IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 37668-C

March 22, 2012

Ms. Sally Hill, Director of Memory Care
Senior Star at Elmore Place Memory Care
4504 Elmore Avenue
Davenport, IA 52807

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

Dear Ms. Hill:

I. Final Complaint/incident Investigation Report – Senior Star at Elmore Place Memory Care, Davenport, 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: Program Reporting to Department, Evaluation, Criteria for Admission and Retention and Service Plans. **Senior Star at Elmore Place Memory Care** ("Program") is being assessed a $1,000 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 **Jim Berkley** and remit the civil penalty assessed by check or money order in the amount of six hundred fifty dollars ($650) 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 $1,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on March 9, 2012, has been reviewed and will constitute the final POC related to the on-site visit of February 1 & 2, 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:

Complaint/Incident Intake #: 37668-C

Sally Hill, Director of Memory Care
Senior Star at Elmore Place Memory Care
4504 Elmore Avenue
Davenport, IA 52807

Date of Complaint/Incident Investigation:

February 1 & 2, 2012

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	18
Total Population of Program at time of on-site	20
TOTAL census of Assisted Living Program	20

Program History – The program received Regulatory Insufficiencies in the area of Dementia Specific Education, Nurse Review and Policies and Procedures during this certification period.

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

A. Program Reporting to the Department

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

- Monitoring Observation: Nine tenant files were reviewed.

  Tenant #1, a 72 year old, was admitted on 10-14-11 and diagnoses include Aneurysm with Subarachnoid Hematoma, Hypertension (HTN), Atrial Fibrillation, Hyperlipidemia, Arthritis and Hypothyroidism. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline.

  According to Nurse's Notes on 11-30-11, at 12:10 a.m. staff was alerted via the pager of delay egress at the front door, a nurse immediately responded to find Tenant #1 standing outside in front of the door. Tenant #1 came back inside without difficulty and said he/she was looking for his/her car. According to the State Climatologist, on 11-30-11 at 12:52 a.m. at the Davenport Airport, the temperature was 24 degrees, clear skies, winds were from the north at 7 miles per hour and the wind chill was 16 degrees.

  According to Nurse's Notes on 12-8-11 staff responded to front door wander alert system and found Tenant #1 standing outside of the Program. Tenant #1 was easily redirected back inside. According to the State Climatologist, on 12-8-11 at the Davenport Airport, the high was 34 degrees and the low was 24 degrees. There was 0.2 inch of snow after 9:30 p.m. to midnight and winds started once the snow came.

According to an Incident Report Form on 1-3-12 at 2:00 a.m. staff received a wander alert, two staff responded to the front door and a nurse went outside and checked the entire front of the building. A staff member was inside and checked the hallways. A staff member received a pager message and responded to the south door and Tenant #1 was located outside the door on the sidewalk pulling on the door handle to get back in. The form indicated the time elapsed between the alert and "res in site" was less than two minutes. The form indicated Tenant #1 was out of the building, was alert/confused and did not have any apparent injuries. Staff was notified by the wander alert system. The form indicated Tenant #1 was placed on half hour rounds with the door alarm on the apartment in place and functioned appropriately. Staff was to sit at the end of hallways when possible. According to the State Climatologist, on 1-3-12 at 1:52 a.m. at the Davenport Airport, the temperature was 9 degrees, clear skies, the wind was 4 miles per hour and the wind chill was 2 degrees. Tenant #1's elopements were not reported to the Department.

Tenant #2, an 84 year old was admitted on 11-22-11 and diagnoses include Atrial Fibrillation and High Blood Pressure. Tenant #2 was staged at a five on the GDS, which indicated moderately severe cognitive decline.

According to the Nurse's Notes on 1-21-12 at 2:15 p.m. staff responded to the north exit alarm and found Tenant #2 walking in the parking lot, attempting to get into a parked vehicle. Staff directed Tenant #2 back into the building. According to the State Climatologist on 1-21-12 at 1:52 p.m. at the Davenport Airport, the temperature was 19 degrees, cloudy skies, winds out the of east at 8 miles per hour and the wind chill was 9 degrees. Tenant #2's elopement was not reported to the Department.

Tenant #3, an 87 year old was admitted on 12-16-11 and diagnoses include Pacemaker, Confusion (most likely sun downing), HTN, Appendectomy, Endoscopic Retrograde Cholangiopancrea of the Pancreatic Duct, Left Knee Replacement, Subdural Hematoma and Cerebral Vascular Accident (CVA). Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. According to the service plan dated 1-27-12, Tenant #3 was moved out of the Program.

According to the Nurse's Notes dated 12-25-11 at 1:00 p.m. Tenant #3 became agitated after a conversation via phone with a family member. Tenant #3 became irate and yelled at staff. Staff responded to the north door wander alert and saw Tenant #3 ambulating with a wheeled walker into the parking lot. Attempts were made to redirect Tenant #3. Tenant #3 yelled and twice attempted to hit staff. Tenant #3 returned to the building via the front doors. The Power of Attorney (POA) was notified and came to the Program and attempted to calm Tenant #3. This was effective for a while, according to the notes.

According to an Incident Report Form on 12-25-11 at 10:45 a.m., staff responded to the north exit alarm and found Tenant #3 walking to the parking lot. Tenant #3 attempted to hit staff when redirected. Per the POA's request, conversations with the family member would be limited. Scheduled rounds were to be continued. Staff was to be observant of any changes in behaviors after phone calls and if so, staff to intervene.

According to the State Climatologist, on 12-25-11 at 12:52 p.m. at the Davenport Airport, the temperature was 44 degrees, clear skies, winds out of the west at 16 miles per hour and the wind chill was 37 degrees. Tenant #3's elopement was not reported to the Department.

According to the Program's Elopement of Residents policy and procedure, in the event a tenant wandered away from the community or when on an outing away from a community representative, an immediate search would be implemented. If a tenant was not recovered within a reasonable amount of time authorities and the tenant's family/responsible party would be notified and a description and picture of the tenant would be provided to authorities. Staff was to respond immediately to door alarms and locate the tenant that had wandered outside and to direct the tenant back inside. Immediately alert other team members including leadership staff if a tenant could not be located. Staff was to check log books to see if the tenant had gone out and begin a search of the community. The time of the alert was to be noted and if the tenant had not been located within 10 minutes continue the interior search, have selected individuals begin a search by car within a one mile radius of the community. The policy and procedure indicated to contact the tenant's responsible party, call the main office and police if the tenant was not located within a reasonable amount of time, as determined by the manager in charge. Continue a coordinated search until the tenant was found, complete an incident report and any other documentation upon the tenant's return. Complete the procedures and implement follow-up to help prevent recurrence of the event.

The Assistant Director of Memory Care stated when a tenant exited and they did not see them it was considered an elopement. If they saw the tenant it was considered an incident. She said the wander alert system indicated the tenant's room number and the exit door. She said there had been no elopements.

Tenants #1, #2 and #3 eloped and the Program did not report the elopements to the Department.

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

B. Staffing

Complaint/Incident Allegation: It was alleged several fall interventions were needed to ensure tenant safety.

- Monitoring Observation: Nine tenant files were reviewed.

Tenant #4, a 97 year old, was admitted on 8-1-10 and diagnoses include Dementia, Grief Reaction, History of Colon Cancer, HTN, Osteoarthritis and Right Hemicolectomy (1999). Tenant #4 was staged at a five on the GDS, which indicated moderately severe cognitive decline. The service plan reflected a side rail when in bed, bed/chair alarms at all times and a floor mat to be next to the bed at all times. Fall interventions were indicated.

Tenant #6, an 80 year old was admitted on 5-3-11 and had a diagnosis of Frontal Lobe Dementia. Tenant #6 was staged at a four on the GDS, which indicated moderate cognitive decline. The service plan reflected staff would assist Tenant #6 with mobility and transfers, would encourage use of call device before getting up and staff would continue to re-educate on how to utilize the personal help button prior to getting up on his/her own. Staff would monitor for proper use of walker for short distances and wheelchair for long distances. Staff would observe and remind Tenant #6 to sit in the wheelchair and not walk behind it. Staff would make sure room was clear of clutter and would monitor for proper fit of shoes and clothes. Staff would check for compliance with chair and bed alarms and would use gait belt and walker for all ambulation. Fall interventions were indicated.

Tenant #7, an 81 year old was admitted on 1-27-12 and diagnoses include Huntington's Chorea and Atrial Fibrillation. Tenant #7 was staged at a four on the GDS, which indicated moderate cognitive decline. The service plan reflected staff would educate Tenant #7 on how to utilize personal help button. Staff would assist with transfers and monitor ability to push self in wheelchair to dining room or activities. Staff would report any falls to nurse immediately. According to Nurse's Notes dated 1-27-12, Tenant #7's spouse preferred a side rail and floor mat, which they would bring. They also requested a bed/chair alarm. Nurse's Notes dated 1-27-12 and 1-30-12 indicated the side rail and bed alarm were in place. Fall interventions were indicated.

Tenant #8, an 84 year old was admitted on 11-1-10 and diagnoses include Brain Tumor, CVA, Esophageal Strictures, Renal Insufficiency, Glaucoma, HTN, Benign Tumor in posterior head (evaluated) and Pneumonia. Tenant #8 was staged at a five on the GDS, which indicated moderately severe cognitive decline. The service plan reflected staff would provide a safe environment for Tenant #8 including wander alert system, secured doors and would provide guidance/redirection as needed. Staff would give simple choices and utilize chair/bed alarms and side rail per family preference. The electric bed was to be kept in lowest position when Tenant #8 was using it. Fall interventions were indicated.

Tenant #9, an 84 year old, was admitted on 1-14-11 and diagnoses include Lewy Body Dementia, Anxiety, Osteoporosis and Hypothyroidism. Tenant #9 was staged at a four on the GDS, which indicated moderate cognitive decline. Nurse's Notes on 1-16-12 indicated staff was alerted to his/her room per Tenant #9. He/she was found on the floor and said he/she was sitting on the edge of the bed and slipped off to the floor. This was the only fall documented in Nurse's Notes from 11-14-11 to 1-25-12. The service plan indicated staff would monitor for increased risk of falls and would ensure fall risks were minimized within the community. Staff was to monitor that Tenant #9 used a walker when ambulating and had a half rail on the bed for repositioning. Fall interventions were indicated.

Tenant #4, #6, #7, #8 and #9's service plans reflected fall interventions for tenant safety.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged tenants had a personal emergency response (PER) pendant; however, the tenants did not comprehend how to use the pendant.

- Monitoring Observation: Nine tenant files were reviewed.

  Chapter 69 administrative rules indicated each tenant shall have access to a 24-hour personal emergency response system that automatically identified the tenant in distress and could be activated with one touch. In lieu of providing access to a personal emergency response system, a program serving one or more tenants with a cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program would respond to the emergency needs of the tenant(s). The Program was dementia-specific by dedication.

  According to the Program's Staffing policy and procedure, if a tenant was unable to use the response system or the system was down, staff would check on each tenant a minimum of every 60 minutes within the Memory Care Building (the Program) or more often as indicated by the tenant service plan. According to the Resident Safety Checks-Memory Care policy, safety checks would be provided as indicated in the tenant service plan. Checks would be conducted at a minimum of every 60 minutes for those tenants who were unable to use the response system or if the response system was not working properly. Checks were performed as assigned according to the service plan; each check would be documented on the "Rounds sheet."

  Check sheets were reviewed for January 2012 and checks were consistently documented for Tenants #4, #5, #6, #8 and #9.

  A seven day history of the PER records was reviewed from 12:58 p.m. on 1-26-12 to 11:40 a.m. on 2-2-12 and indicated several tenants; including Tenants #6, #8 and #9 activated their pendants.

  Tenant #4's file was reviewed and the service plan indicated routine rounds were provided.

  Tenant #5, a 62 year old, was admitted on 6-9-11 and diagnoses include Multiple Sclerosis (MS) and Frontal Lobe Dementia. Tenant #5 was staged at a five on the GDS, which indicated moderately severe decline. Tenant #5's service plan indicated he/she did not use the pendant on a consistent basis and was not always able to verbalize understanding of pendant. The service plan indicated routine rounds were to be provided.

  Tenant #6's file was reviewed and the service plan reflected staff would assist Tenant #6 with mobility and transfers, would encourage use of call device before getting up and staff would continue to re-educate on how to utilize the personal help button prior to getting up on his/her own. PER records indicated Tenant #6 activated his/her pendant.

  Tenant #8's file was reviewed and the service plan indicated routine rounds were provided. PER records indicated Tenant #8 activated his/her pendant.

Tenant #9's file was reviewed and the service plan indicated routine rounds were provided. PER records indicated Tenant #9 activated his/her pendant.

Check sheets were reviewed for January 2012 and checks were consistently documented for Tenants #4, #5, #6, #8 and #9. The Program completed checks per their policy.

- Regulatory Insufficiency: None noted.

C. Evaluation

Complaint/Incident Allegation: It was alleged tenants were not evaluated as needed.

- Monitoring Observation: Nine tenant files were reviewed.

Tenant #1's file was reviewed. According to Nurse's Notes on 11-30-11, staff was alerted via the pager of delay egress at the front door, a nurse immediately responded to find Tenant #1 standing outside in front of the door. Tenant #1 came back inside without difficulty and said he/she was looking for his/her car. According to Nurse's Notes on 12-8-11 staff responded to front door wander alert and found Tenant #1 standing outside of the Program. Tenant #1 was easily redirected back inside. On 12-25-11 staff was entering the building and found Tenant #1 exiting the front door. The wander alert system was going off. Tenant #1 was assisted back into the building and he/she stated he/she was going to get his/her car. According to an Incident Report Form on 1-3-12 at 2:00 a.m. staff received a wander alert, two staff responded to the front door and a nurse went outside and checked the entire front of the building. A staff member was inside and checked the hallways. A staff member received a page message and responded to the south door and Tenant #1 was located outside the door on the sidewalk pulling on the door handle to get back in. Nurse's Notes dated 1-8-12, indicated Tenant #1 was observed to be at the front exit door looking towards top of the door at switch, attempting to reach. The switch would allow access outside with no delayed egress alert when turned off. Staff redirected Tenant #1 away from the door successfully. It was reported by a staff member that she found Tenant #1's door alarm on the floor. The alarm was placed back on the door and it was functioning. Evaluations were not completed as needed.

Tenant #2's file was reviewed. According to the Nurse's Notes on 1-10-12 at 11:45 a.m. Tenant #2 was found sitting on the bathroom floor of another tenant's apartment. On 1-12-12 at 10:50 p.m. Tenant #2 was in and out of other tenants' apartments during the second shift. According to the Nurse's Notes on 1-17-12 at 7:00 p.m. Tenant #2 demonstrated increased exploring and wandering into other tenants' apartments. During rounds Tenant #2 was found sitting on the bed in another tenant's apartment wearing a shirt and protective undergarments. A tenant of the opposite sex was in the apartment but standing away from Tenant #2. On 1-22-12 at 7:30 p.m. Tenant #2 continued to enter other tenants' apartments and was found without wearing his/her shirt. Tenant #2 became agitated when staff assisted him/her from the apartment. On 1-30-12 at 4:30 p.m. a nurse was assisting a family member put socks on a tenant when Tenant #2 opened the door and walked into the room.

When approached by staff, Tenant #2 hollered "No" and started to slap the nurse four times across the face. On 1-31-12 at 5:30 p.m. Tenant #2 hollered at staff asking what they wanted. On 2-1-12 at 4:00 p.m. Tenant #2 was aggressive at times and tried to hit staff. On 2-1-12 at 8:30 p.m. Tenant #2's family member, who had taken Tenant #2 out for supper, returned Tenant #2 to the Program due to wandering frequency and elopement attempts. According to the Nurse's Notes on 1-21-12 at 2:15 p.m. staff responded to the north exit alarm and found Tenant #2 walking in the parking lot attempting to get into a parked vehicle. Staff directed Tenant #2 back into the building. Evaluations were not completed as needed.

Tenant #4's file was reviewed. Staff #1, #2, #3 and #4 indentified Tenant #4 as a routine two person assist with transfers. Staff #5 stated she was not aware of anyone who transferred Tenant #4 by themselves. The Assistant Director of Memory Care stated Tenant #4 was not always a routine two person assist. She said 75% of the time (some mornings) and Tenant #4 was not as much in the afternoons. Tenant #4 was observed transferring on two occasions. One time Tenant #4 was observed, three staff members were used, two staff assisted with the transfer while a third staff member assisted with care. The other transfer that was observed two staff members were used to transfer Tenant #4. The evaluation completed on 11-8-11 indicated for transfers he/she required some assistance, one person to assist from bed, chair, wheelchair, toilet, and he/she could stand, support own weight and pivot. An order was received on 12-30-11, for Geri Sleeves on in a.m. and off in p.m. due to multi-bruising on the bilateral arms. Evaluations were not completed as needed.

Tenant #5's file was reviewed. Evaluations were completed on 12-29-11 and reflected Tenant #5's MS did not always allow him/her to stand or ambulate and some days were better and some were worse. The evaluation dated 12-29-11 indicated Tenant #5 was unable to stand and make his/her legs move and many days he/she was unable to ambulate despite encouragement. The evaluation indicated he/she verbalized pain but could not always give specifics. The evaluation reflected he/she needed extensive assistance with toileting and grooming and was totally dependent for bathing and dressing. Evaluations were completed as needed.

Tenant #6's file was reviewed. According to the Nurse's Notes on 12-27-11 at 10:00 p.m. assistance of two staff members was required to assist Tenant #6 into bed. According to the Nurse's Notes on 12-29-11 at 2:30 a.m. the second shift reported on 12-28-11 Tenant #6 was very non-compliant with ambulation, taking two staff doing 90% of the work to assist Tenant #6 to bed safely. Staff reported Tenant #6 attempted to sit on the floor and refused to bear weight. Tenant #6 was very unsteady on the night shift and staff utilized the wheelchair for safety to and from the bathroom. On 12-29-11 at 5:50 a.m. Tenant #6 paged staff for assistance to the bathroom and Tenant #6 was encouraged to assist but refused to comply, thus a two person assist was required. Staff #3 said after 9:00 p.m. Tenant #6 was difficult to transfer and required two staff. Staff #4 said that later in evening Tenant #6 required two staff. Evaluations were not completed as needed.

Tenant #9's file was reviewed. Evaluations were completed on 12-28-11 and reflected Tenant #9 needed staff assistance with toileting, bathing, grooming, dressing, eating/nutrition and medications. The evaluation reflected Tenant #9 had vision impairment.

The service plan indicated (under Fall Risk) staff was to monitor that Tenant #9 used a walker when ambulating. The evaluation did not reflect the use of an assistive device; however, evaluations were completed as needed.

- 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))

D. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant was totally incontinent, required a two person transfer, could not assist with any daily cares, the tenant was non-weight bearing and could not ambulate. It was alleged a tenant required a three person transfer and required three people to assist most Activities of Daily Living (ADLs). It was alleged a tenant was a two person transfer at times and was aggressive with the use of a gait belt. It was alleged a tenant was difficult to put into bed and get settled.

- Monitoring Observation: Nine tenant files were reviewed.

Tenant #4's file was reviewed. Staff #1, #2, #3 and #4 indentified Tenant #4 as a routine two person assist with transfers. Staff #1 said every time she used two people and no staff could assist with one person. She said he/she was a two person transfer for all types of transfers. Staff #2 said Tenant #4 was a two to three person transfer and said it was 90 to 100% of the time. Staff #3 said Tenant #4 was definitely a two person transfer and was sometimes a three person transfer. Staff #4 said Tenant #4 transferred 50% of the time with one person. Staff #5 stated she was not aware of anyone who transferred Tenant #4 by themselves. The Assistant Director of Memory Care stated Tenant #4 was not always a routine two person assist. She said 75% of the time (some mornings) and Tenant #4 was not as much in the afternoons. Tenant #4 was observed transferring on two occasions. One time Tenant #4 was observed, three staff members were used, two staff assisted with the transfer while a third staff member assisted with care. The other transfer that was observed two staff members were used to transfer Tenant #4. Per observation and staff interviews, Tenant #4 was a routine two person assist with transfers. Tenant #4 exceeded the admission and retention criteria by requiring a routine two person assist with transfers.

Tenant #5's file was reviewed. Evaluations were completed on 12-29-11 and reflected Tenant #5's MS did not always allow him/her to stand or ambulate and some days were better and some were worse. The evaluation dated 12-29-11 indicated Tenant #5 was unable to stand and make his/her legs move and many days he/she was unable to ambulate despite encouragement.

The evaluation reflected he/she needed extensive assistance with toileting and grooming and was totally dependent for bathing and dressing. Staff #1, #2, #5 and the Assistant Director of Memory Care did not identify Tenant #5 as a routine two person transfer or requiring maximum assistance with ADLs. Per review of the file and staff interviews, Tenant #5 was not a routine two person transfer and did not require maximum assistance with ADLs. Tenant #5 did not exceed admission and retention criteria.

Tenant #6's file was reviewed. According to the Nurse's Notes on 12-27-11 at 10:00 p.m. assistance of two staff members was required to assist Tenant #6 into bed. According to the Nurse's Notes on 12-29-11 at 2:30 a.m. the second shift reported on 12-28-11 Tenant #6 was very non-compliant with ambulation, taking two staff doing 90% of the work to assist Tenant #6 to bed safely. Staff reported Tenant #6 attempted to sit on the floor and refused to bear weight. Tenant #6 was very unsteady on the night shift and staff utilized the wheelchair for safety to and from the bathroom. On 12-29-11 at 5:50 a.m., Tenant #6 paged staff for assistance to the bathroom and Tenant #6 was encouraged to assist but refused to comply, thus a two person assist was required. Staff #1, #2, #5 and the Assistant Director of Memory Care did not identify Tenant #6 as a routine two person transfer. Staff #3 said after 9:00 p.m. Tenant #6 was difficult to transfer and required two staff. Staff #4 said the later in evening Tenant #6 required two staff. Per review of the file and staff interviews, Tenant #6 did not require a routine two person transfer and did not exceed admission and retention criteria.

Tenant #7's file was reviewed. According to Nurse's Notes dated 1-27-12, Tenant #7's spouse preferred a side rail and floor mat, which they would bring. They also requested a bed/chair alarm. Nurse's Notes dated 1-27-12 and 1-30-12 indicated the side rail and bed alarm were in place. The service plan indicated staff would assist Tenant #7 for transfers and monitor ability to push self in wheelchair to dining room or activities. Staff was to be aware that Tenant #7 was not always able to feel his/her feet or make them move at will. The side rail was to be on the bed at all times when lying down. Staff would report any falls to nurse immediately. Staff #1, #2, #3, #4, #5 and the Assistant Director of Memory Care did not identify Tenant #7 as a routine two person assist with transfers. Per review of the file and staff interviews, Tenant #7 did not require a routine two person transfer and did not exceed admission and retention criteria.

Staff #1, #2 and the Assistant Director of Memory Care did not identify anyone who was aggressive when a gait belt was used.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: Requires routine, two-person assistance with standing, transfer or evacuation. (IAC r. 481-69.23(1)(b))

E. Service Plans

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

- Monitoring Observation: Nine tenant files were reviewed.

  Tenant #1's file was reviewed. According to Nurse's Notes on 11-30-11, staff was alerted via the pager of delay egress at the front door, a nurse immediately responded to find Tenant #1 standing outside in front of the door. Tenant #1 came back inside without difficulty and said he/she was looking for his/her car. According to Nurse's Notes on 12-8-11 staff responded to front door wander alert and found Tenant #1 standing outside of the Program. Tenant #1 was easily redirected back inside. On 12-25-11 staff was entering the building and found Tenant #1 exiting the front door. The wander alert system was going off. Tenant #1 was assisted back into the building and he/she stated he/she was going to get his/her car. According to an Incident Report Form on 1-3-12 at 2:00 a.m. staff received a wander alert, two staff responded to the front door and a nurse went outside and checked the entire front of the building. A staff member was inside and checked the hallways. A staff member received a page message and responded to the south door and Tenant #1 was located outside the door on the sidewalk pulling on the door handle to get back in. Nurse's Notes dated 1-8-12, indicated Tenant #1 was observed to be at the front exit door looking towards top of the door at switch, attempting to reach. The switch would allow access outside with no delayed egress alert when turned off. Staff redirected Tenant #1 away from the door successfully. It was reported by a staff member that she found Tenant #1's door alarm on the floor. The alarm was placed back on the door and it was functioning. The service plan reflected rounds and a chime on the apartment door for staff awareness of night exploring. The service plan did not reflect Tenant #1's elopements and elopement attempts. The service plan did not reflect the identified needs of Tenant #1.

  Tenant #2's file was reviewed. According to the Nurse's Notes on 1-10-12 at 11:45 a.m. Tenant #2 was found sitting on the bathroom floor of another tenant's apartment. On 1-12-12 at 10:50 p.m. Tenant #2 was in and out of other tenants' apartments during the second shift. According to the Nurse's Notes on 1-17-12 at 7:00 p.m. Tenant #2 demonstrated increased exploring and wandering into other tenants' apartments. During rounds Tenant #2 was found sitting on the bed in another tenant's apartment wearing a shirt and protective undergarments. A tenant of the opposite sex was in the apartment but standing away from Tenant #2. On 1-22-12 at 7:30 p.m. Tenant #2 continued to enter other tenants' apartments and was found without wearing his/her shirt. Tenant #2 became agitated when staff assisted him/her from the apartment. On 1-30-12 at 4:30 p.m. a nurse was assisting a family member put socks on a tenant when Tenant #2 opened the door and walked into the room. When approached by staff, Tenant #2 hollered "No" and started to slap the nurse four times across the face. On 1-31-12 at 5:30 p.m. Tenant #2 hollered at staff asking what they wanted. On 2-1-12 at 4:00 p.m. Tenant #2 was aggressive at times and tried to hit staff. On 2-1-12 at 8:30 p.m. Tenant #2's family member, who had taken Tenant #2 out for supper, returned Tenant #2 to the Program due to wandering frequency and elopement attempts.

According to the Nurse's Notes on 1-21-12 at 2:15 p.m. staff responded to the north exit alarm and found Tenant #2 walking in the parking lot attempting to get into a parked vehicle. Staff directed Tenant #2 back into the building. The service plan did not reflect Tenant #2's wandering, elopement attempts and behaviors. The service plan was not updated as needed and did not reflect the identified needs of Tenant #2.

Tenant #4's file was reviewed. Staff #1, #2, #3 and #4 indentified Tenant #4 as a routine two person assist with transfers. Staff #5 stated she was not aware of anyone who transferred Tenant #4 by themselves. The Assistant Director of Memory Care stated Tenant #4 was not always a routine two person assist. She said 75% of the time (some mornings) and Tenant #4 was not as much in the afternoons. Tenant #4 was observed transferring on two occasions. One time Tenant #4 was observed, three staff members were used, two staff assisted with the transfer while a third staff member assisted with care. The other transfer that was observed two staff members were used to transfer Tenant #4. The service plan dated 11-9-11, indicated he/she required one person transfer assistance, required stand by assistance for all ambulation or unable to propel wheelchair any distance. The service plan indicated staff was to use a gait belt and walker/wheelchair for all transfers and ambulation. The service plan also indicated he/she required occasional assistance of two if increased confusion caused him/her to be unable to follow directions. An order was received on 12-30-11, for Geri Sleeves on in a.m. and off in p.m. due to multi-bruising on the bilateral arms. The service plan did not reflect Tenant #4's Geri Sleeves and routine two person transfer assistance. The service plan was not updated as needed and did not reflect the identified needs of Tenant #4.

Tenant #5's file was reviewed. An order was received on 1-18-12 for a pad next to the bed to cushion his/her fall if he/she fell out of bed. The service plan did not reflect the pad next to the bed. A fax to the physician dated 12-30-11 indicated Tenant #5's mobility had declined and he/she had not been able to walk. The evaluation dated 12-29-11 indicated Tenant #5 was unable to stand and make his/her legs move and many days he/she was unable to ambulate despite encouragement. The evaluation indicated Tenant #5's MS did not always allow him/her to stand or ambulate. Some days were better and some were worse. Staff #3 and #4 stated Tenant #5 was a routine two person transfer. Staff #5 said some staff could transfer Tenant #5 alone but he/she occasionally required two people for transfers. The service plan dated 12-29-11, indicated staff would assist Tenant #5 with mobility and transfers and would encourage Tenant #5 to use call device before getting up. The service plan also indicated Tenant #5 did not use the PER button on a consistent basis and was not always able to verbalize understanding of the button. The service plan indicated Tenant #5 required a one person assist with transfers and required stand by assistance for all ambulation or unable to propel wheelchair any distance. Staff was to assist Tenant #5 with transfers and escort and give assistance of one and a gait belt. The service plan did not reflect the need for a two person transfer; although not on a routine basis. The service plan did not reflect the identified needs of Tenant #5.

Tenant #6's file was reviewed. According to the Nurse's Notes on 12-27-11 at 10:00 p.m. assistance of two staff members was required to assist Tenant #6 into bed. According to the Nurse's Notes on 12-29-11 at 2:30 a.m. the second shift reported on 12-28-11 Tenant #6 was very non-compliant with ambulation, taking two staff doing 90% of the work to assist Tenant #6 to bed safely. Staff reported Tenant #6 attempted to sit on the floor and refused to bear weight. Tenant #6 was very unsteady on the night shift and staff utilized the wheelchair for safety to and from the bathroom. On 12-29-11 at 5:50 a.m. Tenant #6 paged staff for assistance to the bathroom and Tenant #6 was encouraged to assist but refused to comply, thus a two person assist was required. Staff #3 said after 9:00 p.m. Tenant #6 was difficult to transfer and required two staff. Staff #4 said that later in evening Tenant #6 required two staff. The service plan reflected staff would assist Tenant #6 with mobility and transfers, would encourage use of call device before getting up and staff would continue to re-educate on how to utilize the personal help button prior to getting up on his/her own. Staff would monitor for proper use of walker for short distances and wheelchair for long distances. The service plan did not reflect the assistance of two staff in the evening. Tenant #6's service plan was not updated as needed and did not reflect the identified needs of Tenant #6.

Tenant #7's file was reviewed. A physician's order dated 1-26-12 indicated to continue an antibiotic for two more days and to have nasal packing removed by the Primary Care Physician in two to three days. According to the Nurse's Notes on 1-30-12 at 10:30 a.m. Tenant #7 was picking at his/her nose and slight bleeding was noted. Nasal packing was still in place. The service plan did not reflect antibiotic therapy or the presence of nasal packing and care needs for the packing. According to Nurse's Notes dated 1-27-12, Tenant #7's spouse preferred a side rail and floor mat, which they would bring. They also requested a bed/chair alarm. Nurse's Notes dated 1-27-12 and 1-30-12 indicated the side rail and bed alarm were in place. The service plan did not reflect the bed alarm. The service did not reflect the identified needs of Tenant #7.

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

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

F. Nurse Review

Complaint/Incident Allegation: It was alleged a tenant had an injury and an evaluation was not completed after the injury healed and with a fall with injury.

- Monitoring Observation: Nine tenant files were reviewed.

Tenant #3's file was reviewed. According to the Nurse's Notes on 1-20-12 at 9:00 a.m. Tenant #3 was found on the floor in his/her apartment with underpants down around his/her ankles. The walker was not nearby.

Vital signs were obtained and Tenant #3 was assisted to his/her feet by two staff members. Tenant #3 complained of right hip and leg pain and assisted to a lying position on the bed. The POA was notified and medics were called to transport Tenant #3 to the emergency room (ER). No other visible injuries were noted. The physician was notified of the incident.

According to the Nurse's Notes on 1-20-12 at 10:15 a.m. the Program was notified Tenant #3 had a hip fracture. According to the Nurse's Notes on 1-23-12 at 2:00 p.m., Tenant #3's family member reported Tenant #3 was doing well after surgery. The family member reported Tenant #3's doctor stated the bone was very thin and could have caused a spontaneous fracture. The family member did not know where Tenant #3 would go for skilled care or if he/she would return to the Program. According to the service plan dated 1-27-12 Tenant #3 was moved out of the Program. Nurse reviews were completed.

Tenant #4's file was reviewed. According to an Incident Report Form, on 9-2-11 at 6:40 p.m. Tenant #4's left ankle was swollen, light pink/purple in color and was sore to touch. Tenant #4's right big toe had a 2 cm abrasion on it. Tenant #4 informed staff and it was not witnessed. Tenant #4's responsible party and physician were notified. Nurse's Notes indicated the sore on the big toe (right foot) was likely from shoes. Nurse's Notes indicated on 9-3-11 the left ankle remained swollen with a bruise forming, it was tender to touch and he/she had complaints of pain to area. Tenant #4 did not know what happened. Ice was applied for 20 minutes, APAP was given and an order was received for treatment to right great toe for TAO/bandaid every day until healed. Nurse's Notes dated 9-3-11, indicated Tenant #4's family member agreed to continue elevating and placing cold pack through the weekend as they were out of town and would re-evaluate and decide whether an x-ray should be done. Staff was educated to assist with transfers and avoid any twisting of the left ankle, according to notes. Tenant #4's family member was at the Program to visit with Tenant #4 and look at his/her ankle the next day. On 9-5-11 Tenant #4's physician was faxed a condition report and a request for as needed Tylenol for discomfort. The physician ordered an x-ray to left ankle and Tylenol 650 mg by mouth every four hours as needed. An x-ray was obtained and the conclusions indicated an acute non-displaced fracture of distal fibula without disruption of ankle mortise. It also indicated moderate lateral soft tissue swelling, mild osteoporosis demonstrated and mild degree of osteoarthritis. The x-ray revealed a non-displaced Weber C lateral malleolus fracture. On 9-9-11 Tenant #4 returned from an orthopedics office with a cast on the lower left extremity. On 9-27-11 Tenant #4 returned from an appointment and the lower left extremity was healing well. An order was received for weight bearing as tolerated lower leg extremity with cast boot. The boot was to be on during all transfers and weight bearing and off when sleeping. According to Nurse's Notes dated 10-25-11 Tenant #4 went back for an orthopedic appointment and the cast was removed. Weight bearing as tolerated with splint when out of bed for one month was ordered 10-25-11. Nurse's Notes from 9-2-11 to 10-27-11 indicated nurse reviews were completed as needed related to Tenant #4's injury. The service plan was updated after nurse review and reflected updates and interventions related to Tenant #4's condition. Tenant #4 was unable to recall how the injury occurred and there were no witnesses. Nurse reviews were completed appropriately.

Tenant #4 had a fall with injury on 1-25-12. According to an Incident Report Form dated 1-25-12 at 6:10 a.m. staff heard a loud crash followed by sounding bed alarm. Tenant #4 was found laying on the right side, beside the bed. Tenant #4 had a hematoma and bruising. Tenant #4's responsible party and physician were notified. The physician called for an update on the injuries and recommended Tenant #4 go to the ER for assessment. Tenant #4 was sent out to the ER and returned the same day. Nurse's Notes from 1-25-12 to 1-27-12 indicated nurse reviews were completed as needed related to Tenant #4's fall. Nurse reviews were completed.

- Regulatory Insufficiency: None noted.