055		

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A 055	Continued From page 32 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 observation, interview and record review the Program failed to provide sufficient staffing to meet a tenant's identified needs. This pertained to 1 of 1 tenant reviewed that eloped (Tenant #2). Findings follow: Record review revealed an Incident Report dated 9-6-20 indicated staff let Tenant #2 outside to walk around. Staff went outside to check on Tenant #2, he was not found and had eloped. Police and emergency medical services were notified to assist in bringing Tenant #2 back to the building. Tenant #2 returned to the building with no injuries. Continued record review on 12-7-20 to 12-16-20 of Tenant #2's file indicated diagnoses included: vascular dementia and Alzheimer's disease. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #2's service plan in place at the time of elopement indicated he required 24 hour supervision and visual checks. Tenant #2 preferred to walk outside. It identified Tenant #2 was an elopement risk and if he eloped to follow at a safe distance, encourage him to return to the building and call other staff for assistance. The service plan reflected #2 demonstrated deficits in judgement related to safety and preferred assistance with decision making.	A 055		

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A 055	Continued From page 33 The weather conditions on 9-6-20 between 4:00 p.m. and 5:00 p.m. at the Davenport Municipal Airport were as follows: temperature was 88 degrees, winds were from the south southwest at 16 miles per hour (mph) with gusts to 33 mph, relative humidity was 52% and visibility was clear, there was no cloud cover or precipitation. When interviewed on 12-17-20 at approximately 2:30 p.m. Nurse #1 said she was contacted by staff who could not locate Tenant #2. Staff had taken him outside in the courtyard and staff went inside and took her eyes off of him briefly. Nurse #1 and the Director were both notified. The Director took over and Nurse #1 was notified when Tenant #2 was found. Nurse #1 did not know where he was located and estimated the time Tenant #2 was gone was approximately 15 minutes. She said it was believed Tenant #2 exited through an opening in the fence (damaged from a storm). Tenant #2 did not sustain any injuries. She said staff was educated on the policy and staff should not have left him unattended. When interviewed on 12-22-20 at 1:42 p.m. the Director said on 9-6-20 at 4:30 p.m. she was notified by Staff K that Tenant #2 was in the courtyard and had eloped. She told Staff K to call 911 and she had already called. She was told they had been outside and another tenant set off a door alarm on the A side door. Staff K turned away from Tenant #2 and he was gone. There was a fence damaged from a storm and he squeezed through a fence. It was an assumption that he left through the fence. All gates in the courtyard were secured. Staff K called back and told the Director Tenant #2 was located a street over and the police helped bring him back to the building. He crossed 46th street and it was estimated he was gone 10 minutes. Tenant #2	A 055		

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A 055	Continued From page 34 returned to the building with no injuries. At some point notifications were made to administrative staff and management company staff. Tenant #2's family was also notified. Tenant #2 had no prior elopements; however, had exit seeking behavior prior to the incident. Verbal education was provided to Staff K and there was an in-service related to elopements. Observation on 12-15-20 at approximately 10:15 a.m. revealed a portion of the west facing courtyard fence was damaged and a chain link fence with padlocks was placed over the damaged fence. When interviewed on 12-15-20 at approximately 10:15 a.m. Staff I reported Tenant #2 eloped through the damaged portion of the fence and it was repaired the next day. She said the damage occurred during a severe storm in the area (8-10-20). In summary, Tenant #2 eloped on 9-6-20 and it presumed he exited through a damaged portion of the courtyard fence. The fence was damaged in a storm on 8-10-20 and was not temporarily repaired until nearly a month later and after Tenant #2 eloped. The fence had a temporary repair of chain link fence over the damaged fence when observed and was awaiting permanent repair with a contractor.	A 055		
A 061	481-67.9(4)d Staffing 481-67.9(231B,231C,231D) 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	A 061		

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shall, at a minimum, include the following:
d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to ensure staff received training on all service plan tasks. This pertained to 4 of 4 staff reviewed that assisted with the tasks (C, E, F and H).

1. Record review of Tenant #2's file on 12-7-20 to 12-16-20 revealed service plans dated 10-22-20, 11-11-20 and 11-20-20 (dates provided by the Program) reflected Tenant #2 had a continuous glucose reader attached to his stomach and to change approximately every 10 days when the meter indicated a change. Tenant #2 carried strips with him in his pocket. The service plans also reflected Tenant #2 had an order for Prothrombin Time and International Normalized Ratio (PT/INR) checks weekly on Fridays. The results needed to be called in and new orders would be received as needed.

2. Continued record review revealed the October 2020 medication administration records (MARs) reflected INR was to be completed one time weekly on Friday for atrial fibrillation with a start date of 10-9-20. It was documented as completed on 10-9-20 by Staff F, documented as completed by Staff E on 10-23-20 and Staff C on

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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 061	Continued From page 36 10-30-20. There was also one other entry documented on 10-16-20 by a staff not listed on the current staff signature key. On the November 2020 MARs, it was documented as completed by Staff H on 11-6-20 and Staff E on 11-13-20 and 11-20-20. 3. Further record review revealed the nurse delegations for Staff C, E, F and H did not reflect training for the service plan task that was documented as completed. The nurse delegation documents reflected training for a glucometer; however, did not reflect nurse delegated training on the continuous glucometer for Tenant #2. 4. When interviewed on 12-21-20 at 3:08 p.m. the Clinical Care Coordinator reported the nurses completed the INR. 5. When interviewed on 12-22-20 at 1:42 p.m. the Director said the nurses completed the INR. She also said Tenant #2 was the only tenant who had the INR completed in house and had a continuous glucometer.	A 061		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.	A 118		

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A 118	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete background checks for prospective employees prior to employment. This pertained 3 of 5 staff reviewed that did not require a request check evaluation staff reviewed (Staff B, C and D). Findings follow: 1. Record review of Staff B's training documents on 12-3-20 and 12-7-20 revealed Staff B was hired on 9-30-20. A criminal history background check was on 10-12-20 and indicated further research was needed and no record was found on 10-13-20. The abuse registries background check was completed on 10-12-20 and revealed no results were found. Continued record review revealed timecard records for Staff B indicated she first worked 9-30-20. Nurse delegated training tasks were documented as completed on 10-6-20; prior to the completion of the background check. 2. Record review of Staff C's training documents on 12-3-20 and 12-7-20 indicated Staff C was hired on 6-22-20. A criminal history background check and abuse registries background check was not completed. At the time of the onsite a background check for Staff C had not been completed. Continued record review revealed timecard records for Staff C indicated she first worked on 6-22-20. 3. Record review of Staff D's training documents on 12-3-20 and 12-7-20 revealed Staff D was	A 118		

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A 118	Continued From page 38 hired on 9-10-20. A criminal history background check and abuse registries background check was completed on 9-10-20 at 11:01 a.m. and no results were found. Continued record review revealed timecard records for Staff D indicated she first worked on 9-10-20 from 9:00 a.m. to 5:00 p.m., which was prior to the completion of the background check on 9-10-20 at 11:01 a.m. 4. When interviewed on 12-22-20 at 1:42 p.m., the Director revealed no additional background check information available for the staff reviewed. Staff C's background check was not found.	A 118		
A 121	481-67.19(3)c Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to request the Department of	A 121		

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A 121	Continued From page 39 Human Services (DHS) complete an evaluation to determine if employment was prohibited for a person considered for employment. This pertained to 1 of 1 staff reviewed that required a record check evaluation (Staff A). Findings follow: 1. Record review on 12-3-20 and 12-7-20 of Staff A's training documents indicated Staff A was hired on 9-7-20. A criminal history background check and abuse registries background check was completed on 9-3-20. No records were found on the abuse registry background check and further research was indicated on the criminal history background check. The Iowa Record Request Form S indicated a record was found on 9-9-20. The evaluation by DHS was not completed. The Record Check Evaluation form was signed by Staff A on 12-2-20 (the date employee files were requested). 2. Continued record review revealed timecard records for Staff A indicated she first worked on 9-7-20. 3. When interviewed on 12-22-20 at 1:42 p.m. the Director revealed there was no additional background check information available for Staff A.	A 121		
A 071	481-69.25(1)i Tenant Documents 481-69.25(231C) 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	A 071		

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A 071	Continued From page 40 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 document nurses' notes by exception. This pertained to 2 of 4 tenants reviewed (Tenants #2 and #3). Findings follow: 1. Record review on 12-7-20 to 12-16-20 of Tenant #2's file reveled a new order was received for hospice services on 11-20-20. A new order was received on 11-25-20 for Atropine 1% drops, under the tongue, for terminal secretions. Progress Notes dated 11-26-20 (move out note) indicated Tenant #2 died on 11-26-20. A Program document reflected Tenant #2 tested positive for COVID-19 on 11-24-20. Nurses' notes were not completed with Tenant #2's positive test for COVID-19 or with what occurred with Tenant #2's health from his admission to hospice on 11-20-20 until his death on 11-26-20. Nurses' notes were not completed by exception. 2. Record review on 12-10-20 to 12-16-20 of Tenant #3's file revealed Tenant #3 received hospice services. Progress Notes dated 9-24-20 reflected Tenant #3 complained of pain to the head/neck area and went to the emergency room (ER) for evaluation. The next health status note dated 9-26-20 indicated Tenant #3 was not eating or taking medications and was in a lot of pain. The note referenced Tenant #3 going to the ER two days prior. A nurses' note was not completed	A 071		

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A 071	Continued From page 41 regarding Tenant #3's return from the ER (9-24-20) and if there were any new orders received. Continued record review revealed ED Physician Notes (hospital records) indicated Tenant #3 was seen in the ER on 9-26-20 and 9-27-20. Further record review revealed Progress Notes dated 9-26-20 indicated Tenant #3 was sent to the hospital via ambulance on 9-26-20. The next health status note dated 9-27-20 indicated Tenant #3 returned from the hospital with hospice services. Nurses' notes were not completed with Tenant #3's return from the ER on 9-26-20 or when Tenant #3 was sent back out to the ER on 9-27-20. Nurses' notes were not completed by exception. 3. When interviewed on 3-15-21 at 11:30 a.m. the Director said all nurses' notes requested for the tenants reviewed were provided.	A 071		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) 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 develop service plans to reflect the identified needs of the tenants. This	A 089		

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A 089	Continued From page 42	A 089		

pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow:

1. Record review on 12-7-20 to 12-16-20 of Tenant #1's file revealed Progress Notes dated 11-5-20 indicated staff reported "significant" redness under Tenant #1's abdominal fold. The physician was notified and a request was made for Nystatin. Progress Notes dated 11-6-20 indicated an order was received for Nystatin to be applied to the rash twice daily as needed.

Continued record review revealed the November 2020 medication administration records (MARs) reflected the order for Nystatin cream 100,000 unit/gram, applied to rash topically every 12 hours as needed. The MARs did not reflect any doses of the cream administered, despite the note from 11-5-20 that indicated Tenant #1 had "significant" redness to her abdominal fold.

Further record review revealed Tenant #1's service plan dated 10-28-20 did not reflected the reddened area or treatment.

2. Record review on 12-7-20 to 12-16-20 of Tenant #2's file reflected Tenant #2 received hospice services. An Order Summary Report reflected an order dated 8-20-20 per nursing to check Tenant #2's blood glucose as needed when his continuous blood glucose monitor alarmed for a low blood glucose reading or when he presented with symptoms of low blood glucose. The service plan dated 11-20-20 reflected Tenant #2 had a continuous glucose reader attached to his stomach. The service plan did not reflect to check Tenant #2's blood glucose as needed when the continuous blood glucose reader alarmed.

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A 089	Continued From page 43 3. Record review on 12-10-20 to 12-16-20 of Tenant #3's file reflected Tenant #3 received hospice services. Progress Notes dated 10-8-20 indicated Tenant #3 was in a Broda chair with his chin to his chest. The service plan dated 10-1-20 reflected Tenant #3 received hospice services; however, did not include the services provided with the exception of nurse visits per their care plan. The service plan reflected Tenant #3 was independent with mobility. The service plan did not reflect the use of a Broda chair as indicated in Progress Notes. 4. Record review on 12-10-20 to 12-16-20 of Tenant #4's file reflected Tenant #4 received hospice services. Progress Notes dated 11-6-20 indicated new orders were received to discontinue medications including: aspirin 81 milligram (mg) and clopidogrel 75 mg. The service plan dated 10-28-20 reflected Tenant #4 was prescribed medications that caused bleeding and bruising. The service plan was not updated to reflect the discontinuation of the anti-coagulant medication. 5. When interviewed on 3-15-21 at 11:30 a.m. the Director confirmed the most recent service plans were provided for the tenants reviewed.	A 089		
A 096	481-69.27(1)c Nurse Review 481-69.27(231C) Nurse review. 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	A 096		

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A 096	Continued From page 44 health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(1)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 for tenants that were COVID-19 positive. This pertained to 4 of 4 tenants reviewed. (Tenants #1, #2, #3 and #4). Findings follow: 1. Record review on 12-7-20 to 12-16-20 of Tenant #1's file revealed Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Progress Notes dated 11-18-20 (late entry) indicated Tenant #1 tested positive for COVID-19. Tenant #1's family and physician were notified. Continued record review revealed a handwritten statement from Staff D was provided dated 11-25-20 indicated on Saturday morning Tenant #1 was sweating "ferociously." She called the nurse on-call and was told to check her vitals, ensure she was not hurt and then put her into bed. She asked for assistance from another co-worker to lift her and put her into bed. A nurse review was not completed related to	A 096		

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A 096	Continued From page 45 Tenant #1's COVID-19 positive status. 2. Record review on 12-7-20 to 12-16-20 of Tenant #2's file revealed Tenant #2 was staged at a six on the GDS, which indicated severe cognitive decline. A Program document reflected Tenant #2 tested positive for COVID-19 on 11-24-20. Tenant #2 died on 11-26-20. A nurse review was not completed related to Tenant #2's COVID-19 positive status. 3. Record review on 12-10-20 to 12-16-20 of Tenant #3's file revealed Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Progress Notes dated 11-16-20 (late entry) indicated Tenant #3 was tested for COVID-19 due to exposure and symptoms. The test was performed on 11-12-20 and returned with a positive result. A nurse review was not completed related to Tenant #3's COVID-19 positive status. 4. Record review on 12-10-20 to 12-16-20 of Tenant #4's file revealed Tenant #4 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Progress Notes dated 11-26-20 (late entry) indicated Tenant #4 tested positive for COVID-19. Tenant #4's family and physician were notified. A nurse review was not completed related to Tenant #4's COVID-19 positive status. 5. Continued record review revealed the Program had a COVID-19 outbreak with 24 tenants that had positive COVID-19 test results between 11-2-20 and 12-10-20 (date of tests). There were also eight staff that tested positive in that timeframe. The Former Healthcare Coordinator's last day of employment was 11-25-20.	A 096		

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A 096	Continued From page 46 6. When interviewed on 3-15-21 at 11:30 a.m. the Director confirmed all nurse reviews for the tenants requested were provided.	A 096		
A 097	481-69.27(1)d Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(1)d To provide the program with written documentation of the nurse review, showing the time, date and signature. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to note physician orders with time, date and signature. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Record review on 12-7-20 to 12-16-20 of Tenant #1's file revealed physician orders that were received were not noted with time, date and signature. 2. Record review on 12-7-20 to 12-16-20 of Tenant #2's file revealed physician orders that were received were not noted with time, date and signature.	A 097		

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A 097	Continued From page 47 3. Record review on 12-10-20 and 12-16-20 of Tenant #3's file revealed physician orders that were received were not noted with time, date and signature. 4. Record review on 12-10-20 and 12-16-20 of Tenant #4's file revealed physician orders that were received were not noted with time, date and signature. 5. Continued record review revealed the Program's policy and procedure for nurse review revealed for tenants receiving medication management the review would include: date, time, and signature of nurse that completed the review, it ensured health care professionals' orders were current, ensured that prescription orders are current, ensured that medications were administered consistent with orders and documentation that noted pharmacy and doctor reviews and frequency. 6. When interviewed on 12-21-20 at 3:08 p.m. the Clinical Care Specialist confirmed the above finding.	A 097		
A 118	481-69.29(4) Staffing 481-69.29(231C) Staffing 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons	A 118		

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A 118	Continued From page 48 who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document the completion of checks as indicated in the tenants' service plans. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Record review on 12-7-20 and 12-16-20 of Tenant #1's file indicated Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The service plan dated 10-28-20 reflected 24 hour supervision and visual checks were to be completed. Continued record review of the time stamped Documentation Survey Report for November 2020 indicated visual checks were documented as completed on 11-22-20 at the following times: the 3:00 p.m. and 4:00 p.m. checks were documented at 3:39 p.m., the 5:00 p.m. check was documented at 6:09 p.m., the 6:00 p.m. and 7:00 p.m. checks were documented at 6:39 p.m., the 8:00 p.m. check was documented at 8:12 p.m., the 9:00 p.m. and 10:00 p.m. checks were documented at 9:41 p.m., the 11:00 p.m. and 12:00 a.m. (on 11-23-20) were documented at 12:27 a.m. Visual checks were documented as completed on 11-23-20 at the following times: the	A 118		

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12:00 a.m. check was documented at 12:27 a.m. (as indicated above with the 11:00 p.m. check), the 1:00 a.m. and 2:00 a.m. checks were documented at 1:34 a.m., the 3:00 a.m. check was documented at 3:07 a.m., the 4:00 a.m. and 5:00 a.m. checks were documented at 4:36 a.m. and the 6:00 a.m. check was documented at 6:00 a.m. Visual checks were documented as completed on 11-23-20 at the following times: the 7:00 a.m., 8:00 a.m., 9:00 a.m. and 10:00 a.m. checks were documented at 11:57 a.m. The 11:00 a.m. check was documented at 12:51 p.m.

2. Record review on 12-7-20 to 12-16-20 of Tenant #2's file indicated Tenant #2 was staged at a six on the GDS, which indicated severe cognitive decline. Tenant #2's service plan dated 11-20-20 reflected 24 hour supervision and visual checks in memory care.

Continued record review of Tenant #2's time stamped Documentation Survey Report for November 2020 indicated visual checks were not documented as completed on 11-1-20, 11-5-20, 11-12-20, 11-15-20, 11-19-20, 11-22-20 and 11-24-20 at 11:00 p.m. On 11-4-20 the 3:00 a.m., 4:00 a.m., 5:00 a.m. and 6:00 a.m. checks all reflected the same time of 6:09 a.m. On 11-14-20 the 3:00 a.m., 4:00 a.m., 5:00 a.m. and 6:00 a.m. checks all reflected the same time of 6:18 a.m. On 1-21-20 the 1:00 a.m., 2:00 a.m. and 3:00 a.m. checks were all documented at 2:52 a.m. The 4:00 a.m. check was documented at 6:06 a.m. and the 5:00 a.m. and 6:00 a.m. check were both documented at 6:07 a.m.

3. Record review on 12-10-20 to 12-16-20 of Tenant #3's file indicated Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #3's service

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	S0017	A. BUILDING: _____ B. WING _____	C 03/15/2021

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
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plan dated 10-1-20 reflected 24 hour supervision and visual checks in memory care.

Continued record review of Tenant #3's time stamped Documentation Survey Report for November 2020 indicated visual checks were not documented as completed on 11-13-20, 11-20-20 and 11-26-20 at 11:00 p.m. Visual checks documented as completed on 11-8-20 at 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m. and 6:00 a.m. all reflected the same time of 5:54 a.m. Visual checks documented as completed on 11-13-20 at 3:00 a.m., 4:00 a.m., 5:00 a.m. and 6:00 a.m. all reflected the time of 6:17 a.m. On 11-20-20 the 12:00 a.m. and 1:00 a.m. checks were both documented at 12:38 a.m., the 2:00 a.m., 3:00 a.m. and 4:00 a.m. checks were all documented at 3:52 a.m. and the 5:00 a.m. and 6:00 a.m. checks were both documented at 5:32 a.m.

4. Record review on 12-10-20 to 12-16-20 of Tenant #4's file indicated Tenant #4 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #4's service plan indicated 24 hour supervision and visual checks eight times per shift in memory care.

Continued record review of Tenant #4's file revealed the time stamped Documentation Survey Report for November 2020 indicated visual checks were not documented as completed on 11-1-20 from 7:00 a.m. through 2:00 p.m. Checks were also not documented as completed on 11-13-20, 11-20-20, 11-22-20, 11-26-20 and 11-29-20 at 11:00 p.m. Visual checks documented as completed on 11-8-20 at 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m. and 6:00 a.m. all reflected the time of 5:58 a.m. On 11-8-20 at the 3:00 p.m. and 4:00 p.m.

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A 118	Continued From page 51 visual checks were both documented at 4:10 p.m. The 5:00 p.m. and 6:00 p.m. were both documented at 6:31 p.m. The 7:00 p.m. and 8:00 p.m. visual checks were both documented at 7:38 p.m. 5. Further record review revealed the Program's policy regarding visual checks indicated for tenants with a GDS or four or greater, or as determined by the nurse, staff would complete eight visual checks per shift. 6. When interviewed on 12-21-20 at 3:08 p.m. the Clinical Care Specialist said the general expectation was that the check would be documented when it was completed. 7. When interviewed on 12-22-20 at 1:42 p.m. and 3-15-21 at 11:30 a.m. the Director said visual checks were to be completed eight times per shift and to be documented when completed. The preference was every hour and the policy reflected eight per shift.	A 118		
A 154	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure the building was wellmaintained. This pertained to 1 of 1 tenant reviewed that eloped (Tenant #2) and potentially affected all tenants (census of 25).	A 154		

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Findings follow:

1. Record review revealed an Incident Report dated 9-6-20 indicated staff let Tenant #2 outside to walk around. Staff went outside to check on Tenant #2, he was not found and had eloped. Police and emergency medical services were notified to assist in bringing Tenant #2 back to the building. Tenant #2 returned to the building with no injuries.

Continued record review on 12-7-20 to 12-16-20 of Tenant #2's file indicated diagnoses included: vascular dementia and Alzheimer's disease. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #2's service plan in place at the time of elopement indicated he required 24 hour supervision and visual checks. Tenant #2 preferred to walk outside. It identified Tenant #2 was an elopement risk and if he eloped to follow at a safe distance, encourage him to return to the building and call other staff for assistance. The service plan reflected #2 demonstrated deficits in judgement related to safety and preferred assistance with decision making.

The weather conditions on 9-6-20 between 4:00 p.m. and 5:00 p.m. at the Davenport Municipal Airport were as follows: temperature was 88 degrees, winds were from the south southwest at 16 miles per hour (mph) with gusts to 33 mph, relative humidity was 52% and visibility was clear, there was no cloud cover or precipitation.

When interviewed on 12-17-20 at approximately 2:30 p.m. Nurse #1 said she was contacted by staff who could not locate Tenant #2. Staff had taken him outside in the courtyard and staff went

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inside and took her eyes off of him briefly. Nurse #1 and the Director were both notified. The Director took over and Nurse #1 was notified when Tenant #2 was found. Nurse #1 did not know where he was located and estimated the time Tenant #2 was gone was approximately 15 minutes. She said it was believed Tenant #2 exited through an opening in the fence (damaged from a storm). Tenant #2 did not sustain any injuries. She said staff was educated on the policy and staff should not have left him unattended.

When interviewed on 12-22-20 at 1:42 p.m. the Director said on 9-6-20 at 4:30 p.m. she was notified by Staff K that Tenant #2 was in the courtyard and had eloped. She told Staff K to call 911 and she had already called. She was told they had been outside and another tenant set off a door alarm on the A side door. Staff K turned away from Tenant #2 and he was gone. There was a fence damaged from a storm and he squeezed through a fence. It was an assumption that he left through the fence. All gates in the courtyard were secured. Staff K called back and told the Director Tenant #2 was located a street over and the police helped bring him back to the building. He crossed 46th street and it was estimated he was gone 10 minutes. Tenant #2 returned to the building with no injuries. At some point notifications were made to administrative staff and management company staff. Tenant #2's family was
also notified. Tenant #2 had no prior elopements; however, had exit seeking behavior prior to the incident. Verbal education was provided to Staff K and there was an in-service related to elopements.

Observation on 12-15-20 at approximately 10:15 a.m. revealed a portion of the west facing

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courtyard fence was damaged and a chain link fence with padlocks was placed over the damaged fence.

When interviewed on 12-15-20 at approximately 10:15 a.m. Staff I reported Tenant #2 eloped through the damaged portion of the fence and it was repaired the next day. She said the damaged occurred with storm in the area (8-10-20).

When interviewed on 12-23-20 at 2:00 p.m. the Maintenance Coordinator reported the fence was damaged when a tree fell on it in a storm on8-10-20. The fence was repaired with the chain link after Tenant #2's elopement on 9/6/20. The area of the fence affected was 12 feet long. There was no other damage to the fence. The Program worked with a contractor to repair the fence.

When interviewed on 3-15-21 at 11:30 a.m. the Director reported the fence was still awaiting permanent repair due to the weather.

In summary, Tenant #2 eloped on 9-6-20 and it presumed he exited through a damaged portion of the courtyard fence. The fence was damaged in a storm on 8-10-20 and was not temporarily repaired until nearly a month later and after Tenant #2 eloped. The fence had a temporary repair of chain link fence over the damaged fence when observed and was awaiting permanent repair with a contractor.

2. Observation on 12-15-20 at approximately 10:15 a.m. revealed one of two exit doors from the dining area to the courtyard (in the front building) did not release when Staff I entered the code to exit through the door.

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A 154	Continued From page 55 When interviewed on 12-15-20 at approximately 10:15 a.m. Staff I said the door had not been working since the day prior (12-14-20) and maintenance staff would be out until 12-21-20. When interviewed on 12-23-20 at 2:00 p.m. the Maintenance Coordinator said the exit door into the courtyard was fixed on 12-18-20 and it was not a fire exit.	A 154		

COUNTRY MANOR
MEMORY CARE

April 23, 2021

Country Manor complaint visit, recertification, and infection control 12/1/20-3/15/21

Iowa Department of Inspection & Appeals
Catie Campbell
Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

To Whom It May Concern,

Please consider this our plan of correction for the regulatory insufficiency cited during 12/1/20-3/15/21 complaint visit, recertification, and infection control completed by the Department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 231C and Iowa Administrative Code, chapter 481-69, pertaining to regulatory insufficiencies.

481-67.2 Program policies and procedures
A003
481-67.2(1)d Program Policies and Procedures

481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

This requirement is not met as evidenced by the Program failed to follow established policy and procedures. (Nebulizer with COVID+ and Hand washing/Glove use)

1. **Elements detailing how the program will correct the regulatory insufficiency**.
    a. Resident #5's nebulizer was changed to an inhaler on 12/5/20.
    b. Staff members received counseling on Glove use and Handwashing Procedures.

2. **What measures will be taken to ensure the problem does not recur?**
    a. All staff will be reeducated on pandemic policies by 5/20/21.
    b. All staff will be redelegated on handwashing/glove use by 5/20/21.

3. **How the program plans to monitor performance to ensure compliance**.
    a. HCC, Director or designee will provide weekly spot checks for four weeks, then monthly as determined by the Director or designee to ensure continued compliance.

4. **Date by which the regulatory insufficiency will be corrected?**
    a. Regulatory Insufficiency will be corrected by 5/20/21.

481-67.2 Program policies and procedures
A007
481-67.2(1)d Program Policies and Procedures

481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

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.

1. **Elements detailing how the program will correct the regulatory insufficiency**.

    a. Director, or designee will ensure the incident reports have witness statements.
    b. Witness statements are in included in the Programs policy on Incident Reporting.

2. **What measures will be taken to ensure the problem does not recur?**

    a. All staff will be retrained on the completion of incident reports and witness statements by 5/20/21.

3. **How the program plans to monitor performance to ensure compliance**.

    a. HCC, Director or designee will review incident reports prior to locking them to ensure incident reports have witness statements when applicable as determined by the Director or designee to ensure continued compliance.

4. **Date by which the regulatory insufficiency will be corrected?**

    a. Regulatory Insufficiency will be corrected by 5/20/21.

481-67.3(2) Tenant Rights

COUNTRY MANOR
MEMORY CARE

A013
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.
The Program failed to provide care, treatment and services that were adequate and appropriate.

1. **Elements detailing how the program will correct the regulatory insufficiency**.
    a. Resident services provided will be documented.
    b. All staff will be educated on resident rights, services provided, and nurse notification.

2. **What measures will be taken to ensure the problem does not recur?**
    a. Director or designee will complete training with staff by 5/20/21 regarding documentation of services provided, resident rights, and nurse notification.

3. **How the program plans to monitor performance to ensure compliance**.
    a. Director or designee will review care/services documentation for missing or untimely documentation daily, weekly, monthly. as determined by the Director or Designee to ensure compliance.
    b. Director or designee will review incident reports and RN communication forms to ensure timely notifications are completed, daily, weekly, monthly, as determined by the Director or Designee to ensure compliance.

4. **Date by which the regulatory insufficiency will be corrected?**
    a. Regulatory Insufficiency will be corrected by 5/20/21.

481-67.9(231B,231C,231D) Staffing.
A055

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:

The Program failed to provide sufficient staffing to meet a tenant's identified needs.

1. **Elements detailing how the program will correct the regulatory insufficiency**.
    a. Director or designee will ensure sufficient staffing for residents' needs identified.

2. **What measures will be taken to ensure the problem does not recur?**
    a. Director or designee will provide education to staff regarding Elopement, Visual checks and supervision of residents.

3. **How the program plans to monitor performance to ensure compliance**.

a. Director or designee will monitor staffing levels to ensure residents' needs are met daily, weekly, monthly as determined by the Director or designee to ensure compliance.

4. **Date by which the regulatory insufficiency will be corrected?**
   a. Regulatory Insufficiency will be corrected by 5/20/21.

481-67.9(4)a Staffing
A061
481-67.9(231B,231C,231D) 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:

d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.

This Requirement is not met as evidenced by: The Program failed to ensure staff received training on all service plan tasks.

1. **Elements detailing how the program will correct the regulatory insufficiency**.

   a. New Registered Nurse was hired on 1/13/21, delegations have been completed with all current staff. New staff delegations are completed within 30 days of their hire date.
   b. Director or designee will ensure all staff are delegated on services plan tasks as needed.
   c. No current residents receiving in-house INR checks or continuous Glucose Monitoring.

2. **What measures will be taken to ensure the problem does not recur?**

   a. Director or designee will review current service plans to ensure staff are delegated on all services provided.

   b. Changes to residents Service Plans will be communicated to the direct caregivers daily, weekly, monthly, as needed, as determined by the Director or designee.

3. **How the program plans to monitor performance to ensure compliance**.

   a. Director or designee will review service plans daily, weekly, monthly, as needed, as determined by the Director or designee to ensure compliance.

4. Date by which the regulatory insufficiency will be corrected?

b. Regulatory Insufficiency will be corrected by 5/20/21.

481-67.19(3) Record Checks
A118
481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks.

67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.

This requirement is not met as evidenced by: The Program failed to complete background checks for prospective employees prior to employment.

1. **Elements detailing how the program will correct the regulatory insufficiency**.

   a. Director or designee completed employee file audits to ensure all current employees have proper record checks completed.

   b. Retraining and Education provided regarding background check procedure prior to employment.

   c. Director or designee will ensure all prospective employees have proper record checks completed prior to employment.

2. **What measures will be taken to ensure the problem does not recur?**
   a. Director or designee will utilize an employee checklist to ensure all prospective employees have proper record checks completed prior to employment.

3. **How the program plans to monitor performance to ensure compliance**.
   a. Director or designee will review new employee checklist daily, weekly, monthly, as needed, as determined by the Director or designee to ensure compliance.

4. **Date by which the regulatory insufficiency will be corrected?**
   a. Regulatory Insufficiency will be corrected by 5/20/21.

481-67.19(3) Record Checks
A118
481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks.

67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program.

This Requirement is not met as evidenced by: The Program failed to request the Department of Human Services (DHS) complete an evaluation to determine if employment was prohibited for a person considered for employment.

1. **Elements detailing how the program will correct the regulatory insufficiency**.

   a. Director or designee completed employee file audits to ensure all current employees have proper record checks completed.

   b. Retraining and Education was provided regarding background check procedure prior to employment.

   c. Director or designee will ensure all prospective employees have proper record checks completed prior to employment.

2. **What measures will be taken to ensure the problem does not recur?**
   a. Director or designee will utilize an employee checklist to ensure all prospective employees have proper record checks completed prior to employment.

3. **How the program plans to monitor performance to ensure compliance**.
   a. Director or designee will review new employee checklist daily, weekly, monthly, as needed, as determined by the Director or designee to ensure compliance.

4. **Date by which the regulatory insufficiency will be corrected?**

   a. Regulatory Insufficiency will be corrected by 5/20/21.

481-69.25(1) i Tenant Documents
A071
481-69.25(231C) 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: The Program failed to document nurse's notes by exception.

1. **Elements detailing how the program will correct the regulatory insufficiency**.
    a. Nurse or designee will complete documentation of health professionals' orders, treatment, therapy, and medication in each resident's health record, charting by exception as needed for each resident.

2. **What measures will be taken to ensure the problem does not recur?**
    a. Nurse or designee to receive education about charting by exception to include documentation of health professionals' orders, treatment, therapy, and medication as needed for each resident.

3. **How the program plans to monitor performance to ensure compliance**.
    a. Director, Nurse, or designee will review resident's health records daily, weekly, monthly, as needed, as determined by the Director or designee.

4. **Date by which the regulatory insufficiency will be corrected?**
    a. Regulatory Insufficiency will be corrected by 5/20/21.

481-69.26(1) Service Plans
A083
481-69.26(231C) Service plans. 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: The Program failed to develop service plans to reflect the identified needs of the tenants.

1. **Elements detailing how the program will correct the regulatory insufficiency**.
    a. Tenant # 1 no longer resides at Country Manor Memory Care.
    b. Tenant # 2 no longer resides at Country Manor Memory Care.
    c. Tenant # 3 no longer receives Hospice Care or uses a Broda Chair, service plan reflects current needs and preferences for assistance.
    d. Tenant #4 no longer resides at Country Manor Memory Care.

2. **What measures will be taken to ensure the problem does not recur?**
    a. Nurse or designee will receive education about development of service plans to reflect the identified needs of the tenants.

3. **How the program plans to monitor performance to ensure compliance.**
    a. Director, Nurse, or designee will review resident's service plans daily, weekly, monthly, as needed, as determined by the Director or designee.

4. **Date by which the regulatory insufficiency will be corrected?**
    a. Regulatory Insufficiency will be corrected by 5/20/21.

COUNTRY MANOR
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481-69.27(1)c Nurse Review
A096

481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:

69.27(1)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;

1. **Elements detailing how the program will correct the regulatory insufficiency**.
    a. Tenant # 1 no longer resides at Country Manor Memory Care.
    b. Tenant # 2 no longer resides at Country Manor Memory Care.
    c. Tenant # 3- Change of Conditions assessments have been completed 2 times in March 2021 for this resident related to condition changes.
    d. Tenant #4 no longer resides at Country Manor Memory Care.

2. **What measures will be taken to ensure the problem does not recur?**
    a. Nurse or designee education provided related to significant changes in residents conditions requiring assessments.

3. **How the program plans to monitor performance to ensure compliance**.

    a. Director, Nurse, or designee will review residents that have changes to their Cognitive, Functional, Physical, or Health status daily, weekly, monthly, as needed, as determined by the Director or designee.

4. **Date by which the regulatory insufficiency will be corrected?**

    a. Regulatory Insufficiency will be corrected by 5/20/21.

481-69.27(1)c Nurse Review
A097
481 69.27(231C) Nurse review. If a tenant does not receive personal or health related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:

69.27(1)d To provide the program with written documentation of the nurse review, showing the time, date and signature.

This requirement is not met as evidenced by: The Program failed to note physician orders with time, date, and signature.

1. **Elements detailing how the program will correct the regulatory insufficiency**.
    a. Resident documentation will be reviewed to ensure physician orders with time, date, and signature.
2. **What measures will be taken to ensure the problem does not recur?**
    a. Education provided to Nurse regarding noting of orders with time, date, and signature.

3. **How the program plans to monitor performance to ensure compliance**.
    a. Director or designee will review daily, weekly, monthly, as needed, as determined by the Director or designee that physicians' orders are noted with time, date and signature.

4. **Date by which the regulatory insufficiency will be corrected?**
    a. Regulatory Insufficiency will be corrected by 5/20/21.

481-69.29(4) Staffing
A118
481-69.29(231C) Staffing

69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the approximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans.

This requirement is not met as evidenced by the Program failed to document the completion of checks as indicated in the tenant's service plans.

1. **Elements detailing how the program will correct the regulatory insufficiency.**
    a. Residents with visual checks as determined by their service plans; based on their individual needs, with a GDS or 4 or higher, will receive visual checks timely.

2. **What measures will be taken to ensure the problem does not recur?**

    a. Staff education regarding visual checks, timeliness of checks, documentation of visual checks is being completed.

3. **How the program plans to monitor performance to ensure compliance.**

a. Director or designee will complete audits of visual check documentation for completeness and timeliness daily, weekly, monthly, as needed, as determined by the Director or designee.

4. **Date by which the regulatory insufficiency will be corrected?**
   a. Regulatory Insufficiency will be corrected by 5/20/21.

481-69.35(1)b Structural Requirements
A154
481-69.35(231C) Structural requirements.

69.35(1) General requirements.
b. The buildings and grounds shall be well-maintained, clean, safe and sanitary.

The requirement is not met as evidenced by the Program failed to ensure the building was well maintained.

5. **Elements detailing how the program will correct the regulatory insufficiency**.
   a. Fencing area was permanently fixed March 2021.
   b. Courtyard door was fixed 12-18-20.

6. **What measures will be taken to ensure the problem does not recur?**
   a. Director or designee will ensure community is well-maintained, clean, safe and sanitary.

7. **How the program plans to monitor performance to ensure compliance**.
   a. Director or designee will complete a walk through of community/grounds daily, weekly, monthly, as needed, as determined by the Director or designee.
   b. Director or designee will note items requiring attention and will schedule appropriate servicing.

8. **Date by which the regulatory insufficiency will be corrected?**
   a. Regulatory Insufficiency will be corrected by 05/20/21.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Thank you for your time and consideration in correcting these important matters.

Sincerely,

M Lewis

Miranda Lewis, Community Director