IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
43751-I
43741-C
44166-C

July 18, 2013

Jeanne Steinkamp, Director
Bickford Cottage II of Sioux City
4022 Indian Hills Drive
Sioux City, IA 51108

RE: Final Complaint/Incident Investigation Report, Bickford Cottage II of Sioux City, Sioux City, Iowa

Dear Ms. Steinkamp:

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 Insufficiency, 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:

Jeanne Steinkamp, Director
Bickford Cottage II of Sioux City
4022 Indian Hills Dr.
Sioux City, Iowa 51108

Complaint/Incident Intake #:

43751-I
43741-C
44166-C

Date of Complaint/Incident Investigation:

June 5, 6, 15 and 17, 2013

Monitor(s):

Maribeth Freland RN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: *In preparing this report, the following information was considered:*

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	22
Total Population of Program at time of on-site	24
TOTAL census of Assisted Living Program	24

Program History – The program received no regulatory insufficiencies during this recertification period.

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

A. Criteria for Admission and Retention

Complaint/Incident Allegation: 43751-I- It was reported an exit seeking tenant had eloped from the program twice within a 30 day period.

- Monitoring Observation: The program had 36 apartments within the building, three common living room areas and one common dining room area. The program was certified as a dementia specific program by dedication. The entire building was secured and housed 24 tenants, 22 who were cognitively impaired, at the time of the onsite visit. The building did not have a separate secured area identified as the memory care unit.

  The program had one main front entrance and six side exit doors which led to an unsecured area. The program utilized an alarm system that sounded when the interior doorway leading to an area containing an exit door leading to an outside area was opened. The alarm sounded audibly when a door was opened. When the door opened, the location of the door was lit up and visible on a panel located in each hallway of the building.

  The program also used an alarm system that utilized a watch worn by cognitively impaired tenants. This system was located at the front entrance and at the interior door leading to the area containing each of the six side exit doors. The program placed the watches on those tenants that were cognitively impaired and had a history of wandering and/or exit seeking behaviors.

When a tenant wearing the watch that was connected to the program's alarm system went through an open doorway that exited to the outside area, this second alarm system sent a message to a pager worn by staff members identifying the tenant name and location of the exit door by which the tenant was nearing.

The front entrance and all six side exit doors utilized an egress bar that, when pushed for several seconds continually, would release automatically after 15 seconds to allow free access out of the building. The instructions for use of the egress bar were posted on the egress bar itself. When this egress bar is pushed continuously for a few seconds, thereby engaging the automatic egress feature, an audible alarm sounded and a message is also sent to a pager worn by staff members identifying the location of the exit door which had been opened using the egress bar.

The Director identified no current tenants who wandered throughout the program and identified Tenant #1 as the only tenant who exhibited exit seeking behaviors.

During interview, Staff #1, certified nursing aide (CNA), and Staff #8, CNA, reported Tenant #1 frequently wandered and exhibited exit seeking behavior. During interview, Staff #2, CNA, Staff #3, certified nurse aide (CMA), Staff #4, CNA, and Staff #5, CMA, all reported Tenants #1, #3 and #4 wander throughout the program and exhibit exit seeking behavior; however, each indicated Tenant #1 was the only tenant who had actually gotten outside the building. Staff #1, #2, #3, #4, #5 and #8 all reported Tenant #1 frequently attempted to leave the building, mostly during the evening shift, without staff supervision and each indicated Tenant #1 was very fast, seeking all exit doors multiple times when exit seeking and not hesitating with the sounding of the audible alarms.

The monitor reviewed the clinical records of Tenants #3 and #4, finding no evidence of elopement.

During interview, the program registered nurse (RN) reported Tenant #5, a tenant who previously resided at the program, went to the hospital on 5-14-13 and never returned, had exhibited exit seeking behaviors prior to the hospital admission.

The monitor reviewed Tenant #5's clinical record, finding no evidence of elopement.

Tenant #1, a 78 year old, was admitted to the program on 5-10-12 with diagnoses of: Dementia; Anxiety; Depression; Arthritis; Osteoporosis and Chronic Leg Edema. Tenant #1 scored a 6 on the Global Deterioration Scale (GDS) completed on 5-8-13, indicating severe cognitive decline. Tenant #1 required physical assistance with bathing, grooming, dressing and toileting. Tenant #1 was independent with eating and all mobility. Tenant #1 did not use an assistive device with ambulation.

According to the service plan, dated 3-4-13, Tenant #1 exhibited a history of restlessness toward evening, often becoming anxious and following staff members around. Tenant #1 wore a watch that was connected to the program's alarm system.

Tenant #1's clinical record indicated Tenant #1 eloped from the building on 4-11-13. Nurse Notes, dated 4-12-13, documented staff members found Tenant #1 outside on the front porch at approximately 6:35 a.m. after responding to the alarm system.

Tenant #1 exited from the 400 hall side exit door, setting off the door alarm and the watch alarm system. Tenant #1 was returned to the program without difficulty and experienced no injury. The service plan was updated on 4-12-13 to include identification of Tenant #1's elopement risk and direction to staff members to provide one to one supervision should Tenant #1 exhibit restlessness or exit seeking behavior. Staff members administered Lorazepam (an anti-anxiety medication) to Tenant #1 when he/she became restless, agitated or exit seeking.

Tenant #1 exhibited a pathologic reaction to the Lorazepam resulting in an increase in agitation so the medication had to be discontinued. Neurotin was initiated and Tenant #1 seemed to show a decrease in agitation.

Tenant #1's clinical record indicated Tenant #1 eloped from the building again on 5-7-13. Nurse Notes, dated 5-8-13, documented staff members found Tenant #1 outside the building at approximately 8:00 p.m. after responding to the alarm system. Tenant #1 exited from the 100 hall side exit door, setting off the door alarm and the watch alarm system. Tenant #1 was returned to the program without difficulty and experienced no injury. Tenant #1's Neurotin was increased following the elopement and a low dose (0.5 milligrams (mg)) of Risperidone was initiated three times daily.

Tenant #1 was sent for medical evaluation on 5-14-13. According to the physician's transcription following the evaluation, the physician documented Tenant #1 had been exit seeking with difficulty treating his/her wandering behaviors. The physician indicated Tenant #1 exhibited extreme sundowning behavior where increased agitation was evident. The physician documented concern that the exit seeking behaviors exhibited by Tenant #1 placed him/her a risk. Tenant #1's family had expressed concerns with increasing Tenant #1's Risperidone dose to help decrease the exit seeking behavior. The physician conceded at that time to make no changes to Tenant #1's Risperadone, increased Tenant #1's Sertraline (an antidepressant) but indicated if further exit seeking behaviors and agitation continued, Tenant #1 would require a full time private duty nurse paid for by the family in order to remain at the assisted living or would need placement into an intermediate care facility.

Nurse Notes, dated 5-20-13, indicated Tenant #1 was continuing to wander throughout the building, exit seek and exhibit agitation. The nurse contacted Tenant #1's family and obtained permission to increase Tenant #1's Risperidone dosage. Tenant #1's physician increased the dosage of Risperidone to 0.5 mg at 8:00 a.m. and 1 mg at 2:00 p.m. and 6:00 p.m. daily on 5-20-13.

Tenant #1's clinical record indicated Tenant #1 eloped from the building again on 5-21-13. Nurse Notes, dated 5-22-13, documented staff members found Tenant #1 outside the building at approximately 6:10 p.m. after responding to the alarm system. Tenant #1 exited from the main front building exit door, setting off the door alarm and the watch alarm system. Tenant #1 was returned to the program without difficulty and experienced no injury.

A private outside caregiver began coming to the program on 5-22-13 with a plan to stay with Tenant #1 from 5:00 p.m. to 10:00 p.m. daily. The private caregiver continued to visit from 5:00 p.m. to 10:00 p.m. daily at the time of the onsite visit.

During interview, Staff #1, #2, #3, #4 and #5 all indicated Tenant #1 continued to frequently wander and exit seek despite the presence of the private caregiver. Staff #3 and #4 reported noting Tenant #1 was becoming agitated more frequently due to being followed around by the private caregiver.

The monitor observed Tenant #1 wandering throughout the program but did not observe Tenant #1 seek exits from the building onsite visit on 6-5-13 or 6-6-13. The monitor observed Tenant #1 wander throughout the program on 6-15-13 during the 8:00 a.m. to 2:00 p.m. onsite visit, at times nearing exit doors, causing a triggering of the program's alarm system.

Tenant #1's clinical record contained a physician's order, dated 6-3-13, increasing Tenant #1's Risperidone to 1 mg three times daily due to reported continued restlessness throughout the day.

Tenant #1 exhibited wandering behaviors, exit seeking behaviors and agitation. Tenant #1 eloped from the program three times in 6 weeks. Despite medication management and one to one supervision, Tenant #1 continued to wander and exhibit exit seeking behaviors. Tenant #1 exceeded the level of care allowed to reside in an assisted living.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: a. Is bed-bound; or b. Requires routine, two-person assistance with standing, transfer or evacuation; or c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk; or d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or e. Is under the age of 18; or f. Requires more than part-time intermittent health related care; or g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or h. Is medically unstable; or i. Requires maximal assistance with activities of daily living. (IAC r. 481-69.23(1))

B. Staffing

Complaint/Incident Allegation: 43741-C and 44166-C- It was alleged the program did not have any staff members present in the memory care unit during the weekends but did have staff present in other areas of the facility. 44166-C- It was alleged tenant falls increased on the weekends due to a lack of staff member supervision.

- Monitoring Observation: The program had 36 apartments within the building, three common living room areas and one common dining room area. The program was certified as a dementia specific program by dedication. The entire building was secured and housed 22 cognitively impaired tenants. The building did not have a separate secured area identified as the memory care unit.

The monitor reviewed the staff schedules for February, March, April, May and June 2013. Each schedule routinely had three direct care staff members scheduled on the day shift, three direct care staff members scheduled on the evening shift and two direct care staff members scheduled on the night shift.

During interview, Staff #1, CNA, Staff #2, CNA, Staff #3, CMA, Staff #4, CNA, Staff #5, CMA, and Staff #7, CNA, reported the program routinely had three staff members working on the day and evening shift and routinely had two staff members working each night shift seven days weekly. All staff members also indicated kitchen staff members were present during the day and evening shift seven days per week. All staff members reported the activity coordinator and administrative staff were present Monday through Friday mornings through supper time. All five staff members reported the amount of staff scheduled was adequate to assure all care was provided to each tenant, however, noted on occasion staff members did not get breaks during times of extreme tenant behaviors.

The monitor contacted the family members of Tenants #2, #6, #7, #8 and #9. The family members all lived close enough to visit on a regular basis, both during the week and on the weekends. The family members were very complimentary of the program, noting no concerns while visiting.

During interview, Tenant #2's family member reported he/she visited at different times during the day, including morning hours, afternoon hours and evening hours. Tenant #2's family member reported an appropriate number of staff members were always present and available to meet tenant needs during the week and on the weekends.

During interview, Tenant #6's family member reported he/she visited at different times of the day, usually during the evening or in the afternoon, about every other day. Tenant #6's family member reported visiting during the week and on the weekends and always saw staff members present and available to meet tenant needs. Tenant #6's family member reported during the week days administrative staff members were also present and were not present on weekends.

During interview, Tenant #7's family member reported he/she visited at different times, usually during the week day evenings and on the weekends. Tenant #7's family member reported an appropriate number of staff members were always present and available to meet tenant needs during the week and on the weekends.

During interview, Tenant #8's family member reported he/she visited every Saturday, arriving sometime between 8:00 a.m. and 10:00 a.m., staying for approximately one hour each visit. Tenant #7's family member reported an appropriate number of staff members were always present and available to meet tenant needs.

During interview, Tenant #9's family member reported he/she visited once monthly. Tenant #9's family member reported an appropriate number of staff members were always present and available to meet tenant needs.

The monitor observed three day shift direct care workers and three evening shift direct care workers present in the building during the onsite visit on both Wednesday 6-5-13 and Thursday 6-6-13. Upon entrance into the building on Saturday 6-15-13, the monitor observed three direct care workers (Staff #2, #5 and #8) in the building. Staff #2 was walking down the 200 hallway, Staff #5 was in the front entrance common area and Staff #8 was in the program common dining room area when the monitor entered the building. The program's Dietary Manager was also in the dining room/kitchen area. The program RN and the program Director entered the program at approximately 8:30 a.m. and remained at the program during the entire onsite visit on 6-15-13.

The monitor observed program tenants from 8:00 a.m. until 1:45 p.m. on Saturday 6-15-13, noting no tenants left unsupervised in the common areas in the 200 hall, the 300 hall or the common area by the beauty shop. The monitor noted tenants at times sitting and sometimes sleeping in the front entrance common area but staff members were within close proximity and available to respond if needed. The monitor noted Staff #2, #5 and #8 provided adequate supervision of the program tenants throughout the entire onsite visit.

The monitor reviewed incident reports for all incidents occurring during March, April, May and June 2013. The program documented 51 incidents during the above time period, including 47 falls, 3 elopements and 1 bruise of unknown origin. All 3 elopements occurred during the week days, 33 of the falls occurred during the week days and 14 of the falls occurred during the weekends.

The entire building had been dedicated as the secured memory care unit. Schedules and staff member interview indicated the program had three staff members present each day and evening shift and two staff members present each night shift. Family member interviews indicated adequate staff members were present during visits occurring during the week and on the weekends. Approximately one-third of all falls or other incidents occurred on the weekend. Two-thirds of the incidents occurred during the week days. The monitor noted staffing to be adequate during the onsite visits. The building was quite large and had multiple common areas; however, regulation requires the program to have staff members be available in close proximity to meet tenant individualized needs. Close proximity was defined as having a response time of five minutes or less.

- Regulatory Insufficiency: None noted.

C. Medications

Complaint/Incident Allegation: 43741-C and 44166-C- It was alleged tenants were over-medicated, noted to be sleeping on couches in the program common areas. 44166-C- It was alleged tenant falls increased due to overmedication.

- Monitoring Observation: The monitor reviewed the program's incident reports for March, April, May and June 2013, noting Tenants #1, #2, #4, #5, #6, #7, #8 and #9 experienced one or more falls during the above stated time period.

During the onsite visit, the monitors noted Tenants #1, #3, #4, #6, #7, #8, #9 and #10 either wandered throughout the program or were seated in common areas of the program.

During staff member interview, staff members reported Tenants #1, #3, #4 and #5 had frequently exhibited wandering and exit seeking behaviors.

The monitor reviewed the clinical records and medication administration records (MARs) of Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10, noting the following:

Tenant #1's clinical record indicated Tenant #1 showed agitation, wandering and exit seeking behaviors. Tenant #1 was independent with ambulation without utilization of any device. Tenant #1 eloped from the building on Thursday 4-11-13, Tuesday 5-7-13 and Tuesday 5-21-13. Staff members administered Lorazepam (an anti-anxiety medication) 15 days in March 2013 due to anxiousness, restlessness and agitation. At times the medication was ineffective, requiring a second dosage.

In April 2013, staff members administered Lorazepam 24 days due to anxiousness, restlessness, agitation and exit seeking behaviors. At times the medication was ineffective, requiring a second dosage. In May 2013, the physician determined Tenant #1 exhibited a pathologic reaction to the Lorazepam resulting in an increase in agitation so the medication had to be discontinued. Neurontin (an anticonvulsant used investigationally for some psychological disorders) was initiated and Tenant #1 seemed to show a decrease in agitation.

Tenant #1's clinical record indicated Tenant #1 fell on Saturday 5-11-13, resulting in an abrasion.

Tenant #1's clinical record indicated Tenant #1 eloped from the building again on Tuesday 5-7-13. Tenant #1's Neurontin was increased following the elopement and a low dose (0.5 milligrams (mg)) of Risperidone (an antipsychotic medication) was initiated three times daily.

Nurse Notes and staff member interview indicated Tenant #1 continued to wander throughout the building, exit seek and exhibit agitation. Tenant #1's physician increased the dosage of Risperidone to 0.5 mg at 8:00 a.m. and 1 mg at 2:00 p.m. and 6:00 p.m. daily on 5-20-13.

Tenant #1's clinical record indicated Tenant #1 eloped from the building again on Tuesday 5-21-13. On Sunday 5-26-13, Tenant #1 fell, resulting in no injury.

Tenant #1's MARs, clinical record and staff member interviews indicated Tenant #1 was administered multiple medications to curb agitation and exit seeking behaviors. Staff members administered as needed medications frequently due to documented anxiety, agitation and exit seeking behaviors. The medications did not cause over-sedation as Tenant #1 continued to ambulate independently and exhibit the behaviors.

Tenant #2, a 92 year old, was admitted to the program on 10/2/11 with diagnoses of: Dementia; Arthritis; Glaucoma; Diabetes and Hypertension (HTN). Tenant #2 was admitted to hospice services on 4-10-13 and died on 6-14-13.

Tenant #2 scored a 6 on the GDS completed on 5-7-13, indicating severe cognitive decline. Tenant #2 required the assistance of one staff member to transfer and ambulate. Due to Tenant #2's dementia, Tenant #2 attempted to stand unassisted. The service plan, dated 4-10-13, indicated the program placed a pad alarm under Tenant #2 when in bed or chair to notify staff members when he/she attempted to stand unsupervised.

Tenant #2's physician prescribed Lorazepam (an anti-anxiety medication) to be administered as needed for anxiety. Tenant #2's MARs indicated staff members did not have to administer the Lorazepam in March, April or May. Tenant #2 fell on Wednesday 4-10-13, Wednesday 5-1-13 and Saturday 5-11-13, resulting in no injuries.

The monitor observed Tenant #2 on Wednesday 6-5-13 and Thursday 6-6-13, noting no over sedation, however, Tenant #2 was a hospice patient and his/her health status was increasingly deteriorating.

Tenant #2's MARs and clinical record indicated Tenant #2's routine medications were administered as ordered by his/her physician and as needed medications were not administered excessively. Tenant #2 did not exhibit over-sedation.

Tenant #3, a 78 year old, was admitted to the program on 3-25-13 after residing for one month in another assisted living owned by the same company as the program with diagnoses of: Dementia; Diabetes; Anxiety and Agitation. Tenant #3 scored a 5 on the GDS completed on 4-22-13, indicating moderately severe cognitive decline. Tenant #5 was independent with ambulation without the use of an assistive device.

Tenant #3's service plan indicated Tenant #3 had a history of wandering, expressing a wish to go home, packing items to go home and looking for a car to go home. Tenant #3 exhibited increased anxiousness in the afternoons.

Tenant #3's physician ordered Lorazepam (an anti-anxiety medication) to be taken routinely, Lorazepam to be taken on an as needed basis for agitation, Seroquel (an antipsychotic medication) to be taken routinely and Haldol (an antipsychotic medication) to be taken on an as needed basis for agitation.

On 3-5-13, while Tenant #3 lived in the other assisted living, Tenant #3's physician decreased Tenant #3's Haldol dosage from 4 milligram (mg) every four hours as needed for agitation to 1 mg twice daily as needed for agitation.

On 3-11-13, while Tenant #3 lived in the other assisted living, Tenant #3's physician ordered Seroquel 12.5 mg every morning and 25 mg every afternoon. Due to increased agitation, Tenant #3's physician ordered the addition of Seroquel 12.5 mg at noon. On 3-22-13, Tenant #3's physician increased the noon Seroquel dosage to 25 mg and increased Tenant #3's Haldol as needed dosage to 1 mg every four hours instead of twice daily due to continued agitation.

On 4-22-12, the program RN sent a note to Tenant #3's physician, documenting Tenant #3's use of the Haldol on an as needed basis for agitation.

Tenant #3 was administered the as needed Lorazepam dosage or the as needed Haldol dosage 20 days in March and on an almost daily basis during the month of April. Tenant #3's physician increased the Seroquel noon dose to 50 mg in an attempt to decrease the Lorazepam and Haldol usage.

According to the May 2013 MARs staff members administered the as needed dosage of Lorazepam six times between 5-1-13 to 5-18-13 and the as needed dosage of Haldol eight times between 5-1-13 to 5-18-13. On 5-14-13, Tenant #3's spouse was admitted to the hospital and did not return to the program. Administration of the as needed Lorazepam and Haldol was greatly decreased in late May and early June 2013.

During interview, Staff #2, #5 and #8 all reported Tenant #3 exhibited disruptive agitation beginning at admission through mid May 2013 as his/her spouse also exhibited dementia with agitation. When the spouse was agitated, Tenant #3 also became agitated. All three staff members reported when the spouse no longer lived at the program, Tenant #3's agitation decreased and the amount of as needed medications decreased as well.

Tenant #3's clinical record lacked any documentation indicating over sedation.

The monitor observed Tenant #3 on Wednesday 6-5-13, Thursday 6-6-13 and Saturday 6-15-13, noting no sedation. Tenant #3 slept later into the morning but when awake, participated in activities and meals.

Tenant #3 exhibited behaviors requiring the use of as needed medications. All routine and as needed medications were administered according to physician orders. Tenant #3 did not have any documented over-sedation and did not experience any falls.

Tenant #4, a 76 year old, was admitted to the program on 8-20-08 with diagnoses of: Dementia; HTN; Osteoarthritis and Cerebral Vascular Disease. Tenant #4 scored a 6 on the GDS completed on 4-24-13, indicating severe cognitive decline. Tenant #4 was independent with transfers and ambulation without utilizing an assistive device.

Tenant #4's service plan indicated Tenant #4 wandered throughout the program, at times refused to allow staff members to assist with activities of daily living and became anxious frequently.

Tenant #4's physician ordered Xanax (an anti-anxiety medication) to be taken on an as needed basis every six hours for agitation or restlessness.

Tenant #4's MARs indicated staff members did not administer the Xanax on an as needed basis in March 2013, administered the Xanax once in April 2013, twice in May 2013 and once in June 2013. Tenant #4 fell on Wednesday 4-3-13, resulting in no injury.

The monitor observed Tenant #4 on Wednesday 6-5-13, Thursday 6-6-13 and Saturday 6-15-13. Tenant #4 attended meals and activities during the onsite visit and was observed to be up and wandering throughout the program.

Tenant #5, an 80 year old, was admitted to the program on 3-25-13 after residing for one month in another assisted living owned by the same company as the program with diagnoses of: Dementia; Depression; Agitation; Incontinence and a History of Falls. Tenant #5 scored a 5 on the GDS completed on 4-22-13, indicating moderately severe cognitive decline. Tenant #5 was independent with ambulation without the use of an assistive device.

Tenant #5's service plan indicated Tenant #5 had a history of exit seeking behaviors, expressing a wish to go home, packing items to go home and looking for a car to go home. Tenant #5 exhibited increased anxiousness in the afternoons.

Tenant #5's physician ordered Lorazepam (an anti-anxiety medication) to be taken routinely at bedtime, Lorazepam to be taken on an as needed basis twice daily for agitation, Seroquel (an antipsychotic medication) to be taken routinely three times daily and Haldol (an antipsychotic medication) to be taken on an as needed basis for agitation.

On 3-24-13, while still residing at the other assisted living program, Tenant #5 fell, resulting in an abrasion.

On 4-20-13 Tenant #5 was sent to the local emergency room for evaluation after exhibiting extreme aggression. Tenant #5 returned to the program with no change in medication orders.

On 4-22-12, the program RN sent a note to Tenant #5's physician, documenting Tenant #5's use of the Haldol on an as needed basis for agitation. According to the April 2013 MARs, staff members administered the as needed dose of Lorazepam for restlessness and anxiety six times and the as needed dose of Haldol for agitation nearly daily with a second dose required due to ineffectiveness of the medication.

Tenant #5's physician increased the Seroquel noon dose to 50 mg in an attempt to decrease the Lorazepam and Haldol usage, leaving the as needed dosages of Lorazepam and Haldol unchanged.

According to the May 2013 MARs staff members administered the as needed dosage of Lorazepam three times between 5-1-13 to 5-13-13 and the as needed dosage of Haldol nine times between 5-1-13 to 5-13-13. The routine doses of Seroquel were held on 5-14-13 due to Tenant #5's symptoms of illness. On 5-14-13, Tenant #5 was admitted to the hospital and did not return to the program.

Tenant #5 fell on Tuesday 4-9-13, resulting in no injury, fell on Monday 5-13-13, resulting in no injury. The program noted increased confusion and obtained a urine specimen for urinalysis. Tenant #5 again fell on Tuesday 5-14-13, resulting in no injury. Tenant #5 began experiencing a fever on 5-14-13, the urinalysis was positive for infection so Tenant #5 was sent to the emergency room for evaluation.

Emergency room notes indicated Tenant #5 was extremely agitated upon arrival to the hospital. Tenant #5's blood pressure was found to be dangerously high during the episodes of agitation.

The emergency room staff administered Seroquel and Lorazepam intravenously to calm Tenant #5. The blood pressure returned to a normal state during sedation. Tenant #5 was admitted to the hospital on 5-14-13. Tenant #5 continued to exhibit agitation and aggressive behavior which caused his/her blood pressure to elevate, requiring hospital personnel to continue to administer the anti-anxiety medications to control Tenant #5's behaviors. On 5-16-13 Tenant #5 was observed to be pooling secretions, determined to most likely be due to the over-sedation required to calm Tenant #5. Tenant #5 was not able to respond to commands during a swallow test so the physician began decreasing the medication dosages until Tenant #5 was able to respond.

During interview, Staff #2, #5 and #8 all reported Tenant #5 exhibited disruptive agitation between mid March and mid May 2013. Tenant #5's clinical record lacked any documentation indicating over sedation.

Tenant #5 exhibited behaviors requiring the use of as needed medications both at the program and at the hospital. All routine and as needed medications were administered according to physician orders. Tenant #5 did not have any documented over-sedation until the hospital noted the pooling of secretions two days after admission and after administration of anti-anxiety medications given intravenously. Tenant #5 experienced 3 falls, however, none of the falls occurred on the weekend.

Tenant #6, an 87 year old, was admitted to the program on 7/2/12 with diagnoses of: Dementia; Anxiety and Chronic hip pain. Tenant #6 was later diagnosed with Colon Cancer and was admitted to hospice services on 1-10-13. Tenant #6 scored a 6 on the GDS completed on 5-3-13, indicating severe cognitive decline. Tenant #6 required the assistance of one staff member to transfer and ambulate. Due to Tenant #6's dementia, Tenant #6 attempted to stand unassisted. The service plan, dated 5-3-13, indicated the program placed a pad alarm under Tenant #6 when in bed or chair to notify staff members when he/she attempted to stand unsupervised.

Tenant #6's physician prescribed Lorazepam (an anti-anxiety medication) to be administered as needed for anxiety. Tenant #6's MARs indicated staff members did not have to administer the Lorazepam in March 2013, administered the Lorazepam three times in April 2013, administered the Lorazepam three times in May 2013 and administered the Lorazepam six times in June 2013. Tenant #6 fell on Monday 3-11-13, Tuesday 3-19-13 and Friday 4-5-13, resulting in no injuries. Tenant #6 fell on 6-6-13, resulting in a hairline fracture of the wrist.

The monitor observed Tenant #6 on Wednesday 6-5-13, Thursday 6-6-13 and Saturday 6-15-13, noting no over sedation, however, Tenant #6 was a hospice patient and his/her health status was increasingly deteriorating. On 6-15-13 the monitor noted Tenant #6 was sleeping on a couch in the front entrance common area at different times throughout the day but was easily awakened by staff members and attended meals and activities throughout the day.

Tenant #6's MARs and clinical record indicated Tenant #6's routine medications were administered as ordered by his/her physician and as needed medications were not administered excessively. Tenant #6 did not exhibit over-sedation.

Tenant #7, an 84 year old, was admitted to the program on 5-29-12 with diagnoses of: Dementia; Depression; Anxiety and Osteopenia. Tenant #7 scored a 6 on the GDS completed on 6-4-13, indicating severe cognitive decline. Tenant #7 was able to ambulate independently without an assistive device.

Tenant #7's service plan indicated Tenant #7 wandered throughout the program, at times refused to allow staff members to assist with activities of daily living and became anxious frequently.

Tenant #7's physician ordered Lorazepam (an anti-anxiety medication) to be taken on an as needed basis every four hours for agitation.

Tenant #7's MARs indicated staff members did not administer the Lorazepam on an as needed basis in March 2013, administered the Lorazepam twice in April 2013, administered the Lorazepam twice in May 2013 and administered the Lorazepam once in June 2013. Tenant #7 fell on Tuesday 3-19-13, resulting in no injury.

The monitor observed Tenant #7 on Saturday 6-15-13, noting no evidence of over-sedation. The monitor noted Tenant #7 sleeping in the front entrance common area but Tenant #7 awoke on his/her own and changed position in the room several times. Tenant #7 was easily awakened by staff members. Tenant #7 attended meals and activities during the onsite visit and was observed to be up and wandering throughout the program.

Tenant #8 did not have any as needed medications prescribed by his/her physician. Tenant #8 fell on Monday 3-25-13, resulting in no injury. The monitor observed Tenant #8 frequently on Saturday 6-15-13 up and about the program with no sedation noted.

Tenant #9, an 80 year old, was admitted to the program on 5-10-11 with diagnoses of: Alzheimer's Disease and History of Weight Loss. Tenant #9 scored a 6 on the GDS completed on 3-25-13, indicating severe cognitive decline. Tenant #9 required the assistance of one staff member to transfer into and out of a wheelchair and was dependent upon staff members to propel the wheelchair for mobility. Due to Tenant #9's cognitive decline, he/she attempted to stand without staff member supervision. The program placed a pad alarm on bed and chair in an attempt to notify staff members when Tenant #9 attempted to stand without supervision.

Tenant #9 did not have as needed medications ordered by his/her physician for agitation or other behaviors. Tenant #9 fell on Tuesday 3-19-13 resulting in no injury, Friday 3-22-13 resulting in a skin tear, and on Wednesday 5-1-13 resulting in no injury.

The monitor observed Tenant #9 on Saturday 6-15-13 sleeping almost everywhere he/she was located. Tenant #9 was easily awakened by staff members throughout the day and was included in all meals and activities; however, Tenant #9 would fall back asleep either after the meals or during the activities.

Tenant #9 slept a lot during the day; however, Tenant #9 did not appear to be over-sedated.

Tenant #10, an 85 year old, was admitted to the program on 3-15-09 with diagnoses of: Dementia and Depression. Tenant #10 scored a 6 on the GDS completed on 4-30-13, indicating severe cognitive decline. Tenant #10 required the assistance of one staff member to transfer and ambulate. According to the service plan, Tenant #10 was awake most of the night and slept a lot during the daytime.

Tenant #10's physician ordered Lorazepam (an anti-anxiety medication) to be taken on an as needed basis every six hours for agitation.

Tenant #10's MARs indicated staff members did not administer the Lorazepam on an as needed basis in March, April, May and June 2013. Tenant #10 did not experience falls during the above stated time period.

The monitor observed Tenant #10 on Saturday 6-15-13, noting no evidence of over-sedation. The monitor noted Tenant #10 sleeping in the front entrance common area several times but Tenant #10 was easily awakened by staff members and attended meals and activities during the onsite visit.

Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10 received all routine medications as ordered by the physician. Each tenant was given medications on an as needed basis according to physician orders and always documented the date, time and reason for administration. Staff members also documented the effectiveness of the medications when given on an as needed basis. The monitor observed tenants, both awake and sleeping, in the main common area of the program. Each tenant was easily awakened by staff members and was not left sleeping in the areas for an extended amount of time.

- Regulatory Insufficiency: None noted.

D. Activities

Complaint/Incident Allegation: 43741-C and 44166-C- It was alleged the program had no planned activities.

- Monitoring Observation: The program Director presented activity calendars for the months of March, April, May and June 2013. Each calendar had five to nine activities with planned times for participation listed. The monitor noted the June 2013 calendar was posted on a board in the common area of the program.

  During interview, Staff #1, CNA, Staff #2, CNA, Staff #3, CMA, Staff #4, CNA and Staff #5. CMA, reported each activity outlined on the above stated calendars is transcribed onto a list given to each staff member each shift. The identified activities were incorporated into the daily tasks to be completed during the shift. All five staff members reported spontaneous activities were initiated based on a tenant to tenant basis dependent upon each tenants cognitive status. All five staff members reported participating in the provision of activities both during the week and on the weekends. All five staff members reported enough staff members worked each shift to get all scheduled activities done as assigned.

During interview, the program Director reported Staff #6, Activity Coordinator, worked 32 to 40 hours weekly, primarily during the week. Staff #6 puts together the activity calendars and participated in the provision of activities during the week.

The monitor reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10, all tenants with identified cognitive decline. All ten tenants' clinical records contained an Individualized Social Interest Sheet, which included social preferences and interests, which identified hobbies or activity suggestions for spontaneous activities.

During the onsite visits on Wednesday 6-5-13, Thursday 6-6-13 and Saturday 6-15-13, the monitor observed activities occurring as scheduled on the activity calendars and also observed spontaneous activities occurring throughout each day.

The monitor reviewed two weeks of daily task sheets, each documenting the activities, both group, planned and spontaneous, and individual spontaneous activities provided and listed which tenants attended the activities.

The monitor observed Tenants #1, #3, #4, #6, #7, #8, #9 and #10 attending multiple activities both during the week and on the week end. The monitor observed Tenant #2 attend multiple activities during the week prior to his/her death.

The program prepared scheduled daily activities each month, assigned the activities to staff members each shift and assessed each tenant for hobbies and interests to give staff members suggestions for spontaneous activities. All staff members interviewed reported participation in the provision of activities and all reported completion of activities as assigned. The monitor observed activities occurring as scheduled on the activity calendars during the onsite visit.

- Regulatory Insufficiency: None noted.

E. Nurse Review

Complaint/Incident Allegation: 44166-C- It was alleged the program did not identify changes in tenant condition, including weight loss, weight gain and injuries suffered from falls, and address the changes readily. 44166-C- It was alleged the program did not notify tenant physicians when falls or changes in condition occurred.

- Monitoring Observation: The program policy, titled Nutrition Intervention Protocol, dated as revised on 7-2012, indicated all tenants identified as high risk (low ideal body weight, recent weight loss, skin break down or poor food intake) would be given 8 ounces of half and half, 1 tablespoon (TBSP) of butter, 8 ounces of high Vitamin C juice with 1 TBSP corn syrup added and 6 ounces of "Super Cereal" for each breakfast; 8 ounces of whole milk, 1 TBSP butter and 8 ounces high Vitamin C juice with 1 TBSP corn syrup added for each lunch; and 8 ounces whole milk, 1 TBSP butter, 8 ounces high Vitamin C juice with 1 TBSP corn syrup added and 3-4 ounces

of ice cream at each supper meal. The above stated program would add approximately 1500 calories and 20 grams of protein to each high risk tenant diet.

The monitor reviewed the program's weight charts for all tenants residing at the program, including Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10. The monitor reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10 noting the following:

Tenant #1's weight chart documented no significant weight gain or weight loss during the previous four months. Tenant #1's clinical record indicated Tenant #1 showed agitation, wandering and exit seeking behaviors. Tenant #1 eloped from the building on Thursday 4-11-13, Tuesday 5-7-13 and Tuesday 5-21-13. The program notified Tenant #1's physician with each elopement by facsimile with the physician noting receipt of the notification by signature. The physician made changes to Tenant #1's medications multiple times in an attempt to decrease the episodes of exit seeking behaviors. Tenant #1 was seen by his/her physician for medical evaluation on 5-14-13.

Tenant #1's clinical record indicated Tenant #1 fell on Saturday 5-11-13, resulting in an abrasion. Tenant #1's physician was notified of the fall by facsimile with the physician noting receipt of the notification by signature.

Tenant #1's clinical record indicated Tenant #1 eloped from the building again on Tuesday 5-7-13. Tenant #1's Neurontin was increased following the elopement and a low dose (0.5 milligrams (mg)) of Risperidone (an antipsychotic medication) was initiated three times daily.

Nurse Notes and staff member interview indicated Tenant #1 continued to wander throughout the building, exit seek and exhibit agitation. The program notified Tenant #1's physician by facsimile with the physician noting receipt of the notification by signature. Tenant #1's physician made medication adjustments in an attempt to decrease the exit seeking behavior.

On Sunday 5-26-13, Tenant #1 fell, resulting in no injury. The program notified Tenant #1's physician by facsimile with the physician noting receipt of the notification by signature.

Tenant #1 exhibited exit seeking behaviors which resulted in multiple elopements and had multiple falls. The program notified Tenant #1's physician with each change of condition and with each fall, even when the falls did not result in injury.

Tenant #2 exhibited a 19 pound weight loss between 3/13 and 4/13. Tenant #2 was admitted to hospice on 4-10-13 and continued to lose weight until his/her death on 6-14-13. The program notified Tenant #2's physician of the weight loss by facsimile with the physician noting receipt of the notification by signature after the weight loss was verified. The program added Pedialyte to all meals and at bedtime due to the tenant's poor intake, added snacks twice daily and placed Tenant #2 on the program's nutritional intervention protocol.

Tenant #2 fell on Wednesday 4-10-13, Wednesday 5-1-13 and Saturday 5-11-13, resulting in no injuries. The program notified Tenant #2's physician by facsimile with the physician noting receipt of the notification by signature.

Tenant #3 had a documented weight gain of three pounds in 2 months. Tenant #3's service plan indicated Tenant #3 had a history of wandering, expressing a wish to go home, packing items to go home and looking for a car to go home. Tenant #3 exhibited increased anxiousness in the afternoons. The program notified Tenant #3's physician of his/her excessive agitation on 3-22-13 by facsimile with the physician noting receipt of the notification by signature. On 3-22-13, Tenant #3's physician increased the noon Seroquel dosage to 25 mg and increased Tenant #3's Haldol as needed dosage to 1 mg every four hours instead of twice daily due to continued agitation.

On 4-22-12, the program RN sent a note to Tenant #3's physician, by facsimile with the physician noting receipt of the notification by signature, documenting Tenant #3's use of the Haldol on an as needed basis for agitation. Tenant #3 was administered the as needed Lorazepam dosage or the as needed Haldol dosage 20 days in March and on an almost daily basis during the month of April. Tenant #3's physician increased the Seroquel noon dose to 50 mg in an attempt to decrease the Lorazepam and Haldol usage.

On 6-3-13, the program RN sent a note to Tenant #3's physician, by facsimile with the physician noting receipt of the notification by signature, reporting Tenant #3's moderate edema to both ankles. The physician decreased the dosage of Tenant #3's Actos (an anti-diabetic medication) for two weeks, and then discontinued the medication completely after the two week period. During observation, the monitor noted Tenant #3's edema appeared to be lessened.

Tenant #3 exhibited behaviors requiring the use of as needed medications and exhibited ankle edema. The program notified Tenant #1's physician with each change of condition.

Tenant #4 did not exhibit any weight loss or weight gain in the previous four months. Tenant #4's service plan indicated Tenant #4 wandered throughout the program, at times refused to allow staff members to assist with activities of daily living and became anxious frequently.

Tenant #4 fell on Wednesday 4-3-13, resulting in no injury. The program notified Tenant #4's physician by facsimile, noting receipt of the notification by signature.

Tenant #5 exhibited a 15 pound weight loss between 4-16-13 and 5-5-13. During interview, the program RN reported she had noted the change in weight but planned to reweigh Tenant #5 to assure the weight accuracy as Tenant #5 exhibited agitation when staff members attempted to weigh him/her. Tenant #5 became ill on 5-13-13 and was admitted to the hospital on 5-14-13, never returning to the program. The RN reported the reweigh did not occur prior to Tenant #5's hospitalization as it was inadvertently omitted the following week. Tenant #5 was weighed at the hospital on 5-15-13, noting another 9 pound weight loss. (Note: the scales used for the 5-5-13 and 5-15-13 weights were different and may have read differently.)

Tenant #5 was again weighed on 5-24-13 with another 3 pound weight loss occurring while hospitalized.

Tenant #5's service plan indicated Tenant #5 had a history of exit seeking behaviors, expressing a wish to go home, packing items to go home and looking for a car to go home. Tenant #5 exhibited increased anxiousness in the afternoons.

On 4-20-13 Tenant #5 was sent to the local emergency room for evaluation after exhibiting extreme aggression. Tenant #5 returned to the program with no change in medication orders. On 4-22-12, the program notified Tenant #5's physician by facsimile, with the physician noting receipt with a signature. The note reported Tenant #5's use of the Haldol on an as needed basis for agitation. According to the April 2013 MARs, staff members administered the as needed dose of Lorazepam for restlessness and anxiety six times and the as needed dose of Haldol for agitation nearly daily with a second dose required due to ineffectiveness of the medication. Tenant #5's physician increased the Seroquel noon dose to 50 mg in an attempt to decrease the Lorazepam and Haldol usage, leaving the as needed dosages of Lorazepam and Haldol unchanged.

Tenant #5 fell on Tuesday 4-9-13, resulting in no injury, fell on Monday 5-13-13, resulting in no observable injury. The program noted increased confusion and obtained a urine specimen for urinalysis. The program notified Tenant #5's physician by facsimile with the physician noting receipt with a signature. Tenant #5 again fell on Tuesday 5-14-13, resulting in no immediate observable injury. The program notified Tenant #5's physician by facsimile with the physician noting receipt with a signature. Tenant #5 began experiencing a fever on 5-14-13, the urinalysis was positive for infection so Tenant #5 was sent to the emergency room for evaluation. The urinalysis was sent for culture and sensitivity to determine appropriate antibiotic use.

During the hospitalization, bruising and a rug burn on Tenant #5's knee were identified. The wound care nurse placed a dressing on the rug burn on 5-20-13. The hospital documentation did not identify any indication the bruising or rug burn were the result of anything other than the previous falls that occurred at the program on the day before and the day of hospital admission.

During Tenant #5's hospitalization, blood cultures were completed, noting sepsis from e.coli bacteria. The urinalysis showed negative for e.coli bacteria. The physician determined the blood sepsis occurred most likely from oral-fecal route and not from the urinary tract infection. Tenant #5's temperature was brought under control very quickly. Tenant #5's sepsis was treated with intravenous antibiotics and was resolved within 7 days.

During the hospitalization, Tenant #5 was found to also have probable pneumonia. The physician suspected aspiration as Tenant #5 was noted to have some difficulty swallowing therefore was not allowed to take anything in orally. A swallow study was attempted but Tenant #5 was uncooperative with following commands. Tenant #5 eventually cooperated and the swallow study determined Tenant #5 required pureed foods should he/she return to eating. Tenant #5 did not return to eating while hospitalized.

The physician presented the option of insertion of a gastrostomy tube by which Tenant #5 would take in all medications and nutritional supplements. After consideration, the family made the decision to not have the gastrostomy tube inserted. Tenant #5 was placed in hospice on 5-25-13 and Tenant #5 died on 5-29-13.

During interview, Staff #2, #5 and #8, all direct care workers, reported while Tenant #5 resided at the program, Tenant #5 was able to eat independently. All three reported noting a progressive decrease in the amount of food Tenant #5 consumed during each meal. All three indicated snacks were consumed by Tenant #5 twice daily when the meal consumption started to decline. All three denied noting any coughing or choking when Tenant #5 was eating prior to the hospitalization.

During interview, the program RN concurred with the above stated findings, noting no coughing, choking or inability to swallow foods or medications prior to Tenant #5's hospitalization.

Tenant #5 exhibited changes in condition and falls. The program reported all falls and changes in condition to Tenant #5's physician, even when the falls did not result in injury.

Tenant #6 exhibited an 8 pound weight loss between 1/13 and 5/13. Tenant #6 was diagnosed with colon cancer and was admitted to hospice on 1-10-13. The program initiated the Nutritional Intervention Protocol in January 2013. The program notified Tenant #6's physician of the gradual weight loss in May by facsimile, with the physician noting receipt of the notification with a signature. The physician ordered house shakes to be added to Tenant #6's meals three times daily in early May 2013.

Tenant #6 fell on Monday 3-11-13, Tuesday 3-19-13 and Friday 4-5-13, resulting in no injuries. Tenant #6 fell on 6-6-13, resulting in a hairline fracture of the wrist. The program notified Tenant #6's physician of the falls by facsimile, with the physician noting receipt with a signature.

Tenant #6 exhibited weight loss and multiple falls. The program notified Tenant #1's physician with each change of condition and with each fall, even when the falls did not result in injury.

Tenant #7 did not experience either weight loss or weight gain. Tenant #7 fell on Tuesday 3-19-13, resulting in no injury. The program notified Tenant #7's physician of the fall by facsimile, with the physician noting receipt with a signature.

Tenant #8 did not experience any weight loss or weight gain. Tenant #8 fell on Monday 3-25-13, resulting in no injury. The program notified Tenant #8's physician of the fall by facsimile, with the physician noting receipt with a signature.

Tenant #9 did not experience any weight loss or weight gain. Tenant #9 fell on Tuesday 3-19-13 resulting in no injury, Friday 3-22-13 resulting in a skin tear, and on Wednesday 5-1-13 resulting in no injury. The program notified Tenant #9's physician of each fall by facsimile, with the physician noting receipt with a signature.

- Regulatory Insufficiency: None noted.

F. Structural Requirements

Complaint/Incident Allegation: 44166-C- It was alleged a community cat residing at the program had bowel movements on the floor in the common areas/hallways of the program.

- Monitoring Observation: The program housed a community cat and one tenant had a small dog living in his/her apartment. The cat's litter box was located in the laundry room at the front of the building. A small pet door was located in the wall, allowing the cat free access to the laundry room and the litter box.

  During interview, Staff #2, #5 and #8 all denied ever seeing animal feces on the floor. reporting the cat used the litter box routinely. All three staff members reported the dog was taken outside by staff members multiple times during the day and evening hours to urinate and defecate outside in the courtyard area.

  The monitor toured the entire program multiple times throughout the onsite visit on Wednesday 6-5-13, Thursday 6-6-13 and Saturday 6-15-13, never seeing animal feces on the floors.

- Regulatory Insufficiency: None noted.