IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: **40399-I**
40245-I
39706-C
39956-C
40244-C

October 17, 2012

Ms. Kathy Harris, RN
Oakwood Place Assisted Living
4126 Northwest Blvd.
Davenport, IA 52806

RE: Final Complaint/Incident Investigation Report, Oakwood Place Assisted Living, Davenport, Iowa

Dear Ms. Harris:

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.

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

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Kathy Harris, RN
Oakwood Place Assisted Living
4126 Northwest Blvd.
Davenport, IA 52806

Complaint/Incident Intake #: **40399-I**
40245-I
39706-C
39956-C
40244-C

Date of Complaint/Incident Investigation:

August 28th and 30th, 2012

Monitor(s):

Hal Chase, RN BSN MPH
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:	39
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	41

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	12
TOTAL census of Assisted Living Program	53

Program History – The program received regulatory insufficiencies during this certification period in the area of Food Service and Service Plans.

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

A. Program reporting to the Department.

Complaint/Incident Allegation #40399-I: The Program reported a tenant fell and died as a result of the fall.

- Monitoring Observation: Tenant #1, a 93 year old, was admitted on 11-7-09 and had diagnoses of: Hypothyroidism, Hyperlipidemia, Depression, Osteoporosis, Macular Degeneration, Alzheimer's Disease, Chronic Obstructive Pulmonary Disease and a Colostomy. A Global Deterioration Scale (GDS) was completed on 8-2-12 and staged Tenant #1 at five, which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit.

  A service plan of 4-30-12 indicated Tenant #1 needed staff assistance with activities of daily living (ADLs), including bathing, dressing, toileting, but was independent with ambulation and transfer.

  Nurse's notes of 7-31-12 indicated Tenant #1 complained of severe back pain and was found by staff leaning forward with his/her face in his/her lap. Tenant #1 needed stand-by assistance with ambulation. On 8-1-12 Tenant #1 was seen by a physician. An x-ray came back negative for injury. The Program nurse spoke to Tenant #1's family regarding Tenant #1's needing more assistance with cares over the past month, increasing incontinence, and recommended Tenant #1 be transferred to the adjacent intermediate care facility (ICF). Tenant #1's family member requested that Tenant #1 not be transferred immediately.

Nurse's notes of 8-1-12 indicated Tenant #1 complained of back pain and needed stand-by assist with ambulation to and from meals. The Program nurse advised family Tenant #1 would be transferred as soon as the physician signed the request for transfer.

A functional evaluation was completed on 8-1-12 and revealed Tenant #1 needed stand-by assist with ambulation. A GDS completed the same day staged Tenant #1 at five, which indicated moderately severe cognitive decline. On 4-30-12 Tenant #1 had been staged at four, which indicated moderate cognitive decline.

Nurse's notes of 8-3-12 indicated staff found Tenant #1 lying on his/her back with legs extended and complaining of neck pain. Staff noted a hematoma on the left forehead and Tenant #1 had complained of neck pain and pointed to the right side. Ice was applied to forehead and Tenant #1's physician was notified of the injury. Emergency medical services were called for transport to a hospital emergency room for evaluation.

Hospital staff notified the Program Tenant #1 was admitted with a diagnosis of a C-1 & C-2 fracture. Nurse's notes of 8-6-12 indicated Tenant #1 passed away on 8-5-12. The Program notified the department within the required time of when the incident occurred.

- Regulatory Insufficiency: None noted.

B. Tenant Rights

Complaint/Incident Allegation #39956-C: It was alleged staff was mean to tenants, and staff members were using tenants' personal belongings. It was alleged tenants in the dementia unit are forced to do activities beyond their capabilities. Tenants were taunted by a staff member, increasing tenant's agitation. It was alleged tenants were forced to take whirlpool baths when they prefer showers.

- Monitoring Observation: During interview, Staff #5, #7, #8, #9, #10, and #11 reported there were no staff members who were disrespectful to the tenants. These staff members knew of no one using tenants' personal items, and knew of no tenant being forced to do something the tenant did not want to do, including whirlpool baths. Training files were reviewed for Staff #1, #2, #3, and #5 contained documentation of dementia training. During the two days of the onsite monitoring visit, tenants and staff were observed together during activities, meal times, and requests for assistance in both the general population and the dementia unit. Staff was observed to treat tenants kindly and respectfully. No staff members were observed taunting tenants. The activity calendar was reviewed for tenants in the dementia unit. Staff members reported activities were offered and tenants were able to refuse to participate in activities. In the dementia unit, activities were adjusted to the ability of the tenant, and alternate activities were offered if refused.

Five tenants were interviewed. (#6, #11, #12, #13, #14) None reported any staff member being rude or disrespectful. All five tenants reported they made their own choices and were not forced to do something they did not want to do, including whirlpool bathing. Tenant #11 reported enjoying a whirlpool bath. None of the tenants reported staff members using personal items.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #40244-C: It was alleged the program solicited money from tenants for a program profit, the purchase of a television. It was alleged tenants cannot use program towels in the community whirlpool room and tenants are not getting their personal towels back.

- Monitoring Observation: During interview, Staff #5, #7, #9, and #11 reported no tenants have been asked to give money to the Program. Staff members did report a bake sale to raise money for a television. Staff members indicated no tenants had reported concerns to them about raising money for a television. None of the staff members were aware of missing towels. Staff #7 stated if a towel was missing, it was eventually found. The nurse reported the Program held bake sales, a dunk tank, and sold coupon books to raise money for a television. The television was to be used for all tenants in movie theater type room just off the main atrium of the building. The nurse reported although money was received, funds were not solicited. The nurse reported she received no complaints about the fundraising efforts and had received a thank-you note signed by several tenants. The thank you was for the procurement of the television. Five tenants (#6, #11, #12, #13, and #14) were interviewed and none expressed a concern about how funds were raised for the television. The five tenants reported no missing items.

- Regulatory Insufficiency: None noted.

C. Evaluation

Complaint/Incident Allegation #39706-C: It was alleged a tenant had a wound that became infected and a nurse did not look at the wound.

Complaint/Incident Allegation #39956-C: It was alleged the nurse does not evaluate tenants with skin problems. Tenants were monitored by a wound clinic.

Monitoring Observation: Nine tenant files were reviewed. Tenant #6, an 88 year-old, was admitted on 7-31-09 and had diagnoses of: Diabetes, Constipation, Osteoporosis, Edema, Hyperlipidemia, Hypothyroidism, and History of Left Leg Amputation. Tenant #6 resided in the general population. A cognitive evaluation of 6-23-12 indicated Tenant #6 scored 11 out of 11, which indicated normal cognition. Tenant #6 resided in the general population.

Evaluations were completed by the nurse on 6-23-12 for a change of condition, a right foot wound. Nurse's notes from 6-23-12 to current contained documentation from the nurse and the Licensed Practical Nurse (LPN) regarding the right foot wound assessment and treatment. Treatment included care at a wound clinic.

The nurse evaluated and continued to evaluate Tenant #6 with a wound. No issues were found related to evaluation of skin problems for Tenant #6.

Tenant #7, a 91 year-old, was admitted on 12-3-10 and had diagnoses of: Heart Disease, Angina, Spinal Stenosis, Peripheral Neuropathy, Hypothyroidism, Depression and Gastro Esophageal Reflux Disease (GERD). A cognitive evaluation of 5-30-12 indicated Tenant #7 scored 11 out 11, which indicated normal cognition. Tenant #7 resided in the general population.

Nurse's notes of 5-18-12 indicated Tenant #7 had a large skin tear to the lower left leg. Tenant #7 reported he/she hit his/her leg against a wheelchair. A verbal order was received to cleanse the lower left leg with water, pat dry and apply triple antibiotic, cover with telfa and secure and change daily and as needed until healed. Medication Administration Records (MARs) for May-2012 indicated wound care was initiated on 5-18-12. Nurse's notes of 5-27-12 indicated increased swelling to the skin tear. Tenant #7's physician was contacted and ordered ATB therapy. Tenant #7's physician evaluated Tenant #7's wound and ordered Tenant #7's legs be elevated during the day. Nurse's notes of 6-19-12 indicated Tenant #7 received wound care weekly beginning 5-30-12 through 8-8-12. Nurse's notes of 8-8-12 indicated Tenant #7's wound was healed. Tenant #7 was discharged from the wound clinic.

Functional and cognitive evaluations were completed on 5-30-12. A health evaluation completed on 5-31-12 indicated Tenant #7 sustained a skin tear to the lower left leg, received ATB therapy and daily wound care. No issues were found related to Tenant #7's wound and ATB therapy.

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

- Monitoring Observation: Tenant #1's service plan of 4-30-12 indicated Tenant #1 was independent with ambulation and transfer, but needed staff assistance with ADLs.

  Nurse's notes of 7-31-12 indicated Tenant #1 complained of severe back pain and was found by staff leaning forward with his/her face in his/her lap. Tenant #1 needed stand by assistance with ambulation. On 8-1-12 Tenant #1 was seen by a physician. An x-ray came back negative for injury. The Program nurse spoke to Tenant #1's family regarding Tenant #1's needing more assistance with cares over the past month, had increased incontinence recommended Tenant #1 be transferred to the adjacent ICF. Tenant #1's family member requested that Tenant #1 not be transferred immediately.

  Nurse's notes of 8-3-12 indicated staff found Tenant #1 lying on his/her back with legs extended and complaining of neck pain. Staff noted a hematoma on the left forehead and Tenant #1 had complained of neck pain and pointed to the right side. Ice was applied to forehead and Tenant #1's physician was notified of the injury and emergency medical services were called for transport to a hospital emergency room for evaluation. Hospital staff notified the Program Tenant #1 was admitted with a diagnosis of a C-1 & C-2 fracture. Nurse's notes of 8-6-12 indicated Tenant #1 passed away on 8-5-12.

A functional evaluation was completed on 8-1-12 and revealed Tenant #1 needed stand by assist with ambulation. A GDS completed the same day staged Tenant #1 at five, which indicated moderately severe cognitive decline. On 4-30-12 Tenant #1had been staged at four, which indicated moderate cognitive decline.

The Program initiated evaluations, completing a functional and cognitive evaluation on 7-31-12 for changes in Tenant #1's ambulatory and cognitive status, but did not complete a health evaluation with a change in condition.

Tenant #2, an 87 year old, was admitted on 3-5-10 and had diagnoses of: Alzheimer's Disease, Dementia, Atrial Fibrillation, Hypertension (HTN), Hiatal Hernia, Osteoarthritis, Anemia, Pacemaker and Anxiety. A GDS was completed on 5-18-12 and staged Tenant #2 at five, which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit.

A review of incident reports beginning 1-13-12 through 7-12-12 indicated there were at least five incidents of physical aggression toward other tenants, including Tenant's #3 and #4. An incident report of 7-12-12 indicated Tenant #2 was telling other tenants to leave the television area as the television was his/hers and it was time for them to go. Tenant #3 was standing next to Tenant #2 and both tenants began to argue with each other. Tenant #3 moved his/her walker toward Tenant #2 and Tenant #2 attempted to grasp the walker to push it away, resulting in Tenant #3 falling and injuring his/her wrist. Tenant #3 was seen in a hospital emergency room and was diagnosed with a right wrist fracture. Nurse's notes of 5-18-12 through 7-12-12 indicated most of the incidents described above included confrontations between Tenant #2 and Tenant's #3 & #4.

Nurse's notes of 7-13-12 indicated the Program nurse met with Tenant #2's family and discussed Tenant #2's behavior and concerns about Tenant #2's and other tenants safety. It was suggested family start looking for other placement. Nurse's notes of 8-10-12 indicated Tenant #2 transferred from the Program to another facility.

Functional, cognitive and health evaluations were completed on 5-18-12 and 7-16-12 respectively. A health evaluation completed on 5-18-12 indicated Tenant #2 had occasional screaming and striking out toward staff when cares were attempted, but evaluations did not reflect the behavior Tenant #2 exhibited as described above toward Tenant #3 and #4 to determine if any change in services were needed.

Tenant #3, an 84 year old, was admitted on 8-4-06 and had diagnoses of: Lumbago, Abnormality of Gait, Bursitis Disorder, Osteoarthrosis, Muscle Weakness, GERD, HTN, Constipation, Urinary Frequency, Anxiety, Insomnia, Depression and Hypothyroidism. A GDS was completed on 7-16-12, staged Tenant #3 at five on the GDS, which indicated moderately severe cognitive decline. Tenant #3 lived in the dementia unit.

Incident reports beginning 1-20-12 through 7-12-12 indicated there were at least three incidents of physical aggression toward Tenant's #2 and #4 and one incident of aggression toward Tenant #7. The incident of 7-12-12 indicated Tenant #2 had pushed Tenant #3's walker out from underneath Tenant #3 and caused Tenant #3 to fall, resulting in a fractured wrist.

Functional, cognitive and health evaluations of 3-23-12 did not reflect or address the behavior Tenant #3 exhibited as described above toward Tenant's #2 and #4. Evaluations were completed on 7-13-12, which indicated behaviors occur when Tenant #3 is upset with another tenant's behavior, but did not reflect the physical aggression toward other tenants.

- 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 had not exhibited a significant change. (IAC r. 481-69.22(2))

D. Service Plans

Complaint/Incident Allegation #40245-I: The Program reported Tenant #2 pushed Tenant #3's walker out from underneath Tenant #3, resulting in Tenant #3 falling and sustaining a wrist fracture.

Complaint/Incident Allegation #40244-C: It was alleged a tenant hit another tenant, causing the tenant to fall and fracturing his/her wrist.

- Monitoring Observation: Nine tenant files were reviewed. Tenant #2's file indicated on 7-12-12 Tenant #2 was telling other tenants to leave the television area as the television was his/hers and it was time for them to go. Tenant #3 was standing next to Tenant #2 and both tenants began to argue with each other. Tenant #3 moved his/her walker toward Tenant #2 and Tenant #2 attempted to grasp the walker to push it away, resulting in Tenant #3 falling and injuring his/her wrist. Tenant #3 was seen in a hospital emergency room and was diagnosed with a right wrist fracture.

  Tenant #2's incident reports beginning 1-13-12 through 7-12-12 indicated there were at least five incidents of Tenant #2 being physically aggressive toward other tenants. Incident reports and nurse's notes of 5-18-12 through 7-12-12 indicated most of the incidents were confrontations between Tenant's #3 & #4.

  Tenant #2's service plan of 5-18-12 did not include interventions directing staff to intervene related to Tenant #2's behavior toward Tenant #3 and #4. The service plan was updated on 7-16-12, after the injury Tenant #3 sustained and gave interventions directing staff to keep Tenant #2 away from other tenants when agitated, to keep Tenant #2 at least four feet away from Tenant #3 and to separate Tenant #2 when he/she became passive with Tenant #4. The Program did not establish interventions in the service plan of 5-18-12.

Complaint/Incident Allegation #40244-C: It was alleged service plans were manipulated to "save the census."

- Monitoring Observation: Staff interviews were conducted. Staff #7 stated service plans were thorough and identified the needs of tenants. Staff #8 stated service plans met the needs of the tenants and service plans were changed by the nurse when needed. Staff #9 & #10 stated the service plans met the needs of the tenants. Staff #11 stated the nurse was notified of changes in tenant condition and the service plan was updated and issues were found.

Complaint/Incident Allegation #39706-C: It was alleged a tenant had a staph infection on the leg that was not being treated. Wounds were weeping. The tenant appeared to be in pain and nothing was done. The tenant picked the dressing off in community area and wouldn't stop itching.

Complaint/Incident Allegation #400244-C: It was alleged a tenant had become increasingly incontinent and was urinating on the furniture in the dementia unit.

- Monitoring Observation: Nine tenant files were reviewed. Tenant #4, a 90 year-old, was admitted on 6-30-10 and had diagnoses of: Atrial Fibrillation, Diabetes Mellitus, HTN, Hyperlipidemia, Dementia and an Abdominal Aortic Aneurysm. A GDS was completed on 8-10-12 and staged Tenant #4 at five, which indicated moderately severe cognitive impairment. Tenant #4 resided in the dementia unit.

  Nurse's notes of 6-5-12 indicated new orders were received from a wound clinic for treatment of the lower left leg. Nurse's notes of 6-6-12 indicated physician orders to cleanse area to lower left extremity with water pat dry and apply Mycolog cream, cover with telfa wrap daily and as needed. Nurse's notes of 6-20-12 indicated Tenant #4 had an open area on the back of the right knee. Redness was noted around the open area with serous drainage. The Program nurse notified the wound clinic of the new wound. Nurse's notes of 6-21-12 indicated Tenant #4 would be seen at the wound clinic the following day. Nurse's notes of 6-25-12 indicated new orders to cleanse wound to the right posterior knee daily and as needed. Nurse's notes of 6-27-12 indicated new orders were received for an antibiotic (ATB) therapy, 100mg one tablet twice daily for 10 days.

  A service plan of 6-28-12 established interventions directing staff to report to the nurse an increase in redness or scratching. An order for Allegra 60mg – one tablet daily as needed was ordered on 8-24-11. MARs for June 2012 indicated that Acetaminophen 325mg-two tablets every four hours prn was ordered for pain. Tenant #4's service plan of 6-28-12 established contact isolation precautions that directed staff to place soiled items, including dressing changes and gloves, in a red disposable biohazard bag. Nurse's notes of 5-29-12 through 7-23-12 indicated no issues related to Tenant #4 complaining of pain. Nurse's notes of 7-11-12 indicated left lower leg had healed. Nurse's notes of 7-24-12 indicated Tenant #4's wound on the back of the knee had healed. Nurse's notes of 7-25-12 indicated contact isolation had been discontinued. No issues were found related to wound care.

  On 8-3-12, Tenant #4's physician was notified of Tenant #4's increased incontinence during the past two weeks and Tenant #4's incontinent undergarments and clothing were wet and Tenant #4 voided a "good amount" when toileting.

Nurse's notes of 8-6-12 indicated Tenant #4's physician was aware of increased incontinence and did not want a urinalysis with culture and sensitivity. On 8-7-12 Tenant #4's physician discontinued Lasix 40mg-one tablet daily.

A service plan was updated on 8-10-12 and established interventions related to increased incontinence and directed staff to toilet Tenant #4 every hour, before and after meals and toilet after waking in the morning and before going to bed. Staff was to complete peri-care after each incontinent episode, change soiled items as needed and notify the nurse if Tenant #4's clothes became wet with urine. No issues were found related to incontinence of urine.

Complaint/Incident Allegation #39706-C: It was alleged a tenant needed isolation, played with his/her feces and wandered and went into other tenant's rooms. When the tenant is redirected the tenant will become agitated and abusive toward staff. It was alleged tenants wander and weren't properly supervised.

- Monitoring Observation: Tenant #5, an 82 year-old, was admitted on 12-30-10 and had diagnoses of: Hypothyroidism, Dementia and History of Pain. A GDS was completed on 7-17-12 and staged Tenant #5 at four, which indicated moderate cognitive impairment. Tenant #5 resided in the dementia unit.

  A physician's order of 5-4-12 indicated Tenant #5 was diagnosed with a Urinary Tract Infection. An order for Amoxicillin 500mg - one tablet three times daily was ordered for 10 days. On 6-29-12 Cipro 250mg – one tablet twice daily was ordered for seven days. Nurse's notes of 7-1-12 indicated a laboratory reported a urinalysis was completed and indicated Tenant #5 had E.coli in his/her urine. Nurse's notes of 7-2-12 indicated Tenant #5's physician reported Tenant #5 didn't need to be in isolation.

  Nurse's notes of 4-19-12 through 8-21-12 indicated no behavioral issues related to the allegations. Service plan of 7-17-12 indicated no behavioral interventions related to the allegations cited. Interviews with Staff #5, #7, #8, #9, and #10 did not identify Tenant #5 as having behavioral problems related to the allegations cited.

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

- Monitoring Observation: Nine tenant files were reviewed. Tenant #1's service plan of 4-30-12 indicated Tenant #1 was independent with ambulation and transfer, but required staff assistance with ADLs.

  Tenant #1's nurse's notes of 7-31-12 indicated Tenant #1 complained of severe back pain and was found by staff leaning forward with his/her face in his/her lap. Tenant #1 needed stand by assistance with ambulation. On 8-1-12 Tenant #1 was seen by a physician. An x-ray came back negative for injury. The Program nurse spoke to Tenant #1's family regarding Tenant #1's needing more assistance with cares over the past month, having increased incontinence and recommended Tenant #1 be transferred to the adjacent ICF. Tenant #1's family member requested that Tenant #1 not be transferred immediately.

A functional evaluation was completed on 8-1-12 and revealed Tenant #1 needed stand-by assist with ambulation. A GDS completed the same day staged Tenant #1 at five, which indicated moderately severe cognitive decline. On 4-30-12 Tenant #1 had been staged at four, which indicated moderate cognitive decline.

Nurse's notes of 8-3-12 indicated staff found Tenant #1 lying on his/her back with legs extended and complaining of neck pain. Staff noted a hematoma on the left forehead and Tenant #1 had complained of neck pain and pointed to the right side. Ice was applied to forehead and Tenant #1's physician was notified of the injury and emergency medical services were called for transport to a hospital emergency room for evaluation. Hospital staff notified the Program Tenant #1 was admitted with a diagnosis of a C-1 & C-2 fracture.

Evaluations of 7-31-12 noted a change in Tenant #1's ambulatory status from independent to stand-by assist and Tenant #1's GDS changed from moderate cognitive decline to moderately severe cognitive decline. The Program did not update the service plan to reflect interventions directing staff to provide stand-by assistance with ambulation and transfer and increased assistance with ADLs.

Tenant #9, a 78 year-old, was admitted on 10-26-11 and had diagnoses of: Dementia, HTN, Hypothyroidism, Edema, Venous Insufficiency, Glaucoma and Anemia. A GDS was completed on 8-29-12 and staged Tenant #9 at four, which indicated moderate cognitive decline. Tenant #9 resided in the dementia unit.

Nurse's notes of 7-30-12 indicated Tenant #9's behaviors increased with yelling and striking out when staff assisted with cares. Nurse's notes of 8-6-12 indicated Tenant #9 becomes anxious and strikes out at staff. Nurse's notes documented on 8-20-12 indicated Tenant #9 was incontinent and had soiled through clothing. Assistance of three staff members was needed to clean and change Tenant #9's clothes. Tenant #9 was agitated and combative.

Nurse's notes of 8-23-12, at 4:00 p.m., indicated Tenant #9 became agitated when staff attempted to provide personal cares. Tenant #9 was striking staff with fists and was kicking and biting staff when cares were attempted. At 11:20 p.m. a licensed practical nurse was called to Tenant #9's apartment related to abnormal behavior. Tenant #9 was combative earlier but was lethargic and not responding as he/she normally would do. Tenant #9 was sent to a hospital emergency department to be evaluated and was diagnosed with a Urinary Tract Infection. Tenant #9 was prescribed Keflex 500mg – one tablet three times daily for seven days.

A health evaluation completed on 8-29-12 indicated Tenant #9 had increased behaviors of physical aggression that were not controlled by interventions. Tenant #9 would strike out, kick and bite when staff attempted to complete cares.

Tenant #9's service plan of 8-29-12 did not establish interventions related to a history of a UTI and when Tenant #9 becomes physically aggressive toward staff

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30days 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 individualized and shall indicate, at a minimum: a. the tenant's identified needs and preferences for assistance. (IAC r. 481-69.26 (4)(a))

E. Criteria for Admission and Retention

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

- Monitoring Observation: Tenant #9's nurse's notes of 7-30-12 indicated Tenant #9's behaviors increased with yelling and striking out when staff assisted with cares. Nurse's notes of 8-6-12 indicated Tenant #9 becomes anxious and strikes out at staff. Nurse's notes of 8-9-12 indicated Tenant #9's physician prescribed Xanax 0.25mg twice daily as needed, for seven days. Nurse's notes of 8-16-12 indicated Xanax 0.25mg was changed from an as needed medication to a twice daily dose. Nurse's notes 8-20-12 Tenant #9 was incontinent and had soiled through clothing. Assistance of three staff members was needed to clean and change Tenant #9's clothes. Tenant #9 was agitated and was combative. Nurse's notes of 8-21-12 indicated Tenant #9's physician increased Xanax to 0.5mg twice daily.

  Nurse's notes of 8-23-12, at 4:00 p.m., indicated Tenant #9 became agitated when staff attempted to provide personal cares. Tenant #9 was striking staff with fists and was kicking and biting staff when cares were attempted. At 11:20 p.m. a licensed practical nurse was called to Tenant #9's apartment related to abnormal behavior. Tenant #9 was combative earlier but was lethargic and not responding as he/she normally would do. Tenant #9 was sent to a hospital emergency department to be evaluated and was diagnosed with a Urinary Tract Infection. Tenant #9 was prescribed Keflex 500mg – one tablet three times daily for seven days.

  A health evaluation completed on 8-29-12 indicated Tenant #9 had increased behaviors of physical aggression that were not controlled by interventions. Tenant #9 would strike out, kick and bite when staff attempted to complete cares.

  Despite interventions directing staff related to behaviors and prescribing medication to reduce anxiety, Tenant #9 continued to be physically aggressive toward staff.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who is, c. dangerous to self or other tenants or staff, including but not limited to a tenant who, 1. Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggress; or 2. Displays behavior that places another tenant at risk. (IAC r. 481-69.23(c)(1)(2))

F. Medications

Complaint/Incident Allegation #40244-C: It was alleged the Program nurse refused to allow staff to contact the nurse from the adjacent nursing facility to review a new order for pain medication and to use pain medication from the skilled nursing facility's emergency supply for a tenant who was in pain.

- Monitoring Observation: Nine tenant files were reviewed. An incident of 7-12-12 indicated Tenant #2 had pushed Tenant #3's walker out from underneath Tenant #3 and caused Tenant #3 to fall, resulting in a fractured wrist. Nurse's notes of 7-13-12 indicated Tenant #3 was treated for the wrist injury and returned to the Program with physician orders for Naproxen 220mg tablet –one tablet every 12 hours for pain. MARs indicated Tylenol 500mg-two tablets given three times daily was given routinely 7-1-12 through 7-16-12. Tylenol was held as Hydrocodone 5mg/Acetaminophen 325 mg –one to two tablets every four to six hours were routinely given beginning 7-16-12 through 7-31-12. Naproxen 220mg was administered on 7-13-12 until the morning of 7-16-12, when the Program requested Naproxen be discontinued due to concerns of exceeding 4000mg daily of Acetaminophen.

- Regulatory Insufficiency: None noted.

G. Staffing

Complaint/Incident Allegation #39956-C, 40244-C & 39706-C: It was alleged tenants are not properly supervised. It was alleged the program was staffed with two aides. One was called away for an emergency leaving one staff for the whole program for an hour.

- Monitoring Observation: Staff #5 was interviewed and reported there were only two staff members in the general population due to staff calling in, unable to work. Staff #5 reported she has stayed to cover a shift. She was not aware of cares not being done. Staff #7 reported two staff members were scheduled, but other staff filled in, the LPN assisted and all tasks were completed with no tenant harm. Staff #8 reported two staff members were scheduled to work weekends in July. Staff members were slow to serve meals, and shower schedules were adjusted. All medications were given and cares were provided. Staff #8 reported she was away from the building 10 to 15 minutes as she was scheduled to cover in the independent living building. Staff #8 reported two staff scheduled had occurred four times in the last three months. Staff #8 reported no tenants were injured. Staff #9 reported there has never been a time when just two people were scheduled to work, because the nurse would help out if needed because another staff person called in, unable to work. Staff #9 reported tenants have not complained about cares not being done, and call lights have been answered on time. Staff #10 reported there has never been a time when only two staff members were scheduled for the general population. Staff #11 reported she was not aware of only two staff members on at a time because it wasn't scheduled that way.

  The nurse was interviewed and reported there were always two persons scheduled in the dementia unit. Due to illness, vacation, and medical leave, sometimes there was two staff scheduled in the general population. One staff member from the general population was assigned to be the visiting home service (VHS) staff to the independent unit. The VHS staff was assigned to the assisted living program and would leave to pass medications to one person, or respond to call lights. A staff member from the attached care facility was also available if the VHS staff was unable to respond. The nurse reported schedules were adjusted and she and the LPN would assist as needed. Other staff members were also asked to cover the shift.

A review of the staff schedule for July 28 & 29, 2012 revealed only two staff members were scheduled for the day shift in the general population.

Five tenants were interviewed. All reported call lights were answered quickly.

Complaint/Incident Allegation #39956-C & 39706-C: It was alleged wound care is done by aide and the orders are in depth and require a nurse to do. It was alleged Tenants are not being tended to by nurses when they have wounds. Treatments to wounds are delegated to untrained staff.

Complaint/Incident Allegation #39706-C & 39956-C: It was alleged tenants needed isolation supplies because of Staph and E. Coli infections and the supplies were not available to staff. It was alleged the program did not follow infection control guidelines.

- Monitoring Observation: Tenant #4's service plan of 6-28-12 established contact isolation precautions and to place soiled items, including dressing changes and gloves, in a red disposable biohazard bag. Nurse's notes of 7-24-12 indicated Tenant #4's wound on the back of the knee had healed. Nurse's notes of 7-25-12 indicated contact isolation had been discontinued. No issues were found related to wound care.

  Tenant #6 had foot wounds. A review of the medication administration record for July 2012 revealed wound care involved cleansing the area, applying ointment or dressing, and securing with tape.

  Staff #7, #8, #9, #10, and #11 were interviewed and reported there were no tenants who required isolation. All reported an adequate supply of gloves. Staff #5 stated no isolation was ordered but laundry bio-bags were used on a tenant with a staph infection. There were no instances of running out of supplies. The nurse was interviewed and stated one tenant was in contact isolation for a staph infection which required the use of gloves and double-bagged, red trash bags. No masks or gowns were required, and supplies were plentiful and available.

  Staff #5, #7, #8, and #9 reported they had been delegated to provide wound care and dressing changes. Staff #9 reported she has not been delegated to do more than she is capable of doing.

  Staff training files were reviewed for Staff #1, #2, #3, #4, and #5. All five had documentation of delegation of hand washing and caring for an open wound which included, cleansing the area, applying ointment and dressing as directed, and securing the dressing with a wrap or tape. Staff #1, #2, and #3 had documented delegation of the application of topical medications. Staff #4 was no longer employed at the Program according to the nurse, and Staff #5 stated she did not administer medications, which was confirmed by the nurse. Staff #1, #2, #3, #4, and #5 had training on blood-borne pathogens and universal precautions.

Complaint/Incident Allegation #39956-C: It was alleged aides flush tenants ears and aides have not been delegated.

- Monitoring Observation: During interview, Staff #7, #8, #9, and #10 reported the nurse does ear irrigations. Staff #8 stated she had not been delegated and had not been asked to do irrigations. Staff #9 stated she had not been delegated to do more than she was capable. Training files for Staff #1, #2, and #3 contained documentation of delegation of ear flushing. Staff #4 was no longer employed by the Program and Staff #5 was not delegated to pass medications. The nurse reported she sometimes did ear irrigations, but usually the task was completed by the LPN. The nurse reported staff members were not asked to do something they were not comfortable doing.

Complaint/Incident Allegation #40244-C: It was alleged a tenant flushed a lifeline down the toilet and staff did not come in to replace it and hourly checks were not performed. The tenant had history of falls and needed device.

- Monitoring Observation: Nine tenant files were reviewed. Tenant #8, a 97 year-old, was admitted on 5-17-12 and had diagnoses of: Back Pain, Indigestion, GERD, Constipation, Osteoporosis, HTN, Spinal Stenosis, Acid Reflux Disease and Edema. A cognitive evaluation was completed on 5-16-12, with Tenant #8 scoring 11 out 11, which indicated normal cognition. Tenant #8 lived in the general population. Functional and health evaluations indicated no history of falls. A service plan of 6-4-12 indicated Tenant #8 used a walker, but was independent with ambulation and transfer. Tenant #8 was interviewed and reported he/she accidently flushed the lifeline down the toilet. Tenant #8 reported the lifeline pendent was replaced the following day.

- Regulatory Insufficiency: None noted.

H. Nurse Review

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

- Monitoring Observation: Nine tenant files were reviewed and indicated the Program nurse did not consistently complete a medication review as part of a 90-day nurse review for medications recently prescribed by tenant's physician for Tenant's #1, #2, #3, #4, #5, #6, #7, #8 and #9.

- 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 medication 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 order. (IAC r. 481-69.27(1))

I. Life Safety

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

- Monitoring Observation: A tour of the dementia unit was taken with the nurse. A set of double doors was noted to exit the building into a courtyard. Both doors had a 15-second delayed egress. One of the double doors was noted to be disarmed and did not alarm when exited. The nurse stated tenants could come and go during the day and the alarm was turned back on at night. Interviews with Staff #5, #7, #9, and #11 confirmed the door from the dementia unit, which exited to the courtyard, was disarmed in nice weather and secured at night. At the time of the tour, one tenant was unattended in the dining room area of the dementia unit. The nurse immediately alarmed the door and instructed staff to keep the door alarmed at all times. The doors were observed to be alarmed during later tours of the dementia unit.

- Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. (IAC r. 481-69.32(2))

J. Record Checks

Complaint/Incident Allegation 39956-C: It was alleged a staff member was convicted of fraud and was still working with tenants.

- Monitoring Observation: Background checks were reviewed for four staff, #1, #2, #3, and #4. Background checks were completed appropriately and all four staff were eligible to be hired. The nurse was interviewed and stated Staff #2 notified her of Staff #2's conviction for embezzlement. The nurse stated Staff #2 was removed from the schedule and employment was terminated. The nurse reported the embezzlement did not involve any tenants at the Program.

- Regulatory Insufficiency: None noted.