IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 34794-C
34822-C
34948-C
35109-C
35122-C
35164-C

October 11, 2011

Ms. Kara Bernsee, Administrator
Silvercrest at Woodlands Creek
12605 Woodlands Parkway
Clive, IA 50325

RE: I. Final Complaint and Incident Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Bernsee:

I. Final Complaint and Incident Investigation Report – Silvercrest at Woodlands Creek, Clive, IA

Enclosed is the **Final Complaint and Incident 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. The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Documents, Service Plan, Medications, Nurse Review, Staffing, Policies and Procedures, Life Safety and Structural. **Silvercrest at Woodlands Creek** ("Program") is being assessed a $5,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

II. Civil Penalty

If, within 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 civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order in the amount of three thousand two hundred fifty dollars ($3250) 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 thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $5,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on October 6, 2011, has been reviewed and will constitute the final POC related to the on-site visit of July 19-21 & 25-29, 2011.

The Request for Reconsideration regarding Evaluations is not accepted. Evaluations were done after the visit does not indicate program was in compliance at the time of the onsite.

The Request for Reconsideration regarding Service Plans is not accepted. Tenant #7 was diagnosed with MRSA on June 28, 2011. The Service Plan was not updated until July 16, 2011.

The Request for Reconsideration regarding Medications is not accepted. The medical documentation submitted does not match the documentation gathered at the time of the onsite. The Final Report has been changed to reflect the order was noted for Tenant #2 to May 9, 2011.

The Request for Reconsideration regarding Nurse Review is not accepted. Tenant #7 was diagnosed with MRSA on June 28, 2011 and no nurse review was conducted.

The monitoring observation regarding Retaliation has been modified and the Final Report has been amended as requested.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal 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 enclosed 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 and Incident Investigation Report

Assisted Living Program:

Kara Bernsee Administrator
Silvercrest at Woodlands Creek Assisted Living
12605 Woodlands Parkway
Clive, IA 50325

Complaint Intake #: 34794-C
34822-C
34948-C
35109-I
35122-C
35164-C

Date of Investigation:

July 19-21 & 25-29, 2011

Monitor(s):

Hal Chase, RN BSN MPH
Lori Miner, RN BSN
Rose Boccella, MA
Ann Martin, 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 and incident investigation on-site visit was conducted at Silvercrest at Woodlands Creek Assisted Living on July 19-21 & 25-29, 2011. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS:	12
Current number of tenants without cognitive disorder:	46

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

Total Population of DSP:	15
Total Census of ALP:	73

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

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

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

A. Criteria for Exclusion of Tenants

Complaint Allegation 34794-C & 34822-C: It was alleged Tenants #1, #2, #3 needed two staff assist with transfer and or ambulation.

Monitoring Observation: Tenant #1 (the Tenant), an 80 year-old, was admitted on 3-25-08 and had diagnoses of: Alzheimer's Dementia, Hypertension (HTN), History of Left Hip Fracture, Glaucoma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Atrial Fibrillation, and Gastro Esophageal Reflux Disease (GERD). A cognitive evaluation was completed on 7-16-11 and staged the Tenant at four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Service plan of 7-16-11 revealed the Tenant was independent with a wheelchair, and needed one staff assist with a gait belt when ambulating long distances and with transfer. Fifteen staff was interviewed. Staff #13 and #15 reported the Tenant was a routine two-staff assist with transfer and ambulation. A monitor observed one staff transfer the Tenant on three separate occasions from a wheelchair to the toilet and toilet to chair. The Tenant could be transferred safely with the assist of one staff.

Tenant #2 (the Tenant), a 93 year-old, was admitted on 9-16-05 and had diagnoses of: HTN, Depression, Degenerative Joint Disease (DJD), GERD, Cognitive Impairment,

Constipation, Diarrhea, and Pain. A cognitive evaluation was completed on 7-15-11 and staged the Tenant at six on the GDS, which indicated severe cognitive decline. The Tenant resided in the dedicated dementia unit. Clinical Notes of 7-15-11, revealed staff reported the Tenant was a two-person assist with transfer. The service plan was updated on 7-15-11, and indicated the Tenant used a wheelchair for mobility and one to two-staff were needed for ambulation when the Tenant "cycled" and became lethargic and weak.

The Nurse reported Tenant #2 did not routinely require two persons for transfer. Staff #2, #3, #4, #5, #6, #7, #13 and #15 reported the Tenant needed two staff to assist with transfer and ambulation. A monitor observed one staff transfer the Tenant from a chair to wheelchair, wheelchair to the toilet, and toilet to wheelchair. The Tenant could be transferred safely with the assist of one staff.

Tenant #3, (the Tenant) an 84 year old, was admitted on 4-15-11 and had diagnoses of: Parkinson's Disease, Cognitive Disorder, Dementia, Bipolar Disorder, History of Headaches, Dysphagia, and Bipolar Depression. A cognitive evaluation was completed on 7-15-11 and staged the Tenant at five on the GDS, which indicated moderately severe cognitive decline. Service plan of 7-15-11 revealed the Tenant needed one staff assist with mobility and transfer. The service plan of 7-15-11 revealed the Tenant had a history of falls. Sixteen incidents were recorded of the Tenant falling or being found on the floor between 5-14-11 and 7-14-11. The Tenant tried to ambulate independently or with the help of his/her spouse, to use the toilet or to go to bed. Two injuries from falls were noted on 5-23-11 and 7-14-11. Fifteen staff interviewed did not identify the Tenant as needing routine two-staff assist with transfer or ambulation. A monitor observed one staff transfer the Tenant on three separate occasions from a wheelchair to the toilet and toilet to chair. The Tenant could be transferred safely with the assist of one staff.

Complaint Allegation 34794-C: It was alleged Tenant #6 eloped from the memory care unit numerous times.

Monitoring Observation: Tenant #6 (the Tenant), an 89 year-old, was admitted on 1-4-11 and had diagnoses of: Dementia, Urinary Incontinence, History of Atrial Fibrillation, Prostate Cancer, HTN, and CAD. A cognitive evaluation was completed on 2-2-11 and staged the Tenant at five on the GDS, which indicated moderately severe cognitive decline. The Tenant resided in the dedicated dementia unit. Clinical notes of 1-11-11 and 1-12-11 documented the Tenant was physically aggressive toward staff, broke a leg off a table and hit a staff member. The Tenant wandered the halls and went into other tenant's rooms and made several attempts to elope from the program by pushing on the alarmed door. On 1-13-11, the Tenant was admitted to local hospital for psychiatric care. Clinical notes did not indicate when the Tenant returned to the program. On 1-17-11, the Tenant was evaluated at the hospital. Clinical notes of 2-2-11 revealed a 30-day service plan update was completed. Clinical notes of 2-2-11 through 7-15-11 revealed no incidents of behavioral issues.

Fifteen staff was interviewed. Staff #3 stated the Tenant has left the dementia unit and came down the stairs, but never left the building. Staff #4 reported the Tenant wandered the unit, pushed the exit door, but when the alarm sounded the Tenant would stay in the dementia unit. Staff #6 identified the Tenant as having eloped but didn't give specific dates.

Complaint Allegation 34822-C: It was alleged there was tenants who require "complete" assistance with activities of daily living (ADLs).

Monitoring Observation: Tenant #1 through #15's files were reviewed and revealed tenants did not need routine total dependence on staff for the performance of a minimum of four ADLs for a period that exceeded 21 days. Fourteen staff interviewed did not identify tenants who were totally dependent on staff for the completion of four ADLs.

- Regulatory Insufficiency: None noted.

B. Tenant Documents

Complaint #34822-C: It was alleged tenants who required two-hour toileting were consistently soiled with urine.

Monitoring Observation: Fifteen tenant files were reviewed, Tenants #2, #3, #7, and #9 required toileting and perineal care every two-hours. Fifteen staff was interviewed. Staff # 3, #4, #6, #13, and #15 reported Tenant's #2, #3, #7 and #9 were continuously soiled with urine.

Tenant #2's service plan of 7-15-11 revealed the Tenant was incontinent of urine and used absorbent pads. Staff was to change the pads when wet. The service plan of 7-15-11 did not reveal the Tenant was on a two-hour toileting schedule. Clinical notes of 7-21-11 reported staff had reported Tenant #2 had been in bed all morning. Staff reported the Tenant had a "bad" day, and this was part of a cycle. The Tenant was noted to be unresponsive to verbal stimuli and light touch, his/her eyes were closed, and the Tenant was drooling. The Tenant was observed to be soiled with urine once. The program provided a task list for the month of July 2011 The Tenant had no documentation of eating breakfast or lunch on 7-4, 7-8, 7-12, 7-14, or 7-20. Documentation on the task list indicated the Tenant slept through breakfast and lunch on 7-14-11. It was also noted on the task list the Tenant did not receive morning cares on 7-4, 7-8, 7-12, 7-13, and 7-20-11. Evening cares were not completed on 7-3, 7-9, 7-10, 7-18, and 7-20-11. No other task lists were found. The Program did not accurately document the completion of routine personal and health-related cares on task sheets, for a Tenant who could not advocate on his/her own behalf.

Tenant #3's service plan of 7-15-11 revealed the Tenant required assistance with toileting every two hours and perineal care. At least 16 incidents were recorded of the Tenant falling or being found on the floor between 5-14-11 and 7-14-11. The Tenant tried to ambulate independently or with the help of his/her spouse, to use the toilet or to go to bed. Two injuries from fall were noted on 5-23-11 and 7-14-11. The service plan of 7-15-11 revealed the tenant required toileting assistance and perineal care and was on a two-hour toileting schedule. The Tenant was also on one-hour safety checks related to numerous falls. The Program did not accurately document the completion of routine personal and health-related cares on task sheets, for a Tenant who could not advocate on his/her own behalf.

Tenant #7 (the Tenant) a 92 year old, was admitted on 8-22-09 and had diagnoses of: Cataracts, Urinary Incontinence, Alzheimer's Dementia, Chronic Rash, Rheumatoid Arthritis, Monoclonal Gammopathy of Undetermined Significance, History of Deep Vein

Thrombus (DVT) of the Left Leg. A cognitive evaluation was completed on 5-3-11, and staged the Tenant at five on the GDS, which indicated moderately severe cognitive decline. Clinical notes of 5-3-11 and Medication Administration Records (MARs), for the same month revealed the Tenant was treated with a topical crème to the left leg, as there were multiple open and scabbed sores. The Tenant had been scratching at his/her skin and scabbed areas could be seen on legs, arms, back and coccyx. On 5-5-11, the Tenant was taken to a local hospital emergency room, as the Tenant had picked at an open lesion on the Tenant's lips. On 7-21-11, a monitor observed staff assisting the Tenant to the restroom. The Tenant had open areas on the left leg and was seen scratching his/her back. A scratch mark was seen on the Tenant's lower back. An open sore, in addition to scabbed areas were seen on the Tenant's buttocks. Staff #16 reported the Tenant had problems with itching. Staff #13 and #15 identified Tenant #7 as having open sores. Staff #15 reported the sores were from the Tenant "picking."

On 5-20-11 the Tenant's physician was notified the Tenant continued to have increased incontinence and an antibiotic was started. An order was obtained to complete a urinalysis in seven days. On 6-23-11, the Tenant's physician was notified of increased frequency in urination, was combative and refused staff attempts to toilet. An order was obtained for a urinalysis. Lab results of 6-28-11 indicated the Tenant had a urinary tract infection (UTI) and Methicillin Resistant Staphylococcus Aureus (MRSA). The tenant was treated. Notes of the same entry revealed the physician was notified the Tenant had increased incontinence and was not feeling well and requested to stay in his/her apartment. On 7-5-11, the physician was notified the Tenant had fallen in the dining room when attempting to sit in a chair. On 7-13-11, the physician was notified the Tenant had completed antibiotic treatment for MRSA, but continued to complain of not feeling well

Clinical notes of 5-3-11 through 7-13-11 revealed the Tenant had at least three instances of increased frequency of urination and treatment for MRSA. A Service plan of 7-16-11 revealed the Tenant was incontinent and needed two hour toileting and perineal care routinely. The Program did not accurately document the completion of routine personal and health-related cares on task sheets, for a Tenant who could not advocate on his/her own behalf.

Tenant #9 (the Tenant), an 86 year-old, was admitted on 4-6-10 and had diagnoses of: HTN, CHF, Benign Prostatic Hypertrophy, DJD, Obesity, Cataract, and Venous Stasis. A cognitive evaluation was completed on 7-13-11 and staged the Tenant at five on the GDS which indicated moderately severe cognitive decline. The service plan dated 4-15-11 revealed the Tenant was to be toileted every two hours and as needed while awake. The Tenant was noted to resist toileting when out of the apartment and required staff to try different approaches to toilet the Tenant. The Tenant required assistance to correctly place new absorbent pads and properly dispose of used pads. The Program did not accurately document the completion of routine personal and health-related cares on task sheets, for a Tenant who could not advocate on his/her own behalf.

Complaint Allegation #34822-C: It was alleged Tenant #8 needed to be fed by staff for every meal.

Monitoring Observation: Tenant #8 (the Tenant), a 102 year-old, was admitted on 12-3-02 and had diagnoses of: Atrial Fibrillation, HTN, Osteoarthritis, CHF, Hypothyroidism,

and Pain. A cognitive evaluation was completed on 7-15-11 and staged the Tenant at five on the GDS, which indicated moderately severe cognitive decline. The Tenant was admitted to hospice on 4-27-09 for CHF. The Program was granted a waiver for the Tenant from the Department on 2-28-11, as it was reported the Tenant needed routine two staff assist with transfer and ambulation. Hospice provided an aide to do personal cares two to three times a week. The service plan did not identify the frequency of the hospice services. Clinical notes dated 7-15-11 revealed the staff reported the Tenant had experienced increased confusion and was not consistently using the call pendant. The service plan dated 7-15-11 directed the staff to perform two-hour safety checks.

On 8-11-10, the Tenant weighed 107 pounds. On 7-13-11 the Tenant weighed 99 pounds, an eight pound weight loss. The service plan of 7-15-11 revealed the Tenant was on a mechanical soft diet and required staff assistance with cutting food. The Tenant had difficulty eating and chewing and staff was to do hand-over-hand. On 7-19-11 at 5:25 p.m. a monitor asked Staff #8 to identify the Tenant. Staff reported the Tenant had left the dining room, but directed the monitor to the Tenant's table. A plate of cut-up food was observed. Most of the food remained on the plate. Staff #8 reported the Tenant did not eat much. Staff #8 reported kitchen staff had been instructed to cut up food, but not to assist the Tenant with eating. The Tenant had been shaky, had poor vision and had difficulty getting the food to his/her mouth. On 7-20-11 at 7:50 a.m. the Tenant was observed eating a bowl of applesauce. The Tenant used a spoon to feed himself/herself and the applesauce ended up on the table. Staff was observed assisting the Tenant until the Tenant reported he/she was not feeling well and the Tenant was taken to his/her room. On 7-20-11, a monitor observed the noon meal. The Tenant was served a turkey mignon. Dietary staff was observed staff cutting the meat and the Tenant attempted unsuccessfully to chew the food then spit it out.

The Nurse and Nurse Consultant were informed the Tenant was not given a mechanical soft diet and were shown the cut meat on the plate. Both were told staff had not assisted the Tenant with eating. On 7-21-11, a monitor observed the noon meal. The food served was a mechanical soft diet, but staff was not observed assisting the Tenant. Fifteen staff was interviewed. The Nurse, Staff #4, #6, and #8 reported at times Tenant #8 required feeding assistance. Staff #13 reported Tenant #8 required feeding assistance with every meal. The Program did not accurately document the completion of routine personal and health-related cares on task sheets, for a Tenant who could not advocate on his/her own behalf.

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

Tenant #3's clinical notes of 7-6-11, revealed the Program notified the physician the Tenant had been observed pocketing food when eating. The Program requested a speech therapy consult. A speech evaluation completed on 7-18-11 revealed the Tenant presented mild to moderate oral stage Dysphagia. The Tenant presented a decrease in oral mouth strength, range of motion and coordination, increased mastication time with solid textures and the holding/pocketing of food. Clinical notes of 7-15-11 revealed staff reported the Tenant was pocketing food. The Nurse noted the Tenant struggled when eating eggs during breakfast of 7-15-11. The Program did not accurately document the completion of routine personal and health-related cares on task sheets, for a Tenant who could not advocate on his/her own behalf.

Tenant #12, (the Tenant) an 85 year old, was admitted on 11-20-10 and had diagnoses of: Dementia, Parkinson's Disease, Weakness, History of Falls, Anxiety and Urinary Incontinence. The Tenant was staged at four on the GDS, which indicated moderate cognitive decline. The Tenant resided in the dementia unit. The Tenant's service plan revealed the Tenant had "freezing episodes," where the Tenant was unable to move his/her body and had difficulty opening his/her eyes. The Tenant had hallucinations "later in the day" and staff was not to correct the Tenant if the Tenant was safe. Staff was to use a gait belt when ambulating the Tenant. A bed and chair alarm had been placed under the plastic cover to prevent the Tenant and his/her spouse from finding and removing them. The service plan revealed the Tenant was incontinent of urine, but was independent with toileting. The Tenant was independent with eating and staff was to complete one hour safety checks, as the Tenant had increased falls and was inconsistent on the use of the call pendent.

A review of incident reports revealed the Tenant had fallen or was found on the floor by staff at least 16 times between 5-1-11 and 7-10-11. Of these falls, staff reported the Tenant sustained injury and a change in status on 5-18-11, 5-21-11, 6-6-11, 6-8-11, 6-29-11, 7-5-11 and 7-9-11. Staff #2 and #3 reported the Tenant would try and ambulate to the restroom on his/her own, would fall and would have soiled his/her undergarment. On 7-20-11, staff #1 and #15 were interviewed by a monitor and reported the bed and chair alarms were not used the previous evening and night of 7-19-11, as staff could not find them. On 7-20-11, a monitor informed the Operations Manager LPN the Tenant's chair and bed alarm was missing. The Operations Manager LPN searched the Tenant's apartment and did not locate either alarm. The Operations Manager LPN reported staff had called the Nurse at 10:00 p.m. the previous evening and reported the chair alarm was missing. The Nurse reported she did not give staff any new interventions to implement related to the safety of the Tenant during the evening and night hours.

On 7-20-11, a monitor observed the Tenant attempted to eat breakfast. The Tenant's eyes were closed while attempting to use a fork to pick up a pancake. Staff #2 came into the dining room approximately 10 minutes after the Tenant attempted to eat breakfast and assisted the Tenant with eating. On 7-21-11, a monitor observed the Tenant having great difficulty ambulating from his/her apartment to the dining room. The Tenant's eyes were closed while attempting to lift his/her feet and the Tenant's gait was unsteady. The Tenant wasn't following staff's direction while attempting to ambulate into the dining room. The Tenant turned and bumped into a wall. Staff #2 and #3 reported the Tenant would have his/her eyes shut when he/she attempted to eat breakfast and lunch. The Tenant's spouse would often help the Tenant with meals. The Program did not accurately document the completion of routine personal and health-related cares on task sheets, for a Tenant who could not advocate on his/her own behalf.

Tenant #15 (the Tenant), an 82 year old, was admitted on 10-15-04 and had diagnoses of: Depression, B-12 Deficiency, Paroxysmal Atrial Fibrillation, Bladder Spasms, Anxiety, and Chronic Diarrhea. A cognitive evaluation was completed on 7-23-11 and staged the Tenant at five on the GDS, which indicated moderately severe cognitive decline. The Tenant resided in the dementia unit. On 7-23-11, a hospice initial assessment was completed and the Tenant was admitted to hospice with an admitting diagnosis of Terminal Dementia. The Tenant's service plan was updated on 7-23-11 and revealed staff was to turn and reposition every two hours, assist with toileting and perineal care and place protective cream on the peri-area and coccyx to protect skin breakdown. Staff

was to offer oral care swabs and fluids every two-hour. Clinical notes of 7-24-11 revealed the Tenant fell the previous evening and sustained injury to the right knee. Clinical notes of the same entry revealed the Tenant had no intake of food and had "very minimal amounts of water" since 7-21-11. A nurse review completed by the Nurse of 7-24-11, revealed the Tenant continued to become weaker and was unable to hold any nutrition or hydration. A review of the Tenant's file revealed a task list was initiated on 7-23-11 at 4:00 p.m. Task list of 7-25-11 revealed staff had not documented at 2:00 a.m., 4:00 a.m. and 6:00 a.m. tasks related to toileting, perineal care, repositioning, oral care and fluids. The Program did not accurately document the completion of routine personal and health-related cares on task sheets, for a Tenant who could not advocate on his/her own behalf.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include; when the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care on task sheets. If tasks are doctor- ordered, the tasks shall be part of the medication administration record (MARs). (IAC r. 481-69.25(1)(q))

C. Tenant Rights

Complaint Allegation 34948-C: It was alleged staff brought minor children to work with them, who were in the nurse's office where tenants' private and confidential information was stored. It was alleged they carried medications to the tenants' rooms.

Monitoring Observation: The Nurse, the Nurse Consultant, and fifteen staff members were interviewed. Staff #2 reported seeing the Operation Director's minor family member sitting in the nurse's station. Staff #9 reported seeing the Operation Director's family frequently sitting in the nurse's station. The Administrator, Operations Director, and Nurse reported during the onsite, their children had been at the program on several occasions, but did not have access to tenants' personal and confidential information, including medications. During the onsite visit, monitors saw the Administrator's minor family member coming in and out of the program and was seen sitting in the Administrator's office.

Complaint Allegation #34948-C: It was alleged staff "made fun" of and yelled at Tenant #9. It was alleged staff made Tenant #11 scrub the kitchen dining area in the memory unit.

Monitoring Observation: Tenant #9 was observed receiving cares from and interacting with staff over the course of the onsite visit. The Tenant was observed in the apartment, the dining room, and the lobby. Staff treated the Tenant appropriately. The Tenant reported being treated well by staff.

Tenant #11 (the Tenant), an 82 year-old, was admitted on 4-27-10 and had a diagnosis of: Dementia. A cognitive evaluation was completed on 4-28-11 and staged the Tenant at five on the GDS which indicated moderately severe cognitive decline. The Tenant resided in the dementia unit. The service plan dated 4-29-11 revealed the Tenant enjoyed folding laundry, setting the table, sweeping, and scrubbing the floor. During the course of the onsite visit, the Tenant was not observed scrubbing the kitchen area.

The Nurse, the Nurse Consultant and thirteen staff members were interviewed. Staff interviewed reported they had not seen or heard staff make fun of or yell at tenants. Staff #1 reported another tenant reported staff was rude to him/her. Staff #3 reported staff had joked with tenants but staff were not mean. None of the staff reported a tenant was forced to clean.

Incident Allegation #35109-I: It was reported Staff #17 witnessed Staff #1 yelling at Tenant #1 to "quit being so f...ing lazy and pick up your catheter bag." Staff #17 stated the incident occurred approximately two and a half weeks ago.

Monitoring Observation: Tenant #1's service plan of 7-16-11, revealed the Tenant required assistance of one staff for toileting and suprapubic catheter care. An incident report of 7-20-11 documented the above statement of Staff #17. Staff #1 and Staff #17 were interviewed by a monitor. Staff #17 stated Staff #1 was verbally abusive toward the Tenant two and a half weeks earlier. Staff #17 stated she wasn't sure of the date or time when the incident occurred. She stated she was standing outside of the Tenant's room and heard Staff #1 tell the Tenant to "quit being f...ing lazy and pick up your catheter bag." When asked why she didn't report the incident she stated Staff #1 was her friend and she didn't want her to get into any trouble. Program records revealed an incident report was completed on 7-20-11. The program notified the Department on 7-21-11 of suspected dependent adult abuse. Program records revealed the program interviewed 10 staff and 10 tenants. Tenants and staff reported they had not witnessed staff be verbally or physically abusive toward Tenant #1 or to other tenants. A monitor interviewed staff and tenants and none reported witnessing a staff member being physically or verbally abusive.

Program records revealed Staff #1 was suspended from employment on 7-20-11. Staff #1 was interviewed on 7-25-11. She denied being verbally abusive toward Tenant #1. A review of the personnel file revealed no previous incidents of being inappropriate to tenants. Tenant #1 was interviewed by a monitor and he/she reported Staff had not been verbally inappropriate. Staff #17 was interviewed by a monitor and confirmed what she had stated previously regarding the incident she had witnessed two and a half weeks ago.

- Regulatory Insufficiency: None noted.

D. Service Plan

Complaint Allegation #34794-C: It was alleged Tenant #10 needed mental health assistance and was neglected by the program.

Monitoring Observation: Tenant #10, (the Tenant) an 81 year old, was admitted on 10-23-10 and had diagnoses of: History of Abdominal Pain, Depression, Dyspepsia, Edema, Facial Pain Syndrome, Hyperlipidemia, HTN, Insomnia and Neck Strain. A cognitive evaluation was completed on 7-8-11 and staged the Tenant at six on the GDS, which indicated severe cognitive decline. The Tenant resided in the dementia unit. A physician's evaluation of 10-20-10 revealed the Tenant had multiple psychiatric hospitalizations for chronic depression. The Tenant complained "bitterly" of right-sided facial pain. The Tenant's service plan of 7-8-11 established interventions related to the Tenant's pain management for facial pain, anxiety and the completion of one hour safety

checks. Fifteen staff interviewed did not identify the Tenant as needing mental health assistance or being neglected by the program.

Complaint Allegation #34794-C & #34822-C: It was alleged service plans did not reflect the needs of Tenant's #1, #2, #4 and #5. It was alleged Tenant #4's service plan were altered in order to keep the Tenant at the program.

Monitoring Observation: Tenant #1, #2, #4 and #5's service plans were reviewed and represented the identified needs of the tenants.

- Regulatory Insufficiency: None noted.

Complaint Allegation #34948-C: It was alleged Tenant #7 was allowed to stay in bed "until noon" and bedding was soaked from urine. It was alleged the Tenant had multiple sores on his/her back, some of which were open.

Monitoring Observation: Tenant #7's Clinical notes of 5-3-11 and Medication Administration Records (MARs), for the same month revealed the Tenant was treated with a topical crème to the left leg, as there were multiple scabbed areas. The Tenant had been scratching at his/her skin and scabbed areas could be seen on legs, arms, back and coccyx. On 5-5-11, the Tenant was taken to a local hospital emergency room, as the Tenant had picked at an open lesion on the Tenant's lips. On 7-21-11, a monitor observed staff assisting the Tenant to the restroom. The Tenant had open areas on the left leg and was seen scratching his/her back. A scratch mark was seen on the Tenant's lower back. An open sore, in addition to scabbed areas were seen on the Tenant's buttocks. Staff #16 reported the Tenant had problems with itching. Staff #13 and #15 identified Tenant #7 as having open sores. Staff #15 reported sores were from the Tenant "picking."

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

Monitoring Observation: Tenant #3's file revealed on 7-6-11, the Program reported to the Tenant's physician the Tenant was pocketing food. The Program requested a speech therapy consult. An evaluation completed on 7-18-11 revealed the Tenant presented mild to moderate oral stage Dysphagia. The Tenant presented a decrease in oral mouth strength, range of motion and coordination, increased mastication time with solid textures and the holding/pocketing of food. Clinical notes of 7-15-11 revealed staff reported the Tenant was pocketing food. The Nurse noted she had watched the Tenant "struggling with eggs" during breakfast of 7-15-11. The service plan of 7-15-11 revealed the Tenant was independent with eating, but the spouse cut up the food for the Tenant. The Program did not establish interventions related to pocketing of food, to monitor for difficulty in swallowing and to assist the Tenant when needed.

Tenant #7's file revealed on 5-3-11, the Tenant's physician was notified the Tenant had increased incontinence at night. On 5-20-11 the Tenant's physician was notified the Tenant continued to have increased incontinence and an antibiotic was started. On 6-23-11, the physician was notified of increased frequency in urination, the Tenant was combative and refused staff attempts to toilet. An order was requested for a urinalysis. Lab results of 6-28-11 indicated the Tenant had a UTI. Lab results of 6-28-11 revealed the Tenant had MRSA. An order was obtained to treat with an antibiotic. On 6-28-11,

the physician was notified the Tenant had increased incontinence and was not feeling well and had requested to stay in his/her apartment. On 7-5-11, the physician was notified the Tenant had fallen in the dining room when attempting to sit in a chair. On 7-13-11, the physician was notified the Tenant had completed antibiotic treatment for MRSA, but the Tenant continued to complain of not feeling well.

Clinical notes of 5-3-11 through 7-13-11 revealed the Tenant had at least three instances of increased incontinence and was positive for MRSA. The service plan of 7-16-11 indicated the Tenant had a history of chronic UTIs and directed staff to implement universal precautions and notify the nurse of any changes in urine color, frequency and urgency in urination. The Tenant's service plan was updated on 6-27-11 and directed staff to cue and provide reminders and toilet the Tenant every two hours, but didn't establish interventions related to chronic UTIs, treatment with antibiotic therapy, and signs and symptoms of a UTI. The service plan was not updated until 7-16-11, despite being diagnosed with MRSA on 6-28-11.

Tenant #8 was admitted to hospice on 4-27-09. The hospice team care plan dated 7-1-11 revealed the Tenant had an open wound. The goal was to maintain skin integrity. An interview with the Hospice Nurse on 7-21-11 revealed the Tenant previously had skin breakdown, but the breakdown had been resolved for the last one and a half to two weeks. The Hospice Nurse reported the Tenant had been repositioned in his/her chair to keep the Tenant off the buttocks. The service plan initiated by the program and dated 7-15-11 revealed the Tenant napped in the recliner throughout the day. The service plan did not indicate interventions other than ointment to maintain skin integrity. On 7-21-11 the Tenant was noted to have a new, open wound in the coccyx area. The Program did not establish interventions related to the prevention of skin breakdown.

Tenant #11 was noted to swat at a roommate in a fax to the physician dated 1-17-11. The Tenant was yelling at other tenants and staff, and was difficult to calm down. Clinical notes of 5-6-11 revealed the Tenant was more difficult in toileting, refused to be changed when incontinent, and showed irritability with other tenants. The service plan of 4-15-11 was not updated to establish interventions related to behaviors.

Tenant #12's service plan revealed the Tenant had "freezing episodes," where the Tenant was unable to move his/her body. The Tenant would have difficulty in opening his/her eyes. The Tenant had hallucinations "later in the day" and staff was not to correct the Tenant, if the Tenant was safe. Staff was to use a gait belt when ambulating the Tenant. A bed and chair alarm had placed under the plastic cover to prevent the Tenant and his/her spouse from finding and removing them. The service plan revealed the Tenant was incontinent of urine, but was independent with toileting. The Tenant was independent with eating and staff was to complete one hour safety checks, as the Tenant had increased falls and was inconsistent on the use of the call pendent.

A review of incident reports revealed the Tenant had fallen or was found on the floor by staff at least 16 times between 5-1-11 and 7-10-11. Of these falls, staff reported the Tenant sustained injury and a change in status on 5-18-11, 5-21-11, 6-6-11, 6-8-11, 6-29-11, 7-5-11 and 7-9-11. Staff #2 and #3 reported the Tenant would try and ambulate to the restroom on his/her own, would fall and would have soiled his/her undergarment. On 7-20-11, Staff #1 and #15 were interviewed by a monitor and reported the bed and chair alarms were not used the previous evening and night of 7-19-11, as staff could not find

them. On 7-20-11, a monitor informed the Operations Manager LPN the Tenant's chair and bed alarm was missing. The Operations Manager LPN searched the Tenant's apartment and did not locate either alarm. The Operations Manager LPN reported staff had called the Nurse at 10:00 p.m. the previous evening and reported the chair alarm was missing. The Nurse reported she did not give staff any new interventions to implement related to the safety of the Tenant during the evening and night hours.

On 7-20-11, a monitor observed the Tenant attempting to eat breakfast. The Tenant had his/her eyes closed while attempting to use a fork to pick up a pancake. Staff #2 came into the dining room approximately 10 minutes after the Tenant attempted to eat breakfast and assisted the Tenant with eating. On 7-21-11, a monitor observed the Tenant having great difficulty ambulating from his/her apartment to the dining room. The Tenant's eyes were closed while attempting to lift his/her feet and the Tenant's gait was unsteady. The Tenant wasn't following staff's direction while attempting to ambulate into the dining room. The Tenant turned and bumped into a wall. Staff #2 and #3 reported the Tenant would have his/her eyes shut when he/she attempted to eat breakfast and lunch. The Tenant's spouse would often help the Tenant with meals.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate; at a minimum the tenant's identified needs and preferences for assistance. For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interest. (IAC r. 481-69.26(4)(a)(d))

E. Medications

Complaint Allegation #34794-C: It was alleged the program stored narcotic medications of tenants who have left the program.

Monitoring Observation: A monitor and the Nurse inspected the medication rooms located on the first and second floor. Narcotics were double-locked and narcotic count sheets for administered narcotics were reviewed. There was no evidence the Program kept narcotics for tenants that no longer resided at the program or had been discontinued by a tenant's physician. The Nurse reported once narcotics had been discontinued, they were destroyed. The Program had a policy on destroying drugs.
Fifteen staff was interviewed. Staff #13 reported narcotics of tenants who were no longer at the program, were in a locked box in the Nurse's office.

- Regulatory Insufficiency: None noted.

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

Medication passes were observed. Staff # 23 used a wheeled, computerized MAR system, attached to a rolling cart. Staff did not take the computerized system into the tenants' rooms when administrating medication. Medication packs were taken from the tenant's apartment into the hallway to check the medication labels against the MAR. At one point, the MAR quit working and Staff #23 plugged it into a wall outlet. Staff #23 reported the computer did not always keep documentation, and Staff #23 was observed documenting an 8:00 a.m. medication at approximately 11:30 a.m. Staff #23 reported she had given the medication and had documented it, but the computer screen was not

showing the medication as given. The documentation on the MAR revealed the staff person who gave the medications, but the time the medication was given was not indicated. Staff #23 was observed passing medications to Tenant #3. The pill pack was not taken from the apartment to the MAR to check the medication labels against the MAR. Tenant #21 was observed at the dining room table at approximately noon on 7-19-11. The MAR revealed the Tenant required insulin based on a blood sugar reading. Tenant #21 had already started to eat. The Tenant was taken from the dining room to his/her apartment and a blood sugar level was checked and found to be 222. Insulin was given based on a blood sugar reading taken after the Tenant had started to eat lunch.

Tenant #2's chart contained a fax with a handwritten date of 5-2-11 and a fax date of 5-5 11 which was sent to the physician regarding susceptibility testing on a post-antibiotic urinalysis. The fax was returned on 5-9-11 with a fax time of 8:13 a.m. with an order for Bactrim SS. The order was noted on 5-9-11 at 1400 (2:00 p.m.) A review of the MAR revealed the medication was started on 5-10-11. The MAR lacked documentation of the administration of the Bactrim at 9:00 a.m. on 5-15-11 and 6:00 p.m. on 5-13, 5-14, 5-17, and 5-18-11.

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

F. Nurse Review

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

Monitoring Observation: Tenant #3's file revealed least 16 incidents falls between 5-14-11 and 7-14-11, with injuries noted on 5-23-11 and 7-14-11. Clinical notes of 5-11-11 through 7-16-11 revealed the Operations Manager LPN recorded entries describing some of the incidents of falls. Additional entries were titled as nurse reviews. However, The Operations Manager LPN stated entries made were from reports given to her from staff verbally and notes from 24-hour staff report sheets. She stated she had not assessed the health status of the tenant. The Program did not complete a nurse review after the Tenant had fallen. Two of the incidents, 5-23-11 and 7-14-11, revealed staff reported a change in the Tenant's status and injury.

Tenant #7's file revealed on 5-3-11, the Tenant's physician was notified the Tenant had increased incontinence at night. The program evaluated the Tenant and updated the service plan on 5-3-11. On 5-20-11, the physician was notified the Tenant had increased incontinence and antibiotic therapy was initiated. On 6-23-11, the physician was notified of increased frequency in urination, the Tenant was combative and refused staff attempts to toilet. An order was requested for a urinalysis. Lab results of 6-28-11 indicated the Tenant had a UTI. Lab results of 6-28-11 revealed the Tenant had MRSA. An order was obtained to treat with an antibiotic. On 6-28-11, the physician was notified the Tenant had increased incontinence and was not feeling well and had requested to stay in his/her apartment. On 7-5-11, the physician was notified the Tenant had fallen in the dining room when attempting to sit in a chair. On 7-13-11, the physician was notified the

Tenant had completed antibiotic treatment for MRSA, but the Tenant continued to complain of not feeling well.

Clinical notes of 5-20-11 through 7-13-11 revealed the Tenant had at least three instances of increased incontinence and was diagnosed with MRSA on 6-28-11. Clinical notes of 5-31-11 and 6-23-11 revealed the Operations Manager LPN completed a nurse review related to increased incontinence, antibiotic therapy, refusal and combativeness with toileting. However, the Operations Manager LPN stated entries made were from reports given to her from staff verbally and notes from 24-hour staff report sheets. She stated she had not assessed the health status of the tenant. The Program did not complete a nurse review to assess and document the health status of the Tenant related to incidents described above.

Tenant #12's file revealed the Tenant had fallen or was found on the floor by staff at least 16 times between 5-1-11 and 7-10-11. Of these falls noted, staff reported the Tenant sustained injury and a change in status on 5-18-11, 5-21-11, 6-6-11, 6-8-11, 6-29-11, 7-5-11 and 7-9-11. Clinical notes of the same time period revealed the Operations Manager LPN recorded entries describing some of the incidents of falls. Additional entries were titled as nurse reviews; however, the Operations Manager LPN stated entries made were from reports given to her from staff verbally and notes from 24-hour staff report sheets. She stated she had not assessed the health status of the tenant. The Program did not complete a nurse review to assess and document the health status of the Tenant related to incidents described above.

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

G. Food Service

Complaint Allegation #34948-C: It was alleged food served by the Program was cold and the glassware was "gritty and dirty."

Monitoring Observation: A meeting was held with 50 tenants. Tenants reported most of the time the food was cold and not always cooked. It was reported the food could be better. The quality of the food was not consistent.

Fifteen staff was interviewed. Staff #3, #6, and #13 indicated the food was either not cooked, cold, or the menu was repetitive. None of the 15 staff found the glassware to be gritty or dirty.

Complaint Allegation #34948-C: It was alleged tenants would have old and nasty food in their refrigerators and staff was asked to clean them.

Monitoring Observation: Fifteen staff was interviewed. Staff # 6 and #13 reported there were tenants with old food in refrigerators. Food was either moldy or past the expiration date. There are no assisted living regulations requiring staff to remove food belonging to tenants from their refrigerators.

- Regulatory Insufficiency: None noted

H. Staffing

Complaint Allegation #34948-C: It was alleged staff have been observed "being rough" with Tenants #7 and #8.

Monitoring Observation: During the course of the on-site, a monitor observed staff performing appropriate assistance with personal and health-related cares to Tenant #7 and #8. Fifteen staff was interviewed and none reported staff being rough or providing inappropriate care to tenants. A community meeting was held with 50 tenants. Tenants reported staff gave appropriate care and treated them with respect.

- Regulatory Insufficiency: None Noted.

Complaint Allegation #34794-C: It was alleged medications were not given on time due to poor staffing levels.

Monitoring Observation: A community meeting was held with 50 tenants in attendance. Tenants reported their medications were "sometimes" administered later than prescribed. Fifteen staff was interviewed. The Nurse, Staff #2, #3, #11, #13, and #15 revealed they were aware medications were not given on time. During a medication pass, the Nurse reported the program's policy was to allow staff to administer medications one hour before and one hour after the scheduled time. Staff #14 and #23 reported medications administered to tenants was given late on a daily basis. Staff #23 reported when she started medications at 7:00 a.m., the medication pass would finish by 10:00 to 10:30 a.m. Staff #14 reported on weekends, medications administered to tenants were always late, finishing at 12:00 p.m.

Complaint Allegation #34794-C and #34948-C: It was alleged staff did not respond to tenant calls in a timely manner. The Program was short on staff and response times were sometimes up to 40 minutes.

Monitoring Observation: Computerized call-light records were reviewed from 6-4-11 at 12:00 a.m. to 6-5-11 at 11:59 p.m. and 6-8-11 from 12:00 a.m. to 6-9-11 at 3:00 p.m. A minimum of 25 to 70 calls were made by tenants requesting staff assistance per shift. Some of the calls for assistance were repeated when the initial call was not answered. Staff response times varied from less than one minute to over 40 minutes. On 6-8-11, between 6:30 a.m. and 7:00 a.m., it took more than 35 minutes to answer two call lights. On 6-8-11, just before 11:00 p.m. one call took more than 35 minutes to answer. On 6-9-11, between 7:30 a.m. and 3:00 p.m., at least three calls took longer than 30 minutes to answer. Two of the calls took longer than 40 minutes for staff to answer. The Program did not respond to tenant calls in a timely manner.

Fifteen staff was interviewed. Staff #4, #10, and #15, reported it could take "awhile," sometimes up to 20 to 30 minutes to answer call lights. A family member of Tenant #19 reported the Tenant went to the bathroom after lunch, pushed the call button several times, and assistance was not provided until 2:45 p.m.

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

Monitoring Observation: A review of Staff #1, #6, #13, #14, #17, #18, #19, and #20's training files, revealed the Nurse completed nurse delegated training of personal and health related cares, with return demonstration by staff. The Nurse was interviewed and initially reported she had completed nurse delegated training to all staff. She reported staff was oriented to the floor and to the tenants. She reported peer training was not done related to medication administration and personal and health-related cares.

Staff #2 reported the Nurse never trained her on personal and health related cares. Staff #4 reported staff did the training and the nurses would complete the paperwork. Staff #13 reported the Nurse gave her a packet of training sheets. The Nurse sat down with three to four staff and went over each item, asking if staff knew how to complete personal and health-related cares. Staff would answer "yes" or "no." If staff answered "no," the Nurse went over each step of completing the task. Staff and the Nurse then initialed each care competency. This completed the training. Not all of the cares were reviewed but staff was asked to initial all competencies. New staff was given the same packet and a similar process was repeated. Staff #14 reported she was not sure whether she was trained by the Nurse. Staff #15 reported the Operations Manager LPN, observed her administering medications to tenants. The Operations Manager LPN asked her about providing personal and health related cares and observed her toileting a tenant. Staff #15 was then asked to sign off on the nurse delegation checklist.

The Operations Manager LPN was interviewed and reported she provided nurse delegated training of personal and health-related cares to staff. She demonstrated how cares were to be completed and staff returned demonstration of cares. The Nurse reviewed the check list with staff and staff was to verbalize his/her understanding of how to complete personal and health-related cares. The Operations Manager LPN reported she trained Staff #15 on personal and health-related cares and had her initial the check list. She reported she didn't document she had trained staff and their competency. The check list was given to the Nurse to review.

The Nurse was interviewed again and reported she delegated personal and health-related care training to the LPN. A review of program files revealed no documentation of delegating training of personal and health related cares to the Operations Manager LPN. She and the Operations Manager LPN reviewed any concerns from staff related to the training received and she would follow-up with staff. The Nurse reported she reviewed nurse delegated training with staff in groups but she did not document any follow-ups she may have done. She reported the Operations Manager LPN did not sign off on completing the training and she signed the checklist.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

I. Policies and Procedures

Complaint Allegation #34948-C: It was alleged housekeepers did not have personal protective equipment and were not trained in bodily fluid clean-up or blood-borne pathogens.

Monitoring Observation: A review of program's policy related to housekeeping isolation precautions revealed procedures required staff to use "appropriate protective equipment." Protective equipment was defined by the program as gowns, masks and goggles. Training files for housekeeping Staff #12, #21 and #22, were reviewed and revealed staff had not been trained on universal precautions, housekeeping isolation precautions and the cleaning and decontamination of spills, or splashes of blood or body fluids.

- Regulatory Insufficiency: The program shall follow the policies and procedures established by the program. (IAC r. 481-67.2

J. Life Safety

Complaint Allegation #34794-C: It was alleged the program's alarm system did not work correctly.

Monitoring Observation: Staff #2, #3 and #16 reported the dementia unit exit door alarms malfunctioned and didn't alarm when opened. Staff #6 reported the dementia unit exit door alarm did not work all the time. On occasion the doors quit working. On one occasion, the exit door alarms did not work for an entire weekend. Staff #13 reported tenants pushed the door and the alarm did not always go off. Staff #15 reported the dementia unit exit door alarms did not always work. In the last two months there have been numerous incidents of the exit door alarm sounding, but staff was unable reset the alarm and the alarm had to be silenced.

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

Monitoring Observation: On 7-20-11, a monitor interviewed Staff #2, on the dementia unit, regarding cares given to Tenant #14. During the interview, the monitor observed a staff person going through the northwest exit of the dementia unit. Inspection of the exit door revealed the exit door alarm mechanism had been deactivated, allowing anyone to leave the dementia unit without the door alarming. Upon realizing the door had been deactivated, Staff #2 activated the door alarm with a key. The Nurse was apprised of the incident and couldn't provide an explanation why and how the exit door had been deactivated.

- Regulatory Insufficiency: The program shall have an operating alarm system to each exit door in a dementia-specific setting. (IAC r. 481-69.32(2))

K. Structural

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

Monitoring Observation: On 7-20-11, a monitor and the Nurse went to the dementia unit to look for Tenant #14's service plan. A monitor observed a bottle of bleach on a chair in the dining room. There were tenants sitting in the dining room and staff was not present. Staff #16 came into the dining room and the Nurse asked Staff #16 who had left a bottle of bleach sitting on the chair. Staff #16 stated she had left it out by mistake. The Nurse placed the bottle of bleach in a locked closet

- Regulatory Insufficiency: The building and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481-69.35(1)(b))

L. Retaliation

Complaint Allegation #34948-C: It was alleged staff members have been fired for reporting their concerns and other staff are now afraid to report their concerns.

Monitoring Observation: Staff # 3, #4, #5, #6, #7, #11, #13, and #15 were interviewed and reported they were not aware of staff being terminated for reporting concerns and did not feel the program threatened them with retaliation.

Complaint Allegation #35122-C: It was alleged staff was fired from the program after speaking with monitors from the Department.

Four staff files were reviewed. Staff #1 was hired 7-27-09. She was suspended from employment on 7-20-11 due to an allegation of verbal abuse toward a tenant. An incident report of 7-20-11 revealed Staff #17 reported she had witnessed Staff #1 being verbally abusive toward Tenant #1. Staff #17 witnessed Staff #1 yelling at Tenant #1 to "quit being so f...ing lazy and pick up your catheter bag." An incident report of 7-20-11 documented the above statement of Staff #17. The program interviewed Staff #1 and Staff #17 related to the incident. Additional staff and tenants were interviewed and reported they had not witnessed tenants being verbally abused by staff.

On 7-21-11, the Program notified the Department of potential dependent adult abuse. On 7-25-11, the Department determined dependent adult abuse did not occur but an incident investigation would be completed. Staff #1 was interviewed, and stated she had never hurt, neglected, or abused a tenant in any way. She did not feel the allegations were true. She stated she tried to keep tenants as independent as possible and did her best to encourage tenants to complete a task independently or to participate in completing the task. She stated she did not remember the event as described. Staff #17 was interviewed by a monitor and she stated on 7-5-11 or 7-6-11, between 8:30 p.m. and 9:30 p.m. she was standing outside Tenant #1's apartment when she heard Staff #1 in the Tenant's apartment. She stated she heard Staff #1 tell the Tenant to "pick up your f...ing catheter bag and quit being lazy." She heard the Tenant say he/she was trying to pick up the bag and heard the Tenant complain of pain. Staff #17 stated she walked into the Tenant's apartment and watched Staff #1 transfer the Tenant from a wheelchair to a recliner. Staff #17 stated she and Staff #1 left the Tenant's apartment at the same time and went their

separate ways. Tenant #1 reported being treated well and that staff were polite, caring and encouraged him/her to do things independently and to participate in completing cares. Program records revealed the Tenant was interviewed by the Nurse. The Tenant reported everyone treated him/her "good," and none used curse words.

Staff #26 was hired on 6-13-11 and terminated 6-27-11. A review of the personnel file revealed a notation on the payroll data form Staff #26 was terminated for "not performing job." The file contained no documentation of the specific performance issues that led to the termination. The Administrator reported the Nurse had information on the termination. The Nurse provided a written statement which revealed Staff #26 was terminated because she was caught on her cell phone even after verbal counseling not to do so.

Staff #27 was hired on 10-11-10 and terminated 3-25-11. A review of the personnel file revealed a notation on the payroll data form Staff #27 was terminated for "performance." The file contained no documentation of the specific performance issues that led to the termination. The Administrator provided a written statement at the request of the monitor which revealed Staff #27 was terminated because she consistently missed deadlines and attendance was unacceptable.

Complaint Allegation 35164C: It was alleged Staff #14 was terminated because she talked to monitors during the onsite investigation and reported a tenant had an open wound on his/her coccyx. A short time later she was terminated for misconduct.

- Monitoring Observation: Staff #14 was interviewed by a monitor on 7-21-11. She reported concerns about several tenants. She reported Tenant #8 had an open wound developing on his/her coccyx. She stated the Tenant had a history of open wounds on his/her coccyx, but staff was not given any direction as to what care to provide. An interview with the hospice nurse on 7-21-11 revealed Tenant #8 previously had an open wound which had been resolved for one and a half to two weeks. The Hospice Nurse reported the Tenant had no open areas at this time. The Hospice Nurse reported the Tenant had been repositioned in the recliner to keep pressure off the buttocks. The hospice service plan dated 7-1-11 revealed the program staff was providing wound care. The hospice service plan update dated 7-21-11 revealed skin integrity was an ongoing problem. The Program service plan dated 7-15-11 revealed that with toileting; protective ointment was used for good skin integrity. The Program service plan did not identify specific interventions to prevent skin breakdown.

  The Nurse reported she was not aware of any open wound on the coccyx of Tenant #8. A monitor accompanied Staff #16 to the Tenant's apartment to observe toileting cares. Staff #16 was asked if the Tenant had an open wound on his/her coccyx. She reported she was not aware of any open wound. The Tenant's hospice nurse arrived at the program and was interviewed. She reported she was not aware of the Tenant having an open wound on the Tenant's coccyx, but the Tenant had a history of open wounds on the coccyx. The hospice nurse stated she would evaluate the Tenant to determine if there was an open wound. Sometime later, the Program and hospice nurse reported the Tenant had an open wound developing on his/her coccyx.

Staff #14 was interviewed and stated had been called to the Nurse's office where she was asked if there were any tenants with "skin issues." She reported the Tenant had an open wound on his/her coccyx. She was asked if she "informed State of this" and reported she had. She was asked if she had reported this to any of the nurses. She had reported the Tenant's open wound a week and a half or two weeks earlier. The Nurse reported she had not been informed of the Tenant's open wound. Staff #14 had told the Nurse of the open wound and the Nurse said the Tenant's cushion maybe unplugged. She stated she reported the Tenant's open wound in the staff 24-hour report sheets.

A review of the staff 24-hour report sheets revealed report sheets retained by the program were for the following dates: 7-7-11, 7-10-11, 7-14-11, 7-15-11, 7-16-11, 7-18-11, 7-19-11, 7-20-11, 7-23-11, 7-24-11, 7-26-11, 7-24-11, and 7-25-11. A review of report sheets revealed at least seven sheets without dates and report sheets reviewed were not consistent with reporting all of the tenants residing at the program. Two entries were made regarding the Tenant, but neither entry was dated and didn't mention any open wounds. No other report sheets were available. The program reported staff 24 hour report sheets are destroyed after two weeks.

Staff #16 was interviewed on 7-25-11. She stated she had a conversation with Staff #14 regarding the open sore on the Tenant's coccyx. She stated Staff #14 told her to tell the monitors the Tenant had an open wound on his/her coccyx and to say she forgot. Staff #14 stated she was terminated for misconduct.

- Regulatory Insufficiency: None noted.

Dated this 18th day of August, 2011