IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 32548-C

February 24, 2011

Jack Collins, Program Director
Walnut Ridge at Clive Senior Campus
1701 Campus Drive
Clive, IA 50325

RE: I. Final Complaint Investigation & Recertification Report
II. Civil Penalty
III. Appeals/Hearings
IV. Standard Certification
V. Conclusion

Dear Mr. Collins:

I. Final Complaint Investigation and Recertification Report – Walnut Ridge at Clive Senior Campus, Clive, IA

Enclosed is the **Final Complaint Investigation and Recertification Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapter 481—67 and 481—69. The Report notes the Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Criteria for Exclusion of Tenant, Service Plan, Medications, Nurse Review, Staffing, Tenant Rights, and Other (non notification to department of elopement). **Walnut Ridge at Clive Senior Campus** ("Program") is being assessed a $1500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). .

DIA is accepting the Plan of Correction (POC) following the Program's submission of information.

II. Civil Penalty

If, within thirty (30) days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant in accordance with IAC 67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send cover letter to the attention of **Rose Boccella** and remit the penalty assessed by check or money order in the amount of nine hundred seventy five dollars ($975) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within 30 days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to IAC chapter 481—10. If the Program appeals, the civil penalty will be suspended, pending the appeal process. If the Program does not appeal, the fine is due within 30 days of notice.

IV. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0289** with effective dates of **November 17, 2010** through **November 16, 2012**.

V. Conclusion

The Program is being assessed a $1500 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The POC submitted on February 22, 2011, has been reviewed and will constitute the final POC related to the on-site visit of January 12, 18 and 19, 2011.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

If you have any questions in regard to this letter and report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #: 32548-C**

Jack Collins, Program Director
Walnut Ridge at Clive Senior Campus
1701 Campus Drive
Clive, IA 50325

Date of Investigation:

January 12, 18 and 19, 2011

Monitor(s):

Ann Martin, RN
Joyce Kix, RN
Maribeth Freland, RN

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. IAC r. 481-67.10(5). 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 481 IAC chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation and recertification on-site visit was conducted at Walnut Ridge at Clive Senior Campus on January 12, 18 and 19, 2011. In preparing this report, the following information was considered:

Current Program Census:

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

Current number of tenants without cognitive disorder:	30
Current number of tenants with cognitive disorder:	3
Total Population of GPP:	33

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	19
Total Census of ALP:	52

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

Tenant/Family Satisfaction Results – A community meeting was held with 15 tenants. The tenants reported they liked, "everything" at the program. They stated the nurse and staff were available and well trained. The tenants said the food was great and activities plentiful. They felt safe at the program and would recommend it to others.

Program History – The program did not receive any regulatory insufficiencies during this certification period.

On-Site Monitoring Evaluation – The monitors made the observations detailed in the following areas.

A. Evaluation of Tenant

- Monitoring Observation: Tenant #2, an 82 year old, was admitted 4-24-10 with diagnoses of: Hypertension (HTN), Dementia and Constipation. The tenant resided in the general population and the Global Deterioration Scale (GDS) dated 10-13-10, staged the tenant at 5 which indicated moderately severe cognitive decline. The Evaluation/Assessment completed at admission identified the tenant at risk for falls. The service plan signed and dated 4-22-10, directed staff to encourage the tenant to walk as much as possible to increase strength, use a wheelchair to and from meals and assist as needed on, "weak" days. The clinical record contained documentation of falls sustained by the tenant on 10-18, 12-7, two times on 12-10-10, 1-10-11 and 1-12-11. The clinical record lacked evidence of completion of cognitive, health and functional evaluations for multiple falls which resulted in the tenant's report of continued discomfort on 1-11-11.

  Tenant #5, a 63 year old residing in the secured Memory Care Unit, was admitted on 11-17-10 with diagnoses of: Anoxic Brain Injury, Depression and Aphasia (a disorder affecting speech and language abilities). On 12-14-10, the tenant was staged at a 5 on the GDS, which indicated moderately severe cognitive decline.

  The Elopement Risk Evaluation, (contained within the program's Evaluation/Assessment), dated 11-15-10, indicated the tenant was not considered to be at risk for elopement (when a tenant with impaired decision making abilities leaves the program without the knowledge or authorization of staff).

  According to the Incident Report, dated 12-12-10, staff found Tenant #5 unattended in an enclosed outdoor courtyard unsuccessfully attempting to get inside the building. The report indicated he/she had exited the building through the sunroom door, which was usually alarmed to alert staff to an elopement attempt. The alarm did not sound, thereby allowing the tenant to exit the building without staff knowledge.

  On 12-14-10 Staff #6 completed a 30 day Resident Care Nurse Review reassessing the tenant's functional, health and cognitive status. The evaluation and accompanying narrative notes lacked any mention of Tenant #5's elopement.

  The nurse failed to identify the tenant's change in elopement risk following the tenant's elopement on 12-12-10.

  Tenant #6, an 88 year old residing in the secured Memory Care Unit, was admitted on 11-6-10 with diagnoses of: Dementia, Arthritis and Back Pain. On 11-18-10, the tenant was staged at a 4 on the GDS, which indicated moderate cognitive decline. According to the Incident Report, dated 1-6-11, staff found Tenant #6 lying on the floor in his/her doorway. The Nurse Narrative Notes, dated 1-7-11, indicated the tenant had fractured his/her left wrist and had a splint applied at the emergency department.

The service plan dated 11-6-10 documented that oral cares, dressing, transferring and toileting were completed by the tenant independently. The updated service plan of 1-7-11 documented the tenant needed assistance with grooming, transferring, toileting, dressing, and eating.

On 1-19-11 at approximately 10:15 AM, the Director and the nurse consultant both reported the tenant's fractured wrist should have been considered to be a significant change.

The tenant's clinical record lacked documentation of functional, cognitive and health evaluations after a significant change in condition related to an injury from a fall 1-6-11.

The clinical records for Tenants #1, #2, #3, #4, #5, #6, and #8 indicated the tenants scored moderate to severely cognitive decline on the Mini Mental Status Exam (MMSE) which required the program to complete a GDS for each tenant. The program used a form on which the nurse documented a number from the GDS but did not include documentation of how the nurse concluded the tenant scored at that level.

- Regulatory Insufficiency: A program shall evaluate each prospective tenant's functional, cognitive, and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the needed services are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the evaluation indicated moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. (IAC r. 481-69.22(1))

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Criteria for Exclusion of Tenants

- Monitoring Observation: Tenant #8, an 80 year old residing in the secured Memory Care Unit, was admitted on 7-3-10 with diagnoses of: Dementia, Aortic Stenosis and Hypertension. On admission to the program, the tenant was staged at a 4 on the GDS, which indicated moderate cognitive decline. On 12-23-10, the tenant was staged at a 6 on the GDS, which indicated deterioration to severe cognitive decline.

According to the tenant's clinical record, the tenant exhibited wandering behaviors, anxiety and exit seeking behaviors upon admission to the program.

The Nurse Notes, medication administration records (MAR) and Individualized Service Assignments and accompanying Notes, completed by the Memory Care Unit staff during December 2010 and January 2011, reported the following:

12-6-10: The tenant began exhibiting "strange behavior" when moving personal linens into the common area of the unit, citing the reason as a bear was in his/her room.

The tenant received an as needed (prn) dose of Haldol (an antipsychotic medication) due to anxiety and exit seeking behavior. Staff documented the medication was not effective.

12-9-10: The tenant received a prn dose of Haldol due to anxiety, restlessness and exit seeking behavior. Staff documented an inadequate response to the medication.

12-10-10: The tenant received a prn dose of Haldol due to anxiety and exit seeking behavior. Staff documented the medication was not effective.

12-13-10: The program's nurse sent a note to the tenant's physician reporting the tenant's anxiousness and aggressive behaviors appeared to be occurring more frequently. The physician ordered Seroquel (an antipsychotic medication) to be given twice daily with Risperidone (an antipsychotic medication) to be used prn without relief of symptoms from the Seroquel.

12-14-10: The tenant exhibited anxiousness, exit seeking and aggression. The tenant hit a staff member in the stomach, attempted to take silverware and food away from other tenants and urinated in the hallway. The tenant was not easily redirected by staff from any of the above stated behaviors.

The tenant attempted to exit from the building while accompanying staff on a walk around the general population area. Staff was unable to redirect the tenant from exiting the building. He/she got into an ambulance that was parked at the wheelchair ramp. The tenant was eventually redirected from the ambulance to the Memory Care Unit.

The tenant continued to exhibit wandering behaviors with exit seeking, resulting in another elopement from the unit into the general population area with staff attempting redirection unsuccessfully.

12-15-10: The tenant exhibited anxiousness, exit seeking and wandering behaviors. The tenant eloped from the Memory Care Unit into the general population area of the building, entered other tenants' rooms to remove personal items and swept up crumbs from the dining room tables, sprinkling the crumbs onto another tenant's plate of food while the tenant was still eating.

12-17-10: The tenant lowered his/her pants and urinated in the dining room which was witnessed by two other tenants.

12-18-10: The tenant exhibited aggression by forcing him/herself into locked areas of the unit.

12-19-10: The tenant exhibited anxiousness and was exit seeking.

12-20-10: The tenant defecated on a chair in the dining room which was witnessed by another tenant.

12-21-10: The tenant removed all of his/her clothing and went into two other tenants' rooms.

12-22-10: The tenant defecated on a chair in the dining room, exhibited restlessness and wandering into other tenants' rooms. The tenant was not easily redirected by staff from the wandering behavior.

The tenant received a prn dose of Risperidone due to anxiety and extreme wandering. Staff documented the medication was not effective.

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12-27-10: The tenant exhibited restlessness, removing other tenants' personal belongings from their rooms to "redecorate" the common areas of the unit, refused to sit to eat meals, attempted to remove other tenants' plates and silverware from the table while the tenants were still eating and attempted to elope from the unit with a family member. The tenant was not easily redirected by staff from any of the above stated behaviors. The tenant received a prn dose of Haloperidol due to anxiety. Staff documented the medication was not effective.

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12-28-10: The tenant exhibited restlessness and moved his/her personal belongings to the common areas of the unit.

1-2-11: The tenant exhibited anxiousness and moved furniture around the unit. The tenant was not easily redirected by staff from this behavior.

1-13-11: The tenant exhibited anxiousness, moving furniture around the unit, attempting to use the other tenants' bathrooms, was wandering and exit seeking. The tenant received a prn dose of Risperidone and Haldol at the same time due to anxiety. Staff documented the medication was not effective.

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1-15, 16 and 17, 2010: The tenant received prn doses of Risperidone and Haldol at the same time due to anxiety. Staff documented both medications were ineffective in symptom relief.

The Resident Care Nurse Review, dated 12-23-10, documented the nurse assessed the tenant to have recently exhibited agitation, elopement attempts and increased wandering, all of which were uncontrolled with medications

The Review indicated the tenant had been experiencing multiple behavioral changes including: elopement attempts, aggression, anxiousness, wandering, entering other tenants' rooms, urinating and defecating in unusual places and throwing objects.

On 1-18-11 at 2:15 PM, Staff #5, a resident care assistant (RCA), told the monitors Tenant #8 attempts to exit from the Memory Care Unit approximately 5 times weekly. The RCA had to reset the alarm on the dining room door earlier in the day as the tenant opened the door in an attempt to exit, thereby setting off the alarm.

On 1-18-11 at 3:35 PM, Staff #8, an RCA, told the monitors Tenant #8 often attempts to exit from the Memory Care Unit "sometimes all day long".

On 1-18-11 at 4:00 PM the monitors observed Tenant #8 to be anxious, pacing and attempting to enter doors off of the dining room area. Staff attempted to redirect the tenant without success.

Despite medication use, medication changes and staff intervention, Tenant #8 was physically aggressive, displayed unmanageable aggression, exhibited increased wandering and exit seeking behavior which placed the tenant at risk for self injury and displayed behavior that placed other tenants at risk. Tenant #8 exceeded the criteria for retention in assisted living setting.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression. (IAC r. 481-69.23(1) (1))

C. Service Plan

- Monitoring Observation: Tenant #1, a 60 year old, was admitted 11-18-10 with diagnoses of: Progressive Supraneuclear Palsy, Parkinson's Disease and HTN. The tenant resided in the secured Memory Care Unit and the GDS dated 12-16-10 staged the tenant at 5 which indicated moderately severe cognitive decline. The service plan of 12-16-10 indicated Tenant #1 was independent with oral care, was to have showering assistance every other day and staff were to obtain a physical therapy (PT) order for water therapy. The Resident Care Nurse Review completed 12-16-10 documented the tenant needed assistance to prepare the toothbrush for oral care and had daily assistance with showers. The January 2011 medication administration record (MAR) directed staff to thoroughly crush the tenant's medications and put in applesauce. Staff #6 reported the tenant attended water therapy with the physical therapist but did not know how often. The current service plan was not updated including water therapy with PT and individualized interventions to meet the needs of the tenant...

  Tenant #2, an 89 year old, was admitted 4-15-10 with diagnoses of: Alzheimer's, Congestive Heart Failure, Hyperkalemia and Chronic Obstructive Pulmonary Disease (COPD). The tenant resided in the secured Memory Care Unit and the GDS dated 12-31-10 staged the tenant at 5 which indicated moderately severe cognitive decline. The Resident Care note of 12-10-10 indicated the tenant was hospitalized for a

bleeding duodenal ulcer and returned to the program 12-14-10. Another note dated 12-17-10 documented the tenant was hospitalized and returned 12-23-10 with periods of confusion, was generally weaker and required staff assist of one to transfer. Hospice care was initiated with art therapy. Physician's orders dated 1-3-11, related to current diagnosis of cellulitis, directed the use of a heating pad to arms and shoulders, wrap legs from ankles to knees in a.m. and off at bedtime and drink another protein drink daily. The service plan signed and dated 8-27-10 contained handwritten directions dated 12-14-10 to observe the tenant's stools and report black tarry stools and to add a protein drink at meals. Another addition dated 12-23-10 directed to elevate the tenant's legs through the day and night. The interventions of assistance of one with transfer, wrapping legs, and Hospice care were not noted. Functional, cognitive and health evaluations were completed by the nurse 12-31-10; however, the service plan was not updated to include current physician's orders and interventions including Hospice.

Tenant #5's clinical record contained an Elopement Risk Evaluation, (within the program's Evaluation/Assessment), dated 11-15-10, which indicated the tenant was not considered to be at risk for elopement.

According to the Incident Report, dated 12-12-10, staff found Tenant #5 unattended in an enclosed outdoor courtyard unsuccessfully attempting to get inside the building. The report indicated he/she had exited the building through the sunroom door, which was usually alarmed to alert staff to an elopement attempt. The alarm did not sound, thereby allowing the tenant to exit the building without staff knowledge.

The tenant's service plan of 12-14-10 did not include interventions addressing exit seeking behaviors and elopement.

Tenant #7, a 71 year old, was admitted 7-18-10 with diagnoses of: Depression, Fibromyalgia, COPD, and Chronic Pain. The tenant resided in the general population. The Tenant scored 29 of 30 on the Mini Mental Status Exam completed 6-18-10 and the Global Deterioration Scale (GDS) dated 10-13-10 staged the tenant at 2-3 which indicated mild cognitive decline. Documentation completed by the tenant's physician on 7-12-10 indicated no evidence of dementia. The service plans dated 7-15-10, 8-16-10 and 11-4-10 lacked the tenant's signature.

- Regulatory Insufficiency: 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. (IAC r. 481 – 69.26(1))

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review or update of the service plan, the updated service plan shall be signed and dated by all parties. (IAC r.481 – 69.26(3) (a.))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance. c.

The service providers, if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy and physical therapy. (IAC r. 481 – 69.26 (4)(a) and (c.))

D. Medications

- Monitoring Observation: Tenant #5's clinical record contained a physician's order, dated 11-17-10 and signed by the tenant's physician, ordering the program staff to administer Peridex MT (a medicated mouthwash) twice daily (BID). The clinical record contained a Pharmacy Consent Form, dated as signed by the tenant's Power of Attorney on 11-12-10, indicating an agreement between the program and its designated pharmacy to assure provision of pharmaceutical services 24 hours a day, 7 days a week, 365 days per year.

  The clinical record contained a MAR showing medications administered to the tenant in December 2010. The MAR included a Medication Note page to be used for documentation of reasons for omission of any medication. The Medication Notes page indicated staff omitted the administration of the tenant's Peridex from 12-1-10 through 12-9-10, documenting the reason for the omission to be unavailability of the mouthwash. The clinical record lacked any documentation of physician notification following the omissions.

  The program failed to administer medications to Tenant #5 as ordered by the physician.

  Tenant #6's clinical record contained a physician's order, dated 11-6-10 and signed by the tenant's physician, ordering the program staff to apply a Fentanyl Patch (a narcotic pain medication which slowly releases via the skin) topically every 72 hours.

  The clinical record contained a Pharmacy Consent Form, dated as signed by the tenant's Power of Attorney on 11-4-10, indicating an agreement between the program and its designated pharmacy to assure provision of pharmaceutical services 24 hours a day, 7 days a week, 365 days per year.

  The clinical record contained a MAR showing medications administered to the tenant in November 2010. The MAR included a Medication Note page to be used for documentation of reasons for omission of any medication. The Medication Notes page indicated staff omitted the administration of the tenant's Fentanyl patch from 11-6-10 through 11-11-10, documenting the reason for the omission to be unavailability of the patch. The clinical record lacked any documentation of physician notification following the omissions.

  The program failed to administer medications to Tenant #6 as ordered by the physician.

  Tenant #8's clinical record contained a physician's order, dated 12-13-10 and signed by the tenant's physician, ordering the program staff to administer Seroquel 50 mg for 3 days (BID) and then increase to 100 mg BID.

The clinical record contained a MAR which documented the medication was not given on 12-14-10 at 8:00 am or 8:00 pm. The MAR included a Medication Note page used for documentation of reasons for omission of any medication which indicated the reason for the omission to be unavailability of the medication. The clinical record lacked any documentation of physician notification following the omissions. The program failed to administer medications to Tenant #8 as ordered by the physician.

The nurse typed November 2010 MAR for Tenant #8 contained documentation completed on 10-19-10 by the program nurse which indicated the physician's order for Haldol 1 mg as needed for anxiousness. The nurse typed December 2010 MAR contained documentation by the nurse of a physician's order for Risperidone 1 mg as needed for anxiety. The nurse typed January 2011 MAR contained documentation completed by the program nurse which indicated a physician's order for Haldol 1 mg as needed for anxiety and Risperdone 1 mg as needed for anxiety. Review of the physician's orders for September, October, November, December and January revealed the physician had not specified any reasons for which the prn medications Haldol or Risperdol were to be given. Review of the medication notes indicated the staff had administered medications as follows:

1. Haldol 1 mg in November 13 times and documented the reason as anxiety.
2. Haldol 1 mg in December 16 times with the reason given as anxiety.
3. Risperdone 1 mg in December 3 times with the reason given as anxiety.

The program generated their own MARs by the nurse typing or handwriting in the physician's orders. The program failed to clarify with the physician the reason the prn medications were to be given and gave the medication over 30 times for anxiety which was not identified by the physician as a indication for use.

- Regulatory Insufficiency: The administration of medications shall be provided by a registered nurse, a licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6) a.))

E. Nurse Review

- Monitoring Observation: The following table indicates physician's orders found in the clinical record which did not have proper notation of the time that the order was noted by the nurse.

Tenant #	Physician order	Date of Nurse notation	Observation
#1	12-29-10 Tylenol 500 milligrams (mg) every 4 to 6 hours	12-29-10	No time noted by Staff #12
#3	1-3-11 Lasix 40 mg twice a day (BID)	1-4-11	No time noted by Staff #6
#5	Chlorhexidine mouthwash 15 ml	12-29-10	No time noted by Staff #6

	BID		
#5	Kenalog cream prn	1-7-11	No time noted by Staff #6
#6	Fentanyl 50 mcg every 3 days	12-23-10	No time noted by Staff #6
#6	Physical Therapy to treat	1-7-11	Noted but not dated and no time documented by Staff #6
#6	Vitamin B12 1000 mcg weekly IM for one month then monthly	1-7-11	No time noted by Staff #6
#6	Vicodin 1 to 2 tablets every 4 hours prn	1-7-11	No time noted by Staff #6

An Evaluation/Assessment completed at admission identified the tenant Tenant #2 at risk for falls. The service plan signed and dated 4-22-10 directed staff to encourage the tenant to walk as much as possible to increase strength, use a wheelchair to and from meals and assist as needed on, "weak", days. The 90 day review completed 10-13-10 documented increased confusion was noted. The clinical record contained documentation of falls sustained by the tenant on 10-18, 12-7, two times on 12-10-10, 1-10-11 and 1-12-11. The MAR dated 1-10-11 documented the tenant received Tramadol (a pain medication) which was not effective. The individualized Service Assignment dated 1-11-11 completed by the RCA documented the tenant hurt all over and stated he/she would rather be dead. The clinical record lacked evidence of completion a nurse review after multiple falls which resulted in the tenant's report of continued discomfort on 1-11-11.

Tenant #4, a 97 year old, was admitted 12-6-08 with diagnoses of Dementia and Depression. The tenant resided in the secured memory care unit. The clinical record contained a form which indicated a GDS dated 1-4-11 staged the tenant at 6 which indicated severe cognitive decline. The patient was enrolled with Hospice benefit. The service plan indicated the tenant was dependent on staff for assistance to turn in bed every two hours. A note by the universal worker dated 12-30-10 indicated the tenant had a "sore bottom" and documented notification made to the nurse of the report. The clinical record lacked evidence of a review completed by the nurse to evaluate the tenant's change in health status for treatment or recommendations.

The Nurse Notes, MAR and Individualized Service Assignment and accompanying Notes for Tenant #8, completed by the Memory Care Unit staff during December 2010 and January 2011, reported the following:

12-27-10: The tenant exhibited restlessness, removing other tenants' personal belongings from their rooms to "redecorate" the common areas of the unit, refused to sit to eat meals, attempted to remove other tenants' plates and silverware from the table while the tenants were still eating and attempted to elope from the unit with a family member. The tenant was not easily redirected by staff from any of the above

stated behaviors. The tenant received a prn dose of Haloperidol due to anxiety. Staff documented the medication was not effective.

12-28-10: The tenant exhibited restlessness and moved his/her personal belongings to the common areas of the unit.

1-2-11: The tenant exhibited anxiousness and moved furniture around the unit. The tenant was not easily redirected by staff from this behavior.

1-11-11 The tenant was walking hunched over and the nurse reported an increase in the tenant's back pain for which the physician ordered an analgesic.

1-13-11: The tenant exhibited anxiousness, moving furniture around the unit, attempting to use the other tenants' bathrooms, was wandering and exit seeking. The tenant received a prn dose of Risperidone and Haldol at the same time due to anxiety. Staff documented the medication was not effective.

1-15, 16 and 17, 2010: The tenant received prn doses of Risperidone and Haldol at the same time due to anxiety. Staff documented both medications were ineffective in symptom relief.

On 1-18-11 at 2:15 PM, Staff #5, a resident care assistant (RCA), told the monitors Tenant #8 attempts to exit from the Memory Care Unit approximately 5 times weekly. The RCA had to reset the alarm on the dining room door earlier in the day as the tenant opened the door in an attempt to exit, thereby setting off the alarm.

On 1-18-11 at 3:35 PM, Staff #8, an RCA, told the monitors Tenant #8 often attempts to exit from the Memory Care Unit "sometimes all day long".

On 1-18-11 at 4:00 PM the monitors observed Tenant #8 to be anxious, pacing and attempting to enter doors off of the dining room area. Staff attempted to redirect the tenant without success.

The clinical record lacked evidence of a review completed by the nurse to evaluate for treatment and recommendations, the tenant's continued behaviors and increased pain during January , which did not respond to medications.

- Regulatory Insufficiency: 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. (IAC r. 481-69.27(3))

- Regulatory Insufficiency: To provide the program with written documentation of the activities under the service plan, as set forth in rule 481-69.26(231C), showing the time, date and signature. (IAC r. 481-67.27(4))

F. Staffing

- Monitoring Observation: Staff #1, an RCA, was hired 12-22-10 and continued to work at the program. The personnel record contained a form titled Resident Care Staff Orientation which the program reported documented the registered nurse's (RN) delegation of assigned tasks. This form was signed only by the staff person and lacked documentation by the RN that delegation had been completed.

  Staff #5, RCA, was hired 7-20-10 and continued to work at the program. During interview on 1-12-11, Staff #5 reported she had never had the RN instruct, train and observe demonstration of assigned skills. She stated when she came to work the first day, another RCA showed her how to perform catheter care and then next night she did the task independently.

  Staff #8, a RCA, was hired 9-8-10 and continued to work at the program. During interview on 1-18-10, Staff #8 reported that she had worked at the program for four months and had never had any nurse observation of tasks requiring delegation. She stated she had been given a form at orientation and told to sign it.

  Staff did not have appropriate delegation by the RN prior to performing assigned cares for the tenants.

- Regulatory Insufficiency: The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. (IAC r. 481-69.29(3))

G. Tenant Rights

- Monitoring Observation: Tenant #7 signed an occupancy agreement prior to admission which acknowledged the program's smoke free policy. The tenant resided in the general population. The Tenant scored 29 of 30 on the Mini Mental Status Exam completed 6-18-10 and the GDS dated 10-13-10 staged the tenant at 2-3 which indicated mild cognitive decline. Documentation completed by the tenant's physician on 7-12-10 indicated no evidence of dementia. The tenant signed a negotiated risk statement on 8-2-10 which documented the tenant was to be given two cigarettes and a lighter at each meal. The tenant was to decide if he/she wanted to smoke the cigarettes before or after the meal. The tenant was to stay in the dining room and wait for an escort and return the lighter to them. The agreement continued to state the tenant would receive six cigarettes per day and if the tenant abused the privilege, the cigarettes would be taken away. The service plan, signed by an RN but not the tenant, on 11-4-10 directed staff to bribe the tenant with cigarettes to take a shower. The Individualized Service Assignment (task sheet completed for staff to sign off tasks) dated January 2011 directed staff to give the tenant two cigarettes before breakfast and lunch and at 4:00 p.m. The Assignment also directed staff to give the tenant one cigarette as a reward after assisting with a shower. During observation of medication pass on 1-12-11 at 11:15 a.m., Staff #7 allotted the tenant two cigarettes and reported the tenant had signed an agreement for only two cigarettes with

medications before mealtimes on day shift but would often request additional cigarettes.

Nurse's notes dated 9-16-10 documented the tenant had been on a plan of six cigarettes a day with huge success. Another note dated 12-31-10 documented the tenant had been smoking 3-4 times a day for the last three to four days. On 1-5-11 nurse's notes documented the tenant was noted again to have been smoking in his/her room. The tenant's room was searched and lighters and cigarettes were removed from the apartment.

During an interview with the tenant on 1-19 11, the tenant acknowledged the negotiated risk agreement, stating the program's smoking area was located outside and he/she did not like going outside during the winter but would like to renegotiate the agreement during the summer months. The tenant stated his/her family and the RN did not want him/her to smoke.

The program did not obtain the tenant's signature on the service plans dated 7-14-10, 8-26-10 and 11-4-10. The program obtained a negotiated risk agreement 8-2-10 regulating the tenant's ability to control his/her cigarette usage but did not follow the agreement. The program staff entered the tenant's room, searched it and appropriated the tenant's lighters and cigarettes. The program failed to treat the tenant with consideration and respect warranted to a cognitively intact individual.

- Regulatory Insufficiency: All tenants have the following rights: To be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

H. Other

Complaint Allegation # 32548-C: During the recertification survey, an incident report identified that a tenant had eloped from the secured unit.

- Monitoring Observation: An incident report dated 12-12-10 documented that Tenant #5 was found outside in the fenced yard of the secured dementia unit at 10:00 a.m. It was unknown how long the tenant had been outside. The local weather report for the area at 10:10 a.m. was 7 degrees with a northwest wind of 3 miles per hour and snow on the ground. Staff reported the alarm had not sounded to alert them to someone leaving the locked unit. The tenant was brought back in and warmed with blankets and sustained no permanent injury. Staff #12 completed a follow-up report of the incident on 12-13-10 in which she documented the tenant had a first time elopement for which she initiated a check list to have all doors checked at each shift change. The tenant's clinical record contained a memo from Staff #12 dated 12-13-10 which documented that the issue was that someone used the key to deactivate the lock on both doors and put tenants at risk by not relocking it.

  During interview on 1-18-10, Staff #3 stated that she was aware of a tenant who had eloped and indicated it was Tenant #5.

  The Director stated that he did not consider the incident an elopement and did not report it in to the Department.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available, when a tenant elopes from a program. (IAC r. 481-67.4(4))

Dated this 28th day of January 2011.