IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
43787-C

July 18, 2013

Ms. Kimberly Stodgel, Executive Director
Lakeside Village Assisted Living
2067 Hwy 4
Panora, IA 50216

RE: Final Complaint/Incident Investigation Report, Lakeside Village Assisted Living, Panora, Iowa

Dear Ms. Stodgel:

Enclosed is the **Final Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

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

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

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Kimberly Stodgel, Executive Director
Lakeside Village Assisted Living
2067 Hwy 4
Panora, Iowa 50216

Complaint/Incident Intake #:

43787-C

Date of Complaint/Incident Investigation:

May 28 and 29, 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.

General Population Program	
Number of tenants without cognitive disorder:	25
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	25
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	5
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	9
TOTAL census of Assisted Living Program	34

Program History – During the recertification visit in September 2011 the program received regulatory insufficiencies in the area of Service Plan and Dementia-Specific Education.

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: It was alleged a tenant chronically eloped from the program without staff knowledge.

- Monitoring Observation: The Executive Director identified no tenant elopements since January 2013. During interview, staff members identified Tenants #1, #2, #4 and #5 wandered throughout the secured memory care unit. Staff members identified Tenants #2, #4 and #5 as exit seeking. Staff members identified Tenant #2 as exiting a door leading into the general population area of the building but never outdoors, Tenant #4 as leaving the building multiple times to the general population area and the outside, however, all indicated the program's alarm system functioned appropriately notifying staff members to Tenant #4's opening an exit door allowing for adequate response to avoid an actual elopement, and Tenant #5 as pushing on the door leading to the general population area causing the alarm to sound and entering other tenant rooms without permission but never exiting to the outside. Following staff member interview and clinical record review, the monitor identified the following information:

  Tenant #1, a 75 year old, was admitted to the program on 2-22-12 with diagnoses of: Dementia, Depression, Hypertension (HTN), Osteoarthritis, Lymphedema and

Chronic Cellulitis. Tenant #1 resided in the program's secured memory care unit. Tenant #1 scored a 4 on the Global Deterioration Scale (GDS) completed on 3-4-13, indicating moderate cognitive decline. The service plan, dated 2-21-13, indicated Tenant #1 required assistance with bathing, grooming, dressing and toileting assistance. Tenant #1 wore incontinence products.

According to the functional assessments, completed on 11-26-12, 12-15-12, 1-21-13, 1-25-13, 2-3-13, 2-21-13, 3-4-13, Tenant #1 exhibited verbal aggression, physical aggression and was resistive to care provision. The assessments completed on 11-26-12, 12-15-12, 1-25-13, 2-3-13 and 3-4-13, identified physical aggression and resistance to care provision one to three times weekly. The assessment completed on 1-21-13 identified physical aggression four to six times per week and resistance to care provision one to three times weekly. The assessment completed on 2-21-13 identified physical aggression four to six times weekly and resistance to care provision one or more times daily.

During interview, Staff #1, certified nursing assistant (CNA), Staff #2, universal worker (UW), Staff #4, UW, Staff #6, Licensed Practical Nurse (LPN), Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported Tenant #1 was resistive to care provision attempts by staff members, becoming combative by hitting, kicking, pinching, scratching and throwing his/her walker at staff members. All seven staff members reported Tenant #1 was combative toward staff members on a daily basis. Staff #1, #2, #4, #7 and #8 reported no injury resulting from Tenant #1's combative behaviors. Staff #6 reported she had been scratched by Tenant #1, drawing blood, once. Staff #9 reported Tenant #1 swung his/her walker at Staff #9's legs, tripping Staff #9. Staff #9 fell to the floor but did not receive any injuries from the fall.

Staff #6 reported Tenant #1 at times pushed at other tenants but had never caused injury. Staff #7 reported Tenant #1 had pushed his/her walker into other tenants but never knocked any other tenant down or caused injury.

During interview, Staff #1, #2, #4, #6, #7, #8 and #9 reported Tenant #1 would urinate and defecate in unusual places throughout the memory care unit one to two times every week or two. The staff members reported Tenant #1 often became agitated and aggressive when toileted with staff member assistance. Tenant #1 did not always use the toilet during toileting, then later would pull his/her pants down and urinate or defecate in places other than the toilet. Staff #1, #2 and #4 reported Tenant #1 had pulled his/her pants down and defecated on the dining room chair located in the common area of the memory care unit the previous week.

Tenant #1 exhibited unmanageable bowel and bladder incontinence and displayed unmanageable physical aggression toward staff and other tenants despite staff member attempts at intervention, thereby placing both staff members and other tenants at risk for injury. Tenant #1 exceeded the level of care allowable to remain in the program.

Tenant #2, an 83 year old, was admitted to the program on 1-21-11 with diagnoses of: Dementia, Myasthenia Gravis, Anxiety, Osteoarthritis and Seizures. Tenant #2 resided in the program's secured memory care unit. Tenant #2 scored a 5 on the GDS completed on 5-9-13, indicating moderately severe cognitive decline. The service

plan, dated 5-7-13, indicated Tenant #2 required assistance with bathing and dressing. The same service plan indicated Tenant #2 was independent with toileting, requiring only reminding by staff members to use the toilet. Tenant #2 wore incontinence products. Tenant #2 wore a watch that was part of the program's alarm system which would sound an alarm both audibly and trigger a response to each staff member's pager to notify them that Tenant #2 was near an exit door.

On 5-28-13, during observation of Tenant #2's apartment, the monitor noted a very strong smell of urine.

During interview, Staff #1, CNA, Staff #2, UW, Staff #4, UW, Staff #6, LPN, Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported Tenant #2 would urinate on the bathroom floor and on the carpet in the living room/bedroom area of the apartment on an almost daily basis. All seven staff indicated Tenant #2 often removed soiled incontinence products and dropped the incontinence product "wherever he/she was at" citing the areas to be at times in Tenant #2's apartment and other times in the common areas of the memory care unit. All of the staff members reported making attempts to toilet Tenant #2 multiple times every shift but he/she did not always urinate when toileted. Staff #1 reported observing Tenant #2 pulling his/her pants down and urinating in the common dining room and in the nursing office area.
On 5-28-13, during observation of the noon meal, the monitor observed Tenant #2 attempting to take food from multiple tenants' plates while the tenants were eating from them. When staff members or the other tenants attempted to keep Tenant #2 from taking the food, Tenant #2 became very agitated and was very difficult to redirect. Tenant #2 grabbed at other tenants with Staff #1, #2 and the program registered nurse (RN) intervening before contact could be made. Tenant #2 hit at staff, pushed staff members in the chest and muttered unintelligible words in anger. Tenant #2 was eventually directed to his/her own plate of food. Tenant #2 refused to sit down and began eating the food with his/her fingers. Tenant #2 scooped up the entire serving of peach cobbler into his/her hand and began eating the cobbler. The cobbler was dropping onto the floor and was smeared across Tenant #2's face. Tenant #2 grabbed hold of a glass goblet and refused to let go of the goblet. Tenant #2's grip on the goblet caused Staff #2 to fear that the glass might break. Staff #2 attempted to remove the glass from Tenant #2's grip. Tenant #2 became agitated, scooped up a hand full of baked potato with sour cream and wiped the food across the face of Staff #2 then pushed Staff #2 in the chest. The program RN attempted to intervene. Tenant #2 slapped at the RN's hands. The RN stated "he/she never acts this way". Staff #1 and #2 responded "yes he/she does all the time."

According to the functional assessment, completed on 5-9-13, Tenant #2 exhibited verbal aggression one to three times weekly, was resistive to care provision one to three times weekly and showed no physical aggression.

During interview, Staff #1, Staff #2, Staff #4, Staff #6, Staff #7, Staff #8 and Staff #9 all reported Tenant #2 was resistive to care provision attempts by staff members, becoming combative by slapping and pushing staff members while trying to provide care several times weekly. All seven staff members reported Tenant #2 had not been physically aggressive toward other tenants in the past and had never caused injury to staff members during times of aggression. All seven staff members reported Tenant

#2 attempted to take food from other tenants' plates during meals multiple times on a daily basis.

Tenant #2 exhibited unmanageable bowel and bladder incontinence and displayed unmanageable physical aggression, placing staff members at risk for injury, and disruption to other tenants' meal times on a daily basis despite staff member attempts at intervention. Tenant #2 exceeded the level of care allowable to remain in the program.

Tenant #3, a 76 year old, was admitted to the program on 2-12-12 with diagnoses of: Dementia, Depression, Diabetes, Congestive Heart Failure and Acute Renal Failure. Tenant #3 was admitted to hospice services in January 2013. Tenant #3 resided in the program's secured memory care unit. Tenant #3 scored a 4 on the GDS completed on 5-1-13, indicating moderate cognitive decline. The service plan, dated 2-11-13, indicated Tenant #3 required assistance with bathing, grooming and dressing. The same service plan indicated Tenant #3 was independent with eating and was dependent with toileting, requiring changing of incontinence products when soiled, required the assistance of two staff members to transfer from one surface to another and rarely got out of bed. Tenant #3 wore incontinence products.

On 5-28-13, during observation, the monitor observed Tenant #3 lying in bed, positioned with pillows to face the wall. Tenant #3 did not get out of bed the entire day. Staff #1 fed Tenant #3 his/her lunch meal. Tenant #3 did not verbally interact with Staff #1 during the lunch meal.

During interview, Staff #1, CNA, Staff #2, UW, Staff #4, UW, Staff #6, LPN, Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported Tenant #3 required two staff members to transfer if getting up into the wheelchair. The staff members indicated Tenant #3 rarely got out of bed except for breakfast and lunch, was repositioned by staff members multiple times during each shift, could not self propel his/her own wheelchair when placed in the chair by staff members, had to be totally fed by staff members, was checked and changed for incontinence with the incontinence products being changed while lying in bed and was completely dependent with bathing, grooming and dressing. Staff members reported Tenant #3 was dependent with the above stated tasks for greater than 2 months and had required two staff members to transfer him/her due to an inability to bear weight for approximately two to three months.

The program RN reported she talked with Tenant #3's family on 5-28-13, the day of the monitor's on-site visit, to report a need for a transfer to a higher level of care. The RN indicated Tenant #3 would be moving from the program by the end of the week. During interview, the program RN indicated she had not applied for a hospice waiver to allow Tenant #3 to remain at the program

Tenant #3 was dependent with bathing, grooming, dressing for greater than 21 days. Tenant #3 required staff members to feed him/her, required repositioning by staff members, was mostly bed bound since February, required routine two person assistance with transfers, was unable to self propel his/her wheelchair when out of bed, and was checked for incontinence and changed while lying in bed following an incontinent episode for greater than 21 days. The program had not obtained a hospice

waiver allowing Tenant #3 to remain residing at the program. Tenant #3 exceeded the level of care allowable to remain at the program.

Tenant #4, an 87 year old, was admitted to the program on 3-13-13, with diagnoses of: Alzheimer's Type Dementia, HTN, and Urinary Frequency. Tenant #4 resided in the program's secured memory care unit. Tenant #4 scored a 4 on the GDS completed on 4-12-13, indicating moderate cognitive decline. The service plan, dated 4-12-13, indicated Tenant #4 was independent with transfers, mobility, eating and toileting. Tenant #4 required assistance with bathing, grooming and dressing. Tenant #4 wore incontinence products. Tenant #4 wore a watch that was part of the program's alarm system which would sound an alarm both audibly and trigger a response to each staff member's pager to notify them that Tenant #4 was near an exit door.

According to the functional assessments, completed on 3-11-13 and 4-12-13, Tenant #4 did not exhibit any verbal aggression, physical aggression, wandering or resistance to care provision.

During interview, Staff #1, CNA, Staff #2, UW, Staff #3, Certified Medication Aide (CMA), Staff #4, UW, Staff #6, LPN, Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported Tenant #4 wandered throughout the memory care unit exit seeking several times a week, mostly on the evening shift. Tenant #4 had exited into the general population area or outside into the program's parking lot multiple times on the evening shift several evenings per week. Tenant #4 would at times become angry with staff members, threatening verbally, when staff members intervened during Tenant #4's exit seeking. All staff members reported the alarm system functioned appropriately each time, allowing staff members to stop Tenant #4 from leaving the building without staff knowledge and to prevent Tenant #4 from going anywhere other than just outside the door in the program parking lot.

The program's building was located adjacent to a highway that had a speed limit of 55 miles per hour. The parking lot directly exited into the highway. The building had a large lake located at the rear of the building.

During interview, the program RN indicated she had talked with Tenant #4's family on 5-28-13, the day of the monitor's on-site visit, to report a need for a transfer to a higher level of care secondary to the multiple elopements. The RN indicated Tenant #4 would be moving from the program but did not yet know a date of planned discharge.

Tenant #4 exhibited multiple repetitive attempts to exit seek and leave the building without staff member supervision, thereby placing him/herself at risk for injury. Tenant #4 exceeded the level of care allowable to remain at the program.

- 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. Program Reporting to the Department

Complaint/Incident Allegation: It was alleged a tenant eloped from the program without staff knowledge and the program failed to report the elopement as required by regulation.

- Monitoring Observation: The Executive Director identified no tenant elopements since January 2013. During interview, staff members identified Tenants #1, #2, #4 and #5 wandered throughout the secured memory care unit. Staff members identified Tenants #2, #4 and #5 as exit seeking. Staff members identified Tenant #2 as exiting a door leading into the general population area of the building but never outdoors, Tenant #4 as leaving the building multiple times to the general population area and the outside, however, all indicated the program's alarm system functioned appropriately notifying staff members to Tenant #4's opening an exit door allowing for adequate response to avoid an actual elopement, and Tenant #5 as pushing on the door leading to the general population area causing the alarm to sound and entering other tenant rooms without permission but never exiting to the outside.

  Tenant #4 wore a watch that was part of the program's alarm system which would sound an alarm both audibly and trigger a response to each staff member's pager to notify them that Tenant #4 was near an exit door.

  During interview, Staff #1, CNA, Staff #2, UW, Staff #4, UW, Staff #6, LPN, Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported Tenant #4 wandered throughout the memory care unit exit seeking several times a week, mostly on the evening shift. Tenant #4 had exited into the general population area or outside into the program's parking lot multiple times on the evening shift several evenings per week. Tenant #4 would at times become angry with staff members, threatening verbally, when staff members intervened during Tenant #4's exit seeking. All staff members reported the alarm system functioned appropriately each time, allowing staff members to stop Tenant #4 from leaving the building without staff knowledge and to prevent Tenant #4 from going anywhere other than just outside the door in the program parking lot.

  Tenant #4 had gotten outside into the program's parking lot; however, the program's alarm system functioned appropriately, notifying staff members of Tenant #4's opening of the exit door and allowing staff members to respond in a timely manner. Tenant #4 was never outside without staff knowledge therefore Tenant #4 did not elope from the program. The program did not have to report the exit seeking behavior to the Department of Inspections and Appeals.

- Regulatory Insufficiency: None noted.

The monitor identified the following while conducting the complaint investigation:

C. Structural Requirements

- Monitoring Observation: According to the International Building Code 2009 edition; 1008.1.9, "except as specifically permitted by this section, egress doors shall be readily openable from the egress side without the use of a key or special knowledge or effort.

  The program's secured memory care unit had two identified exit doors that were used for egress from the unit in an emergency: one exiting into the interior of the building into the general population area of the building and one exiting to the front parking lot area.

  The exit door leading into the general population area allowed open access in and out of the memory care unit unless a tenant who was cognitively impaired was near the door. Each cognitively impaired tenant residing in the program's memory care unit wore a watch which was connected to the program's alarm system. Whenever one of the watches came near the door, the door automatically locked and sounded an audible alarm as well as sent a page to each staff members' pager, alerting staff members that a tenant may be seeking exit from the unit. When a tenant wearing the watch was near the door, the exit door remained locked. One side of the double door had an egress bar that could be pushed continuously for 15 seconds, then would automatically release even when one of the alarm system watches was located near the exit door. The instructions for use of the egress bar were posted on the egress bar itself.

  The exit door leading to the program's front parking lot was locked at all times from the outside to prevent unauthorized entrance into the building but allowed open access to leave the memory care unit unless a tenant who was cognitively impaired and wearing an alarm watch was near the exit door. When a tenant wearing the watch was near the door, the exit door automatically locked and sounded audibly and went to each staff members' pager to notify of an impending elopement from the building. When a tenant wearing the watch was near the door, the exit door remained locked. The door had an egress bar that could be pushed continuously for 15 seconds, then would automatically release even when one of the alarm system watches was located near the door. The instructions for use of the egress bar were posted on the egress bar itself. The parking lot exit door also had a slide pin type lock located at the top left hand side of the door. The slide pin was engaged, disallowing exit from the building even after release of the door by using the egress bar.

  During interview, the Executive Director reported the slide pin-type lock had been installed approximately two years previously in an effort to keep tenants from eloping from the building.

  During interview, Staff #1, certified nurse aide CNA, and Staff #2, UW, both reported the slide pin-type lock was to be engaged at all times to prevent unauthorized tenant exit from the secured memory care unit as the door would release if pushed for 15 seconds even if the tenant wore the alarm system watch.

The memory care unit also had two doors exiting to a small secured courtyard. Both courtyard doors were locked at all times, requiring a key to unlock each door. During tour, Staff #1, CNA, was the only staff member working in the memory care unit at the time and she did not have a key to unlock either courtyard door for the monitor.

The program had two doors exiting to the enclosed courtyard that were locked at all times and staff members working in the unit did not have access to a key to unlock the doors should an emergency occur. The program had one door identified as an exit door for emergency purposes locked, disallowing exit from the building without knowledge of the lock or effort to unlock the door to exit. By manually locking the exit door leading into the parking lot area, the program prevented ease of egress for tenants, staff and visitors in the event of a fire.

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

D. Evaluation

- Monitoring Observation: Tenant #1's clinical record contained a GDS completed on 3-4-13 which identified a score of 4, indicating moderate cognitive decline. The RN did not mark any clinical characteristics on the assessment to identify which characteristics applied to Tenant #1.

  The clinical record also contained a note to the physician, dated 11-26-12, reporting newly noted aggressive behaviors toward staff members, including resistance to care provision, hitting, and throwing his/her walker at staff members, refusal to have clothing removed and experiencing both auditory and visual hallucinations which were believed to cause the behaviors as described above.

  According to the functional assessments, completed on 11-26-12, 12-15-12, 1-21-13, 1-25-13, 2-3-13, 2-21-13, 3-4-13, Tenant #1 exhibited verbal aggression, physical aggression and was resistive to care provision. The assessments completed on 11-26-12, 12-15-12, 1-25-13, 2-3-13 and 3-4-13, identified physical aggression and resisting care provision one to three times weekly. The assessment completed on 1-21-13 identified physical aggression four to six times per week and resistance to care provision one to three times weekly. The assessment completed on 2-21-13 identified physical aggression four to six times weekly and resistance to care provision one or more times daily.

  During interview, Staff #1, CNA, Staff #2, UW, Staff #4, UW, Staff #6, LPN, Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported Tenant #1 was resistive to care provision attempts by staff members, becoming combative by hitting, kicking, pinching, scratching and throwing his/her walker at staff members. All seven staff members reported Tenant #1 was combative toward staff members on a daily basis. Staff #1, #2, #4, #7 and #8 reported no injury resulting from Tenant #1's combative behaviors. Staff #6 reported she had been scratched by Tenant #1, drawing blood, once. Staff #9 reported Tenant #1 swung his/her walker at Staff #9's legs, tripping Staff #9. Staff #9 fell to the floor but did not receive any injuries from the fall.

Staff #6 reported Tenant #1 at times pushes at other tenants but had never caused injury. Staff #7 reported Tenant #1 had pushed his/her walker into other tenants but never knocked any other tenant down or caused injury.

During interview, Staff #1, #2, #4, #6, #7, #8 and #9 reported Tenant #1 would urinate and defecate in unusual places throughout the memory care unit one to two times every week or two. The staff members reported Tenant #1 often became agitated and aggressive when toileted with staff member assistance. Tenant #1 did not always use the toilet during toileting, then later would pull his/her pants down and urinate or defecate in places other than the toilet. Staff #1, #2 and #4 reported Tenant #1 had pulled his/her pants down and defecated on the dining room chair located in the common area of the memory care unit the previous week.

Tenant #1 exhibited unmanageable bowel and bladder incontinence, experienced delusional behaviors and displayed unmanageable physical aggression toward staff and other tenants despite staff member attempts at intervention, all identified on the GDS as characteristics associated with a score of 5 to 6, thereby indicating moderately severe to severe cognitive decline.

Tenant #3's clinical record contained a GDS completed on 5-1-13 which identified a score of 4, indicating moderate cognitive decline. The RN did not mark any clinical characteristics on the assessment to identify which characteristics applied to Tenant #3. The functional assessment, dated 5-1-13, indicated Tenant #3 required total assistance with bathing, grooming and dressing. The same functional assessment required intermittent assistance with eating and was dependent with toileting, requiring changing of incontinence products when soiled, required the assistance of two staff members to transfer from one surface to another and rarely got out of bed. Tenant #3 wore incontinence products. The same functional assessment indicated Tenant #3 was unable to self-propel in a wheelchair.

On 5-28-13, during observation, the monitor observed Tenant #3 lying in bed, positioned with pillows to face the wall. Tenant #3 did not get out of bed the entire day. Staff #1 fed Tenant #3 his/her lunch meal. Tenant #3 did not verbally interact with Staff #1 during the lunch meal.

During interview, Staff #1, CNA, Staff #2, UW, Staff #4, UW, Staff #6, LPN, Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported Tenant #3 required two staff members to transfer if getting up into the wheelchair. The staff members indicated Tenant #3 rarely got out of bed except for breakfast and lunch, was repositioned by staff members multiple times during each shift, could not self propel his/her own wheelchair when placed in the chair by staff members, had to be totally fed by staff members, was checked and changed for incontinence with the incontinence products being changed while lying in bed and was completely dependent with bathing, grooming and dressing. Staff members reported Tenant #3 was dependent with the above stated tasks for greater than 2 months and had required two staff members to transfer him/her due to an inability to bear weight for approximately two to three months.

Tenant #3 was dependent with bathing, grooming, dressing and eating. Tenant #3 had been repositioned by staff members, was mostly bed bound since February,

required routine two person assistance with transfers, was unable to self propel his/her wheelchair when out of bed, and was checked for incontinence and changed while lying in bed following an incontinent episode, all identified on the GDS as characteristics associated with a score of 5 to 6, thereby indicating moderately severe to severe cognitive decline.

Tenant #4's clinical record indicated he/she wore a watch that was part of the program's alarm system which would sound an alarm both audibly and trigger a response to each staff member's pager to notify them that Tenant #4 was near an exit door.

According to the functional assessments, completed on 3-11-13 and 4-12-13, Tenant #4 did not exhibit any verbal aggression, physical aggression, wandering or resistance to care provision.

During interview, Staff #1, CNA, Staff #2, UW, Staff #4, UW, Staff #6, LPN. Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported Tenant #4 wandered throughout the memory care unit exit seeking several times a week, mostly on the evening shift. Tenant #4 had exited into the general population area or outside into the program's parking lot multiple times on the evening shift several evenings per week. Tenant #4 would at times become angry with staff members, threatening verbally, when staff members intervened during Tenant #4's exit seeking. All staff members reported the alarm system functioned appropriately each time, allowing staff members to stop Tenant #4 from leaving the building without staff knowledge and to prevent Tenant #4 from going anywhere other than just outside the door in the program parking lot.

Tenant #4 exhibited wandering, agitation and multiple repetitive attempts to exit seek and leave the building without staff member supervision. The RN failed to identify Tenant #4's behaviors when completing the functional assessments on 3-11-13 and 4-12-13.

Tenant #5, a 78 year old, was admitted to the program on 10/7/11 with diagnoses of: Dementia and Congestive Heart Failure. Tenant #5 scored a 3 on the GDS completed on 5-8-13, indicating mild cognitive decline. The RN did not mark any clinical characteristics on the assessment to identify which characteristics applied to Tenant #5. Tenant #5 resided in the program's secured memory care unit.

According to the functional assessments, dated 4-30-13 and 5-8-13, Tenant #5 required staff member assistance with bathing, grooming and dressing. The assessment indicated Tenant #5 did not experience any wandering, exit seeking or physical aggression.

On 5-28-13, during observation, the monitor observed Tenant #5 wandering throughout the secured memory care unit attempting to enter other tenant apartments without permission and exhibiting exit seeking behaviors. When Staff #2, UW, attempted to redirect Tenant #5, Tenant #5 became agitated, berating Staff #2 verbally and then slammed his/her apartment door in Staff #2's face.

During interview, Staff #1, CNA, and Staff #2, UW, reported Tenant #5 often wanders throughout the unit, attempting to go into other tenant apartments or exit seek into the general population area of the program. Both staff members indicated Tenant #5 often became verbally agitated when redirected from both behaviors.

Tenant #5 exhibited wandering, agitation and exit seeking behaviors. The RN failed to identify Tenant #5's behaviors when completing the functional assessments on 4-30-13 and 5-8-13. Tenant #5 required staff member assistance with bathing, grooming and dressing, wandering, agitation and exit seeking behaviors, all identified on the GDS as characteristics associated with a score of 4 or 5, thereby indicating moderate to moderately severe cognitive decline.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall 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 with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

- Regulatory Insufficiency: A program shall evaluate each prospective tenant's and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the needed services are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the evaluation indicated moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. (IAC r. 481-69.22(1))

E. Service Plans

- Monitoring Observation: Tenant #1's clinical record contained a note to the physician, dated 11-26-12, reporting newly noted aggressive behaviors toward staff members, including resistance to care provision, hitting, and throwing his/her walker at staff members, refusal to have clothing removed and experiencing both auditory and visual hallucinations which were believed to cause the behaviors as described above.

  According to the functional assessments, completed on 11-26-12, 12-15-12, 1-21-13, 1-25-13, 2-3-13, 2-21-13, 3-4-13, Tenant #1 exhibited verbal aggression, physical aggression and was resistive to care provision. The assessments completed on 11-26-12, 12-15-12, 1-25-13, 2-3-13 and 3-4-13, identified physical aggression and resisting care provision one to three times weekly. The assessment completed on 1-21-13 identified physical aggression four to six times per week and resistance to care provision one to three times weekly. The assessment completed on 2-21-13 identified

physical aggression four to six times weekly and resistance to care provision one or more times daily.

During interview, Staff #1, CNA, Staff #2, UW, Staff #4, UW, Staff #6, LPN, Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported Tenant #1 was resistive to care provision attempts by staff members, becoming combative by hitting, kicking, pinching, scratching and throwing his/her walker at staff members. All seven staff members reported Tenant #1 was combative toward staff members on a daily basis. Staff #1, #2, #4, #7 and #8 reported no injury resulting from Tenant #1's combative behaviors. Staff #6 reported she had been scratched by Tenant #1, drawing blood, once. Staff #9 reported Tenant #1 swung his/her walker at Staff #9's legs, tripping Staff #9. Staff #9 fell to the floor but did not receive any injuries from the fall.

Staff #6 reported Tenant #1 at times pushed at other tenants but had never caused injury. Staff #7 reported Tenant #1 had pushed his/her walker into other tenants but never knocked any other tenant down or caused injury.

During interview, Staff #1, #2, #4, #6, #7, #8 and #9 reported Tenant #1 would urinate and defecate in unusual places throughout the memory care unit one to two times every week or two. The staff members reported Tenant #1 often became agitated and aggressive when toileted with staff member assistance. Tenant #1 did not always use the toilet during toileting, then later would pull his/her pants down and urinate or defecate in places other than the toilet. Staff #1, #2 and #4 reported Tenant #1 had pulled his/her pants down and defecated on the dining room chair located in the common area of the memory care unit the previous week.

Tenant #1's service plan, dated 2-21-13, lacked direction to staff members on how to deal with Tenant #1's unmanageable bowel and bladder incontinence, delusional behaviors and physical aggression toward staff and other tenants.

Tenant #4's clinical record indicated he/she wore a watch that was part of the program's alarm system which would sound an alarm both audibly and trigger a response to each staff member's pager to notify them that Tenant #4 was near an exit door.

According to the functional assessments, completed on 3-11-13 and 4-12-13, Tenant #4 did not exhibit any verbal aggression, physical aggression, wandering or resistance to care provision.

During interview, Staff #1, CNA, Staff #2, UW, Staff #4, UW, Staff #6, LPN, Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported Tenant #4 wandered throughout the memory care unit exit seeking several times a week, mostly on the evening shift. Tenant #4 had exited into the general population area or outside into the program's parking lot multiple times on the evening shift several evenings per week. Tenant #4 would at times become angry with staff members, threatening verbally, when staff members intervened during Tenant #4's exit seeking. All staff members reported the alarm system functioned appropriately each time, allowing staff members to stop Tenant #4 from leaving the building without staff knowledge and to prevent Tenant #4 from going anywhere other than just outside the door in the program parking lot.

Tenant #4 exhibited wandering, agitation and multiple repetitive attempts to exit seek and leave the building without staff member supervision. The RN failed to identify Tenant #4's behaviors when completing the service plan for Tenant #4. The service plan, dated 4-12-13, lacked direction to staff members on how to deal with Tenant #4's exit seeking behaviors and agitation with staff redirection.

According to the functional assessments, dated 4-30-13 and 5-8-13, Tenant #5 required staff member assistance with bathing, grooming and dressing. The assessment indicated Tenant #5 did not experience any wandering, exit seeking or physical aggression.

On 5-28-13, during observation, the monitor observed Tenant #5 wandering throughout the secured memory care unit attempting to enter other tenant apartments without permission and exhibiting exit seeking behaviors. When Staff #2, UW, attempted to redirect Tenant #5, Tenant #5 became agitated, berating Staff #2 verbally and then slammed his/her apartment door in Staff #2's face.

During interview, Staff #1, CNA, and Staff #2, UW, reported Tenant #5 often wanders throughout the unit, attempting to go into other tenant apartments or exit seek into the general population area of the program. Both staff members indicated Tenant #5 often became verbally agitated when redirected from both behaviors.

Tenant #5 exhibited wandering, agitation and exit seeking behaviors. The RN failed to identify Tenant #5's behaviors when completing the service plan for Tenant #5. The service plan, dated 10-7-12, lacked direction to staff members on how to deal with Tenant #5's wandering, exit seeking behaviors and agitation with staff redirection.

- 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 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: The service plan shall be individualized and shall indicate the tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)a)

F. Tenant Documents

- Monitoring Observation: The program's policy, titled Tenant Incident Reports, directed staff to report all behaviors resulting in injury to a tenant or staff member on an incident report. All inappropriate behaviors that did not result in an injury were to be documented on a behavior tracking form, in the tenant's chart and on a 24-hour summary.

  Staff members reported Tenants #1 and #2 both exhibited aggressive behaviors toward staff members and/or other tenants and experienced unmanageable bowel

and/or bladder incontinence, urinating and defecating in their apartments and common areas of the program. Tenant #1 and Tenant #2's clinical records lacked any documentation related to the aggressive behaviors or unmanageable bowel/bladder incontinence.

Staff members reported Tenants #2, #4 and #5 all exhibited multiple attempts to elope from the program. Tenant #2, Tenant #4 and Tenant #5's clinical records lacked any documentation related to the elopement attempts.

During interview, Staff #1, CNA, Staff #2, UW, Staff #6, LPN, Staff #7, UW, Staff #8, UW, and Staff #9, UW, all reported the inappropriate behaviors were to be documented in a communication book stored in the office located in the secured memory care unit. All six staff members reported they do not routinely document tenant inappropriate behaviors on incident reports, on behavior tracking forms or in tenant clinical records.

During interview, the program RN reported the program does not have behavior tracking forms for documentation by staff members. The RN reported staff members had been documenting inappropriate tenant behaviors in the communication book. The RN reads the documentation in the communication book and transposes pertinent information into the clinical records of tenants. The communication book documentation was shredded after being read by the nurse and the Executive Director.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: (i) when any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception; and (o) incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record). (IAC r. 481.69.25(1)i and o.)