IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 41696-C

February 4, 2013

Ms. Cheryl Rogan, Administrator
Oak Park Place Assisted Living
1381 Oak Park Place
Dubuque, IA 52002

RE: Final Complaint/Incident Investigation Report, Oak Park Place Assisted Living, Dubuque, Iowa

Dear Ms. Rogan:

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:

Cheryl Rogan, Administrator
Oak Park Place Assisted Living
1381 Oak Park Place
Dubuque, IA 52002

Complaint/Incident Intake #: 41696-C

Date of Complaint/Incident Investigation:

December 18 & 19, 2012

Monitor(s):

Hal L. Chase, RN BSN MPH

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 Definition	
Number of tenants without cognitive disorder:	43
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	48

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	9
Number of tenants with cognitive disorder:	15
Total Population of Program at time of on-site	24
TOTAL census of Assisted Living Program	72

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

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

A. Staffing

Complaint/Incident Allegation: It was alleged there wasn't enough staff available when tenants needed to be transferred.

Monitoring Observation: Eight tenant files were reviewed. Tenant's #1, #2, #3, #5, #6 and #8 files indicated they were independent with transfer. Eight staff was interviewed. Staff #1, #2 and #5 reported Tenant's #4 and #7 needed the assistance of one staff with transfer.

Staff #1, #2, #3, #4, #5, #6, #7 and #8 was interviewed and each reported there was enough staff available when tenants needed to be transferred. Staff reported there were four staff available in the general population and three staff available in the Dementia unit for both the day and evening shift. For the night shift there was two staff available for both the general population and dementia unit.

Tenant #4, a 93 year old, was admitted on 1-30-12 and had diagnoses of: Bi-Polar Disorder, History of Prostate Cancer, History of Kyphoplasty, Congestive Heart Failure (CHF), History of Kidney Stones, Chronic Left Hip Pain, History of Urinary Tract Infections, Atrial Fibrillation and possible episodes of Transient Ischemic Attacks. A Global Deterioration Scale (GDS) completed on 10-27-12 staged Tenant #4 at six, which indicated severe cognitive decline. Tenant #4 resided in the dementia unit.

Nurse's notes of 10-27-12 indicated Tenant #4 was admitted to hospice on 10-26-12. Hospice orders of 10-26-12 indicated a tab/pad alarm was to be used at all times and the family was in agreement with this order. Nurse's notes of 10-27-12 indicated family requested Tenant #4 remain independent with ambulation and to only use the pad alarm when Tenant #4 has increased weakness or unsteadiness.

A service plan of 10-27-12 indicated Tenant #4 was a fall risk, but was independent with ambulation and transfer. Tenant #4's physician was notified there had been at least eight incidents between 10-17-12 and 12-2-12, of staff finding Tenant #4 on the floor and at least one incident of witnessing the tenant falling when ambulating. Incident reports of 12-5-12 through 12-13-12 12 indicated at least four additional incidents related to falls or being found on the floor. Interdisciplinary progress notes of 12-17-12 indicated Tenant #4 was found on the floor by staff and sustained a small skin tear to the left arm. A late entry of 12-18-12 indicated Tenant #4 was found on the floor by staff on 12-13-12. Family was with Tenant #4 when the fall occurred. Family reported Tenant #4 was shuffling himself/herself backwards, fell and hit his/her head.

Tenant #7, an 80 year old, was admitted on 6-21-12 and had diagnoses of: Atrial Fibrillation, Hypertension (HTN), High Cholesterol, History of Polio, History of Urinary Tract Infections, Depression and Stress Incontinence. Tenant #7 scored 31 out of 31 on the Mini Mental Status Questionnaire. Tenant #7 resided in the general population.

Tenant #7's service plan of 10-19-12 indicated Tenant #7 needed standby assistance of one staff with transfer and ambulation.

- Regulatory Insufficiency: None noted.

B. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged some of the tenants required too much care to reside in an assisted living program.

- Monitoring Observation: Eight tenant files were reviewed. No issues were found with Tenant's #2, #3, #4, #5, #6, #7 and #8.

Tenant #1, a 94 year old, was admitted on 8-13-10 and had diagnoses of: HTN, Memory Loss, History of Squamous Cell Carcinoma of the right hand, History of UTI's and Neoplasm of the Colon. A GDS was completed on 11-12-12 and staged Tenant #1 at six, which indicated Severe Cognitive Decline. Tenant #1 resided in the dementia unit.

Nurse's notes of 9-8-12 indicated on 9-7-12 Tenant #1 was incontinent of bowel. Staff assisted in cleaning up Tenant #1 and he/she became combative. A scratch and bruising appeared on the left side of Tenant #1's cheek. A physician was notified on 10-14-12 that Tenant #1 had removed his/her depends and soaked through three sets of clothes. Staff attempted to shower and change Tenant #1's clothes and Tenant #1 became combative; hitting, pinching, kicking and scratching staff.

Staff #1 was interviewed and reported Tenant #1 consistently refused cares; specifically bathing and toileting. Due to Tenant #1's refusal of bathing Tenant #1 would not receive routine baths. Staff #3 was interviewed and reported Tenant #1 would routinely refuse cares, including bathing, grooming and toileting. Tenant #1 would consistently hit, kick, and scratch staff when cares were given. Staff #7 was interviewed and reported Tenant #1 was combative with cares. There was one instance when four staff was needed to bathe Tenant #1. Tenant #1 would hit, spit and kick and would do anything to avoid being touched. Once in the shower Tenant #1's combative behavior subsided. Staff #7 reported Tenant #1's combative behavior had been ongoing for the past three to four months. Staff #8 was interviewed and reported Tenant #1's personal cares were completed on the second and third shift, as first shift hadn't been successful in completing Tenant #1's cares. Tenant #1 had been combative – hitting and kicking when staff attempted to shower him/her.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: c. is dangerous to self or other tenants or staff, including but not limited to a tenant who, despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression. (IAC r. 481-69.23(1)(c)(1))

C. Policies and Procedures

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

- Monitoring Observation: Eight tenant files were reviewed. No issues were found with Tenant's #1, 2, #3, #5, #6 and #8.

  Tenant #4's physician was notified there had been at least eight incidents between 10-17-12 and 12-2-12, of staff finding Tenant #4 on the floor and at least one incident of witnessing the tenant falling when ambulating. Incident reports of 12-5-12 through 12-13-12 12 indicated at least four additional incidents related to falls or being found on the floor. Interdisciplinary progress notes of 12-17-12 indicated Tenant #4 was found on the floor by staff and sustained a small skin tear to the left arm. The Program did not consistently complete an incident report after Tenant #4 had either fallen or found on the floor.

  Tenant #7's nurse's notes of 8-2-12 indicated Tenant #7 was found by staff on the bathroom floor. Tenant #7 reported he/she had lost his/her balance. Nurse's notes of 9-18-12 through 11-13-12 indicated Tenant #7 sustained at least four falls. Nurse's notes of 12-7-12 through 12-10-12 indicated Tenant #7 sustained at least three separate falls. A monitor requested incident reports related to the above falls but the Program did not provide or indicate incident reports related to the falls had been completed.

- 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. The program's policies and procedures on incident reports, at a minimum, shall include the following: a. the program shall have available incident report forms for use by the program staff b. an incident report shall be in detail and shall be provided on an incident report form, c. the person in charge at the time of the incident shall prepare and sign the report, d. the incident report shall include statements from individuals, if any, who witnessed the incident, and e. all accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. (IAC r. 481-67.2(1)(a-e))

D. Evaluation

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

- Monitoring Observation: Eight tenant files were reviewed. No issues were found with Tenant's #1, #2, #5 and #6.

  Tenant #3, an 85 year old, was admitted on 9-30-11 and had diagnoses of: Parkinson's Disease, Alzheimer's Disease, Cerebral Vascular Accident, Degenerative Disc Disease and Scoliosis. A GDS was completed on 8-20-12 and staged Tenant #3 at five, which indicated moderately severe cognitive decline. Tenant #3 resided in the dementia unit.

  A functional evaluation of 8-20-12 indicated Tenant #3 needed full assistance with ambulation, but a health evaluation of the same date indicated Tenant #3 was independent with ambulation. Nurse's notes of 9-5-12 indicated Tenant #3 had fallen twice. On 9-12-12, Tenant #3 was seen by physical therapy and orders were received for strengthening of Tenant #3's back. On 10-3-12 physical therapy was discontinued as Tenant #3 refused to complete exercises. Interdisciplinary notes of 11-11-12 indicated Tenant #3 had an episode of unresponsiveness. Tenant #3 was evaluated in a hospital emergency room and later admitted for observation. Interdisciplinary progress notes of 11-13-12 indicated Tenant #3 returned to the Program. Nurse's notes of 11-14-12 indicated a physician order for stand by assistance as needed.

  Interdisciplinary notes of 12-6-12 indicated staff found blood on Tenant #3's sheets and a small skin tear on the right elbow. On 12-17-12 staff noted dried blood all over Tenant #3's face, head and ears. Tenant #3 was transported to a local hospital emergency room for evaluation and treatment. Tenant #3 returned the same day with orders for antibiotic (ATB) therapy and wound care for sutures, including head bandana dressing for compression to left ear for three days. On 12-18-12, at approximately 11:35 a.m. staff found Tenant #3 on the floor without injury. On 12-18-12, at approximately 3:00 p.m. staff found Tenant #3 on the floor in the living room. Another tenant reported Tenant #3 got up from a sofa, walked into the middle of the room and fell.

A late entry of 12-19-12 indicated a licensed practical nurse (LPN) contacted a triage nurse at the hospital emergency room Tenant #3 had been to on 12-17-12. The hospital triage nurse reported Tenant #3 complained of chronic back pain. The LPN instructed staff to apply ice to both areas (referring to the top of the left ear and back of head, right of center where stitches had been placed.) The LPN contacted Tenant #3's physician and requested and received an order for a urinalysis with culture and sensitivity.

The Program did not accurately evaluate Tenant #3's functional and health status on 8-20-12. The Program did not complete a functional, cognitive and health evaluation with a significant change of condition as indicated between 9-5-12 and 12-18-12.

Tenant #4's functional evaluation of 10-26-12 indicated Tenant #4 ambulated independently with occasional assistance and guidance. A health evaluation of 10-27-12 indicated Tenant #4 was independent with ambulation and transfer. Tenant #4's physician was notified beginning 10-17-12 through 12-2-12 that Tenant #4 had at least eight incidents of staff finding Tenant #4 on the floor and one witnessed fall.

Incident reports of 12-5-12 through 12-13-12 indicated at least four additional incidents of staff found Tenant #4 on the floor. Interdisciplinary progress notes of 12-17-12 indicated Tenant #4 was found on the floor by staff and sustained a small skin tear to the left arm. A late entry of 12-18-12 indicated Tenant #4 was found on the floor by staff on 12-13-12. Tenant #4's family was with Tenant #4 when the fall occurred. Family reported Tenant #4 was shuffling himself/herself backwards and fell and hitting his/her head.

Tenant #4's functional and health evaluation on 10-26-12 and 10-27-12 respectively were not accurately completed as they contraindicated each other. Functional, cognitive and health evaluation were not completed after a series of suspected falls were documented in the interdisciplinary notes and incident reports that occurred between 10-27-12 through 12-18-12.

Tenant #7's nurse's notes of 8-2-12 indicated Tenant #7 was found by staff on the bathroom floor. Tenant #7 reported he/she lost their balance. Tenant #7 was reminded of his/her fall risk and to use his/her pendant for all transfers and ambulation. Nurse's notes of 8-9-12 indicated Tenant #7 needed to be toileted every 90-minutes. Nurse's notes of 8-29-12 indicated a physician order was given for staff to assist with all transfers. Nurse's notes of 9-18-12 through 11-13-12 indicated Tenant #7 sustained at least four falls. Nurse's notes of 12-2-12 indicated Tenant #7 was more confused and tearful. A physician's order for ATB therapy was received from results of a urinalysis completed on 11-30-12. Nurse's notes of 12-7-12 through 12-10-12 indicated Tenant #7 sustained at least three separate falls. Nurse's notes of the same date, but separate entry indicated Tenant #7's physician was notified of increased falls and increased confusion. Nurse's notes of 12-13-12 indicated staff was to monitor for confusion and symptoms of UTI's. Functional, cognitive and health evaluations completed on 8-1-12 indicated Tenant #7 needed full assistance with ambulation, and occasional reminders or assistance with toileting.

Functional, cognitive and health evaluations were not completed with a significant change in status as demonstrated beginning 8-2-12 through 12-13-12.

Tenant #8, a 77 year old, was admitted on 9-26-12 and had diagnoses of: Dementia, HTN, Dyslipidemia, Bells Palsy and Anemia. A GDS completed on 11-20-12 staged Tenant #8 at six, which indicated severe cognitive decline. Tenant #8 resided in the dementia unit.

A functional evaluation of 9-26-12 indicated Tenant #8 needed occasional assistance of staff with ambulation. A health evaluation of the same date indicated Tenant #8 was independent with ambulation. Interdisciplinary progress notes of 9-27-12 and 9-30-12 indicated two separate incidents of staff finding Tenant #8 on the floor. On 10-1-12, staff found Tenant #7 on the floor next to his/her bed. Tenant #8 was sent to a hospital emergency room for evaluation due to a bump on the back of the head. Tenant #8 returned the same day without any new orders. On 10-23-12 and 11-5-12, Tenant #8 was found on the floor in his/her apartment.

Interdisciplinary notes of 11-11-12 indicated that on 11-8-12 at 11:40 a.m. Tenant #8 had slid off the couch and complained of right leg pain. Later the same day, at 5:00 p.m. staff found Tenant #8 on the floor and complaining of left wrist pain. A physician's order of 11-9-12 indicated staff to provide stand by assistance and to use an alarm when Tenant #8 was in his/her room.

Nurse's notes 11-13-12 indicated Tenant #8 was found on the floor during the night time hours of 11-8-12. Nurse's notes of the same entry indicated Tenant #8 had been unsteady on feet the last couple of days and staff had been assisting with ambulation. Nurse's notes of 11-19-12 indicated Tenant #8 was found on the floor twice; once by a recliner at 8:40 a.m. and later at 11:45 a.m. adjacent to the bed. Tenant #8 reported he/she had rolled out of bed. Nurse's notes of the same entry indicated Tenant #8 was very weak and lethargic when attempting to stand. Three staff was needed to assist Tenant #8 off the floor.

Nurse's notes of 11-20-12 indicated Tenant #8 was seen by his/her physician and diagnosed with a UTI. ATB therapy was started. Nurse's notes of the same entry indicated Tenant #8 was incontinent and refused to use his/her walker with ambulating. Staff was instructed to assist at all times with ambulation and transfer. Nurse's notes of 12-3-12 indicated staff was to encourage Tenant #8 to drink fluids daily.

Functional and health evaluations of 9-26-12 contraindicated each other and weren't completed accurately. Evaluations were not completed despite a significant change as documented above.

A functional evaluation completed on 11-21-12 indicated Tenant #8 needed full assistance of one or more staff with ambulation. A health evaluation of the same date indicated partial assistance with ambulation. A cognitive evaluation of the same date indicated a GDS of six, which indicated severe cognitive decline. Evaluations were completed on 11-20-12 but not within 30-days of admission.

- 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 services 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 Plan

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

Monitoring Observation: Eight tenant files were reviewed. No issues were found with Tenant #6.

Tenant #1's service plan of 11-12-12 indicated Tenant #1 needed assistance with ambulation, bathing, grooming and dressing. The service plan indicated Tenant #1 demonstrated irritability when someone touched or moved personal belongings. Staff was to remove the tenant from the community area and from others at the first sign of irritability.

Nurse's notes of 9-8-12 indicated on 9-7-12 Tenant #1 was incontinent of bowel. Staff assisted in cleaning up Tenant #1 and he/she became combative. A scratch and bruising appeared on the left side of Tenant #1's cheek. A physician was notified on 10-14-12 that Tenant #1 had removed his/her depends and soaked through three sets of clothes. Staff attempted to shower and change Tenant #1's clothes Tenant #1 became combative; hitting, pinching, kicking and scratching staff.

Staff #1 was interviewed and reported Tenant #1 will consistently refused cares; specifically bathing and toileting. Due to Tenant #1's refusal of bathing Tenant #1 would not receive routine baths. Staff #3 was interviewed and reported Tenant #1 would routinely refuse cares, including bathing, grooming and toileting. Tenant #1 would consistently hit, kick, and scratch staff when cares were given. Staff #7 was interviewed and reported Tenant #1 was combative with cares. There was one instance when four staff was needed to bathe Tenant #1. Tenant #1 would hit, spit and kick and would do anything to avoid being touched. Once in the shower Tenant #1's combative behavior subsided. Staff #7 reported Tenant #1's combative behavior has been ongoing for the past three to four months. Staff #8 was interviewed and reported Tenant #1's personal cares were completed on the second and third shift, as first shift hadn't been successful in completing Tenant #1's cares. Tenant #1 had been combative – hitting and kicking when staff attempted to shower him/her.

The service plan of 11-12-12 did not establish interventions related to Tenant #1's combative and aggressive behavior when cares were attempted or given by staff.

Tenant #2, an 82 year old, was admitted on 10-3-09 and had diagnoses of: Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type II, Diverticulosis, HTN, Colon Polyps, Mitral Valve Prolapse, Mixed Hyperlipidemia and Pneumonia.

A GDS was completed on 11-8-12 and staged Tenant #2 at five, which indicated moderately severe cognitive decline. The service plan of 11-8-12 did not establish planned and spontaneous activities based on the tenant's abilities and person interests.

Tenant #3's service plan of 8-20-12 indicated Tenant #3 was independent with ambulation and staff was to assist with the use of a wheelchair "at times." Nurse's notes of 9-5-12 indicated Tenant #3 had fallen twice. On 9-12-12, Tenant #3 was seen by physical therapy and orders were received for strengthening of Tenant #3's back.

On 10-3-12 physical therapy was discontinued as Tenant #3 refused to complete exercises. The service plan was updated to reflect interventions related to the falls Tenant #3 sustained and physical therapy.

Interdisciplinary notes of 11-11-12 indicated Tenant #3 had an episode of unresponsiveness. Tenant #3 was evaluated in a hospital emergency room and later admitted for observation. Interdisciplinary progress notes of 11-13-12 indicated Tenant #3 returned to the Program. Nurse's notes of 11-14-12 indicated physician orders for stand by assistance as needed.

The service plan was updated on 11-14-12 and indicated Tenant #3 was independent with ambulation. Staff was to observe and assist with ambulation when unsteady. The service plan of 11-14-12 did not include interventions related to previous falls and an episode of unresponsiveness. The service plan of 11-14-12 was not supported by evaluations.

Interdisciplinary notes of 12-6-12 indicated staff found blood on Tenant #3's sheets and a small skin tear on the right elbow. On 12-17-12 staff noted dried blood all over Tenant #3's face, head and ears. Tenant #3 was transported to a local hospital emergency room for evaluation and treatment. Tenant #3 returned the same day with orders for antibiotic (ATB) therapy and wound care for sutures, including head bandana dressing for compression to left ear for three days.

On 12-18-12, at approximately 11:35 a.m. staff found Tenant #3 on the floor with no apparent injuries. On 12-18-12, at approximately 3:00 p.m. staff found Tenant #3 on the floor in the living room. Another tenant reported Tenant #3 got up from a sofa, walked into the middle of the room and fell. A late entry of 12-19-12 indicated a licensed practical nurse (LPN) contacted a triage nurse at the hospital emergency room Tenant #3 had been to on 12-17-12. The hospital triage nurse reported Tenant #3 complained of chronic back pain. The LPN instructed staff to apply ice to both areas (referring to the top of the left ear and back of head, right of center where stitches had been placed.) The LPN contacted Tenant #3's physician and requested and received an order for a urinalysis with culture and sensitivity.

The program did not update the service plan of 11-14-12 to include interventions related to falls and wound care beginning 12-6-12 through 12-19-12.

Tenant #4's service plan of 10-27-12 indicated Tenant #4 was independent with ambulation, used a walker and staff was to observe and assist as needed.

Family requested the pad alarm was to be used when Tenant #4 appeared to be having an episode of weakness or unsteadiness. A hospice order of 10-26-12 indicated a tab/pad alarm was to be used at all times and the family was in agreement. Nurse's notes of 11-1-12 indicated the pad alarm was to be used only at bedtime.

Tenant #4's physician was notified Tenant #4 had at least eight incidents of staff finding Tenant #4 on the floor or had witnessed Tenant #4 falling to the floor between 10-17-12 through 12-2-12. Incident reports of 12-5-12 through 12-13-12 indicated at least four additional incidents of staff found Tenant #4 on the floor.

Interdisciplinary progress notes of 12-17-12 indicated Tenant #4 was found on the floor by staff and sustained a small skin tear to the left arm. A late entry of 12-18-12 indicated Tenant #4 was found on the floor by staff on 12-13-12.

The service plan of 10-27-12 did not accurately direct staff when to use of the pad alarm. The service plan was not updated to reflect interventions related to fall interventions as documented above.

Tenant #5, a 67 year old, was admitted on 9-26-12 and had diagnoses of: Alzheimer's Disease, Hypertension (HTN) and Hypothyroidism. A GDS was completed on 10-26-12 and staged Tenant #5 at six, which indicated severe cognitive decline. Tenant #5 resided in the dementia unit. A service plan was completed on 9-6-12 and signed by the Program nurse and Tenant #5's legal representative. However, the service plan of 10-26-12 was signed by the Program nurse but not by the legal representative. The service plan of 10-26-12 did not establish planned and spontaneous activities based on the tenant's abilities and person interests.

Tenant #7's service plan of 8-1-12 indicate Tenant #7 was a fall risk due to left leg weakness. Staff was to assist with wheelchair and to remind Tenant #7 to push his/her pendant to transfer or when he/she attempts to walk independently. Staff was to assist with transfer to bed at night and as needed.

Nurse's notes of 7-27-12 indicated a physician order on 7-10-12 for physical therapy evaluation and treatment. Physical therapy was initiated on 7-23-12 and Tenant #7 was to receive balance, strength, safety and incontinence training twice weekly. Tenant #7 had been hospitalized for Pneumonia and a Urinary Tract Infection (UTI) and returned to the Program on 8-1-12.

Nurse's notes of 8-2-12 indicated Tenant #7 was found by staff on the bathroom floor. Tenant #7 reported he/she lost her balance. Tenant #7 was reminded of his/her fall risk and to use his/her pendant for all transfers and ambulation. Nurse's notes of 8-9-12 indicated Tenant #7 needed to be toileted every 90-minutes. Nurse's notes of 8-29-12 indicated a physician order was given for staff to assist with all transfers. Nurse's notes of 9-18-12 through 11-13-12 indicated Tenant #7 sustained at least four falls. Nurse's notes of 12-2-12 indicated Tenant #7 was more confused and tearful. A physician's order for ATB therapy was received from results of a urinalysis completed on 11-30-12.

Nurse's notes of 12-7-12 through 12-10-12 indicated Tenant #7 sustained at least three separate falls. Nurse's notes of the same date, but separate entry indicated Tenant #7's physician was notified of increased falls and increased confusion. Nurse's notes of 12-13-12 indicated staff was to monitor for confusion and symptoms of UTI's

Tenant #7's service plan was updated on 8-9-12 and 10-19-12, but did not include physical therapy twice weekly and did not establish interventions related to a chronic history of UTI's and fall prevention. The service plans of 8-9-12 and 10-19-12 were not supported by evaluations.

Tenant #8's service plan of 9-26-12 indicated Tenant #8 was independent with ambulation and transfer. Interdisciplinary progress notes of 9-27-12 and 9-30-12 indicated two separate incidents of staff finding Tenant #8 on the floor. On 10-1-12, staff found Tenant #7 on the floor next to his/her bed. Tenant #8 was sent to a hospital emergency room for evaluation due to a bump on the back of the head. Tenant #8 returned the same day without any new orders. On 10-23-12 and 11-5-12, Tenant #8 was found on the floor in his/her apartment.

A physician's order of 11-9-12 indicated staff to provide stand by assistance and to use an alarm when Tenant #8 was in his/her room. Interdisciplinary notes of 11-11-12 indicated that on 11-8-12 at 11:40 a.m. Tenant #8 had slid off the couch and complained of right leg pain. Later the same day, at 5:00 p.m. staff found Tenant #8 on the floor and complaining of left wrist pain.

Nurse's notes 11-13-12 indicated Tenant #8 was found on the floor during the night time hours of 11-8-12. Nurse's notes of the same entry indicated Tenant #8 had been unsteady on feet the last couple of days and staff had been assisting with ambulation. Nurse's notes of 11-19-12 indicated Tenant #8 was found sitting on the floor next to his/her bed. Tenant #8 reported he/she had slipped. Nurse's notes of the same entry indicated Tenant #8 was very weak and lethargic when attempting to stand. Three staff was needed to assist Tenant #8 off the floor. On 11-19-12, Tenant #8 was found on the floor twice; once by a recliner at 8:40 a.m. and later at 11:45 a.m. adjacent to the bed. Tenant #8 reported he/she had rolled out of bed. Nurse's notes of 11-20-12 indicated Tenant #8 was seen by his/her physician and diagnosed with a UTI. ATB therapy was started. Nurse's notes of the same entry indicated Tenant #8 was incontinent and refused to use his/her walker with ambulating. Staff was instructed to assist at all times with ambulation and transfer. Nurse's notes of 12-3-12 indicated staff was to encourage Tenant #8 to drink fluids daily.

The service plan was updated on 11-20-12 indicated Tenant #8 was independent with ambulation, to assist when unsteady, encourage the use of his/her walker and encourage him/her to push his/her pendant with needed assistance with cares and when feeling unsteady.

The service plan of 9-26-12 was not updated with a significant change in condition as documented above until 11-20-12. The service plan of 11-20-12 did not accurately establish interventions related to falls, ambulation, and incontinence, the use of an alarm and to encourage Tenant #8 to drink fluids due to a history of UTI's.

The service plan of 11-20-12 did not establish planned and spontaneous activities based on the tenant's abilities and person interests.

- 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: 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))