IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 41964-I

February 14, 2013

Ms. Catherine Hughes, Executive Director
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. Hughes:

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: Criteria for Admission and Retention, Evaluation, Service Plans, Medications, Staffing, Nurse Review, Life Safety and Structural Requirements.

Senior Star at Elmore Place Memory Care is being assessed a $4,500 civil penalty pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program's continued failure (or refusal) to comply with regulatory requirements within the prescribed time frame established has a direct relationship in the health, safety, or security of tenants. The program had repeated regulatory insufficiencies in the areas of Criteria for Admission and Retention, Evaluation, Service Plans, Nurse Review and Structural Requirements.

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 to the State of Iowa in the amount of two thousand nine hundred twenty five dollars ($2,925) 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 $4,500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on February 5, 2013, has been reviewed and will constitute the final POC related to the on-site visit of December 26 & 27, 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 #:** 41964-I

Catherine Hughes, Executive Director
Senior Star Memory Care
4504 Elmore Avenue
Davenport, IA 52807

Date of Complaint/Incident Investigation:

December 26 & 27, 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 Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	18
Total Population of Program at time of on-site	19
TOTAL census of Assisted Living Program	19

Program History – The program received Regulatory Insufficiencies in the areas of Dementia Specific Education, Nurse Review, Service Plan, Evaluation, Criteria for Retention and Admission, Program Reporting, Policies and Procedures, Tenant Documents and Structural Requirements 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

Complaint/Incident Allegation: The Program reported Tenant #1 was found outside of the Program by non facility staff. Program staff was unaware Tenant #1 had left the dementia unit.

- Monitoring Observation: Tenant #1, an 85 year old, was admitted on 10-25-12 and had diagnoses of: Diabetes Mellitus Type II, Hypertension, Senile Dementia, Hyperlipidemia and Osteoarthritis. A Mini Mental Status Examination completed on 10-24-12, indicated Tenant #1 scored 20 out of 29, which indicated mild cognitive impairment. No other cognitive evaluation had been completed.

  A service plan of 11-20-12 indicated Tenant #1 needed staff assistance with activities of daily living (ADLs); including assistance with bathing, grooming, dressing and toileting. Tenant #1's service plan did not identify any behavioral issues related to wandering or exit seeking. Nurse's notes of 10-25-12 indicated a Wander-guard security device was placed on Tenant #1.

  Nurse's notes of 12-16-12 indicated on 12-15-12, at approximately 11:00 a.m. Tenant #1 eloped outside the south door of the Program. A hospice certified nursing assistant (CNA) found Tenant #1 in the parking lot. The Program's door alarm wasn't heard by staff and staff's pagers did not alert staff. Nurse's notes of the same entry indicated Tenant #1 wasn't wearing his/her Wander-guard security device.

  The Program had reported to the Department staff had checked placement of the Wander-guard security device on Tenant #1 during the night shift on 12-14-12. A review of the MARs for 12-15-12, during the 7:00 a.m. to 3:00 p.m. shift indicated staff had not checked the placement of Tenant #1's Wander-guard security device.

National Weather Service reported the mean temperature was 44.7 degrees F. with 0.45 inches of precipitation. The mean wind speed was 13.35 mph. The distance from the south exit door of the Program to the parking lot was greater than 75 feet. The Program reported the elopement to the Department as required.

- Regulatory Insufficiency: None noted.

B. Criteria for Admission and Retention

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

Monitoring Observation: Seven tenant files were reviewed. No issues were found with Tenant's #4, #5, #6 and #7 related to admission and retention criteria.

Tenant #1's service plan of 11-20-12 indicated Tenant #1 needed staff assistance with ADLs; including assistance with bathing, grooming, dressing and toileting. Tenant #1's service plan did not identify any behavioral issues related to combative behavior, wandering or exit seeking as noted below. Nurse's notes of 10-25-12 indicated a Wander-guard security device was placed on Tenant #1.

Nurse's notes of 10-25-12 through 12-23-12 indicated at least 14 separate incidents of Tenant #1 refusing staff assistance with ADLs and becoming physically combative; hitting, kicking, slapping staff with cares and when attempting to exit the Program. (On 12-15-12 Tenant #1 eloped outside the south door of the Program at approximately 11:00 a.m. A hospice CNA found Tenant #1 in the parking lot. The Program's door alarm wasn't heard by staff and staff's pagers did not alert staff. Nurse's notes of the same entry indicated Tenant #1 wasn't wearing his/her Wander-guard security device. Upon returning to the Program a replacement Wander-guard device was placed on Tenant #1's ankle.)

Medications prescribed during the above dates included: Topical Nystatin powder – to be applied to scrotum two-to-three times daily, Haldol 1mg and Ativan 1mg – every six hours as needed (PRN). Vitamin D-400 units with Calcium 650mg twice daily. Olanzepine 5mg twice daily, On 11-11-12, Aricpet 10mg daily, on 11-19-12 Loperamide twice daily as needed (PRN)- changed to 4mg daily PRN, Atenolol 50mg-1/2 tablet daily for five days.

Staff #1, an LPN, was interviewed and reported Tenant #1 had a history of physical aggression and exit seeking behavior. Tenant #1 physically hits, punches, kicks and spits at staff when cares were given. Staff #1 reported staff "can't do anything with ..." Only two male staff can assist Tenant #1 with ADLs, but Tenant #1 would hit and kick them when cares are given. When Tenant #1 was soiled with urine or feces it took two to three staff to clean Tenant #1 and change his/her clothes.

Staff #2 was interviewed and reported Tenant #1 routinely refused personal and health-related cares and medications. Tenant #1 would consistently refuse assistance with bathing, dressing, grooming and toileting. Tenant #1 was combative; hitting and striking at staff. Shortly after admission Tenant #1 was always combative. Tenant #1's behavior has gotten better. Tenant #1 was on Haldol twice daily and Ativan as needed for agitation.

Staff #3 was interviewed and reported Tenant #1 consistently refused assistance with bathing, dressing, grooming and was combative; hitting, kicking and slapping staff when cares were given. It would take two and sometimes three staff to assist Tenant #1 with cares. Tenant #1's combativeness has lessened but continues to be physically combative toward staff when cares were attempted or given.

Staff #4 was interviewed and reported Tenant #1 becomes violent; hitting, punching and at times, bites staff when cares were attempted or given. Tenant #1's attitude has been improved but he/she continues to be violent when assisting with cares. When cares are attempted two to three staff was used.

Tenant #2, an 87 year old, was admitted on 8-13-12 and had diagnoses of: Alzheimer's Dementia, Adjustment Disorder and Bell's Palsy affecting the Right side of face and Gait. A Global Deterioration Scale (GDS) completed on 10-1-12 staged Tenant #2 at five, indicating moderately severe cognitive decline.

Tenant #2's service plan of 8-13-12 indicated Tenant #2 needed reminders to bathe, reminders to use a walker for ambulation and transfer and staff was to administer medications. A behavioral intervention directed staff to provide support/assistance to self-manage behaviors to reduce the risk of disturbance of injury to self or others. Staff was to utilize methods to positively affect Tenant #2's behavior, including supervision, distraction and redirection and to give Tenant #2 simple choices and reminders to use his/her walker.

On 8-17-12, a physician was notified Tenant #2 was agitated and was exit seeking "all the time." An order for Ativan – 1mg twice daily for seven days and then as needed (PRN) was prescribed. Nurse's notes of 8-22-12 indicated Tenant #2 attempted to leave the Program through the front door. Nurse's notes of the same day, but separate entry, indicated staff found Tenant #2 attempting to unbutton a female tenant's blouse while sleeping.

Nurse's notes of 8-29-12 indicated Tenant #2 attempted to force himself/herself into a restroom occupied by another tenant. Nurse's notes of 10-14-12 indicated Tenant #2 was uncooperative during evening cares. Nurse's notes of 10-28-12 indicated Tenant #2 had increased confusion and exit seeking behaviors. Tenant #2 attempted to pound on tenants doors and stated he/she wanted to find the elevator. Tenant #2 was physically aggressive, trying to hit staff when redirected.

Nurse's notes of 11-19-12 indicated staff attempted to administer medications and Tenant #2 threatened to hit staff if they didn't go away. Nurse's notes of 12-3-12 indicated Tenant #2 came out of his/her apartment with nothing on but a t-shirt. Staff attempted to redirect Tenant #2 back to his/her apartment and Tenant #2 was physically aggressive toward staff. Tenant #2 continued to raise his/her fist toward staff and threatened to hit staff. Tenant #2 was escorted back to his/her room and feces fell from Tenant #2's pant leg. Tenant #2 picked up and threw feces at staff and struck staff in the arm. On 12-7-12 Tenant #2 was "very combative all day towards staff."

On 11-21-12 Tenant #2 had increased volatile aggressive behaviors; threatened to hit and had swung at staff, was uncooperative when redirected and threw his/her walker toward staff.

On 12-3-12, Tenant #2 refused his/her medications and was combative and uncooperative with cares. An order was given for Risperdal 0.25mg twice daily. Nurse's notes of 12-9-12 indicated Tenant #2's behavior had improved since starting Risperdal.

Staff #1 reported Tenant #2 had a history of physical aggression. Tenant #2 would hit staff when cares were attempted. Tenant #2 was intimidating, but his/her behavior had improved in the last two weeks.

Staff #2 reported Tenant #2 was combative; hitting and kicking when personal cares were attempted. Staff #3 reported Tenant #2 was combative with all cares. Tenant #2 has slapped staff and has thrown feces at staff. Two staff was needed to assist Tenant #2 with cares. Staff #4 reported Tenant #2 was combative; hitting staff when cares were attempted.

Tenant #3, an 89 year old, was admitted on 8-24-11 and had diagnoses of: Alzheimer's disease and a hospice diagnosis of Adult Failure to Thrive. A GDS was completed on 12-11-12 and staged Tenant #3 at six, indicating severe cognitive decline.

Tenant #3's physician was notified on 8-6-12 and 8-9-12 Tenant #3 was aggressive toward staff. On 8-6-12 Tenant #3 grabbed a staff's arms, refused to let go and pulled staff around the room, trapping staff next to a dresser. Staff was advised to take another staff with them when they entered Tenant #3's apartment.

Nurse's notes of 8-9-12 indicated Tenant #3 blocked another tenant from entering his/her apartment; believing the apartment was his/hers. Tenant #3 grabbed the other tenant's arms and began to shake him/her. Staff attempted to redirect and Tenant #3 attempted to hit staff in the chest.

Nurse's notes of 9-14-12 indicated Tenant #3 had several exit seeking attempts. Staff attempted to redirect during these incidents and Tenant #3 would kick doors and would swear.

Nurse's notes of 12-23-12 indicated Tenant #3 refused supper and attempted to spit out medications. A glass of water was offered and Tenant #3 hit the glass out the staff's hand. Staff assisted with toileting Tenant #3 was combative; hitting staff. It was noted three staff was needed to assist with cares.

Nurse's notes of 12-26-12 indicated Tenant #3 was incontinent of bowel. Staff attempted to assist with cleaning and Tenant #3 became combative toward staff.

- 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. Evaluation

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

- Monitoring Observation: Seven tenant files were reviewed. No issues were found with Tenant's #3, #6 and #7.

  Tenant #1's file indicated an initial functional, cognitive and health evaluation was completed on 10-24-12. Functional and health evaluations were completed on 11-20-12, but a cognitive evaluation was not completed within 30-days of admission.

  Tenant #2's file indicated a functional, cognitive and health evaluations were not completed within 30-days of admission. A cognitive evaluation was not completed within 30-days of admission. Evaluations were not updated with a significant change in condition as indicated above.

  Tenant #4, an 87 year old, was admitted on 8-16-12 and had diagnoses of: Generalized Weakness, Non-displaced fracture of the Right Phalanx, Degenerative Joint Disease, Coronary Artery Disease, History of Myocardial Infarction and a hospice Pneumonia. A GDS was completed on 11-12-12 and staged Tenant #4 at five, indicating moderately severe cognition.

  Functional and health evaluations were completed on 11-13-12 and a cognitive evaluation was completed on 11-12-12. Evaluations indicated Tenant #4 needed assistance with ADL's; including bathing, dressing, ambulation and transfer. Tenant #4 was independent with toileting and grooming.

  Nurse's notes of 11-5-12 indicated Tenant #4 had increased confusion, was looking for family and the next bus home. Nurse's notes of 11-12-12 indicated Tenant #4 was taken to a hospital emergency room for evaluation after falling out of bed and complaining of pain. Tenant #4 returned later that evening. A physician's order given for placement of a chair and bed alarm as Tenant #4 was unsteady and refused staff assistance with ambulation. Tenant #4 became angry about the use of the alarms and removed the chair alarm and would get up independently, refusing staff assistance; blocking the bathroom door and not allowing staff in the restroom.

  Nurse's notes of the same entry indicated Tenant #4 was unsteady and off balance. Staff was to assist Tenant #4 to bed and to place side rail in the up position.

  Nurse's notes of 11-16-12 indicated Tenant #4 was non-compliant with the chair alarm and refused to use walker at times. The chair alarm was removed from Tenant #4's room. Nurse's notes of the same date but separate entry indicated Tenant #4 made several attempts to elope from the Program.

Tenant #4 refused to use his/her walker and refused cares. Tenant #4 was later found in another tenant's room and was determined to leave the Program.

Nurse's notes of 11-22-12 at 2:00 p.m., indicated Tenant #4 had fallen and sustained abrasions on the forehead, nose and left side of face. Tenant #4's left forearm and wrist were swollen with minor edema. At 8:00 p.m. staff reported increased confusion and discomfort to the Right wrist.

Nurse's notes of 11-23-12 indicated Tenant #4's spouse was concerned about Tenant #4's discomfort to both wrists. A physician's order was obtained for a portable x-ray to both wrists. X-ray results indicated no fracture. Staff noted both wrists were bruised with some swelling. Staff reported Tenant #4 had refused cares, but staff noted an open red area between the buttocks. Casmoseptine crème was to be applied daily and PRN until healed. Nurse's notes of 11-25-12 indicated increased confusion. During evening cares, staff noted Tenant #4's peri-area was excoriated. Casmoseptine was ordered to be applied to the peri-area.

Nurse's notes of 12-4-12 indicated a physician's order for Duoderm – to be placed on open sore of buttocks – change every three days and PRN until healed. Nurse's notes of 12-7-12 indicated an open wound to buttocks was not resolving. An order of 12-11-12 indicated a wound nurse would assess and treat the wound.

Nurse's notes of 12-13-12 indicated Tenant #4 had wheezing and crackle sounds to lungs. An order was received for a portable chest x-ray and antibiotic (ATB) therapy was started for seven days. Nurse's notes of 12-14-12 indicated Tenant #4 was diagnosed with Pneumonia. An order was obtained for a hospice evaluation and treatment. Tenant #4 was evaluated and admitted to hospice on 12-14-12 with an admitting diagnosis of Pneumonia.

Nurse's notes of 12-19-12 indicated Tenant #4 had a sub acute non-displaced fracture of the distal radial and ulna metophysis. Nurse's notes of 12-21-12 indicated Tenant #4 was to wear a brace on the right wrist.

A hospice evaluation of 12-23-12 indicated a decline in health status and new orders were written for medications, including narcotics for pain and respiratory distress, oxygen by nasal canula at two-liters and wound care to open wound on Tenant #4's buttocks.

The Program did not evaluate Tenant #4's functional, cognitive and health status with a significant change in condition as documented above.

Tenant #5, an 80 year old, was admitted on 3-14-12 and had diagnoses of: Alzheimer's Disease, Falling Episodes, Gastro Esophageal Reflux Disease and General Pain. A GDS was completed on 4-12-12 and staged Tenant #5 at six, indicating severe cognitive decline.

Functional and health evaluations were completed on 4-12-12 and indicated Tenant #5 needed assistance with ADLs; including bathing, dressing, and assistance with meals. Tenant #5 was independent with ambulation and transfer, but was a fall risk.

Nurse's notes of 9-3-12 indicated Tenant #5 had crying episode and increased anxiety. Tylenol 500mg – one tablet every six hours as prn for headaches was ordered. Nurse's notes of 9-5-12 indicated staff was to monitor Tenant #5's behavior, related to crying and hollering improved with the use of Tylenol. Nurse's notes of 9-3-12 through 11-5-12 indicated at least seven episodes of increased anxiety, crying episodes and panic.

Nurse's notes of 9-24-12, at approximately 10:00 a.m. indicated Tenant #5 had a seizure like activity while sitting. Tenant #5 was shaky and confused. Two staff assisted Tenant #5 to bed. At approximately 2:50 p.m. the Program nurse found Tenant #5 lying on the floor and unable to tell anyone if he/she had fallen. At 4:30 p.m. Tenant #5 was unsteady and jittery. Staff was directed to monitor Tenant #5 for possible falls. At 8:30 p.m. Tenant #5 had an unsteady gait and was lethargic. At 10:00 p.m. emergency medical services transported Tenant #5 to a local hospital emergency room for evaluation.

Nurse's notes of 9-25-12 at 1:00 a.m. indicated Tenant #5 returned to the program. Tenant #5 was reported to have possible Atrial Fibrillation. Medication orders included Aspirin 81mg daily and Metoprolol 25mg daily.

Nurse's notes of 11-5-12 through 12-7-12 indicated at least three incidents of suspected falls. Tenant #5's physician was notified of the falls after taking Lorazepam 1mg. Lorazepam was discontinued due to suspected over sedation.

Nurse's notes of 12-12-12 indicated Tenant #5 had red vaginal discharge. A urinalysis and culture and sensitivity were ordered. Tenant #5 was seen by a physician and an order was received for Tenant #5 to use a wheelchair when up. Notes of the same date, but separate entry, indicated Tenant #5 was non weight bearing with standing and combative with staff. Nurse's notes of 12-19-12 indicated Tenant #5 had a Urinary Tract Infection (UTI) and ATB therapy was started. Nurse's notes of 12-21-12 and 12-23-12, indicated Tenant #5 needed to be fed.

The Program did not evaluate Tenant #5's functional, cognitive and health status with a significant change in condition as documented above.

- 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. Service Plans

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

Monitoring Observation: Seven tenant files were reviewed and no issues were found with Tenant's # 6 and #7.

Tenant #1's service plan of 11-20-12 indicated Tenant #1 needed staff assistance with ADLs; including assistance with bathing, grooming, dressing and toileting. The service plan placed in the chart was not readable, as the printing lacked ink. At the request of a monitor, another copy was printed. The service plan directed staff was to "utilize methods to positively affect resident's behavior, including supervision, distraction and redirection. Tenant #1 becomes agitated and aggressive easily. If Tenant #1 becomes combative, leave ... safely and approach at a later time."

Nurse's notes of 10-25-12 through 11-10-12 indicated Tenant #1 would wander throughout the Program and attempted to leave the Program on at least eight occasions. Nurse's notes of 11-5-12 indicated staff found a "very sharp" small toenail scissors in Tenant #1's apartment. The toenail scissors had been stuck in the arm of a chair.

Nurse's notes of 10-27-12 through 12-23-12 indicated at least 14 separate incidents of Tenant #1 refusing staff assistance with ADLs and becoming physically combative; hitting, kicking, slapping staff when cares were attempted and when staff attempted to redirect Tenant #1 when he/she was wandering and exit seeking.

Nurse's notes of 12-6-12 indicated the program nurse had concerns Tenant #1 had swallowing difficulties. Tenant #1's family reported Tenant #1 had a history of swallowing difficulties since 2010.

Nurse's notes of 12-8-12 indicated Tenant #1 was walking across the dining room and suddenly went to the floor and was unresponsive. Staff reported shallow breathing, vomited and was foaming at the mouth. Tenant #1 was transported to a hospital emergency room for evaluation. Tenant #1 returned later the same day. Hospital staff reported Tenant #1 was dehydrated and was given intravenous normal saline.

Nurse's notes of 12-10-12 indicated Tenant #1 was taken to a hospital emergency room for evaluation – nurse's notes did not elaborate as to the reason Tenant #1 was sent for evaluation to a hospital emergency room. A hospital emergency room physician reviewed previous emergency tenant records and a swallow study and referral for speech/swallow therapy was ordered. Nurse's notes of 12-13-12 indicated physician orders for full fluid diet nectar thick and Ensure supplement three times daily.

Tenant #1's service plan of 11-20-12 was not supported by a cognitive evaluation. The service plan did not establish interventions related to wandering, exit seeking and the Wander-guard security device Tenant #1 was wearing. The service plan did not establish additional interventions related to swallowing difficulties, combative behaviors and did not establish activities that were individualized and spontaneous; based on Tenant #1's ability and personal interests.

Tenant #2's service plan of 8-13-12 indicated Tenant #2 needed assistance with ADLs, including reminders to bathe, reminders to use a walker for ambulation and transfer and staff was to administer medications. A behavioral intervention was established for staff to provide support/assistance to self-manage behaviors to reduce the risk of disturbance of injury to self or others. Staff was to utilize methods to positively affect Tenant #2's behavior, including supervision, distraction and redirection, to give Tenant #2 simple choices and reminders to use his/her walker.

Tenant #2's physician was notified on 8-17-12 Tenant #2 was agitated and exit seeking "all the time." An order was received for Ativan – 1mg twice daily for seven days and then as needed. Nurse's notes of 10-14-12 through 12-7-12 indicated at least six incidents of physical aggression toward staff; hitting and kicking staff and throwing feces at staff when staff attempted to redirect or when assisting with cares.

On 12-3-12 an order was given to start Risperdal 0.25mg twice daily for refusal of medications, combative behavior when cares were attempted. Nurse's notes of 12-9-12 indicated Tenant #2's behavior had improved since starting Risperdal.

Nurse's notes of 9-9-12 through 11-27-12 indicated at least six incidents of losing balance and falling. Nurse's notes of 9-12-12 indicated a physical therapy evaluation and treatment was ordered. Nurse's notes of 9-24-12 indicated Tenant #2 returned from a hospital emergency room with a diagnosis of a Right Rib Fracture.

Tenant #2's service plan of 8-13-12 was not updated within 30-days of admission and with a significant change in condition. The service plan did not establish interventions related to risk for falls, wandering, exit seeking, combative behaviors when cares were given and did not establish activities that were individualized and spontaneous; based on Tenant #2's ability and personal interests.

Tenant #3's service plan of 12-17-12 indicated Tenant #3 needed assistance with ADLs; including assistance with bathing, dressing, grooming and toileting.

Nurse's notes of 8-6-12 through 12-23-12 indicated at least four incidents of physical aggression toward staff and tenants, at least four incidents of exit seeking behavior, wandering throughout the Program and at least two episodes of urinating in front of other tenant's apartment doors.

Tenant #3's service plan of 12-17-12 did not establish interventions related to wandering, urinating in front of tenant's apartments, exit seeking and physical aggression when cares were attempted and did not establish activities that were individualized and spontaneous; based on Tenant #3's ability and personal interests.

Tenant #4's service plan of 11-12-12 indicated Tenant #4 needed assistance with ADL's; including bathing, dressing, ambulation and transfer. Tenant #4 was independent with toileting and grooming.

Nurse's notes of 11-5-12 indicated Tenant #4 had increased confusion, was looking for family and the next bus home. Nurse's notes of 11-12-12 indicated Tenant #4 was taken to a hospital emergency room for evaluation after falling out of bed and complaining of pain. Tenant #4 returned later that evening.

A physician's order given for placement of a chair and bed alarm as Tenant #4 was unsteady and refused staff assistance with ambulation. Tenant #4 became angry about the use of the alarms and removed the chair alarm and would get up independently, refusing staff assistance; blocking the bathroom door and not allowing staff in the restroom.

Nurse's notes of the same entry indicated Tenant #4 was unsteady and off balance. Staff was to assist Tenant #4 to bed and to place side rail in the up position.

Nurse's notes of 11-16-12 indicated Tenant #4 was non-compliant with the chair alarm and refused to use walker at times. The chair alarm was removed from Tenant #4's room. Nurse's notes of the same date but separate entry indicated Tenant #4 made several attempts to elope from the Program. Tenant #4 refused to use his/her walker and refused cares. Tenant #4 was later found in another tenant's room and was determined to leave the Program.

Nurse's notes of 11-22-12 at 2:00 p.m., indicated Tenant #4 had fallen and sustained abrasions on the forehead, nose and left side of face. Tenant #4's left forearm and wrist were swollen with minor edema. At 8:00 p.m. staff reported increased confusion and discomfort to the Right wrist.

Nurse's notes of 11-23-12 indicated Tenant #4's spouse was concerned about Tenant #4's discomfort to both wrists. A physician's order was obtained for a portable x-ray to both wrists. X-ray results indicated no fracture. Staff noted both wrists were bruised with some swelling. Staff reported Tenant #4 had refused cares, but staff noted an open red area between the buttocks. Camoseptine crème was to be applied daily and PRN until healed. Nurse's notes of 11-25-12 indicated increased confusion. During evening cares, staff noted Tenant #4's peri-area was excoriated. Camoseptine was ordered to be applied to the peri-area.

Nurse's notes of 12-4-12 indicated a physician's order for Duoderm – to be placed on open sore of buttocks – change every three days and PRN until healed. Nurse's notes of 12-7-12 indicated an open wound to buttocks was not resolving. An order of 12-11-12 indicated a wound nurse would assess and treat the wound.

Nurse's notes of 12-13-12 indicated Tenant #4 had wheezing and crackle sounds to lungs. An order was received for a portable chest x-ray and ATB therapy was started for seven days. Nurse's notes of 12-14-12 indicated Tenant #4 was diagnosed with Pneumonia. An order was obtained for a hospice evaluation and treatment. Tenant #4 was evaluated and admitted to hospice on 12-14-12 with an admitting diagnosis of Pneumonia.

Nurse's notes of 12-19-12 indicated Tenant #4 had a sub acute non-displaced fracture of the distal radial and ulna metophysis. Nurse's notes of 12-21-12 indicated Tenant #4 was to wear a brace on the right wrist.

A hospice evaluation of 12-23-12 indicated a decline in health status and new orders were written for medications, including narcotics for pain and respiratory distress, oxygen by nasal canula at two-liters and wound care to open wound on Tenant #4's buttocks.

Tenant #4's service plan was not updated with a significant change in condition as reported above. The service plan did not establish interventions related to exit seeking behavior, refusal of ADLs, refusal to the use of the bed and chair alarm, wound care to face and wrists, the use of the wrist brace for a wrist fracture, wound care and admission to hospice and the cares provided by hospice and Program staff. The service plan did not establish activities that were individualized and spontaneous; based on Tenant #4's ability and personal interests.

Tenant #5's service plan of 4-12-12 indicated Tenant #5 needed assistance with ADLs; including bathing, dressing and grooming. Staff was to assist with meals, but was independent with ambulation and transfer and was a fall risk.

A notation dated 5-22-12 indicated the walker used by Tenant #5 had been discontinued due to short term memory loss and inability to remember to use the walker. On 5-27-12 a notation was added for the use of a bed alarm to prevent falls, but didn't establish when to use the bed alarm.

Nurse's notes of 9-3-12 indicated Tenant #5 had a crying episode and increased anxiety. Tylenol 500mg – one tablet every six hours as prn for headaches was ordered. Nurse's notes of 9-5-12 indicated staff was to monitor Tenant #5's behavior, related to crying and hollering improved with the use of Tylenol. Nurse's notes of 9-3-12 through 11-5-12 indicated at least seven episodes of increased anxiety, crying episodes and panic.

Nurse's notes of 9-24-12, at approximately 10:00 a.m. indicated Tenant #5 had a seizure like activity while sitting. Tenant #5 was shaky and confused. Two staff assisted Tenant #5 to bed. At approximately 2:50 p.m. the Program nurse found Tenant #5 lying on the floor and unable to tell anyone if he/she had fallen. At 4:30 p.m. Tenant #5 was unsteady and jittery. Staff was directed to monitor Tenant #5 for possible falls. At 8:30 p.m. Tenant #5 had an unsteady gait and was lethargic. At 10:00 p.m. emergency medical services transported Tenant #5 to a local hospital emergency room for evaluation.

Nurse's notes of 9-25-12 at 1:00 a.m. indicated Tenant #5 returned to the Program. Tenant #5 was reported to have possible Atrial Fibrillation. Medication orders included Aspirin 81mg daily and Metoprolol 25mg daily.

Nurse's notes of 11-5-12 through 12-7-12 indicated at least three incidents of suspected falls. Tenant #5's physician was notified of the falls after taking Lorazepam 1mg. Lorazepam was discontinued due to possible over sedation.

Nurse's notes of 12-12-12 indicated Tenant #5 had red vaginal discharge. A urinalysis and culture and sensitivity were ordered. Tenant #5 was seen by a physician and an order was received for Tenant #5 to use a wheelchair when up. Notes of the same date, but separate entry, indicated Tenant #5 was non weight bearing with standing and combative with staff. Nurse's notes of 12-19-12 indicated Tenant #5 had a UTI and ATB therapy was started. Nurse's notes of 12-21-12 and 12-23-12, indicated Tenant #5 needed to be fed.

Tenant #5's service plan was not updated with a significant change in condition as reported above. The service plan did not establish interventions related to crying episodes and increased anxiety, falls, assistance with ambulation and transfer, combative behaviors and a history of UTI's. The service plan did not establish activities that were individualized and spontaneous; based on Tenant #5's ability and personal 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))

E. Medications

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

Monitoring Observation: A review of MAR's beginning 12-1-12 through 12-26-12 indicated the following:

Tenant	Medication	Error
#2	Trazadone 50mg tablet – one tablet at night	Not recorded as given on 12-6-12 at 8:00 p.m.
#3	Docusate with Senna 50/8.6 mg two tabs daily	Not recorded as given on 12-2-12
#3	Acetaminophen 500mg – one tablet every morning	Not recorded as given on 12-2-12
#3	Exelon Patch 9.5mg/24	Not recorded as given on 12-12-12
#3	Namenda Tablet 10 mg	Not recorded as given on 12-12-12
#3	Ensure Supplement three times daily	Not recorded as given on 12-1-12 at 8:00 a.m., 12-16-12 at 12:00 p.m.,
#4	Silvadene Crème to buttocks, cover with dressing and change every shift	Not recorded as completed on 12-22-12 on the 11p-7a shift, 12-25-12 on the 11p-7a shift, 12-26-12 on the 3p-11p shift.
#4	Tylenol 650mg – one tablet three times daily	Not recorded as given on 12-26-12 at 1:00 p.m.

#12	Ted Hose on the a.m. and off in the p.m.	Not recorded as removed on 12-25-12.
#13	Alprazolam 0.25mg – one tablet twice daily	Not recorded as given on 12-25-12 at 8:00 p.m.
#13	Simvastatin tablet 40mg – one tablet at night	Not recorded as given on 12-25-12 at 8:00 p.m.

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

F. Staffing

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

Monitoring Observation: According to Tenant #1's nurse's notes that were dated 10-25-12 through 11-1-12 revealed that Tenant #1 wandered throughout the Program attempting to leave the Program on at least five separate occasions. Nurse's notes of 11-5-12 indicated staff found a "very sharp" small toenail scissors in Tenant #1's apartment. The toenail scissors had been stuck in the arm of a chair.

Nurse's notes of 12-16-12 indicated on 12-15-12, at approximately 11:00 a.m. Tenant #1 eloped outside the south door of the Program. A hospice certified nursing CNA found Tenant #1 in the parking lot. The Program's door alarm wasn't heard by staff and staff's pagers did not alert staff. Nurse's notes of the same entry indicated Tenant #1 wasn't wearing his/her Wander-guard security anklet device.

A review of Medication Administration Records (MARs) indicated staff was to check placement of the Wander-guard security anklet every shift (7:00 a.m. – 3:00 p.m., 3:00 p.m. – 11:00 p.m. and 11:00 – 7:00 a.m.) The Program had reported to the Department staff had checked placement of the Wander-guard security anklet on Tenant #1 during the night shift on 12-14-12. A review of the MARs for 12-15-12, during the 7:00 a.m. to 3:00 p.m. shift indicated staff had not checked the placement of Tenant #1's Wander-guard security device.

Tenant #1's MARs beginning 12-1-12 through the afternoon shift of 12-27-12 indicated staff had not checked placement of the Wander-guard security anklet on at least eight separate occasions. The MAR for 12-24-12, during the 11:00 p.m. – 7:00 a.m. shift, indicated staff recorded the Wander-guard security anklet was not on Tenant #1. No record was found of staff reporting the Wander-guard security anklet was missing.

A review of MARs for Tenant's #2, #3, #7, #8, #9, #10 and #11 beginning 12-1-12 through 12-26-12 indicated Wander-guard security devices were not consistently checked for placement during each of three shifts. Staff #1, #2, #3 and #4 reported Wander-guard security devices worn by tenants were to be checked by a staff member during their shift.

The Program did not consistently redirect Tenant #1 when he/she wandered throughout the Program and when Tenant #1 had a history of elopement. The Program did not consistently check placement of the Wander-guard security system to ensure the placement of this device on Tenant #1 and on at least seven additional tenants who resided at the Program.

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

G. Nurse Review

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

- Monitoring Observation: A review of Tenant #1's, #2's, #3's, #4's and #5's chart indicated 90-day nurse reviews were not consistently completed.

- 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))

H. Life Safety

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

- Monitoring Observation: Tenant #1's nurse's notes of 12-15-12 indicated Tenant #1 eloped outside the south door of the Program at approximately 11:00 a.m. A hospice CNA found Tenant #1 in the parking lot. The Program's door alarm wasn't heard by staff and staff's pagers did not alert staff. Nurse's notes of the same entry indicated Tenant #1 wasn't wearing his/her Wander-guard security anklet device. Staff #1, #2, #3 and #4 reported each had known or had been told by other staff the weekend of 12-15-12 the door alarms and pagers weren't working properly. The Administrator reported she knew of no policy or procedure related to the checking and maintenance of exit door alarms and paging systems.

  The Program did not have a policy or procedure for routinely monitoring the exterior door alarms and paging systems the Program uses. The Program did not have a policy or procedure establishing guidelines when staff was to check placement and activation of the Wander-guard security devices tenant's wore.

- Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have: a. written procedures regarding alarm systems and appropriate staff response when a tenant's service plan indicates a risk of elopement or a tenant exhibits wandering behavior. (IAC r. 481-69.32(2))

I. Structural Requirements

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

- Monitoring Observation: During the onsite investigation a monitor toured the Program on 12-26-12 and 12-27-12. The following observations were made.

  On 12-26-12, at approximately 12:20 p.m. a monitor noted a shower room door was left open. Upon inspection, the cabinet doors had child proof plastic locks that were damaged and were easily opened. Inside the top cabinet was two bottles of Clorox "Clean up" with Bleach. Staff reported the two bottles of bleach had been brought in by a tenant's family member to use after a tenant had taken a shower.

  On 12-26-12, at approximately 12:30 p.m., a monitor noted a dining room center island cabinet door; with child proof locks were damaged and easily opened. Inside the cabinet were three cleaning chemicals; Yellow-64 – Ammonium Chloride Disinfectant Cleaner, Foamy Mac-Organic Acid Salt Restroom Cleaner and Double O Seven-Hydrogen Peroxide Cleaner.

  On 12-26-12, at approximately 12:30 p.m., a monitor noted the hallway door leading to the kitchen door was left open. Staff was not aware the door was open. Inside the kitchen were electrical appliances and staff was not present.

  On 12-27-12, at approximately 11:45 a.m., upon returning from the dining room to the front of the Program entrance, noted a maids cart was left unattended to the right of the front entrance. On the maids cart were two bottles of Yellow-64 and Foamy Mac.

  On 12-27-12, at approximately 12:10 p.m., a monitor noted the hallway door leading to the kitchen was open. Inside the kitchen were electrical appliances and staff was not present.

  On 12-27-12, at approximately 4:15 p.m., a monitor noted the shower room that had been left open the day before was open. Upon inspection, the cabinet had the same child proof lock that was damaged was easily opened and a bottle of glass cleaner was found.

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