Iowa Department of Inspections and Appeals
Assisted Living Program
Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 13230, 13229, & 13259**

Mr. Tanner Nippoldt, Administrator
Shores at Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, IA 50327

Date of Investigation:

November 6 & 7, 2006

Monitor(s):
Hal L. Chase, RN BSN MPH
Connie Schaffer

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Shores at Pleasant Hill on November 6 & 7, 2006. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* **–** A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder: 5

Dementia Specific Program (DSP)* **–** A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting: 6

Total Population: 11

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Complaint History – There were no substantiated complaints during the certification period.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

During the course of the investigation, it was determined the program did not evaluate tenants' functional, cognitive and health evaluations as needed, within 30 days as required and did not consistently complete health evaluations prior to admission.

- Monitoring Observation: Tenant #1, an 80 year old, was admitted on 9-1-06 with diagnoses of History of Rib Fractures related to falls, Dementia Mental Status Changes, Pacemaker, Hallucinations, Insomnia, Congestive Heart Failure (CHF), Hypothyroidism, Depression, Anxiety, Myocardial Infarction (MI) and Coronary Heart Disease. The program completed a functional, cognitive and health evaluation prior to admission but did not complete a functional, cognitive and health evaluation within 30 days as required. The current functional and health evaluation was completed on 11-1-06, and a cognitive evaluation was completed on 11-3-06. The tenant was staged at 4.2 on the Global Deterioration Scale (GDS) indicating moderate cognitive decline. Health Profile notes of 9-15-06 indicated a change in the tenant's status. On 9-15-06 the tenant was angry and wanting to go home. The tenant was seen walking toward the door. On 9-16-06 the tenant was seen pacing the halls and wanting a ride home. On 9-20-06 the tenant had a small skin tear to the right elbow. The registered nurse (RN) applied a dressing to the wound. On 9-24-06 staff noted the skin tear had increased in length to approximately five to six centimeters. Telfa and "Coban" was applied and the RN ordered steri-strips to be applied. On 10-20-06 the tenant was noted to be "extremely confused," wandering into other tenant apartments and sleeping in their beds. On 10-23-06 the tenant is noted to be "highly anxious," and standing by the exit door. The tenant stated "you are not going to keep killing me with those things," when medications were given to the tenant. On 11-6-06 the tenant was "exhibiting excessive wandering et exit seeking behaviors." The tenant continues to wander from door to door "attempting to go home." On 11-7-06 the tenant was seen wandering to other apartments and frequently needing redirection. Despite completing a functional and health evaluation on 11-1-06 and a cognitive evaluation on 11-3-06, the program did not complete these evaluations within 30-days and in a timely manner when a change in status occurred.

  Tenant #2, an 87 year old, was admitted on 8-12-06 with diagnoses of Alzheimer's Disease, Enlarged Prostrate, Diverticulosis, Arthritis, Non-Insulin Dependent Diabetes Mellitus, Emphysema, Chronic Obstructive Pulmonary Disease (COPD) and Shortness of Breath (SOB). The tenant was staged at 3.8 on the GDS indicating moderate cognitive decline. Despite completing a functional and cognitive evaluation prior to admission, the program did not complete a health evaluation prior to admission and did not complete a functional, cognitive and health evaluation within 30-days of admission as required.

  Tenant #3, a 77 year old, was admitted on 9-18-06, with diagnoses of Dementia, Arthritis, MI, Hypertension (HTN) and Coronary Artery Disease (CAD). The program completed a functional, cognitive and health evaluation prior to admission but did not complete a functional, cognitive and health evaluation within 30 days as required. The tenant was staged at 3 on the GDS indicating mild cognitive decline.

Health Profile Notes of 9-29-06 indicated a change in the tenant's status. On 9-29-06 the tenant was depressed and crying in his/her room and would not come to the dining room for meals. On 9-28-06 the program updated the service plan to include escorts to activities and meals as needed. On 10-3-06 the program and family met and agreed to update the service plan to include additional services. Despite a change in status, the program did not complete a functional, cognitive and health evaluation within 30 days as required and in a timely manner when a change in status occurred.

Tenant #4, a 77 year old, was admitted on 9-26-06 with diagnoses of CAD, Congestive Cardiomyopathy, HTN, Kidney Stones, Dementia, a Pacemaker, and Cataracts. The tenant's last functional, cognitive and health evaluation was completed on 10-31-06. The tenant was staged at 5.2 on the Global Deterioration Scale (GDS) indicating moderately severe cognitive decline. Health Profile Notes beginning 9-28-06 indicated a change in the tenant's status. On 9-28-06 the tenant was wandering the halls a couple of times throughout the night. On 10-4-06 the tenant was extremely aggressive, banging the apartment window with his/her walker. The tenant had the screen out and "was attempting to go home." On 10-16-06 the tenant's spouse was concerned about the tenant's inability to use his/her right leg. According to notes the RN completed a physical assessment and noted a large ecchymotic area covering the tenant's right hip and lateral thigh. The program updated the tenant's service plan on 10-19-06 and added services which included one to two hour toileting and assist with ambulation. Incident reports of 10-5-06, 10-11-06, 10-12-06, 10-16-06, 10-22-06, and 10-30-06 reported the tenant had fallen. Health Profile Notes of 11-5-06 and 11-6-06 record four entries where the tenant was found on the floor on five separate occasions with staff recording these entries as falls. Injuries related to these falls were sustained on 10-11-06, 10-12-06 and 10-30-06. Despite a change in status evidenced by falls and injuries from 10-5-06 through 10-30-06, and updating the service plan on 10-19-06, the program did not, in a timely manner, complete a functional, cognitive and health evaluation until 10-31-06, well after a status change occurred.

Tenant #5, a 78 year old, was admitted on 8-7-06 with diagnoses of Back Pain, Cataracts, History of Falls, Heart Disease, HTN, Urinary Tract Infection, Alzheimer's disease, Gastro Esophageal Reflux Disease, Depression and Sensory Deficits. The tenant's current functional, cognitive and health evaluations were completed on 10-31-06. The tenant was staged at 5.2 on the GDS indicating moderately severe cognitive decline. The tenant sustained falls and injuries related to ambulating without a standby assist. Incident reports of 9-4-06, 9-11-06, 9-19-06, 9-21-06, 9-24-06, 10-1-06, 10-8-06, 10-11-06, 10-16-06 and10-24-06 indicated the tenant was found on the floor from suspected or witnessed falls. Injuries related to falls occurred on 9-4-06 and 9-24-06. Health Profile notes of 9-22-06 indicated the RN requested from the tenant's physician a Physical Therapy and Occupational Therapy (PT/OT) consult. On 9-28-06 an order was received for a PT/OT consult for strengthening and gait training. On 10-6-06 PT/OT completed an evaluation and agreed to provide exercises and strengthening to be given two to three times weekly. Despite a change in status as evidenced by falls and injuries from 9-4-06 through 10-24-06, an updated service plan of 9-14-06, and PT/OT beginning 10-6-06, the program did not, in a timely manner, complete a functional, cognitive and health evaluation until 10-31-06, well after a status changed occurred.

Tenant #6, an 87 year old, was admitted on 8-7-06, with diagnoses of Dementia, History of Left Hip Fracture, Right Hip Fracture, Right Knee Cap Fracture, History of Heart Attack, Breast Cancer, Mastectomy, Arthritis, History of Stroke and Irregular Heartbeat. The tenant was staged at 4.4 on the GDS indicating moderate cognitive decline. The program completed a functional and cognitive evaluation on 8-1-06, which was prior to admission, but did not complete a health evaluation prior to admission. The program completed a functional evaluation on 10-30-06 and a cognitive and health evaluation on 10-31-06. The program did not complete the evaluations within 30 days as required. Health Profile notes beginning 8-21-06 indicated a change in the tenant's status. On 8-21-06 the tenant's son reported the tenant has a history of hallucinating and "seeing people." On 8-25-06 the tenant tells the RN he/she sees blood and something red, in the toilet. The RN stated there was nothing present in the toilet. On 9-7-06 the tenant is demonstrating "exit seeking behaviors." On 10-5-06 the tenant continues to have frequent moments of paranoia and thinks staff and family are stealing items for his/her apartment. Despite a change in status evidenced by the tenant's hallucinations and continual paranoia, the program did not, in a timely manner, complete a functional, cognitive and health evaluation until 10-30-06 and 10-31-06, well after a status changed occurred.

- Regulatory Insufficiency: The program did not consistently evaluate tenants' functional, cognitive and health status prior to taking occupancy, within 30 days of taking occupancy and as needed with a change in status.

B. Tenant Documents – Program maintains a complete file for each tenant containing all appropriate documentation. [321 IAC 25.27]

Complaint Allegation: It is alleged the program is shredding documents related to medications given to tenants.

- Monitoring Observation: One of four staff reported seeing Medication Administration Records (MARs) being shredded by the RN. A review of program records indicated MARs for the current month of November and previous three months were in each of the tenant files.

- Regulatory Insufficiency: None noted.

During the course of the investigation, it was determined the program did not keep appropriate service notes of cares provided to tenants.

- Monitoring Observation: Task Schedules are worksheets staff use to complete specific personal and health related cares including medication times for tenants residing at the program. Each staff person is given a task schedule to use during their shift. Staff are to check off each task when completed, sign each task schedule and at the end of their shift turn them into the RN. The RN reviews each task schedule and then destroys them. Four of four staff interviewed indicated task schedules are the only way of knowing what needs to be done. Three of four staff interviewed stated they do not have access to tenants' service plans. The RN stated during interview, that staff have access to each tenant's service plan. Four of four staff interviewed stated they are not to write in the tenant's Health Profile Notes. Staff are to write in the program's communication book regarding tenant care needs. The RN stated the

program's communication book and its contents are not retained by the program. Three of four staff interviewed stated personal and health related cares for tenants are not always completed. A review of 11-6-06 task schedules for the day shift indicated not all cares were completed. Task schedule for the night shift was completed but not signed by the staff person who completed the cares.

Tenant #2's daughter and son-in-law were interviewed and stated they visit daily and noted the bathroom hadn't been cleaned for over two weeks. Family stated they had to scrape food off the tenant's dentures as staff did not clean them as requested. Family stated there was times when the tenant wouldn't receive a bath on the weekends.

Tenant #4's spouse was interviewed and stated there were numerous medications missed and "noticed a change in the … mood" and feels it was due to missed medications. The tenant's spouse stated he/she was not sure personal and health related cares were completed as contracted.

Despite being required to maintain and keep documentation related to tenant service notes, the program did not do so. In addition to personal and health related cares listed on the task schedules; staff were dependent upon task schedules to know when prescribed medications were to be given. The RN stated staff were to sign off when services were completed. When asked to see the previous day's task schedule the RN stated they were no longer available. The RN was asked to keep the previous day's task schedules in order to review them the following day. A review of task schedules from the previous day were not completed and signed by the staff responsible, therefore, the program did not ensure tenant cares were completed as assigned.

- Regulatory Insufficiency: The program did not complete and retain service notes of staff performing personal and health related cares for tenants.

C. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

Complaint Allegation: It is alleged the program did not provide appropriate supervision of tenant's personal and health related care needs.

- Monitoring Observation: Tenant #1 had a service plan developed prior to admission but did not have a service plan developed within 30 days of admission and when a change in status occurred. The tenant's current service plan is dated 9-1-06. Since that date there has been a decline in the tenant's status as noted in Health Profile notes of 9-15-06 through 11-7-06. The decline included changes in the tenant's wandering, exit seeking, paranoia, and increasing anxious behavior and need for wound care. The service plan of 9-1-06 did not reference interventions related to the behavior noted and wound care. Despite a change in the tenant's status, the program did not update the service plan to reflect services the tenant needed.

  Tenant #2 had only one service plan dated 9-26-06, which was not completed prior to admission and not updated within 30 days of admission. Despite having a service plan dated 9-6-06, the program did not complete a service plan prior to admission and within 30 days of admission as required.

Tenant #3 had a service plan developed prior to admission but did not have a service plan developed within 30 days of admission. The program completed a separate modification on 9-28-06 to the service plan of 9-18-06 to provide blood pressures weekly, which a family member signed. A second modification is added on 9-28-06, with a verbal agreement date of 10-3-06 to include escorts to activities and meals as needed. The tenant refused to sign this modification. Despite making modifications to the service plan the program did not update the service plan within 30 days of admission. The program added separate modifications on two separate occasions without having the tenant review the entire service plan. Each modification made was not signed by the tenant or their legal representative.

Tenant #4's Health Profile Notes beginning 9-28-06 through 11-6-06 indicated the tenant was wandering the halls, extremely aggressive, banging the apartment window with his/her walker and "was attempting to go home." The program completed a separate modification to the service on 10-19-06 and added services which included one to two hour toileting and assist with ambulation. Despite updating the tenant's service plan on 10-31-06, the program did not have the tenant and a multidisciplinary team of three staff sign the service plan.

Tenant #5's service plan was updated on 10-31-06 but did not include Physical and Occupational therapy which began on 10-6-06. Despite updating the service plan on 10-31-06, the program did not include physical and occupational therapy services and did not have the tenant and a multidisciplinary team of three staff sign the service plan.

Tenant #6's Health Profile notes beginning 8-21-06 through 10-5-06 indicated a history of hallucinating and "seeing people," demonstrating "exit seeking behaviors," having frequent moments of paranoia and thinking staff and family are stealing items for his/her apartment. Despite updating the tenant's service plan on 10-30-06, the program did not have the tenant and a multidisciplinary team of three staff sign the service plan.

Tenant #7's initial service plan was completed on 10-2-06 but did not have the tenant and a human services or healthcare professional signatures.

- Regulatory Insufficiency: The program did not consistently update services plans with a change in status to reflect the current needs of tenants.

- Regulatory Insufficiency: The program did not have the tenant and a multidisciplinary team of three staff sign the service plan.

D. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

Complaint Allegation: It is alleged the RN has made multiple medication errors since the program opened including: set up of medications for tenants' by either putting too many,

not enough, the wrong medications, missed medications, under dosing of an antidepressant and not following physician's order for ophthalmic medications.

- Monitoring Observation: A review of tenant files, MARs, employee and family member interviews indicated the following:

  Tenant #1's MAR for September and October 2006 indicated medications were held with no explanation given. The tenant's MAR for October 2006 states "okay to hold Colace if loose stool present." Despite having a standard of practice for documenting medication administration the program did not apply this standard to their practice of documentation of medication administration.

  Tenant #2's MAR for September and October 2006 indicated seven medications were given at 5:00 p.m. The MAR states medications are to be given with meals. Each staff person is given a "task schedule" which identifies duties to be performed throughout the day. This includes daily responsibilities and specific tasks, which includes medication administration for each tenant residing at the program. The task schedule for Tenant #2 indicated staff is to administer medications between 5:00 p.m. to 5:15 p.m. The task schedule of 11-7-06 states in capital letters "RESIDENT IS TO HAVE HIS MEDS JUST PRIOR TO HIS MEALS!" The program was requested to provide copies of task schedules for October 2006 but the RN stated task schedules are shredded daily. A letter to the RN dated 10-10-06 from the tenant's daughter requested the tenant's medications to be given during supper which is served at 6:00 p.m. and not at 5:00 p.m. as indicated on the MAR as the medications upset the tenant's stomach. According to the letter the RN stated she would change the MAR to read to give medication with all meals. The RN stated she would change the task schedule to direct staff to give medications with all meals. Despite a request from the tenant's family and agreement from the RN to change the task schedule to direct staff to give the tenant medications with his/her evening meal at 6:00 p.m. staff continue to give medications at 5:00 p.m.

  October's MAR indicated on 10-8-06, 8:00 a.m. medications were not given. A circle with no initials was made for each of the 8:00 a.m. medications. October "Special Remarks" page indicated the RN wrote medications were given but not signed for. A medication incident report was not completed despite a policy to do so. A medication error report dated 10-28-06 indicated the tenant's 8:00 a.m. medications were missed. No corrective action was noted in the report. Despite having an established standard of medication administration and the documentation standards that accompany this process the program is inconsistent in applying this standard.

  Tenant #3's MAR for September 2006 MAR indicated the tenant was receiving Seroquel 75 mg 1 ½ tab PO QID. According to the RN Seroquel came in 50 mg tabs, therefore, when setting up this medication for administration she would place one full tab and ½ of a second 50mg tab for each dose to be given four times daily. According to the Pharmacist, the order for Seroquel was dispensed using 25mg tabs and not 50mg tabs as stated by the RN. The Pharmacist stated on 10-30-06 Medicap began dispensing all of this tenant's medications in bubble packs as requested by the tenant's family. The tenant received 37.5mg of Seroquel four times daily and not the correct dosage of 75mg of Seroquel four times daily. According to Health Profile Notes of 9-29-06 the RN noted an error in the dosage and corrected the MAR for

October 2006 to three tabs four times daily. A medication incident report was not completed despite a policy to do so. Medicap Pharmacy is the pharmacy of record for dispensing this medication. Despite having a standard of practice for medication administration the program did not apply this standard to their practice when administering medications to this tenant.

Tenant #5's MAR for October 2006 MAR indicated staff did not use an acceptable standard for documenting when medications are refused. On 10-1- 06 an unidentified staff person wrote each letter from the word "refused" in each box where staff initials would be placed. On 10-8-06 Special Remarks page indicated the tenant refused all of his/her medications. Staff indicated this on the MAR by placing a circle around their initials. Despite having a standard practice for documenting medication administration the program did not apply this standard to their practice when documenting medication administration.

Health Profile Notes of 8-21-06 indicated the tenant's spouse voiced concerns about the administration of eye drops prescribed by the tenant physician. Physician orders give specific instructions to instill one drop into lower eyelid and to instruct the tenant to close eyes gently for two to five minutes. If using more than one drop, wait at least 10 minutes between drops. Health Profile notes of 8-21-06 indicated the RN instructed staff to space out eye drops for 1-3 minutes between different medications. On 8-28-06 the RN is contacted by staff as family is upset as staff are incorrectly administering eye medications. On 8-30-06 the RN writes she will call the "U of I eye care, due to the great length of time request in guidelines section of order sheet," and will wait for a return call. A review of the tenant's file indicated no new orders or changes in the administration of eye medication. Despite having a physician order to administer eye medications, the RN did not follow the physician order and altered the times between each medication.

Date	**Medications/Treatments Not Given as Ordered W/O Explanation**	**Medications Held W/O Explanation**	**Medications/Treatments Initialed and Circled W/O Explanation**
9-1/17-06			**Tenant #1** Zocor
9-2-06	**Tenant #2** Aspirin, Aricept, Pravastatin, Namenda, Ferrous Sulfate, Gylburide/Metformin		
9-8-06		**Tenant #1** Colace	
9-10-06	**Tenant #5** Pravachol, Alphagan P Solution, Timolol, Cosopt Solution, Prednisolone AC, Luculube		
9-15-06	**Tenant #2** Aleve, Aspirin, Aricept, Pravastatin, Namenda, Ferrous Sulfate, Gylburide/ Metformin	**Tenant #1** Colace	

9-20-06			**Tenant #1** Colace,
9-25-06	**Tenant #1** K-Dur **Tenant #6** FiberCon		
10-1-06	**Tenant #4** Xanax, Risperdal		
10-2-06	**Tenant #4** Risperdal		
10-3-06	**Tenant #4** Risperdal		
10/8/06	**Tenant #2** Multivitamin, Vospire, Finasteride, Vitamin E, Avandia, Namenda, Aleve **Tenant #4** Risperdal, Xanax		
10-20-06	**Tenant #4** Colace		**Tenant #1** Tylenol, Ativan
10-21-06	**Tenant #4** Colace		
10-22-06	**Tenant #2** Gylburide		**Tenant #1** Prozac, Vitamin D3, Synthroid, Digitek, Tylenol, Aspirin, Detrol LA, Ativan, Zebeta, K-Dur, Colace,
10-23-06			**Tenant #1** Prozac, Vitamin D3, Synthroid, Digitek, Tylenol, Aspirin, Detrol LA, Ativan, Zebeta, K-Dur, Colace, Monopril, Spironolactone, Lasix, Calcium
10-28-06	**Tenant #2** Multivitamin, Vospire, Finasteride, Vitamin E, Avandia, Namenda, Aleve		

- Regulatory Insufficiency: The program did not consistently document medications given by the program and did not give an explanation if medications were not administered.

- Regulatory Insufficiency: The program did not apply an acceptable standard of practice and did not consistently follow a physician's instructions when administering medications.

E. Nurse Review - Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. [321 IAC 25.30]

During the course of the investigation, it was determined the RN did not sign, date, and time orders as required.

- Monitoring Observation: Seven of seven tenant files reviewed indicated the RN did not consistently time orders when received and transcribed to the tenant's MAR. Despite an applied standard to sign, date and time orders written by a physician and received by the RN, the RN did not consistently time orders.

- Regulatory Insufficiency: The RN did not time orders as required.

F. Nursing Assistant Work Credit – Program shall complete and submit to DIA an Iowa Nurse Aide Registry Application for each nursing assistant working in the program. Quarterly reports shall be submitted when change in employment occurs. [321 IAC 25.31]

During the course of the investigation it was determined the program did not submit an Iowa Nurse Registry application for each nursing assistant working in the program.

- Monitoring Observation: According to the program four of five staff are certified nursing assistants (CNAs). The Administrator and RN stated the program did not complete and submit a Nurse Aide Registry Application for each nursing assistant working at the program.

- Regulatory Insufficiency: The program did not notify the Department of nursing assistants working at the program in order to maintain certification.

G. Food Service – Program shall provide or coordinate with other community providers to provide hot or other appropriate meal(s) at least once a day or make arrangements for the availability of meals. Menus shall be appropriately planned. If applicable, therapeutic diets shall meet all requirements. Food preparation personnel shall meet all requirements. [321 IAC 25.32]

Complaint Allegation: It is alleged hot meals are often served cold and the program did not prepare a therapeutic diet for Tenant #2.

- Monitoring Observation: The program's Food Service Director stated meals are prepared and brought to the dementia unit in a timely manner. Food items are not checked for temperature once they arrive and staff would not always have tenants in the dining room when meals were served. Staff would not serve meals until all tenants were seated in the dining room. Families interviewed stated meat and vegetables are often served cold. Despite being required to prepare and serve meals to established standards the program did not provide hot and appropriate meals to tenants.

  Tenant #2's family stated the tenant is Diabetic and is often served cookies and other sugar desserts even though they have asked for sugar free desserts. Family was assured by the program they would provide a therapeutic diet, however, the program did not consistently prepare therapeutic menus for the tenant.

- Regulatory Insufficiency: The program did not consistently serve meals to established standards and did not provide therapeutic diets as agreed upon.

During the course of the investigation, it was determined staff who are employed by the program who are responsible for serving food did not have an orientation on sanitation and safe food handling prior to handling food.

- Monitoring Observation: The Food Service Director stated none of the staff who serves meals have had an orientation on sanitation or food handling. Four of four staff interviewed stated they help serve meals but did not have an orientation on sanitation and safe food handling.

- Regulatory Insufficiency: The program did not have staff who serve meals complete an orientation for safe food handling.

H. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation: It is alleged the program did not provide adequate supervision of tenants when personal and health related cares are completed.

- Monitoring Observation: Three of four staff files reviewed indicated the program did not have a copy of Certification for staff who were CNAs. Four of four staff files reviewed indicated the program did not have documentation of training for personal and health related cares including medication administration. Three of four staff interviewed stated training for medication administration was inadequate and felt uncomfortable administering medications.

  Staff #3 stated the RN instructed staff to take tenants who couldn't be left alone, with them when completing tasks assigned for other tenants.

  Staff #4 stated on 11-2-06 the RN had a staff meeting that all direct care staff were required to attend. The RN asked the Food Service Director to watch tenants in the dementia specific program. Direct care staff were not available from 1:00 p.m. until 3:00 p.m. Staff #4 stated she went to the program to administer medications around 3:00 p.m., was approached by Tenant #4's spouse asking for assistance, but stated she couldn't help her as she had to return to the staff meeting. Staff #3 and the RN, in separate interviews confirmed the above and stated Tenant #4's spouse interrupted the staff meeting because she needed help with his/her spouse and no one on the unit could provide assistance. The RN stated she asked Staff #3 to assist with Tenant #4's cares. A review of staff files indicated the Food Service Director did not have training on providing personal and health related cares.

  A review of the program's employee schedule for October 2006 indicated one staff person was on-site to meet the care needs for tenants in the general population and the dementia specific program. On 10-1-06 and 10-8-06, one staff person was scheduled from 7:00 a.m. to 3:00 p.m.; on 10-8-06 one staff person was scheduled from 3:00 p.m. to 7:00 p.m.; on 10-15-06 one staff person scheduled from 10:00 p.m. to 3:00 p.m., and one staff from 11:00 p.m. to 7:00 a.m.; 10-20-06 one staff person scheduled from 9:00 a.m. to 10:45 a.m.

During the times when only one staff was available, tenants sustained an injury from falls and prescribed medication were missed. On 10-1-06 at 10:10 a.m. Tenant #5, who resides in the dementia specific program sustained an injury from a fall. On 10-8-06 at 9:35 a.m. Tenant #5 sustained an injury from a fall. On 10-8-06 at 2:00 p.m. medication for Tenant #4 was not given. Despite being required to have sufficient staff available at all times to fully meet tenant's identified needs, the program did not do so.

According to family interviews, Tenant #3 was dropped off at a local mall on 10-16-2006. The tenant was told to meet at a certain time and place in order to be picked up and returned to the program. According to family, a clerk at a store in the mall called family, as the tenant was not able to remember where to meet other tenants or tell anyone where he/she lived. Family gave the phone number of the program to the clerk and the clerk called the program. Program staff arrived and brought the tenant back to the program. According to family the tenant stated he/she was scared when he/she became lost. Family stated they didn't know or wouldn't have approved of the tenant being on his/her own. Family states the tenant has a diagnosis of dementia and did not have the cognitive ability to be left alone. Another family member, interviewed stated shortly after this occurrence, said the activity director was going to drop off tenants, including Tenant #3 at a local casino. Family told the activity director not to take the tenant to the casino or anywhere else unattended.

- Regulatory Insufficiency: The program did not adequately train staff to provide personal and health related cares including medication administration.

- Regulatory Insufficiency: The program did not have sufficient trained staff available at all times to fully meet tenants' identified needs.

I. Managed Risk Statement – Program has a managed risk statement which includes the tenant's or legal representative's signed acknowledgement of the shared responsibility for identifying and meeting needs and the process for managing risk and upholding tenant autonomy when tenant decision making may result in poor outcomes for the tenant or others. [321 IAC 25.36]

During the course of the investigation, it was determined the program did not have a managed risk statement for tenants with identified risk behaviors which may result in poor outcomes.

- Monitoring Observation: Tenant #1 has a history of hallucination and increased confusion at night. Health profile notes indicated a history of attempts to leave the program. On 9-6-06 the tenant's son-in-law called staff concerned about the tenant's orientation and confusion. On 9-15-06 the tenant was upset, wanting to go home and walking toward the door. On 9-16-06 the tenant was asking for a ride home. On 10-20-06 the tenant was wandering into other tenant apartments and sleeping in their beds and refusing medications. On 10-23-06 the tenant was asking for the number (code) to open the door in order to leave the program. On 11-6-06 the tenant exhibited excessive wandering and exit seeking behaviors and continues to wander from door to door attempting to leave. On 11-7-06 the tenant was wandering into tenant apartments despite staff redirection. The monitor observed on two occasions the tenant trying to exit the program. Despite staff interventions related to the

tenant's wandering and exit behavior, the program did not identify shared responsibility with the tenant or legal representative related to the risk of wandering and exit behavior of the tenant.

Tenant #4 has a history of falls and injuries related to ambulating without a standby assist. Incident reports of 10-5-06, 10-11-06, 10-12-06, 10-16-06, 10-22-06 and 10-30-06 reported the tenant had fallen. Health Profile Notes of 11-5-06 and 11-6-06 record four entries where the tenant was found on the floor on five separate occasions with staff recording these entries as falls. Injuries related to these falls were sustained on 10-11-06, 10-12-06 and 10-30-06. Despite staff interventions related to falls, the program did not identify shared responsibility with the tenant or legal representative related to the risk of injury from these falls.

Tenant #5 has a history of falls and injuries related to ambulating without a standby assist. Incident reports of 9-4-06, 9-11-06, 9-19-06, 9-21-06, 9-24-06, 10-1-06, 10-8-06, 10-11-06 10-16-06 and10-24-06 indicated the tenant was found on the floor from suspected or witnessed falls. Injuries related to falls occurred on 9-4-06, 9-24-06 and 9-27-06. Despite staff interventions related to falls, the program did not identify shared responsibility with the tenant or legal representative related to the risk of injury from these falls.

Tenant #6 has a history of hallucinations, seeing people, and exit seeking behaviors. Health profile notes of 8-21-06 indicated the resident has a history of hallucinating and seeing people. Incident reports of 9-16-06 and 10-3-06 reported the tenant had fallen with the tenant sustaining an injury on 10-3-06. Health profile notes of 9-7-06 indicated the tenant exhibited strong exit seeking behaviors. Despite staff interventions related to hallucinations and falls, the program did not identify shared responsibility with the tenant or legal representative related to the risk of injury from these falls.

Tenant #7, a 77 year old, was admitted on 10-2-06 with diagnoses of Alzheimers/Demenita, Cataracts, HTN, and Hypothroidism. Tenant has a history of refusing prescribed medications. Health profile notes of 10-5-06 indicated the tenant refused medications "several times over the last few days." On 10-16-06 the tenant initially refuses medications with several attempts being made by staff with the "resident ending up taking pills." On 10-23-06 the tenant refused medications with paranoia increasing "greatly over last several days." On 10-26-06 the tenant had an "aggressive episode in pushing another resident." On 10-27-06 physician orders were given to increase Abilify to 5milligrams (mg) and Aricept 5 mg. On 11-6-06 the "resident was seen pushing other resident away." On 11-6-06 a late entry reported the tenant refused 5:00 p.m. and 8:00 p.m. medications on 11-5-06. Despite staff interventions related to aggressive behavior and medication refusal, the program did not identify shared responsibility with the tenant or legal representative related to the risk of not taking prescribed medications and assaultive behavior.

- Regulatory Insufficiency: The program did not acknowledge shared responsibility by identifying and meeting needs and the process for managing risk.

J. Life safety – The program shall follow written emergency policies and procedures and structural safety requirements. [321 IAC 25.37]

During the course of the investigation, it was found the program did not report an alleged action of dependent adult abuse.

Monitoring Observation: When interviewed, Staff #1 reported Staff #3 allegedly tied Tenant #4's shoe laces to the pedals of his/her wheel chair in an attempt to keep the tenant in his/her wheelchair at approximately 8:45 p.m. on 11-3-06. The program did not complete an incident report and did not notify the Department of Human Services until 11-7-06 when a request was made by the monitor. The program completed an incident report and a suspected dependent adult abuse report.

- Regulatory Insufficiency: The program did not follow established standards for reporting and documenting suspected dependent adult abuse.

- Regulatory Insufficiency: The program did not have sufficient trained staff available at all times to fully meet tenants' identified needs.

Dated this 28th day of November, 2006.