IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 37358-I

March 7, 2012

Ms. Stephenie Marckmann, Resident Director
Eiler House Assisted Living
920 West Garfield
Clarinda, IA 51632

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

Dear Ms. Marckmann:

I. Final Complaint/Incident Investigation Report – Eiler House Assisted Living, Clarinda, IA

Enclosed is the **Final Complaint/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: Policies and Procedures, Medications, Staffing, Evaluation, Service Plans, Nurse Review and Other. **Eiler House Assisted Living** ("Program") is being assessed a $2,000 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 thirteen hundred dollars ($1300) 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 $2,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on February 27, 2012, has been reviewed and will constitute the final POC related to the on-site visit of January 18, 2012.

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, Jim Berkley, at 515/281-4116.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Stephenie Marckmann, Resident Director
Eiler House Assisted Living
920 West Garfield
Clarinda, IA 51632

Complaint/Incident Intake #: 37358-I

Date of Complaint/Incident Investigation:

January 18, 2012

Monitor(s):

Lori Miner, RN BSN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	22
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	25
TOTAL census of Assisted Living Program	25

Program History – There were substantiated Regulatory Insufficiencies in the area of Life Safety and Other (Dependant Adult Abuse training not completed) during this certification period.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Policies and Procedures

During the course of the investigation, the following was noted:

- Monitoring Observation: The Program provided pages 3-2 to 3-9 of a policy regarding medication orders. The policy stated when a new medication order was received; the name of the medication, strength, and amount, route of administration, frequency, and reason for being taken was to be written on the existing medication record. The notation was to include the current date to show when the order was received. Time-limited orders were to have lines or highlighted areas indicating the days and times the medication should not be given.

  Tenant #1, an 88 year-old, was admitted on 8-30-08 and had diagnoses of: Progressive Dementia, Advanced Glaucoma, Back Pain, Degenerative Joint Disease, Hypothyroidism, and Hypertension (HTN). On 12-30-11 Tenant #1 was staged at four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. Orders were received on 12-26-11 for Tenant #1 to receive Bactrim DS, one tablet twice a day for a toe infection. Twenty tablets were dispensed with no refills which would make the medication time-limited. An order was also received 12-26-11 to administer Remeron 15 mg, one tablet by mouth at bedtime for depression. Orders were received on 12-29-11 for Tenant #1 to receive Cipro, twice a day for 10 days. The medication was time-limited. A review of the Medication Administration Record (MAR) for Tenant #1 revealed for the month of December 2011 the time-limited antibiotic orders were lined to indicate the start date. The reason for taking any of the new medications was not listed. The MAR did not indicate the date the medication order was received. The January 2012 MAR was reviewed.

The new orders failed to indicate a date the order was received. The time-limited medications had no lines to indicate a stop date. The reason for taking the medication was not listed. The Program medication policy was not followed.

On 1-2-12 an order was received to discontinue antibiotics for Tenant #1. Per the Program policy on discontinued orders, the nurse should review the order and verify that an instruction to discontinue medications was correctly entered on the MAR. This was to be completed by initial and date on the MAR entry. In reviewing Tenant #1's MAR for January 2012 and the discontinued medications, there was no initial and date documented by the Program Nurse. At the time of the onsite visit, Tenant #1 was out of the building following a fall and hip fracture on 1-3-12, but had not been discharged from the Program. The Program medication policy was not followed.

Tenant #2, an 83 year-old, was admitted on 6-9-10 and had a diagnosis of Dementia. Tenant #2 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #2 complained of a sore throat and headache according to a facsimile (fax) sent to the physician dated 10-19-11. A Z-pack (antibiotic) was ordered. There was no documentation in the resident services notes of the Program Nurse having knowledge of a Personal Service Attendant (PSA) obtaining an antibiotic order for Tenant #2's sore throat. A review of the MAR did not indicate the reason the medication was being given.

Tenant #3, a 96 year-old, was admitted on 10-9-10 and had diagnoses of: Congestive Heart Failure, Atrial Fibrillation, Bradycardia, Hypothyroidism, and HTN. Tenant #3 was staged at two on the GDS which indicated very mild cognitive decline. Tenant #3 was taken to the emergency room (ER) on 12-30-11 following two episodes of chest pain into the back, traveling to the jaw. The physician ordered Prilosec, and the Coumadin increased. The January 2012 MAR did not contain documentation of the reason the medication was to be taken nor the date the order was received. On 1-1-12 Tenant #3 was prescribed Tums for indigestion. A review of the January 2012 MAR did not indicate the date the order was received.

Because the Coumadin was increased, the previous order was discontinued. Per the Program policy on discontinued orders, the Program Nurse should review the order and verify that instructions to discontinue medications were correctly entered on the MAR. This was to be completed by initial and date on the MAR entry. In reviewing Tenant #3's MAR for January 2012, there was no initial and date documented by the Program Nurse by the discontinued Coumadin order.

The Program did not follow the policy on medications.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)

B. Medications

During the course of the investigation, the following was noted:

- Monitoring Observation: The service plan for Tenant #1 indicated the Program administered medications. Medication orders were reviewed for Tenant #1. On 12-25-11 a fax was sent to the primary physician by a PSA. The PSA requested an antibiotic for a toe infection. On the following day, 12-26-11, Tenant #1 was taken to a physician, but not the primary physician. On 12-26-11, a physician ordered Bactrim DS, an antibiotic, for a toe infection according to the resident services notes. On 12-28-11, the primary physician responded to the fax and ordered an antibiotic, Cephalexin, different than the one ordered on 12-26-11. There was no documentation in the chart to clarify the antibiotic orders. There was no documentation to indicate Tenant #1 ever received Cephalexin. There was no order to discontinue the Cephalexin. There was no documentation in the resident services notes of the Program Nurse having knowledge of a PSA obtaining an antibiotic order for Tenant #1's toe infection.

  According to the resident service notes Tenant #1 was taken to the ER on 12-29-11 following an episode of leg weakness. An order was received from yet another health care provider, a nurse practitioner. An antibiotic, Cipro, was prescribed for a urinary tract infection (UTI). There was no documentation in the resident services notes of the Program Nurse having knowledge of the antibiotic order for Tenant #1's UTI.

  Resident services notes dated 1-1-12 and timed 6:00 p.m. indicated a PSA noted irritated skin on Tenant #1's feet. The PSA documented the Program Nurse advised staff members to hold the antibiotic until the physician was reached. Tenant #1 was on two antibiotics at the time and the MAR indicated both were held. On 1-2-12 a PSA sent a fax to the primary physician that indicated Tenant #1 had been started on an antibiotic for an infected toe and Tenant #1 now had a rash on both feet and ankles. By 1-2-12 Tenant #1 had received 11 of 20 doses of Bactrim for the toe infection and 5 of 20 doses of Cipro for the UTI. There was no documentation the primary physician was notified Tenant #1 had been prescribed antibiotics for a UTI. The primary physician responded to the fax of 1-2-12 and indicated as follows:

  > D/C Antibiotics. If it's done
  > then do generic Zyrtec 10 mg q pm for 7 days

  The antibiotics were discontinued. The Program Nurse was asked about the order and indicated the order was confusing, but provided no documentation during the onsite visit that indicated she sought clarification of the order from the physician. Tenant #1 was started on Zyrtec according to the MAR. Because the antibiotics were not completed, the generic Zyrtec should not have been started as the order reads "If it's done then do generic Zyrtec..."

The Program did not follow accepted professional standards for medication administration.

- Regulatory Insufficiency: Each program shall follow its own written medication policy, which shall include the following: When medications are administered traditionally by the program: (a) 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))

C. Staffing

During the course of the investigation, the following was noted:

- Monitoring Observation: Resident service notes of 11-10-11 indicated Tenant #1 wanted to take a rock to his/her grandparent and parent. Staff #2, a PSA, documented she explained to Tenant #1 the grandparent and parent passed away a few years ago. Tenant #1 was persistent in wanting to go home. Staff #2 told Tenant #1 the Program was home. On 11-14-11 Staff #1, a PSA, documented Tenant #1 was moving to another city and was moving items from the apartment into the hallway. Staff #1 documented she helped Tenant #1 put things back into the apartment, but Tenant #1 "still insists she is moving." On 12-8-11 Staff #2 documented Tenant #1 had on a coat and gloves at 6:15 a.m. looking for the way to the train station to surprise "him." Staff #2, replied the train station had been closed for many years. On 12-13-11 the resident services notes documented Tenant #1 was dressed with three sweatshirt/long sleeved shirts with one tied around the neck. Tenant #1 stated it would take a call to the police to get out of the building. Tenant #1 needed to go see a parent. Staff #2 told Tenant #1 the parents had been gone for some time. Tenant #1 responded with disbelief. On 12-18-11 Staff #1 documented Tenant #1 was looking for the spouse and wanted boxes to pack things. Tenant #1 indicated children were taking him/her to the depot. Staff #1 documented "It doesn't work trying to orientate him/her to reality that only makes him/her mad." On 12-29-11 resident services notes documented Tenant #1 was looking for the spouse and mother-in-law. Tenant #1 asked Staff #1 to take him/her to the train depot to meet the spouse. Staff #1 "asked the resident her age" and he/she "didn't know." Staff #1 told Tenant #1 he/she was 88 years old, and Tenant #1 responded by saying he/she knew that and proceeded to hit his/her forehead with his/her hand three times and became tearful.

  The Program was not dementia specific by definition or dedication.

  The resident services notes documented several occasions between 11-10-11 and 12-29-11 where staff members demonstrated responses for a tenant with dementia which resulted in a negative response by Tenant #1 as evidenced by a response of disbelief, a staff member reporting Tenant #1 got mad, and Tenant #1 hitting the forehead and becoming tearful after learning the actual age.

  Staff members did not demonstrate adequate training to meet the needs of a tenant with dementia.

- 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))

D. Evaluation

Complaint/Incident Allegation: The Program reported Tenant #1 eloped from the building on 12-29-11.

- Monitoring Observation: Functional, cognitive, and health evaluations were completed on 10-1-11 for Tenant #1. The evaluations indicated Tenant #1 had Progressive Dementia and was staged at three on the GDS. Tenant #1 was noted to be independent with ambulation and transfers and used a four-wheeled walker at all times. It was noted on the 10-1-11 evaluations Tenant #1 had no behaviors of anxiety, anger, and agitation, and no behavioral issues of wandering or physical aggression. The GDS completed on 12-30-11 indicated Tenant #1 was staged at four which indicated moderate cognitive decline.

  The Program Nurse completed a monthly review on 10-17-11 which indicated Tenant #1 enjoyed going outside and sitting on the bench on the front porch. It was also noted Tenant #1 from time to time walked out in the parking lot for exercise. Resident services notes documented the following on Tenant #1:

Date	Behavior
11-10-11	Wanted to go home
11-14-11	Was moving out to new city
12-8-11	Dressed with coat and gloves looking for train station
12-9-11	Extremely confused with increased anxiety and agitation
12-12-11	Very confused and agitated
12-13-11	Dressed in long sleeved shirts, going to have to call police to get out, needs to go see a parent
12-13-11	Went into another tenant's room and was going through drawers
12-16-11	Waiting for ride to Omaha. Angry about the front doors being locked. Hit the door with a cane several times
12-16-11	Went out first set of doors when visitors would come in. Was redirected back in after feeling the cold air when second set of doors opened
12-17-11	Confused and crying, looking for family
12-18-11	Looking for spouse and boxes to pack things. Going to the depot
12-18-11	Wanted someone to take him/her to run errands. Spouse was supposed to come (spouse was deceased). Pushed walker into front entry doors three times. Felt like throwing something through the window. Making loud noises and scaring other tenants. Walking around knocking on walls. Not able to be redirected.
12-25-11	Attempting to go outside. "PSA decided that it was within the best interest of resident to lock front door and turn on keypad."
12-29-11	6 a.m. in common area looking for spouse. Wanted to go to train depot to meet spouse. Hit self in forehead when told age was 88 years old
12-29-11	After lunch, confused, accused others of stealing a purse

12-29-11	PSA notes indicated Tenant #1 wanted to leave, was anxious and confused. Wanted to go outside for a walk. Was escorted outside for a walk by Resident Director. Tenant indicated feeling cooped up and needed fresh air. Returned from walk was seated in a chair in the commons area.

In an interview with the Resident Director, she stated Tenant #1 was seated in a chair near the doorway after returning to the building after the walk. Resident services notes documented another tenant informed the Resident Director that Tenant #1 had gone outside. Staff #1 and the Resident Director went outside and saw Tenant #1 down the hill on the road. Tenant #1 was walking eastbound in the westbound lane of Garfield Street. Tenant #1 indicated to Staff #1 he/she was going to find a parent. Tenant #1 was noted to be wearing a long sleeved shirt, slacks, socks, rubber-soled slippers, coat, and gloves. Tenant #1 did not have a cane or walker with him/her outside. Tenant #1 was returned to the building and vital signs were taken. The Program reported the incident occurred around 2:00 p.m. on 12-29-11. An incident report was completed.

The State Climatologist reported the following conditions at the Clarinda airport on 12-29-11 at 1:55 p.m.: Temperature-55 degrees, Wind out of the south at 5 miles per hour, Skies clear.

The building was noted to sit on a slight hill in a rural area. The roadway to the north side of the building, Garfield, was not a heavily traveled road during the onsite visit. The Program doors were noted to be locked upon arrival of this monitor. The combination to the keypad was posted near the entry door for anyone to use.

The Program Nurse was interviewed and stated Tenant #1 would go outside in nice weather and sit on the porch. There had been no previous problems with Tenant #1 leaving the porch. Tenant #1 was independent with ambulation and used a walker. The door alarms were on the day of the elopement.

The Resident Director was interviewed and believes the door alarms were on the day of the elopement. Tenant #1 may have gone out the building when someone else came in.

Staff #1 was interviewed and indicated she was working the day of the elopement. Staff #1 stated door alarms were sometimes not activated when there was no elopement risk. Staff #1 indicated the door alarms were "on" the day of the elopement. Staff #1 indicated she was concerned Tenant #1 would go outside, but did not think Tenant #1 would elope. Tenant #1 had always just gone outside and come back in. Tenant #1 was reported to have a steady gait, and used a cane and wheeled walker. Tenant #1 was reported to have poor eyesight, and could walk fast. Staff #1 indicated Tenant #1 was confused, but stated there had been no change in the weeks leading up to the elopement.

Resident services notes documented by Staff #1 indicated within ten minutes of returning Tenant #1 to the building after the elopement, another staff member called Staff #1 to assist.

Staff #1 saw a staff member holding Tenant #1 "as his/her legs had went weak and he/she started to fall." Emergency services were called and Tenant #1 was transported to the ER. Later the same day, Tenant #1 returned to the Program with a prescription for an antibiotic for a UTI.

Resident services notes documented the following for Tenant #1:

Date	Behavior
1-1-12	In dining room looking for parent. Came to front doors with armful of belongings and started beating on the door to get out
1-1-12	In apartment hitting everything with a pillow. PSA tried to get Tenant #1 to calm down, Tenant #1 got angrier.
1-1-12	Tenant #1 in apartment sitting on walker seat running into things and kicking cupboards
1-2-12 12 a.m.	Tenant #1 found in room sitting on floor. Tenant #1 claimed it was not a fall, but sat on the floor on purpose but could not remember why
1-2-12	2:30 a.m. Tenant#1 in chair screaming, kicking and swatting at the air.
1-2-12	7:00 a.m. Outside a room, waiting for the train
1-2-12 7:45 a.m.	PSA gave pills to Tenant #1. Tenant #1 got very agitated and threw pills.
1-2-12 to 1-3-12	9 p.m.-fell out of chair in hallway. Tenant #1 was clutching head but stated did not hit head. "Severe behaviors" 9 p.m. to 6 a.m. – Tenant #1 combative, scratched, pinched, hit, and attempted to bite PSA. Ran into walls, tables and chairs all night. 5:40 a.m. Tenant #1 ran face first into wall and fell backwards. Was lowered to the floor. Tenant #1 refused help and crawled down hallway screaming. Tenant #1 threw walker. Ate a facial tissue but refused food and drink. Set off door alarms twice. Banged on doors, windows, and tables and woke other tenants. Tenant #1 was reported to have been trying to leave to visit sick friend and baby.

There were several documented occasions between 11-10-11 and 12-25-11 that documented Tenant #1's confusion, agitation, and desire to go outside the building. On 12-25-11 a PSA documented it was in the best interest of Tenant #1 to lock the front door and turn on the keypad. There is no documentation by the Program Nurse after the initiation of the locked doors. There is no documentation in Tenant #1's file by the Program Nurse between the 10-17-11 monthly nurse review and 12-30-11 documentation of a cognitive evaluation which indicated a change in the GDS (up to a stage four, different than the stage three documented10-11-11), elopement risk form, and depression scale form. Tenant #1 exhibited a significant change of condition. Evaluations of Tenant #1's function, cognition, and health were not completed with the confusion, anxiety, agitation, hitting doors and walls, and going into other tenant's room and accusing others of stealing. Tenant #1 was not evaluated after verbalizing and demonstrating attempts to leave the Program. Tenant #1 was diagnosed with a UTI on the same day of the elopement, but the antibiotic prescribed was discontinued on 1-2-12 after five doses. Tenant #1 did not complete the course of antibiotic for the UTI. Evaluations were not completed with a change in condition.

Resident services notes dated 12-30-11 and timed 2:57 p.m. indicated Tenant #3 complained of back, chest and jaw pain. The Program Nurse checked on Tenant #3 according to the documentation of the PSA. Tenant #3 indicated he/she was feeling better. Tenant #3 was instructed to notify staff members if the pain returned. Resident services notes dated 12-30-11 and timed 9:10 p.m. indicated Tenant #3 again complained of chest pain going into the back and traveling to the jaw and into the head. Tenant #3 was sent to the emergency department and returned at 11:40 p.m. with new prescriptions. The chart contained no documentation from the Program Nurse with either episode of chest pain.

Functional, cognitive, and health evaluations were not completed with changes of condition.

- 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))

E. Service Plans

Complaint/Incident Allegation: The Program reported Tenant #1 fell and fractured a hip on 1-3-12.

- Monitoring Observation: An incident report dated 1-3-12 and timed 8:20 a.m. indicated Tenant #1 stood up in the dining room and was walking without the walker. A PSA began to tell Tenant #1 to use the walker, when Tenant #1 went to turn around Tenant #1 fell to the ground. A fax to the primary physician dated 1-3-12 indicated Tenant #1 grabbed the right hip. Tenant #1 was transported to the ER via ambulance and treated for a right hip fracture. Tenant #1 had not returned to the Program at the time of the onsite visit.

  On 10-1-11 the Program Nurse completed the Mobility Management Planning Tool. The tool indicated Tenant #1 had not fallen in the last 90 days, was on medications that may cause drowsiness, dizziness or side effects which could result in a fall—a "yes" answer on the tool. The tool also noted Tenant #1 had a change in blood pressure with positional changes-a "yes" answer on the tool. Tenant #1 was noted to be confused and have poor vision-both "yes" answers on the tool. (The evaluation completed 10-1-11 indicated Tenant #1 refused removal of a blind right eye.) Instructions on the tool indicated if ANY question was answered "yes" staff was referred to mobility interventions to be added to the service plan. A fall risk assessment form was completed on 10-1-11 which scored Tenant #1 at 13. The instructions on the form indicated with a score of 10 or greater the tenant should be considered at high risk potential for falls.

In an interview with the Program Nurse she stated Tenant #1 was not a fall risk because Tenant #1 used the walker at all times. Resident services notes dated 12-29-11 indicated Tenant #1 was not using a walker.

The Mobility Management Tool and the fall risk assessment indicated Tenant #1 was a fall risk. Tenant #1 had previously had at least one episode of ambulation without the walker. The current service plan, with signatures dated 10-17-11, did not identify fall risk interventions. The service plan did not indicate staff was to remind Tenant #1 to use a cane or walker, as a staff member was doing just prior to the fall on 1-3-12.

The service plan did not indicate Tenant#1's identified needs and preferences for assistance.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (a) The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

During the course of the investigation, the following was noted:

- Monitoring Observation: The resident services notes for Tenant #1 between 11-10-11 and 12-29-11 documented on several occasions Tenant #1's desire to leave the building. On 12-25-11 a PSA decided that it was within the best interest of Tenant #1 to lock front door and turn on keypad. The service plan was not updated to include interventions for potential elopement or the use of door alarms, a specific service need of Tenant #1.

  Tenant #1 eloped on 12-29-11. On 12-30-11, the Program Nurse completed a cognitive evaluation, an elopement risk form, and depression scale form. There was no documentation of the completion of a functional or health evaluation. The service plan was updated 12-29-11 after the elopement to include interventions from the managed risk agreement. Updates to the service plan were not based on functional and health evaluations.

  The resident services notes for Tenant #1 between 11-10-11 and 12-29-11 documented on several occasions Tenant #1's confusion, anxiety, and behaviors of hitting doors and walls with a cane or walker. The service plan was not updated to include interventions for anxiety and behaviors.

  Tenant #1 had a diagnosis of Progressive Dementia and was staged at four on the GDS based on a cognitive evaluation completed 12-30-11. The service plan with signatures dated 10-17-11 and updated 12-29-11 did not include Tenant #1's activities, planned or spontaneous, based on abilities and personal interests. The service plan did not identify Tenant #1's preference for nursing facility care.

  The service plan for Tenant #2 did not identify Tenant #2's preference for nursing facility care.

The service plan did not identify Tenant #3's preference for nursing facility care.

Service plans were not based on evaluations or following a change of condition. Service plans did not include planned and spontaneous activities for a person with dementia. Service plans did not identify tenants' preferences for nursing facility care.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (d) 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 interests; and (e) Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. (IAC r. 481-69.26(4)(d)(e))

F. Nurse Review

During the course of the investigation, the following was noted:

- Monitoring Observation: Resident services note for Tenant #1 dated 12-25-11 indicated Tenant #1 complained of the left foot hurting. A PSA looked at the foot and noted toenails needed to be trimmed. Once a toenail was clipped, pus was noticed coming out of the toe near the nail. The PSA noted a toenail on the right foot was beyond what she could repair, and stopped. The PSA called a family member and recommended Tenant #1 be taken to a podiatrist. The PSA sent a fax to the primary physician that indicated Tenant #1 had an infection in a toe on the left foot and an antibiotic was requested. An antibiotic was ordered on 12-26-11. The service plan indicated the Program administered medications.

  A nurse review was not completed documenting the change of condition of the feet or the presence of signs of infection, the appropriateness of the referral to a podiatrist, or a medication review of the newly prescribed antibiotic.

  On 12-29-11, Tenant #1 eloped from the Program. Shortly after returning to the building, Tenant #1 was taken to the ER. Tenant #1 was diagnosed with a UTI, prescribed antibiotics, and returned to the Program.

  A nurse review was not completed following the elopement. A nurse review was not completed following the diagnosis of UTI, a change of condition, and the initiation of antibiotics.

  Resident services noted dated 1-1-12 indicated a PSA contacted the Program Nurse in regards to Tenant #1. Red, irritated skin was noted on Tenant #1's feet.

According to notes documented by the PSA, the Program Nurse advised staff to hold Tenant #1's antibiotic. There was no documentation from the Program Nurse regarding the condition of Tenant #1's feet or the holding of the antibiotic following a possible adverse reaction to medication.

Tenant #1 had the following new medication orders: 12-26-11-Bactrim and Remeron; 12-28-11-Cephalexin; 12-29-11-Cipro; and on 1-2-12 an order to discontinue antibiotics and "if it's done then do generic Zyrtec..." The service plan indicated the Program administered medications. The physician orders were not noted with time, date, and signature by the Program Nurse.

Tenant #1 fell on 1-3-12. The chart lacked documentation of a review of Tenant #1's condition immediately after the fall.

Tenant #1 had a change of condition and newly prescribed medications. Tenant #1 was not monitored after a change of condition for adverse reactions to medications, ensuring prescription medications were administered consistent with the orders, had no documentation of health status after a change of condition, and lacked documentation of physician orders for medications, administered by the Program, noted with time, date, and signature of the Program Nurse.

Tenant #2 had the following new medication orders: 10-19-11- Z pack, an antibiotic for a sore throat and headache. A nurse review was not completed with the sore throat and the start or end of the antibiotic. The service plan indicated the Program administered medications. The physician orders were not noted with time, date, and signature by the Program Nurse.

Tenant #3 had the following medication orders: 11-9-11- Resume Coumadin, a blood thinner; 11-14-11 – Hold Coumadin for three days, give Lovenox while Coumadin being held; 12-31-11 – Start Prilosec, increase Coumadin; and 1-1-12 – Tums as needed for indigestion. The service plan indicated the Program administered medications. The physician orders were not noted with time, date, and signature by the Program Nurse.

Nurse reviews were not completed with a change of condition, including a review of a tenant's condition and a review of the medications ordered. Physician orders for medications lacked notation by the Program Nurse of time, date, and signature.

- 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 a licensed practical nurse via nurse delegation: **(1)** To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders;

(3) 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; and **(4)** To provide the program with written documentation of the activities under the service plan, as set forth in rule 481—69.26(231C), showing the time, date and signature. (IAC r. 481-69.27(1)(3)(4))

G. Other – Managed Risk

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1 eloped on 12-29-11. A managed risk agreement signed on 12-29-11 by the Program Nurse. Documentation in the chart indicated Tenant #1's children were notified of the agreement on 12-30-11. The agreement did not contain documentation of Tenant#1's involvement in the managed risk process or the signature of Tenant #1.

- Regulatory Insufficiency: A consensus-based process to address specific risk situations. Program staff and the tenant shall participate in the process. The result of the consensus-based process may be a managed risk consensus agreement. The managed risk consensus agreement shall include the signature of the tenant and the signatures of all others who participated in the process. The managed risk consensus agreement shall be included in the tenant's file. (IAC r. 481-69.31(2))