IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED

Complaint Intake #'s:

43410-I
43403-C
43498-M
43499-A

July 9, 2013

Ms. Jeri Davidson, Executive Manager
Senior Star at Elmore Place Memory Care
4504 Elmore Avenue
Davenport, IA 52807

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - SENIOR STAR AT ELMORE PLACE MEMORY CARE
II. Reduction of Civil Penalty
III. Sanctions – Conditional Operation
IV. Appeals/Hearings
V. Conclusion

Dear Ms. Davidson:

I. Final Complaint/Incident Investigation Report – Senior Star at Elmore Place Memory Care, Davenport, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued 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, following an investigation by DIA on **May 1-2, and 6-8, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights, Policies and Procedures and Staffing.

Senior Star at Elmore Place Memory Care ("Program") is being assessed a **$2500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.12(3)(a)(2), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of Policies and Procedures and Staffing.

The determination of a **$2500 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Policies and Procedures and Staffing. As the enclosed Report details, Program failed to follow its policy and procedure on how to respond to a tenant exhibiting aggressive behaviors and program failed to instruct staff to keep the medication room locked at all times.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service 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 **one thousand six hundred and twenty five dollars ($1,625)** within 30 days after the notice or service of this demand letter.

III. Sanctions – Conditional Operation

Due to the Program's noncompliance and current Regulatory Insufficiencies, the Program's Conditional Certificate remains in effect as of **June 5, 2013**.

Previous sanctions included: No new admissions. Proof of 2 hours of Dementia Specific training related to behavior management conducted by an outside entity such as Alzheimer's Association for all direct care workers and nursing staff within 30 days.

This training does not count toward the 8 hours of Dementia Specific training as identified in IAC chapter 481 - 69.30. The program will have 30 days to complete the above training and provide proof of the training to the Department.

IV. Appeals/Hearings

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written 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 the notice or service of this demand letter.

V. Conclusion

The Program is being assessed a **$2500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Plan of Correction (POC) submitted on June 19, 2013, has been reviewed and will constitute the final POC related to the on-site visit of May 1-2 and 6-8, 2013.

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 notice or service 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,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Jeri Davidson, Executive Manager of Health Services
Senior Star at Elmore Place Memory Care
4504 Elmore Avenue
Davenport, IA 52807

Complaint/Incident Intake #: 43410-I
43403-C
43498-M
43499-A

Date of Complaint/Incident Investigation:

May 1-2, and 6-8, 2013

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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	6
Number of tenants with cognitive disorder:	13
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, Service Plan, Evaluation, Criteria for Retention and Admission, Medications, Food Service and Non Compliance with Plan of Correction during this certification period.

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

A. Tenant Rights

Complaint/Incident Allegation: The Program reported Tenant #10, a tenant in the secured dementia unit, was talking about having sex with someone who fit the description of a staff member of the Program (43410-I). It was reported a tenant was talking with a tablemate about having sex with a person who fit the description of a staff member at the program. (43403-C).

- Monitoring Observation: Tenant #10, a 91 year-old, was admitted to the assisted living dementia unit on 1-15-13 and had diagnoses of: Dementia, Anemia, Depression, Hypertension (HTN), Osteoarthritis, and Congestive Heart Failure (CHF). On 2-12-13, Tenant #10 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. Tenant #10 was admitted to hospice on 1-15-13 with diagnoses of: Debility and Aortic Insufficiency. Tenant #10 died on 2-28-13.

  Tenant #10 previously resided in a general population assisted living program adjacent to the assisted living dementia unit from 8-30-12 through 1-8-13. Nurse's notes of November 2012 indicated Tenant #10 had incidents of delusions and hallucinations. Nurse's notes dated 12-23-12 indicated Tenant #10 had blood in the toilet. Tenant #10 was observed to have very large protruding hemorrhoids. Notes from 12-23-12 documented Tenant #10 had increased confusion. Nurse's notes dated 1-6-13 documented Tenant #10 was extremely confused and wandering. Tenant #10 was also observed to have audible wheezing and labored breathing. On 1-8-13, Tenant #10 was admitted to the hospital for CHF. On 1-14-13, Tenant #10 was discharged from the general population. Tenant #10 was discharged from the hospital and admitted to memory care on 1-15-13.

Nurse's notes dated 1-15-13 indicated Tenant #10 stated "I don't want to have baby." Notes dated 1-27-13 indicated Tenant #10 was having diarrhea. Hospice notes dated 2-9-13 indicated Tenant #10 reported burning with urination to the hospice nurse.

Nurse's notes dated 2-11-13 through 2-28-13 documented Tenant #10's health status had declined and exhibited signs of confusion, refused to use oxygen therapy and Tenant #10's oxygen saturation levels were in the 70's.

Hospice notes dated 2-9-13 indicated Tenant #10 reported burning with urination to the hospice nurse. The hospice nurse documented she observed a bleeding external hemorrhoid. A cream was ordered for hemorrhoids. During the hospice visit, Tenant #10 was also noted to be short of breath with an oxygen saturation of 77-85% on room air. Oxygen was applied and the saturation rose to normal, 92%. Hospice completed a follow-up visit on 2-10-13 and noted frank red blood in Tenant #10's underwear. Tenant #10 reported a burning sensation and blood was noted in the feces after a small bowel movement. The external hemorrhoid was noted to be present. A family member was also noted to be present.

Hospice interdisciplinary notes dated 2-10-13 indicated the family member talked to the hospice nurse about Tenant #10's increased confusion, low oxygen, and blood in underwear. The family member reported Tenant #10 was talking about sex, but nothing specific. The family member remembered two weeks prior Tenant #10 and Tenant #11 at the dining table talking about having sex with a man. It was reported Tenant #10 did not specifically say sex was occurring. The family member expressed concern of possible sexual abuse, and noted the Program employed male staff members. The hospice nurse documented she had checked Tenant #10's perineal, vaginal, and rectal area and no trauma was observed on 2-10-13. No swelling, tearing or irritation noted. The hospice nurse indicated Tenant #10 was not apprehensive during the examination.

The hospice nurse indicated she did not suspect inappropriate behavior had occurred. The hospice nurse recalled a low oxygen level, which could have explained Tenant #10's confusion and progression of dementia. The hospice nurse reported the incident to her superiors.

The Program completed an internal investigation and recommended Tenant #10 be evaluated at the hospital for possible abuse. Tenant #10's power of attorney declined the recommendation. An internal investigation determined there was no evidence of sexual abuse and an alleged perpetrator was not identified.

Tenant #11, an 85 year-old, was admitted on 11-22-11 and had diagnoses of: Atrial Fibrillation, Alzheimer's Dementia, and Chronic Kidney Disease. Tenant #11 resided in memory care. A GDS was completed on 2-7-13 and staged Tenant #11 at six, which indicated severe cognitive decline. Tenant #11 was admitted to hospice on 9-24-12 for Failure to Thrive and was discharged from hospice on 2-6-13. The clinical record was reviewed and no documentation of verbalization of sexual acts was found. The clinical record documented staff members provided assistance with toileting and perineal care. There was no documentation to suggest any concern regarding the appearance of the genital area, unexplained bleeding or, discomfort in the genital area. Tenant #11 was not interviewed due to cognitive decline.

The Program provided a current list of all staff employed from 1-15-13 through 2-28-13, when Tenant #10 resided at the Program. A staff schedule for the same period indicated three male staff; Staff #9, #10 and #11 worked varying shifts during this period. Staff #9 and #11 were interviewed and reported they provided personal and health-related cares to male tenants and would assist female staff, when needed, in the care of female tenants, including Tenant #10. Staff #10, a Licensed Practical Nurse (LPN) reported he would provide care to all tenants, including Tenant #10, but would ask a female staff to accompany him when personal cares were given to female tenants. Staff #5 and #13 were interviewed and reported female staff was assigned to provide personal care to tenants and when needed, male staff would assist. Staff #5, #9, #10, #11 and #13 reported they were not aware of sexual misconduct by staff.

There was no evidence to suggest an act of sexual abuse occurred at the program.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: The Program reported an incident between Tenant #12 and Staff #11 occurred on 4-15-13. Tenant #12 was observed to have a bruise on the right forearm (43498-I). It was alleged an incident occurred between a tenant and staff members. which resulted in an injury. The staff members continued to work with the tenant (43499-C).

- Monitoring Observation: Tenant #12, an 82 year-old, was admitted to the assisted living dementia unit on 3-15-13 and had diagnoses of: Anxiety, Chronic Low Back Pain, Depression, Gastroesophageal Reflux Disease (GERD), HTN, and Macular Degeneration. A GDS was completed on 3-15-13 and staged Tenant #11 at four, which indicated moderate cognitive decline.

  Tenant #12 previously resided in a general population assisted living Program adjacent to the assisted living dementia unit on 4-13-12 through 3-15-13. A nurse review completed at the assisted living Program dated 3-14-13 indicated Tenant #12 continued to show decline in cognition which lead to continued confusion. Medication had been changed without success. Tenant #12 had exhibited wandering.

  Nurse's notes dated 3-16-13 through 4-12-13 documented Tenant #12 was yelling, uncooperative and wouldn't eat and take medications. Tenant #12 verbalized he/she was being held hostage and drugged. Tenant #12 complained the room smelled and people were in the room playing music. A fax to the physician dated 4-10-13 indicated Tenant #12 spent a lot of time in bed refusing meals, crying, and stating a wish to die during sleep. Nurse's notes of the same time period documented a sharp tone, but did not document physical aggression.

  A functional evaluation dated 4-15-13 indicated no complaints of pain and Tenant #12's skin was noted to be normal with some age spots and without bruises. In regards to behavior patterns, the 30-day evaluation indicated Tenant #12 was free of disturbing or disabling traits or habits. Would an evaluation indicate this?or would nurse's notes?

  Program documentation indicated an incident occurred the evening of 4-15-13 involving Tenant #12 and Staff #7, a licensed practical nurse (LPN), #11 and #13.

Staff #12 (a home health contracted staff) was also present. Staff #7 reported Tenant #12 entered the medication room, was asked to leave but refused. Tenant #12 became agitated and hit Staff #7 with his/her hands and the walker Tenant #12 used to ambulate. Staff #11 assisted in assisting Tenant #12 out of the medication room. Once outside the medication room Tenant #12 screamed loudly and continued to swinging his/her hands and walker at staff. Staff #11 put his arms around Tenant #12 and assisted him/her to his/her room. Accompanying the incident report were two incident witness statements from Staff #11 and #13.

Staff #7, #11, #12, and #13 were interviewed separately by a monitor. Each staff gave differing statements related to the sequence of events that took place during the incident, however, each had reported Tenant #12 wanted to use the phone located in the medication room, to call a family member. Staff #11 had picked Tenant #12 up off the floor on two separate occasions. Staff #11 picked up Tenant #12, placing his arms around Tenant #12's arms and placed Tenant #12 outside the medication room door-way. Tenant #12 became agitated and Staff #11 picked Tenant #12 up a second time in similar fashion and carried Tenant #12 back to his/her apartment, placing Tenant #12 on the bed and then placing Tenant #12 in a supine position in bed. Staff #7, who was the charge nurse during the time of incident reported she had not given Staff #11 direction related to the actions he had taken with Tenant #12.

Tenant #12 was interviewed and reported he/she had asked to use the phone to call a family member. Staff refused to allow him/her to call family and pushed him/her out of the medication room. A male staff grabbed Tenant #12 from behind, placed Tenant #12's arms across his/her chest, picked Tenant #12 up off the floor and carried Tenant #12 to his/her apartment and was threw Tenant #12 on the bed. Tenant #12 reported he/she had repeatedly asked to be "let go."

Tenant #12 was interviewed by the monitors. Tenant #12 stated there was pain in the right shoulder and right arm. Faint bruising was noted on the right forearm.

Tenant #12's service plan dated 4-15-13 indicated staff was to approach Tenant #12 in a calm, mellow, non-threatening manner. Staff were to validate Tenant #12's concerns and feelings even if non-existent. Hallucinations needed validation. Tenant safety was to be ensured at all times during episodes of agitation.

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

A review of nurse's notes for Tenant #12 documented Tenant #12 made "comments about suicide and wanting to die" on 3-13-13, prior to admission to memory care, and on 4-5, 4-6, 4-9 (twice), and 4-20 while in memory care. A review of the service plan did not identify interventions for Tenant #12 who verbalized wanting to die. The Program did not adequately address Tenant #12's suicidal thoughts.

Tenant #12 had a history of agitation, visual and auditory hallucinations. Tenant #12's service plan included interventions directing staff to validate Tenant #12 concerns and feelings and to approach in a calm and non-threatening manner. However, during the incident of 4-15-13, staff violated Tenant #12's rights.

- Regulatory Insufficiency: All tenants have the following rights: To be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

- Regulatory Insufficiency: To receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

- Regulatory Insufficiency: To be free from mental and physical abuse. (IAC r.481-67.3(4))

- Regulatory Insufficiency: To receive from the manager and staff of the program a reasonable response to all requests. (IAC r. 481.67.3(5))

B. Policies and Procedures

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

- Monitoring Observation: On 4-15-13, Tenant #12 walked down the hall and into the medication room to make a phone call. It was reported Tenant #12 began hitting and screaming when staff members attempted to get Tenant #12 to leave the medication room. Staff #11 restrained Tenant #12 twice during this incident.

  The Program's policy on use of restraints or seclusion indicated tenants were not to be physically restrained. Tenants who exhibited behaviors resulting in harm to themselves or others were to be transferred to an appropriate care setting, including hospitalization. Staff were to remove all tenants and staff from the presence of the tenant, call emergency personnel and request assistance from the police, call the executive director or manager on duty, contact tenant's family or responsible party and implement "crisis management process." Staff did not follow the above stated policy.

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

C. Staffing

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

Monitoring Observation: Staff #7, #11, #12 and #13 were interviewed separately by a monitor. Each staff gave differing statements related to the sequence of events that took place during the incident, however, each had reported Tenant #12 wanted to use the phone located in the medication room, to call a family member. Staff #11 had picked Tenant #12 up off the floor on two separate occasions. Staff #11 picked up Tenant #12, placing his arms around Tenant #12's arms and placed Tenant #12 outside the medication room door-way. Tenant #12 became agitated and Staff #11 picked Tenant #12 up a second time in similar fashion and carried Tenant #12 back to his/her apartment, placing Tenant #12 on the bed and then placing Tenant #12 in a

supine position in bed. Staff #7, who was the charge nurse during the time of incident reported she had not given Staff #11 direction related to the actions he had taken with Tenant #12.

Tenant #12 was interviewed and reported he/she had asked to use the phone to call a family member. Staff refused to allow him/her to call family and pushed him/her out of the medication room. A male staff grabbed Tenant #12 from behind, placed Tenant #12's arms across his/her chest, picked Tenant #12 up off the floor and carried Tenant #12 to his/her apartment and was threw Tenant #12 on the bed. Tenant #12 reported he/she had repeatedly asked to be "let go."

Tenant #12 was interviewed by the monitors. Tenant #12 stated there was pain in the right shoulder and right arm. Faint bruising was noted on the right forearm.

Tenant #12's service plan dated 4-15-13 indicated staff was to approach Tenant #12 in a calm, mellow, non-threatening manner. Staff was to validate Tenant #12's concerns and feelings even if non-existent. Hallucinations needed validation. Tenant safety was to be ensured at all times during episodes of agitation.

Staff members did not demonstrate an understanding that the medication room door was required to be locked when no one was using the room. Staff #11 did not demonstrate an understanding of interventions for behaviors exhibited by a tenant in a dementia unit.

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

D. Evaluation

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

- Monitoring Observation: Tenant #10 previously resided in a general population assisted living program adjacent to the assisted living dementia unit from 8-30-12 through 1-8-13. Nurse's notes during this time indicated Tenant #10 experienced increased confusion and labored breathing and was admitted to the hospital. Tenant #10 was admitted to an assisted living dementia unit on 1-15-13 following hospitalization for CHF. The Program utilized a combined functional and health evaluation form. The initial evaluations completed by the Program Nurse included a cognitive and functional evaluation. The health information on the form indicated vital signs were on the chart, and the skin and mouth were normal. The form indicated there was verbalization of pain, but did not indicate the location of the pain or the intensity. Tenant #10 was also noted to have typical activity tolerance. The initial nurse's note entry did not reveal any documentation of Tenant #10's health status. The initial evaluation lacked documentation of an evaluation of Tenant #10's lung function, or the presence or absence of fluid in the extremities following hospitalization for CHF. Faxes to the physician dated 1-15-13 requested an order for daily weights and requested a discontinuation of the daily fluid restriction of 1,500 milliliters and the low sodium diet. Oxygen was ordered for Tenant #10 on an as needed basis on 1-21-13. Compression stockings were ordered on 2-11-13. Oxygen was ordered to be used continuously on 2-12-13.

Hospice visit notes (nursing assessment) dated 1-16-13 documented Tenant #10 had shortness of breath with activity and was wheezing after ambulating 30 feet. Tenant #10 was also noted to have 2+ pitting edema, fluid in the legs, bilaterally. Tenant #10 complained of abdominal discomfort. Visit notes of 1-24-13 indicated Tenant #10 had edema from the knees to feet, and 2+ pitting edema in the right hand. Visit notes of 1-31-13 indicated Tenant #10 used accessory muscles for breathing when ambulating. Tenant #10 also had edema from the upper thighs to the ankles in both legs. Visit notes of 2-5-13 documented 3+ edema from upper thighs to feet bilaterally. There was 2+ edema in the right hand. With ambulation Tenant #10's respiratory rate increased to 30 and Tenant #10 had shortness of breath for the remainder of the hospice visit. On 2-9-13, Tenant #10 had an oxygen saturation of 77-85 % with rapid respirations at rest, up to 36 times a minute. On 2-12-13 was wheezing with ambulation and edema from thighs to ankles.

The program's nurse's notes dated 1-15-13 through 2-4-13 did not contain documentation of Tenant #10's breathing or fluid in the legs. An entry dated 2-11-13 at 2:30 p.m. indicated Tenant #10 had an oxygen saturation of 78%, was non-compliant with use of oxygen, but that oxygen was applied and the saturation rose to 94%. It was also noted once the saturation improved, Tenant #10 became more alert. On 2-22-13, nurse's notes documented bilateral hands and feet were swollen. The notes of 2-28-13 indicated Tenant #10 had died.

The Program utilized a combined functional and health evaluation form. The 30-day evaluations completed by the Program Nurse included a cognitive and functional evaluation. The health information on the form dated 2-12-13 indicated vital signs were on the chart, the Program was monitoring oxygen, weight and vital signs, and skin and mouth were normal. Tenant #10 was noted to tolerate activities for 30-60 minutes in length. The nurse review form labeled 30-day evaluation did not document a general health status (good, fair, poor) and did not identify any difficulty breathing nor any swelling of the hands and legs.

An evaluation of Tenant #10's health was not completed at admission following hospitalization for CHF. Over the next 30 days hospice notes documented a decline in Tenant #10's condition as evidenced by dropping oxygen saturation levels, increased effort at breathing, and increasing fluid in the extremities. Tenant #10 died on 2-28-13. Health evaluations were not completed with changing condition or within 30 days of admission.

Tenant #12 was admitted to the assisted living dementia unit on 3-15-13. The GDS was used, however, the form was not completed to indicated how Tenant #12 was staged at four. The cognitive evaluation was not completed.

While a deviation from the requirements of the rules was found, the dates of the rule violation precede the program's plan of correction dates.

- Regulatory Insufficiency: None noted.

E. Service Plans

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

Monitoring Observation: Tenant #10 was admitted to memory care following hospitalization for CHF. The health evaluation did not contain documentation of Tenant #10's edema in the legs. The service plan dated 1-15-13 indicate Tenant #10's legs needed to be elevated to decrease swelling in the legs. The service plan was not based on evaluations.

The same service plan had a notation dated 1-30-13 which indicated a wander guard was placed on Tenant #10 for safety. Task sheets for the week of 1-20 and 1-28-13 indicated Tenant #10 had been checked as Tenant #10 had been identified as an elopement and fall risk. The evaluations of 1-14-13 indicated Tenant #10 was at low risk for falls. Neither a nurse review nor evaluations were completed to indicate Tenant #10 was a fall risk. The service plan was updated but was not based on an evaluation.

Tenant #11, and 85 year-old, was admitted to memory care on 11-22-11 and had diagnoses of: Atrial Fibrillation, Alzheimer's Dementia, and Chronic Kidney Disease. Tenant #11 was staged at six on the GDS, which indicated severe cognitive decline. The service plan dated 2-7-13 was updated with a notation on 3-18-13 which indicated Tenant #11 was not to be sent to the emergency room for unresponsive episodes. Nurse's notes dated 3-18-13 indicated Tenant #11 was not responsive and "went unresponsive for a few seconds" then began to snore and was having difficulty lifting the head. Notes of 4-26-13 documented Tenant #11 was leaning to the side and drooling. Tenant #11 had garbled speech. Later, Tenant #11 was described as awake. The service plan did not identify how staff members were to support Tenant #11 during episodes of unresponsiveness. The service plan did not meet the identified needs of Tenant #11.

Nurse's notes dated 3-16-13 through 4-12-13 documented Tenant #12 was yelling and uncooperative, would not eat and would not take medications. Tenant #12 also verbalized he/she was being held hostage and was being drugged. Tenant #12 also complained the room smelled and people were in the room playing music. A fax to the physician dated 4-10-13 indicated Tenant #12 spent a lot of time in bed refusing meals, crying, and stating a wish to die during sleep. Nurse's notes documented a sharp tone, but did not document physical aggression.

30-day evaluations were completed for Tenant #12 on 4-15-13. In regards to behavior patterns, the 30-day evaluation indicated Tenant #12 was free of disturbing or disabling traits or habits. A review of the service plan dated 4-15-13 indicated staff members were to approach Tenant #12 in a calm, mellow, non-threatening manner. Staff members were to validate concerns and feelings even if non-existent. Hallucinations needed validation. Tenant safety was to be ensured at all times during episodes. The service plan was not based on evaluations.

While a deviation from the requirements of the rules was found, the dates of the rule violation precede the program's plan of correction dates.

- Regulatory Insufficiency: None noted.