IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 43967-C
44077-C
44123-C

July 25, 2013

Ms. Mary K. Harris, RN Manager
Oakwood Place
4126 NW Boulevard
Davenport, IA 52806

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - OAKWOOD PLACE
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Harris:

I. Final Complaint/Incident Investigation Report – Oakwood Place, Davenport, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **June 10 & 11, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights, Policies and Procedures and Service Plans.

Oakwood Place ("Program") is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2).

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

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

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

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received a Regulatory Insufficiency in the area of Service Plans.

The determination of a **$500 civil penalty** is based upon repeated Regulatory Insufficiency in the area(s) of: Service Plans. As the enclosed Report details, the Program failed to update Service Plans for three tenants.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Jim Berkley** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of **three hundred twenty five dollars ($325)** within 30 days after the notice or service of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of the notice or service of this demand letter.

IV. Conclusion

The Program is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Plan of Correction (POC) submitted on July 18, 2013, has been reviewed and will constitute the final POC related to the on-site visit of June 10 & 11, 2013.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of notice or service of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Jim Berkley, at 515/281-4116.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Mary K. Harris, RN Manager
Oakwood Place
4126 NW Boulevard
Davenport, IA 52806

Complaint/Incident Intake #: 43967-C
44077-C
44123-C

Date of Complaint/Incident Investigation:

June 10 & 11, 2013

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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:	42
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	42

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	12
TOTAL census of Assisted Living Program	54

Program History – The program received regulatory insufficiencies in the area of Food Service, Evaluations, Service Plans, Nurse Review, Criteria for Admission and Retention and Life Safety during this certification period

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

A. Tenant Rights

Complaint/Incident Allegation #44077-C: It was alleged a tenant had expressed suicidal ideations and had elopement tendencies.

- Monitoring Observation: Eight tenant files (Tenants #1, #2, #3, #4, #5, #6, #7 and #8) were reviewed. Incident reports for the past three months were reviewed and there were no elopements documented.

  Tenant #1, an 88 year old, was admitted on 11-8-07 and diagnoses included: Pain, Mouth Sores, Constipation, Dry Eyes, Arthritis, Gastro Esophageal Reflux Disease, Circulation, Hypertension, Anxiety, Hyperlipidemia and Angina. Tenant #1 scored an 8/11 on the cognitive tool which indicated moderately advanced impairment. The service plan indicated Tenant #1 would voice Tenant #1 just wanted to die and join Tenant #1's spouse. The service plan indicated to give verbal reassurance, listen for brief moment, change the topic to cards and encourage Tenant #1 to go to music programs.

The RN Manager indicated once in a while Tenant #1 wanted to join Tenant #1's spouse; however, there were no concerns regarding Tenant #1 harming self. Review of the file indicated the behavior was reflected on the service plan and there were no documented incidents related to this behavior in the past three months.

Tenant #2, an 84 year old, was admitted on 4-5-13 and diagnoses included: Alzheimer's Dementia Episode, Anterograde Amnesia, Hyperlipidemia, History of Breast Cancer (Lumpectomy/Mastectomy), History of Arthritis and History of Anxiety. Tenant #2 scored a 9/11 on the cognitive tool, which indicated no or mild impairment.

According to an Unusual Occurrence Report dated 6-10-13 at 5:00 p.m., on 6-5-13 Staff #10 reported to the RN Manager that Tenant #2 had some extreme behaviors. When the RN Manager asked for specifics Staff #10 said third shift said Tenant #2 was anxious all night, talked about how badly Tenant #2 had been treated by Tenant #2's family and told them Tenant #2 was going to jump out the window. The RN Manager spoke with multiple staff and there were no reports of extreme behaviors or any remarks made about wanting to harm self. Messages were left for all staff regarding the report that incidents/significant changes needed to be reported to the RN Manager immediately and she asked for more information.

Staff #7 (second/third shift) reported she never had any problems with Tenant #2 and Tenant #2 stayed in the apartment all night. On second shift there were no problems. Staff #8 (third shift) reported no behavior problems. Tenant #2 talked to her about family taking money and mail. Tenant #2 was upset about the third shift fire alarm the previous week but was easily re-directed. Staff #9 stated Tenant #2 was "very upset" and "crying" about 5:30 a.m. on 6-5-13 talking about a family matter. Tenant #2 had told her Tenant #2 was not going to do it but it made Tenant #2 feel like jumping out the window. Staff #9 stayed with Tenant #2 until 6:00 a.m. and then had Staff #10 come up and be with Tenant #2. Staff #9 had only seen Tenant #2 once before and did not know anything about the situation or behaviors. Staff #9 reported the window was closed, Staff #9 did not feel like Tenant #2 was going to hurt Tenant #2's self but just needed someone to be there to talk with. Staff #9 did not report the incident to the RN Manager because it happened late in the morning, she remained with Tenant #2, didn't feel Tenant #2 was going to harm self and first shift took over in the apartment for her. Staff #11 reported Tenant #2 stayed in the apartment at night, only called for help at change of shift time and she had no one to one contact with Tenant #2. Staff #11 stated Staff #9 came out that morning and said how sad, crying Tenant #2 was and did not feel like living anymore.

According to the report, the RN Manager indicated Staff #9 was unfamiliar with Tenant #2's behavior and situation. Tenant #2 was not normally awake or asking for assistance during the night. Staff #9 was unfamiliar with the interventions and distractions when Tenant #2 talked about problems and not understanding why Tenant #2 needed to be removed from home, sadness increased and continued while Staff #9 was present. Staff #10 then reassured Tenant #2 and distracted Tenant #2.

The report indicated the RN Manager had routinely monitored Tenant #2's behavior and there were no extreme behaviors, Tenant #2 continued to talk daily about the "injustice" done to Tenant #2 by family taking the home away. Tenant #2 walked outside when weather was appropriate and followed the sidewalk in a routine path as observed outside office window. The RN Manager met with Tenant #2 on 6-5-13 and normal behavior was observed, there was no crying or despair noted, Tenant #2 was out to breakfast, appetite was 100% and Tenant #2 talked with other tenants.

The RN Manager felt at no time was Tenant #2 at risk to harm self. Tenant #2 continued to express sadness over losses, was easily distracted and had never in past expressed a wish to harm self or not live any longer. Tenant #2 had never repeated that Tenant #2 wished to harm self. Tenant #2 did not take any action that morning, going to the window, trying to open it and had not repeated to anyone Tenant #2 wished to harm self. Tenant #2 continued on with usual activities which included visiting with other tenants and staff and attending activities. All staff was instructed on 6-5-13 that if they heard a tenant told someone else or if a tenant told them they wanted to harm self it was to be reported to the RN Manager.

Staff #1, #2 and #4 stated they were not aware of any tenants who stated they had intentions of hurting themselves or had thoughts of suicide.

A typed Unusual Occurrence report was dated 6-10-13 at 5:00 p.m. An incident report was not completed to the incident.

Complaint/Incident Allegation #44123-C: It was alleged there were concerns regarding tenant safety going out with others. :

- Monitoring Observation: Eight tenant files (Tenants #1, #2, #3, #4, #5, #6, #7 and #8) were reviewed.

  Tenant #6, an 80 year old, was admitted on 8-29-12 and diagnoses included: Dementia, Depression, Arthritis and Primary Progress Aphasia. Tenant #6 resided in the dementia unit. According to a service plan dated 5-1-13, Tenant #6 could go to the chapel on Sunday mornings. Tenant #6's spouse was aware the spouse could take Tenant #6 to the chapel and when the service was completed return to the dementia unit. Tenant #6 needed an escort with all appointments in addition to Tenant #6's spouse. A companion would come routinely to take Tenant #6 out to eat, shop and other activities. The companion could take Tenant #6 out in the building for different activities. Tenant #6's spouse could decide to go with Tenant #6 as spouse desired.

  Staff #6 said Tenant #6's family member called earlier that morning and said another family member was coming to pick up Tenant #6. A family member and Tenant #6's spouse had a small interaction that she did not witness and the family member started banging on the door, loudly. The family member rushed/walked past Staff #6 "violently." The family member got Tenant #6 and Tenant #6 looked like Tenant #6 did not want to leave without Tenant #6's spouse.

The spouse did not want Tenant #6 to leave and was upset the spouse could not go. Staff #6 said the family member was in an upset mood, brushed past Staff #6 and it smelled like alcohol when the family member walked past. The RN Manager was called and security was also called. Staff #6 was not there when Tenant #6 returned.

Staff #4 stated Tenant #6's family member came to get Tenant #6. She stated the family member was abusively talking to Tenant #6's spouse and banging on a door. The family member wanted to take Tenant #6 out of town to church. The family member threatened to kill Tenant #6's spouse. She heard staff calling the security guard on the radio and the RN Manager was called. Staff #4 stated Tenant #6 could not verbally indicate if Tenant #6 wanted to leave with the family member but she was sure Tenant #6 would want to go. Tenant #6 returned safely.

Staff #5 said she was coming down the elevator and saw Tenant #6's family member coming out of the unit with Tenant #6. Tenant #6's spouse and staff didn't want Tenant #6 to go. Tenant #6's spouse was very upset. Staff members called the security guard. Staff #5 saw the family member and Tenant #6 walk down the hall. The family member had a hair brush in one hand and was holding Tenant #6's hand in the other hand. Tenant #6's spouse said the family member wanted to beat up the spouse.

The RN Manager said on Sunday morning at approximately 10:00 a.m./11:00 a.m. Tenant #6's family member came to take Tenant #6 to church. The family member and Tenant #6's spouse got into a shouting match. Staff told the RN Manager the family member was yelling at the spouse. The RN Manager said there were no concerns with safety with Tenant #6. The RN Manager talked to Tenant #6's family on Monday and was told the family member who came to pick up Tenant #6 was not drinking or intoxicated. The RN Manager said staff did not report any issues to her regarding alcohol related to the incident.

Staff #1, #2 and #4 stated they had no concerns with tenant safety when leaving the building.

An incident report was not completed related to the incident.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: 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)(o))

Complaint/Incident Allegation #43967-C: It was alleged a staff disclosed information about tenants and their care where non-staff could hear the information.

- Monitoring Observation: Five tenants (Tenants #1, #4, #5, #7 and #8) were interviewed. The tenants did not report any issues or concerns regarding lack of privacy regarding healthcare information.

  Staff #13, was interviewed and stated she didn't think any staff discussed tenant care in an area where they could be overheard by the public. She stated sometimes staff discussed things by her desk but never when the public was present.

  Staff #1, #2 and The RN Manager said they were not aware of any staff that discussed tenant care in an area where they could be overheard by the public. Staff #4 said staff usually went into the office to discuss tenant care and she was not aware of any staff discussing tenant care in an area where they could be overheard by the public.

  Per tenant and staff interviews, staff did not disclose information about tenant cares in an area where non-staff could hear the information.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #43967-C: It was alleged staff was verbally abusive towards tenants.

- Monitoring Observation: Five tenants (Tenants #1, #4, #5, #7 and #8) were interviewed. Tenant #1 stated staff were wonderful, a couple were short once in a while but not abusive. Tenant #1 stated this only occurred once or twice. The tenants did not express any issues or concerns regarding staff being verbally abusive or treating them with a lack of respect.

  Staff #1, #2, and #4 stated staff was not verbally abusive towards tenants.

  The RN Manager said staff was not verbally abusive towards tenants.

  Per tenant interviews, staff interviews and an interview with RN Manager there was no staff that was verbally abusive towards tenants.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation #43967-C: It was alleged the nurses did not assess wounds.

- Monitoring Observation: According to the RN Manager, Tenant #3 was the only tenant with wound care.

  Tenant #3, an 89 year old, was admitted on 7-31-09 and diagnoses included: Diabetes, Constipation, Osteoporosis, Edema, Hyperlipidemia and Hypothyroid. Tenant #3 scored an 11/11 on the cognitive evaluation, which indicated no or mild impairment. According to the service plan, Tenant #3 had an open area on the right foot and had treatment completed at the wound clinic or by staff as directed.

The service plan indicated to refer to the Medication Administration Record (MAR). According to a physician's order, there was a wound to right medial heel and the order indicated to cleanse the wound and peri-wound with non-cytotoxic agent (saline), apply primary dressing (medi-honey gel and alginate to cover the wound), cover wound and secure the dressing in place (4 x 4 gauze and secure with medipore tape) and change dressing every day and as needed. The May 2013 MAR reflected the treatment was consistently completed. A Nurse's Review was completed on 6-5-13 by the RN Manager. The review indicated Tenant #3 continued to be seen by the wound clinic weekly for right heel wound. There were no signs and symptoms of infection (redness, swelling or odor). There were reports of lower right extremity edema and an order for Lasix 20 mg was effective. The review indicated under Skin Turgor, there were open areas, right heel area treatment at wound clinic and skin treatments to refer to the MAR.

The RN Manager said wounds were assessed by the RN Manager or Staff #12, a licensed practical nurse (LPN). If a report was received that something was going on the RN Manager would check. There was currently one tenant (Tenant #3) with wound care. The RN Manager checked the wound once every couple of weeks and there had been no issues reported regarding the wound. Tenant #3 was seen at the wound clinic weekly.

Staff #1, #2 and #3 had a nurse delegation for Skin Care-pressure related to open areas of skin.

Staff #1 stated either an RN or LPN assessed and documented wounds. Staff #2 stated the nurse always assessed and documented wounds. Staff #4 stated she would report wounds to the nurse who would report them to the RN Manager and they handled the wounds.

Review of a tenant file, staff interviews, nurse delegations and an interview with the RN Manager indicated wounds were assessed as needed.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #43967: It was alleged a staff member slept while on duty and used tenant blankets.

- Monitoring Observation: Five tenants (Tenants #1, #4, #5, #7 and #8) were interviewed. The tenants stated staff was marvelous, provided wonderful help and services were provided as indicated on service plans. The tenants did not express any concerns or issues regarding lack of services or staff response when requested.

  Staff #1 stated over a year ago she caught a staff member on first shift coming out of a bathroom after being in there a long time. The staff member's face looked puffy and creased like she had been sleeping. Staff #1 stated the staff member had not done that since and she was not aware of anyone else sleeping on the job. Staff #2, #4 and the RN Manager stated they were not aware of any staff sleeping while on duty.

Per tenant interviews, staff interviews and an interview with the RN Manager there had been no recent incidents of staff sleeping while on duty.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #43967: It was alleged staff came to work under the influence of alcohol and /or illegal drugs.

- Monitoring Observation: Five tenants (Tenants #1, #4, #5, #7 and #8) were interviewed. The tenants stated staff was marvelous, provided wonderful help and services were provided as indicated on service plans. The tenants did not express any concerns or issues regarding lack of services or staff response when requested.

  Staff #1, #2, #4 and the RN Manager stated they were not aware of any staff who reported to work under the influence of drugs or alcohol.

  According to a Rule Violations document provided by the Program, the following was an example of misconduct that may result in disciplinary action up to and including termination: Unauthorized use, possession, sale or purchase of intoxicants or illegal drugs on Program property.

  Per tenant interviews, staff interviews, an interview with the RN Manager and policy review there was no evidence of staff reporting to work under the influence of alcohol and/or illegal drugs.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #43967: It was alleged staff did not give tenants baths, did not have time to give baths but documented the baths had been given. It was alleged a staff member only allowed tenants to have a five minute whirlpool bath even if the tenant wanted a longer bath.

- Monitoring Observation: Five tenants (Tenants #1, #4, #5, #7 and #8) were interviewed. The tenants stated they received assistance with baths and whirlpools twice a week. Tenant #1 stated Tenant #1 was allowed too much time in the whirlpool. Tenant #4 stated enough time was provided for Tenant #4's whirlpool. Tenant #5 stated 10 minutes was allowed for a whirlpool but Tenant #5 only took 7 minutes for the whirlpool. The tenants did not express any issues or concerns regarding lack of services including bathing or the time allowed for bathing.

  Staff #1 stated tenants were allowed 10 minutes to soak in the whirlpool. Staff #2 stated tenants were usually given 10 minutes in the water to soak. Assistance with washing was completed prior to the 10 minute soak. Staff #3 stated assistance with washing the body and hair was completed followed by a 10 minute soak in the whirlpool. Tenants could take 15 minutes but that was usually too much and 15 minutes tired the tenants out. Staff #4 stated she thought tenants were allowed 10 minutes but the tenants could take as much time as they wanted.

Staff #1, #2, #3 and #4 stated to their knowledge, no one documented giving baths that had not been given.

The RN Manager said most often tenants received baths as requested on the service plan. She said if the tenant refused or asked for something different or if there was short shift it might be rescheduled to the next day. She said there were no complaints and said it might happen once per month. She said staff was not documenting baths as given when the baths were not given.

A Shower/Whirlpool Schedule was provided for the first and second shifts. All tenants were scheduled for a minimum of two showers or whirlpools each week, with some tenants receiving services five days per week.

Per tenant interviews, staff interviews, an interview with the RN Manager and review of bath schedules, tenants were allowed as much time as requested for bathing services and bathing services were provided.

- Regulatory Insufficiency: None noted.

C. Medications

Complaint/Incident Allegation #43967: It was alleged a staff member forced a tenant to take medications in the dining room despite the tenant not wanting medications given in the dining room.

- Monitoring Observation: Five tenants (Tenant #1, #4, #5, #7 and #8) were interviewed.

  Tenant #1 stated medications were taken in Tenant #1's apartment. Tenant #5 stated medications were administered wherever requested. If Tenant #5 was going out, medications were left out for Tenant #5. The tenants did not express any issues or concerns with where they took their medications.

  A medication pass was observed in the dining room at 11:30 a.m. on 6-11-13. Two tenants (Tenants #9 and #10) were observed receiving their medications in the dining room. Tenant #9 was interviewed and stated it was okay that medications were delivered in the dining room and Tenant #9 preferred it that way. Tenant #10 stated Tenant #10 always received medications at meals and that way Tenant #10 knew Tenant #10 got them. Tenant #10 preferred receiving the medications in the dining room. Staff was observed talking to tenants in a professional and respective manner.

  A Medication Reminder/Supervision Policy was provided. The policy did not address medication administration in the dining room.

  Staff #1, #2 and #4 stated medications were delivered in the dining room if indicated on the service plan and tenants were not forced to take medications in the dining room.

The RN Manager said tenants could be given medications in the dining room and if so it was addressed on the service plan. She said there were no tenants who received medications in the dining room that had stated they did not want medications delivered during meals.

Per tenant interviews, staff interviews, an interview with RN Manager and an observation of a medication pass in the dining room indicated there were no concerns identified regarding tenants being forced to take medications in the dining room.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #43967: It was alleged a staff member took tenant medications home.

- Monitoring Observation: Staff #1, #2 and #4 stated staff members did not take tenant medications home.

  The RN Manager was not aware of any staff members taking tenant medications home.

  Per staff interviews and an interview with the RN Manager there were no concerns identified regarding staff taking medications home.

- Regulatory Insufficiency: None noted.

D. Structure

Complaint/Incident Allegation #43967-C: It was alleged smoke was allowed to permeate the activity room from the outside smoking area.

- Monitoring Observation: Five tenants (Tenants #1, #4, #5, #7 and #8) were interviewed. The tenants had no issues or concerns regarding smoke in the building.

  Staff #1 stated there was a sign on the activity room door that said to not open the door. Staff #2 said you were not supposed to leave the building by the activity room door as smoke could come in. Staff #4 stated she did not smell smoke and had not heard anything about it. The Activity Director stated sometimes smoke came into the activity room but she and the RN Manager decided to put up a sign that stated to not open the door. She stated once in a rare time a few tenants might say they could smell smoke in the activity room.

  A copy of the door sign was provided which stated "This door is not to be propped open with anything. We must use the other service door when using the outside office or the outside office will be closed."

  On 6-10-13 at 1:55 p.m. a monitor walked down a hallway to an outside smoking area that was used by staff. Several chairs were in an open area inside of brick columns. Around the corner, approximately six feet down a walkway was a door that entered into the activity room.

A sign was posted on the inside of the door. Staff #13 stated the sign had been up between 12 and 18 months. A monitor could not smell smoke in the hallway leading to the outside or in the activity room. At 2:30 p.m. two staff members were smoking outside and a monitor could not detect any smoke odor in the hallway or in the activity room.

The RN Manager said there was a designated smoking area and she was not aware of any recent problems with smoke coming into the building.

A Smoking Policy was provided that stated the Program was a smoke free environment. Smoking was not allowed anywhere inside the building. The policy pertained to all tenants and employees of the Program as well as visitors.

Per tenant interviews, staff interviews, an interview with the RN Manager, an interview with Activity Director, monitor observations and a policy review, smoke was not detected in the building.

- Regulatory Insufficiency: None noted.

E. Activities

Complaint/Incident Allegation #43967-C: It was alleged the Program did not provide any structured activities.

- Monitoring Observation: Five tenants (Tenants #1, #4, #5, #7 and #8) were interviewed. The tenants stated there were so many activities that it was impossible to attend all of them. The tenants did not identify any issues or concerns with lack of activities offered.

  The Activity Director stated she prepared an activity calendar for the general population and the dementia unit. Normally exercises were scheduled for the mornings and a variety of activities were scheduled in the afternoons. She followed the calendar unless tenants preferred to do something else and then she would do whatever the tenants chose. Staff in the dementia unit conducted those activities. She stated no one had expressed any concerns with activities. She always asked at Resident Council meetings for activity suggestions.

  Staff #2 and #4 stated the activity calendar was followed.

  The RN Manager said activity calendars were for the most part being followed in the general population and dementia unit. She said some days the Activity Director was gone and Staff #13 helped with activities. She said staff also assisted with activities. She said there were enough activities offered.

  Activities were observed which included music on 6-10-13, one to one activities on 6-10-13 and a movie on 6-11-13.

Activity calendars for the months of March, April, May and June were provided for the general population and dementia unit. Anywhere from three to eight activities per day were reflected on the calendars.

Per tenant interviews, staff interviews, an interview with the RN Manager, an interview with the Activity Director, observation of scheduled activities and review of activity calendars indicated activities were provided.

- Regulatory Insufficiency: None noted.

F. Policies and Procedures

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

- Monitoring Observation: A policy on incident reports was requested. There was not a policy provided regarding incident reports; however, the Program had a policy regarding Abuse Prevention and Identification. There was not a policy regarding incidents reports.

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

G. Service Plans

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

- Monitoring Observation: Eight tenant files (Tenants #1, #2, #3, #4, #5, #6, #7 and #8) were reviewed.

  Tenant #1's file was reviewed. Tenant #1 had an order for Nitroquick 0.4 mg tab 25's, one tablet under tongue every five minutes as needed times three. The service plan did not reflect Nitroquick. The service plan did not meet the identified needs of Tenant #1.

  Tenant #2's file was reviewed. The service plan reflected Tenant #2 became anxious easily, asked repetitive questions, started stories over and over, was upset with moving to the Program and was not understanding of the need for the move. The service plan reflected to provide verbal reassurance using a caring, empathetic voice that Tenant #2 was being cared for and home was not safe for Tenant #2. The service plan reflected to encourage Tenant #2 to attend activities, visit with others in the common area or play cards. The service plan did reflect anxiety and interventions; however, the service plan did not reflect Tenant #2's comment regarding jumping out the window. On 5-2-13 Buspirone 7.5 milligram (mg) by mouth three times daily was ordered, Xanax was discontinued and Seroquel 25 mg daily was ordered.

It was also indicated Tenant #2 should not leave the premises alone but could go to events if accompanied. The service plan did not reflect the order. The service plan did not reflect the identified needs of Tenant #2.

Tenant #5, a 98 year old, was admitted on 8-12-12 and diagnoses included: Gastrointestinal Bleed, Anemia, Constipation, Hypothyroid, Osteoporosis, Unstable Gout, Small Bowl Obstruction and Malnutrition. Tenant #5 scored an 11/11 on the cognitive tool, which indicated no or mild impairment. Tenant #5 had an order for a heating pad for back (self-managed). The most recent service plan dated 3-20-13 did not reflect the heating pad. The service plan did not meet the identified needs of Tenant #5.

Review of tenant files indicated service plans did not reflect the identified needs of the tenants.

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