IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 31016-C

May 13, 2011

Ms. Christine Brown, Administrator
Martina Place Assisted Living
5815 Winwood Drive
Johnston, IA 50131

RE: Final Complaint Investigation Report, Martina Place Assisted Living, Johnston, Iowa

Dear Ms. Brown:

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #:31016-C**

Ms. Christine Brown, Administrator
Martina Place Assisted Living
5815 Winwood Drive
Johnston, IA 50131

Date of Investigation:

November 2, 2010

Monitor(s):

Hal L. Chase, RN BSN MPH
Lori Miner, RN BSN

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 on-site visit was conducted at Martina Place Assisted Living on November 2, 2010. 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:	53
Current number of tenants with cognitive disorder:	4
Total Population:	57

Dementia Specific Program (DSP)* – Not applicable.

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

Program History – The program received no regulatory insufficiencies during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Occupancy Agreement

During the course of the investigation, the following information was obtained:

- Monitoring Observation:

  Tenant #1's discharge planning notes of 7-8-10 revealed the program nurse indicated the tenant was no longer appropriate for assisted living, although no reason was given. Tenant #2's nurse's notes of 5-26-10 indicated the tenant was not appropriate for assisted living as the tenant had increased confusion, needed stand by assist with activities of daily living (ADLs.) Tenant #3's nurse's notes of 9-24-10 indicated the tenant was an assist with all ADLs and was not appropriate for assisted living. Tenants #2 and #3 were discharged, although the occupancy agreement (OA) dated April, 2007, Section 4, indicated the program would provide assistance with essential activities of daily living in accordance with state regulations.

  The OA does not include the internal appeals process as required under Iowa Code 231.C (5) 2 i., the process for filing a grievance as required under Iowa Code 231.C (2) j and at least a 30-day written notice before changes can be made to the tenant's occupancy, which includs discharge notification.

  Section 6.2 appears to be in conflict with Section 9.

- Regulatory Insufficiency: An assisted living program occupancy agreement shall clearly describe the rights and responsibilities of the tenant and the program. The occupancy agreement shall also include but is not limited to inclusion of all the following information in the body of the agreement or in the supporting documents and attachments. (231 C.5(2))

B. Evaluation of tenant.

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Six tenant files were reviewed. Tenant #1, an 84 year old, was admitted on 2-6-07 and had diagnoses of: History of Mental Disease, Rheumatism, Diabetes Mellitus, Arthritis, Hypertension (HTN), Heart Trouble, Alzheimer's Dementia and a History of Pacemaker Placement. Functional and health evaluation were completed on 2-5-10, however, a cognitive evaluation was not found in the tenant's file. Tenant #1 no longer resides at the program.

  Nurse's notes of 6-12-10 revealed the tenant complained of dizziness and was vomiting. Family was notified and took the tenant to the hospital. Nurse's notes of the same date but separate entry indicated the tenant returned to the program, was diagnosed with a urinary tract infection (UTI) and prescribed an antibiotic. Physician's consultation report of 6-12-10 revealed an order for Bactrim DS, one tablet twice daily for five days. Nurse's notes of 6-13-10 revealed staff assisted the tenant to the bathroom and noted the tenant was "very" unsteady and helped the tenant walk back to bed. Nurse's notes of the same day but separate entry, revealed the nurse was notified the tenant had wandered out of the building, fallen and

sustained an injury and was taken by ambulance to the hospital. Nurse's notes of 6-14-10 revealed family reported the tenant was hospitalized for a laceration to the right hand, an abrasion to the left knee, and a UTI.

Hospital discharge/transfer notes of 6-17-10 revealed the tenant was transferred to skilled nursing care for physical, occupational, and speech therapy and would return to the program. Skilled residence facility encounter form of 6-17-10 indicated the tenant was diagnosed with Hallucinations/Confusion secondary to Bactrim. Nurse's notes of 7-7-10 indicated the tenant was discharged from physical therapy (PT) due to not making progress and was admitted to intermediate nursing care. Discharge planning notes of 7-8-10 revealed the program nurse indicated the tenant was no longer appropriate for assisted living. The program provided an admission agreement of 6-21-10, signed by the tenant's family member for skilled nursing care.

The program did not complete functional, cognitive and health evaluations: when the tenant returned from the hospital on 6-12-10 with a diagnosis of a UTI and antibiotic therapy and when the tenant was discharged from the skilled nursing facility on 7-7-10 and admitted to the intermediate nursing facility on 7-8-10. Although skilled nursing facility staff completed their assessment and determined the tenant was not appropriate for assisted living, the regulations require assisted living staff to complete evaluations when there is a significant change in the tenant's status.

Tenant #2, a 75 year old, was admitted on 1-16-08 and had diagnoses of: Parkinson's Disease, Presenile Dementia, Psychotic Hallucinations, Paralysis Agitans, HTN – Not of Specific Origin (NOS,) Constipation, Distressed Behavior and a History of a Fractured Knee. Functional, cognitive and health evaluations were completed on 8-6-09. The functional evaluation indicated the tenant was independent with ambulation and used a walker. Tenant #2 no longer resides at the program

Nurse's notes of 2-26-10 indicated the tenant called for assistance and staff found the tenant on the bedroom floor next to the bed and chair. Staff called the nurse from the adjacent nursing facility because the tenant had black and blue marks on the right arm and hand. The nurse indicated as long as it did not become more painful and no swelling occurred it should be okay. Staff applied an ice pack to the hand. At 3:28 a.m. the tenant called for bathroom assistance. Staff replaced the ice pack to keep the swelling down. Nurse's notes of 2-26-10 indicated the program nurse noted dark bruising on the right hand and a scrape and bruising to the right outer arm. The tenant denied any pain or discomfort.

Notes of 2-28-10 indicated staff assisted the tenant to the bathroom and changed incontinent undergarments. The tenant asked staff to check his/her back as it was sore. Staff noted black and blue bruising down the middle of the tenant's spine. Staff left a message with the program nurse. Nurse's notes of 3-1-10 indicated the program nurse noted bruising down the center of the tenant's back. Family was contacted and they believed the bruising was from the fall on 2-26-10 when the tenant fell against the bed rail. The program nurse noted no swelling, but the tenant complained of soreness.

Nurse's notes of 3-4-10 and 3-5-10 indicated the tenant had at least two visual hallucinations. Nurse's notes of 3-5-10 indicated the program nurse notified family

of the hallucinations and family said they would call the tenant's physician to see if a change in medication was needed. Nurse's notes of 3-5-10 indicated someone was yelling for help. Staff found the tenant on the floor and called for assistance. The tenant was face down on the floor between the bed and closet; the tenant's head was against the wall and the tenant's arm was bent. Staff called family to ask permission to call 911 and to send the tenant to the hospital. Nurse's notes indicated the tenant's head and arm hurt. When emergency personnel arrived the tenant complained of right hip pain. The side of the tenant's face was bruised and the right shoulder and hip were bruised. Nurse's notes of 3-9-10 indicated the tenant was transferred to the skilled nursing care. Hospital discharge instructions of 3-9-10 indicated the tenant was admitted to sub acute skilled nursing facility for physical and occupational therapy.

Nurse's notes of 3-31-10 indicated the program nurse reported the tenant had increased confusion at the skilled nursing facility, and did not remember to use his/her walker when ambulating. The tenant did not meet the assisted living program's criteria as indicated in the skilled nursing facility's director of nurse's assessment.

Nurse's notes of 4-1-10 indicated a meeting was held with the tenant's family. Family didn't want the tenant discharged from the assisted living program and wanted the physician to review the tenant's medication to determine if improvement could be made in the tenant's physical status. Family wasn't sure if the tenant's status would improve. Nurse's notes of 4-13-10 indicated the tenant's family member was not ready to discharge the tenant from assisted living. Family paid for another month for the assisted living program to see if tenant improved. A return from hospitalization/other facility assessment of 4-28-10 indicated a note dated 4-29-10, written by the program manager indicated the assessment had been placed in the program's mailbox and the tenant would be admitted to intermediate care on 5-1-10;. Nurse's notes of 5-26-10 indicated the tenant was not appropriate for assisted living as the tenant had increased confusion, needed stand by assist with activities of daily living (ADLs.) The program provided an admission agreement to the skilled nursing facility on 7-13-10, which was signed by the tenant's power of attorney.

The program did not complete functional, cognitive and health evaluations; when the tenant sustained two falls with injuries on 2-26-10 and 3-5-10, on 3-4-10 and 3-5-10, when the tenant experienced hallucinations and when the tenant was discharged from the program on 3-31-10 and again on 5-26-10. Although skilled nursing facility staff completed their assessment and determined the tenant was not appropriate for assisted living, the regulations require assisted living staff to complete evaluations when there is a significant change in the tenant's status.

Tenant #3 no longer resides at the program. The tenant, a 98 year old, was admitted on 10-12-05 and had diagnoses of: HTN, Dementia, Depression, Coronary Artery Disease (CAD), Macular Degeneration, Hyperlipidemia and Congestive Heart Failure (CHF). A functional evaluation was completed on 8-27-10 a cognitive and health evaluations were completed on 1-5-10.

Nurse's notes of 9-4-10 indicated the tenant told staff he/she had fallen last night when coming out of the bathroom. The tenant didn't complain of pain but staff checked and no bruises were seen on the back. Nurse's notes of the same date but separate entry indicated staff heard something very loud in the tenant's room. Staff found the tenant's television on the floor, the night stand was upside down, flowers were on the floor and the table and chairs were by the door. The tenant reported two boys were at his/her room. Nurse's notes of 9-5-10 indicated the tenant reported he/she was going to start a fire. Staff indicated the tenant was seeing things and "kids." Nurse's notes of the same date but separate entry indicated the tenant refused to take off his/her clothes and put on pajamas. Family was notified and staff was asked to monitor the tenant.

Nurse's notes of 9-6-10 indicated the program nurse met with the tenant but the tenant didn't acknowledge or talk to the nurse. The tenant held his/her arm out and the tenant's blood pressure was taken. The nurse noted the tenant's skin was warm, dry and color was pasty. The nurse spoke to a family member and reported the tenant was confused and had low blood pressure. Family indicated they would call the tenant's physician and requested medication be held until the physician called the program. The tenant's physician instructed staff to have the tenant go to a hospital emergency room to be evaluated. Family was called and directed staff to call an ambulance. The nurse advised the tenant he/she was going to the hospital but the tenant refused and said "nothing was wrong with me." Family was notified and they would take the tenant. Nurse's notes of the same date but separate entry indicated family reported the tenant was admitted to the hospital. Nurse's notes of 9-7-10 indicated the tenant's was hospitalized related to the fall, Dehydration, and possible Left Lobe Pneumonia.

Nurse's notes of 9-7-10 through 9-24-10 indicated the tenant was out of the building. Nurse's notes of 9-24-10 indicated the tenant was an assist with all ADLs and was not appropriate for assisted living. A staff nurse at the skilled nursing facility contacted the tenant's family and reported the tenant would remain at the skilled nursing facility. The program provided a skilled admission agreement of 9-10-10, signed by the tenant's POA and a physician's order of 9-10-10 to admit to skilled nursing.

The program did not complete functional, cognitive and health evaluations to determine the tenant's eligibility for the assisted living program: when the tenant sustained a fall on 9-4-10, two episodes of hallucinations on 9-5-10 and when the tenant was discharged from skilled nursing to intermediate care nursing.

- 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))

C. Program Initiated Involuntary Transfer

Complaint Allegation: It was alleged a tenant was involuntarily transferred from the assisted living program to a skilled nursing facility following a hospitalization.

Monitoring Observation: Six tenant files were reviewed. Tenant #1's hospital discharge/transfer notes of 6-17-10 revealed the tenant was transferred to skilled nursing care for physical, occupational and speech therapy and would return to the program. Skilled residence facility encounter form of 6-17-10 indicated the tenant was diagnosed with Hallucinations/Confusion secondary to Bactrim. Nurse's notes of 7-7-10 indicated the tenant was discharged from PT due to not making progress and was admitted to intermediate nursing care. Discharge planning notes of 7-8-10 revealed the program nurse indicated the tenant was no longer appropriate for assisted living. The program provided an admission agreement of 6-21-10, signed by the tenant's family member for skilled nursing care.

Tenant #2's nurse's notes of 4-1-10 indicated a meeting was held with the tenant's family. Family didn't want the tenant discharged from the assisted living program and wanted a medication assessment to determine if improvement could be made in the tenant's physical status. Family wasn't sure if the tenant's mental status would improve. Nurse's notes of 4-13-10 indicated the tenant's family member was not ready to discharge the tenant from the assisted living. Family paid for another month for the assisted living program to see if tenant improved. A return from hospitalization/other facility assessment of 4-28-10 indicated the tenant would be admitted to a nursing facility on 5-1-10. Nurse's notes of 5-26-10 indicated the tenant was not appropriate for assisted living as the tenant had increased confusion and needed stand assistance with ADLs.
The program provided an admission agreement to the skilled nursing facility on 7-13-10, which was signed by the tenant's power of attorney.

Tenant #3's nurse's notes of 9-7-10 through 9-24-10 indicated the tenant was out of the building. Nurse's notes of 9-24-10 indicated the tenant was an assist with all ADLs and was not appropriate for assisted living. A staff nurse at the skilled nursing facility contacted the tenant's family and reported the tenant would remain at the skilled nursing facility. The program provided a skilled admission agreement of 9-10-10, signed by the tenant's POA and a physician's order of 9-10-10 to admit to skilled nursing.

The program did not notify the tenant or tenant's legal representative, in accordance with the occupancy agreement (Section 9.2 Notice of Cancellation), the need to and reason for not transferring the tenant back to the program after being discharged from the skilled nursing facility and transferred to the nursing facility. The program did not immediately provide the tenant with contact information for the tenant advocate.

- Regulatory Insufficiency: If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: The program shall notify the tenant or tenant's legal representative, in accordance with the occupancy agreement, of the need to transfer the tenant and of

the reason for the transfer and shall include the contact information for the tenant advocate. The program shall immediately provide to the tenant advocate, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. Pursuant to statute, the tenant advocate shall offer the notified tenant or tenant's legal representative assistance with the program's internal appeal process. The tenant or tenant's legal representative is not required to accept the assistance of the tenant advocate. (IAC r. 481 – 69.24 (1) (a-c))

D. Service Plan

During the course of the investigation, the following information was obtained:

Monitoring Observation: Six tenant files were reviewed. Tenant #2's service plan of 8-6-09 indicated the tenant used a walker but was independent with ambulation. Nurse's notes of 2-26-10 indicated the tenant called for assistance and staff found the tenant on the bedroom floor next to the bed and chair. Staff called the nurse from the adjacent nursing facility because the tenant had black and blue marks on the right arm and hand. The nurse indicated as long as it did not become more painful and no swelling occurred it should be okay. Staff applied an ice pack to the hand. At 3:28 a.m. the tenant called for bathroom assistance. Staff replaced the ice pack to keep the swelling down. Nurse's notes of 2-26-10 indicated the program nurse noted dark bruising on the right hand and a scrape and bruising to the right outer arm. The tenant denied any pain or discomfort.

Notes of 2-28-10 indicated staff assisted the tenant to the bathroom and changed incontinent undergarments. The tenant asked staff to check his/her back as it was sore. Staff noted black and blue bruising down the middle of the tenant's spine. Staff left a message with the program nurse. Nurse's notes of 3-1-10 indicated the program nurse noted bruising down the center of the tenant's back. Family was contacted and they believed the bruising was from the fall on 2-26-10 when the tenant fell against the bed rail. The program nurse noted no swelling, but the tenant complained of soreness.

Nurse's notes of 3-4-10 and 3-5-10 indicated the tenant had at least two visual hallucinations. Nurse's notes of 3-5-10 indicated the program nurse notified family of the hallucinations and family said they would call the tenant's physician to see if a change in medication was needed. Nurse's notes of 3-5-10 indicated someone was yelling for help. Staff found the tenant on the floor and called for assistance. The tenant was face down on the floor between the bed and closet; the tenant's head was against the wall and the tenant's arm was bent. Staff called family to ask permission to call 911 and to send the tenant to the hospital. Nurse's notes indicated the tenant's head and arm hurt. When emergency personnel arrived the tenant complained of right hip pain. The side of the tenant's face was bruised and the right shoulder and hip were bruised.

The program did not update the tenant's service plan to reflect interventions related increased risk for falls, assistance with ambulation and visual hallucinations.

Tenant #3's nurse's notes of 9-4-10 indicated the tenant told staff he/she had fallen last night when coming out of the bathroom. The tenant didn't complain of pain but

staff checked and no bruises were seen on the back. Nurse's notes of the same date but separate entry indicated staff heard something very loud in the tenant's room. Staff found the tenant's television on the floor, the night stand was upside down, flowers were on the floor and the table and chairs were by the door. The tenant reported two boys were in his/her room. Nurse's notes of 9-5-10 indicated the tenant reported he/she was going to start a fire. Staff indicated the tenant was seeing things and "kids." Nurse's notes of the same date but separate entry indicated the tenant refused to take off his/her clothes and put on pajamas. Family was notified and staff was asked to monitor the tenant.

Nurse's notes of 9-6-10 indicated the program nurse met with the tenant but the tenant didn't acknowledge or talk to the nurse. The tenant held his/her arm out and the tenant's blood pressure was taken. The nurse noted the tenant's skin was warm, dry and color was pasty. The nurse spoke to a family member and reported the tenant was confused and had a low blood pressure. Family indicated they would call the tenant's physician and requested medication be held until the physician called the program. The tenant's physician instructed staff to have the tenant go to a hospital emergency room to be evaluated. Family was called and directed staff to call an ambulance. The nurse advised the tenant he/she was going to the hospital but the tenant refused and said "nothing was wrong with me." Family was notified and took the tenant. Nurse's notes of the same date but separate entry indicated family reported the tenant was admitted to the hospital. Nurse's notes of 9-7-10 indicated the tenant's was hospitalized related to the fall, Dehydration and possible Left Lobe Pneumonia.

The program did not update the tenant's service plan to include interventions for increased risk for falls, assistance with ambulation and visual hallucinations.

- 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. (IAC r. 481 – 69.26 (3))

E. Nurse Review

During the course of the investigation, the following information was obtained:

Monitoring Observation: Six tenant files were reviewed. Tenant #1's Nurse's notes of 6-12-10 revealed the tenant complained of dizziness and was vomiting. Family was notified and took the tenant to the hospital. Nurse's notes of the same date but separate entry indicated the tenant returned to the program, was diagnosed with a UTI and prescribed an antibiotic. Physician's consultation report of 6-12-10 revealed an order for Bactrim DS, one tablet twice daily for five days. Nurse's notes of 6-13-10 revealed staff assisted the tenant to the bathroom and noted the tenant was "very" unsteady and helped the tenant walk back to bed. Nurse's notes of the same day but separate entry revealed the nurse was notified the tenant had wandered out of the building, had fallen, sustained an injury and was taken by ambulance to the hospital. Nurse's notes of 6-14-10 revealed family reported the tenant was hospitalized for sustained a laceration to the right hand, an abrasion to the left knee and a UTI.

The program did not complete a nurse review when the tenant returned from the hospital on 6-12-10 with a diagnosis of a UTI which indicated a significant change in the tenant's condition occurred.

Tenant #2's Nurse's notes of 2-26-10 indicated the tenant called for assistance and staff found the tenant on the bedroom floor next to the bed and chair. Staff called the nurse from the adjacent nursing facility because the tenant had black and blue marks on the right arm and hand. The nurse indicated as long as it did not become more painful and no swelling occurred it should be okay. Staff applied an ice pack to the hand. At 3:28 a.m. the tenant called for bathroom assistance. Staff replaced the ice pack to keep the swelling down. Nurse's notes of 2-26-10 indicated the program nurse noted dark bruising on the right hand and a scrape and bruising to the right outer arm. The tenant denied any pain or discomfort.

Notes of 2-28-10 indicated staff assisted the tenant to the bathroom and changed incontinent undergarments. The tenant asked staff to check his/her back as it was sore. Staff noted black and blue bruising down the middle of the tenant's spine. Staff left a message with the program nurse. Nurse's notes of 3-1-10 indicated the program nurse noted bruising down the center of the tenant's back. Family was contacted and they believed the bruising was from the fall on 2-26-10 when the tenant fell against the bed rail. The program nurse noted no swelling, but the tenant complained of soreness.

Nurse's notes of 3-4-10 and 3-5-10 indicated the tenant had at least two visual hallucinations. Nurse's notes of 3-5-10 indicated the program nurse notified family of the hallucinations and family said they would call the tenant's physician to see if a change in medication was needed. Nurse's notes of 3-5-10 indicated someone was yelling for help. Staff found the tenant on the floor and called for assistance. The tenant was face down on the floor between the bed and closet; the tenant's head was against the wall and the tenant's arm was bent. Staff called family to ask permission to call 911 and to send the tenant to the hospital. Nurse's notes indicated the tenant's head and arm hurt. When emergency personnel arrived the tenant complained of right hip pain. The side of the tenant's face was bruised and the right shoulder and hip were bruised.

The program did not complete a nurse review when the tenant sustained two falls with injuries on 2-26-10 and 3-5-10 and when the tenant experienced hallucinations on 3-4-10 and 3-5-10.

Tenant #3's nurse's notes of 9-4-10 indicated the tenant told staff he/she had fallen last night when coming out of the bathroom. The tenant didn't complain of pain but staff checked and no bruises were seen on the back. Nurse's notes of the same date but separate entry indicated staff heard something very loud in the tenant's room. Staff found the tenant's television on the floor, the night stand was upside down, flowers were on the floor and the table and chairs were by the door. The tenant reported two boys were in his/her room. Nurse's notes of 9-5-10 indicated the tenant reported he/she was going to start a fire. Staff indicated the tenant was seeing things and "kids." Nurse's notes of the same date but separate entry indicated the tenant refused to take off his/her clothes and put on pajamas. Family was notified and staff was asked to monitor the tenant.

Nurse's notes of 9-6-10 indicated the program nurse met with the tenant but the tenant didn't acknowledge or talk to the nurse. The tenant held his/her arm out and the tenant's blood pressure was taken. The nurse noted the tenant's skin was warm, dry and color was pasty. The nurse spoke to a family member and reported the tenant was confused and had low blood pressure. Family indicated they would call the tenant's physician and requested medication be held until the physician called the program.

The program did not complete a nurse review when the tenant sustained a fall and complained of pain on 9-3-10 and when the tenant experienced hallucinations on 9-4-10 and 9-5-10 and was going to start a fire on 9-5-10.

- 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))

F. Other

During the course of the investigation, the following information was obtained:

Monitoring Observation: Six tenant files were reviewed. Tenant #1's hospital discharge/transfer notes of 6-17-10 revealed the tenant was transferred to skilled nursing care for physical, occupational and speech therapy and would return to the program. Skilled residence facility encounter form of 6-17-10 indicated the tenant was diagnosed with Hallucinations/Confusion secondary to Bactrim. Nurse's notes of 7-7-10 indicated the tenant was discharged from PT due to not making progress and was admitted to intermediate nursing care. Discharge planning notes of 7-8-10 revealed the program nurse indicated the tenant was no longer appropriate for assisted living. The program provided an admission agreement of 6-21-10, signed by the tenant's family member for skilled nursing care

Tenant #2's Nurse's notes of 3-31-10 indicated the program nurse reported the tenant had increased confusion at the skilled nursing facility, and did not remember to use his/her walker when ambulating. The tenant did not meet the assisted living program's criteria as indicated in the skilled nursing facility's DONs nurse's assessment.

Nurse's notes of 4-1-10 indicated a meeting was held with the tenant's family. Family didn't want the tenant discharged from the assisted living program and wanted a medication assessment to determine if improvement could be made in the tenant's physical status. Family wasn't sure if the tenant's mental status would improve. Nurse's notes of 4-13-10 indicated the tenant's family member was not ready to discharge the tenant from the assisted living. Family paid for another month for the assisted living program to see if tenant improved. A return from hospitalization/other facility assessment of 4-28-10 indicated a note dated 4-29-10, written by the program manager indicated the assessment had been placed in the program's mailbox and the tenant would be admitted to intermediate care on 5-1-10. Nurse's notes of 5-26-10 indicated the tenant was not appropriate for assisted living as the tenant had increased confusion, needed stand by assist with ADLs. The program provided an admission

agreement to the skilled nursing facility on 7-13-10, which was signed by the tenant's power of attorney.

Tenant #3's nurse's notes of 9-7-10 through 9-24-10 indicated the tenant was out of the building. Nurse's notes of 9-24-10 indicated the tenant was an assist with all ADLs and was not appropriate for assisted living. A staff nurse at the skilled nursing facility contacted the tenant's family and reported the tenant would remain at the skilled nursing facility.

The program did not treat the tenant with consideration and autonomy to return to the program.

- 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))

Dated this 12th day of May 2011.