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
	S0470	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW OF DAVENPORT MC	5330 BELLE AVENUE DAVENPORT, IA 52807

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A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 2 Total census of Assisted Living Program: 2 The following regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia. Regulatory insufficiencies were also cited during the investigation into Complaint #117891-C, Complaint #117574-C and Complaint #116989-C.	A 000		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program's Health Services Director failed to treat 1 of 2 discharged tenants reviewed in a considerate manner (Tenant C2). Findings include: Record review of the program communication log	A 155		

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A 155	Continued From page 1	A 155		

on 1/23/24 revealed an entry dated 12/17/23 in which staff documented the Health Services Director (HSD) told staff to stop feeding Tenant C2 so much or his medication would wear off.

On 1/23/24 at 4:13 PM Staff A reported she was present when the HSD came in to evaluate Tenant C2 after a hospitalization. Tenant C2 was sent to the hospital after he punched Staff A the previous day. Tenant C2 had a tendency to pull out his privates and he did so on 12/17/23 in front of the HSD. The HSD reportedly told Tenant C2 I've seen more dick than most prostitutes when Tenant C2 exposed himself. Tenant C2 seemed really medicated on his return. Tenant C2 was able to drink and eat if staff fed him. The smell of his urine was strong. The HSD told Staff A and her co-worker, Staff B, they didn't need to force feed Tenant C2. It did not look like Staff B was force feeding Tenant C2 in her opinion, it just looked like Tenant C2 was starving. On this day they had to move Tenant C2, who was usually ambulatory, via wheelchair because he was so wobbly. The HSD did tell Staff B not to give Tenant C2 food or water because the Lorazepam given to him in the hospital (medication to address anxiety) would wear off. Staff always gave Tenant C2 a half pill of Lorazepam. The HSD said if it was her she would give him the whole pill both times it was administered. Staff A thought the HSD was being completely honest about giving Tenant C2 a whole pill, rather than the doctor-ordered half pill.

On 1/23/24 at 9:05 AM, Staff B reported she was with Tenant C2 when the HSD came in to assess the tenant after his hospitalization. She called the Executive Director because Tenant C2 was in his bed and appeared lethargic with his tongue at the back of his mouth. The Executive Director told

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A 155	Continued From page 2 Staff B to keep giving Tenant C2 his medicine and Staff B was uncomfortable doing so as Tenant C2 had issues with swallowing. When the HSD arrived, she said to quit giving Tenant C2 food or water because it was making his medication wear off and doing so would not cause him to die. Tenant C2 started to pull out his penis and the HSD said I've seen more penises than a prostitute. On 1/23/24 at 3:20 PM the Executive Director reported she did receive a call from a caregiver expressing concerns about the incident involving Tenant C2 on 12/17/23. She thought the caregiver did not agree with the HSD's nursing assessment. When the Executive Director reviewed the incident with the HSD, the HSD's explanations about her interactions with Tenant C2 seemed to make sense. The HSD denied making inappropriate comments to Tenant C2.	A 155		
A 175	481-67.3(5) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67/3(5) To receive from the manager and staff of the program a reasonable response to all requests. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide a timely response regarding restricted visitation for 1 of 2 discharged tenants' reviewed (Tenant C1). Findings include: Record review on 1/23/24 of progress notes	A 175		

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A 175	Continued From page 3	A 175		

dated 11/3/23 revealed an incident which occurred between Tenant C1's spouse and a caregiver. The caregiver notified the Registered Nurse (RN) of an incident in which the spouse's demeanor made the caregiver feel uncomfortable. The Executive Director discussed the situation with the spouse who was notified she may not come into the community at that time. It was discussed the local ombudsman should be notified of the incident. The RN called the Iowa Department of Aging (not the ombudsman) and left a message.

On 1/23/24 at 3:20 PM the Executive Director reported she kept in touch with her leadership team about the issue with visitation between Tenant C1 and his spouse. The Executive Director spoke with the Regional Director of Operations on 11/17/23 as they had not received a call back from the ombudsman's office. The Executive Director contacted the ombudsman on 11/20/23. Tenant C1's spouse made the decision on 11/22/23 to move the tenant from the program.

The spouse shared emails she exchanged with the Executive Director and her boss. On 11/17/23, the spouse emailed the Executive Director to report it had been two weeks since the RN called the ombudsman. The spouse asked if anyone had followed up. She reported her concern the following week was Thanksgiving and wanted to see her husband. On 11/22/23, the spouse contacted the Regional Director of Operations to find out if a decision was made about being able to see her husband. The spouse discharged her husband from the program on 11/29/23.

On 1/23/24 at 11:00 AM, the Corporate RN reported it was not appropriate for the Executive

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A 175	Continued From page 4 Director to suspend visitation for Tenant C1's spouse. On 1/23/24 at 4:20 PM the Regional Director of Operations said she wished the situation with Tenant C1 and his wife had been handled more quickly by getting visits started between the tenant and his wife. Her understanding was the program was trying to monitor the safety and comfort of staff.	A 175		
A 245	481-67.5(2)a Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: a. The program shall not prohibit a tenant from self-administering medications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program did not allow 1 of 2 discharged tenant's legal representatives to administer medication when requested (Tenant C1). Findings include: Record review on 1/23/25 revealed a progress note for Tenant C1 dated 7/30/23 detailing an interaction from 7/25/23 between Tenant C1's spouse, the Corporate Consultant Nurse and the Director of Health Services (DHS). The DHS informed the spouse she needed to discuss some new orders provided by the Veteran's Affairs (VA) Nurse and the monthly bill. The DHS informed the spouse she received additional training and learned there would be new charges for Tenant C1 as he took over 10 medications which staff administered to him. The VA nurse called with	A 245		

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A 245	Continued From page 5	A 245		

new orders that would increase medication passes to four times daily. The program rent included staff administering up to 10 medications and twice daily medication passes. Tenant C1's spouse was very upset with these changes. The Corporate Consultant Nurse told the spouse she was shown all these charges when she signed the occupancy agreement (there was no signed occupancy agreement in the record) when Tenant C1 moved to an apartment in the memory care unit.

The spouse stated she would be completing Tenant C1's wound care and the Corporate Consultant Nurse said that was fine. The wound care items would need to be stored in medication cart in memory care and when the spouse arrived she could perform wound care.

A progress note dated 7/26/23 documented another interaction between the spouse, Corporate Consultant Nurse and the DHS. The spouse asked if she could administer Tenant C1's over the counter medications and the program staff told her she could not do so. The spouse was informed it was not safe to have staff administering some medications for Tenant C1 and another party administering over medication.

The program had a Medication Management in Assisted Living IA policy which noted tenants have the right to self administer their own medications unless otherwise ordered by their physician or the tenant or the tenant's legal representative delegates the responsibility to the assisted living program.

On 1/25/23 at 1:30 PM the Corporate RN confirmed the program kept Tenant C1's legal representative from administering his medication.

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A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to administer medication as prescribed to 2 of 2 current tenants (Tenant #1 and Tenant #2). Findings follow: 1) Record review on 1/23/24 revealed a progress note for Tenant #1 dated 1/1/24 in which the Corporate RN received a new medication order to start Torsemide 40mg. twice daily and discontinue the Lasix he was taking. The Corporate RN entered the medication change into the electronic record. A review of the January Medication Sheet for Tenant #1 revealed he received Lasix from 1/1/24 - 1/24/24. Tenant #1 did not receive Torsemide as of 1/24/24. The program did not start the Torsemide as ordered or stop administering Lasix. 2) A progress note dated 10/9/23 identified Tenant #2 went to the doctor on 10/6/23 and had an order for Seroquel. According to My.ClevelandClinic.org, Seroquel is a medication	A 285		

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A 285	Continued From page 7 which balances the levels of dopamine and serotonin in your brain. These hormones help regulate your mood, behaviors and thoughts. Tenant #2's son was asked to obtain an order by the Executive Director. On 10/24/23 the Register Nurse (RN) documented she placed a call to Tenant #2's doctor and spoke with the nurse about the Seroquel. The RN asked the doctor to send an order to the program so they could administer the medication. The program received an order from Tenant #2's physician on 10/25/23 allowing them to administer the medication. A review of Tenant #2's October Medication Sheet revealed she did not receive her first dose of Seroquel until 10/26/23, 20 days after it was initially prescribed. The Corporate RN confirmed these findings on 1/25/24 at 1:30 PM.	A 285		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by:	A 350		

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A 350	Continued From page 8 Based on interview and record review, the program failed to update a service plan for 1 of 2 current tenants reviewed (Tenant #1) and 1 of 2 discharged tenants reviewed (Tenant C2) when they began to display inappropriate behaviors. Findings include: 1) Record review on 1/23/24 revealed the following communication log entries regarding Tenant #1: - Tenant #1 came out of his apartment naked at 2:30 AM. He refused to go back to his room to get dressed. He was verbally aggressive. - On 12/20/23, Tenant #1 urinated on the wall, walker and floor in his living room and seemed very confused all day. - Tenant #1 was rude and yelled at staff on 12/24/23. - Tenant #1 was in the hallway naked from the waist down. - On 12/27/23, Tenant #1 was rude and cursing at staff. - Tenant #1 urinated on his living room floor on 1/6/24. - On 1/22/23, Tenant #1 yelled at staff because he could not take off his clothing in the common area. Tenant #1 had a Resident Service Agreement (service plan) dated 12/11/23. Tenant #1's service plan did not address toileting, inappropriate urination or yelling at staff. 2) Record review of communication log entries revealed the following for Tenant C2: - On 12/2/23, Tenant C2 was wandering all night. He wiped feces on the wall and urinated in the corner. Tenant C2 resisted his cares and required 1:1 supervision. - On 12/3/23, Tenant C2 was unable to	A 350		

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A 350	Continued From page 9 communicate his needs, urinated on the floor and tables and had not slept for 24-hours. Tenant C2 was sent to the hospital. - On 12/7/23, Tenant C2 urinated on a chair. - Tenant C2 urinated on his apartment floor on 12/8/23. - On 12/9/23, Tenant C2 was very aggressive. - Tenant C2 was noted to still be hitting staff on 12/12/23. - Tenant C2 spoke inappropriately to staff and urinated on a chair on 12/13/23. - On 12/20/23, Tenant C2 was very confused and urinated at the table. - On 12/21/23, Tenant C2 was noted to have urinated all over his floor and ottoman throughout the night. - On 12/24/23, Tenant C2 was very violent, poured other tenant's drinks out, hit staff and urinated on the floor of his apartment and in the hallway. - Tenant C2 urinated on the floor on 12/28/23. He punched and slapped staff and said he would kill staff. Tenant C2 had a service plan dated 12/1/23. His service plan identified he required assistance with toileting. Staff were to take him to the toilet four times a day and encourage him to use it. The service plan did not identify interventions to prevent Tenant C2 from urinating in inappropriate places. The service plan did not identify any interventions to assist Tenant C2 with his aggression. The Corporate Nurse confirmed these findings on 1/25/24 at 1:30 PM.	A 350		
A 355	481-69.26(2) Service Plans	A 355		

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A 355	Continued From page 10 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to have 1 of 2 discharged tenants (Tenant C1) sign an occupancy agreement prior to admission. Findings follow: Record review on 1/23/24 revealed a progress note for Tenant C1 on 6/29/23 which identified Tenant C1 moved from the Assisted Living Program to an apartment on the memory care unit. The memory care unit had a separate licensure and required the signing of a new occupancy agreement. One could not be found in Tenant C1's record. The Executive Director confirmed this finding on 1/25/23 at 2:50 PM.	A 355		