IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 44173-I

July 31, 2013

Ms. Laura Brock, Director
Bickford Cottage Davenport
4040 E. 55th Street
Davenport, IA 52806

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

Dear Ms. Brock:

I. Final Complaint/Incident Investigation Report – Bickford Cottage Davenport, 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 13 and 17, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Staffing, Evaluation, Service Plans, Nurse Review and Policies and Procedures.

Bickford Cottage Davenport ("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.

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: **Complaint/Incident Intake #:** 44173-I

Laura Brock, Director
Bickford Cottage Davenport
4040 E. 55th Street
Davenport, IA 52806

Date of Complaint/Incident Investigation:

June 13 and 17, 2013

Monitor(s):

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:	26
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	30
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	7
TOTAL census of Assisted Living Program	37

Program History – The program received regulatory insufficiencies during this certification period in the area of Dementia Specific Education, Tenant Rights and Service Plans.

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

A. Staffing

Complaint/Incident Allegation: The Program reported a tenant was found outside the Program and taken to an emergency room (ER) by an unknown person. The Program did not know the tenant was missing until the ER called the Program.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1 was admitted on 6-8-13. Tenant #1 had lived at another assisted living program where Tenant #1 had eloped on 6-7-13 and was found at a store down the road and across a 4 lane street. The family chose the Program as it was a locked, secured unit that needed a key pad code to enter and exit. Tenant #1 exited the building without staff knowledge on 6-8-13 and 6-11-13.

  Tenant #1, an 84 year old, was admitted on 6-8-13 and diagnoses included: Coronary Artery Disease, Depression, Hyperlipidemia, Hypertension, Memory Loss and Renal Insufficiency. Evaluations and a service plan were developed prior to taking occupancy. A service plan dated 6-8-13 reflected Tenant #1 was independent with mobility. According to Night Checks, staff was to check frequently that Tenant #1 was fine and if Tenant #1 needed anything.

Tenant #1 might be anxious and nervous about the move to the Program. Staff was to reassure Tenant #1 that they were there to help and Tenant #1 was safe. Tenant #1 would at times walk around later at night. Staff was to offer a snack and companionship and redirect back to Tenant #1's apartment.

According to an incident report dated 6-8-13 at 4:30 p.m., Tenant #1 pulled a fire alarm by the 200 hallway and went out the door. Staff #1 went after Tenant #1 and found Tenant #1 in the back field. Staff #2 also went out to help. Tenant #1 was with Staff #1. Staff #2 and Staff #1 followed Tenant #1 and tried to get Tenant #1 to stop. Finally was able to stop Tenant #1 on a busy road. Firemen came to assist with Tenant #1. The firemen called 911 to assist with Tenant #1. The police escorted Tenant #1 back to the Program and a family member was called.

Staff #1 was interviewed and stated on 6-8-13 Tenant #1 pulled the fire alarm on the 200 hall and exited out the 200 door. Staff #1 was walking towards the door when another tenant came out of an apartment and said they saw Tenant #1 walk by an apartment window. Staff #1 stated she went outside and called Tenant #1 to come back. Tenant #1 was about 10 feet ahead of Staff #1, swinging and trying to hit Staff #1. Staff #1 saw Staff #2 outside when Staff #1 and Tenant #1 were by a house. Tenant #1 walked up to a busy street and tried to cross but Staff #1 stopped Tenant #1. Staff #2 came to help. Cars were stopping and Tenant #1 was yelling "Help." The fire department arrived and Tenant #1 sat down on the grass. The firemen asked for Tenant #1's medical history so Staff #1 returned to the Program to get Tenant #1's chart. The police came and Tenant #1 got in the police car and came back to the Program. Staff #1 called the Director. The incident occurred at approximately 4:30 p.m. and Tenant #1 did not appear to have any injuries. Staff #1 stated Tenant #1 was wearing a shirt and pants and it was hot outside.

According to Staff #2, about 4:30 p.m., Tenant #1 wanted to go outside so Staff #2 told Tenant #1 to go into the courtyard. Staff #2 heard the fire alarm go off and knew it had to be Tenant #1. Staff #2 went outside and was looking in the ravine when she heard her name being called by Staff #1. Staff #1 was running after Tenant #1 who was very quick. Staff #2 joined Staff #1 at a private home, headed towards a busy street. Tenant #1 was combative with Staff #1. A car pulled over and talked to Staff #2. Firemen showed up and Tenant #1 calmed down. The firemen called the police department who came and got Tenant #1 into the police car and brought Tenant #1 and Staff #2 back to the Program. The police called the family and Staff #2 called the Director. Staff #2 talked Tenant #1 into sitting in the dining room and Tenant #1 ate. A family member arrived. Staff #2 checked on Tenant #1 every hour for the rest of the shift. Staff #2 stated Tenant #1 was calm with the family present.

Staff #3 was interviewed and stated about 4:30 p.m. an alarm sounded. He was in the kitchen and came out into the hallway towards the office. Staff #3 was told Tenant #1 had pulled the alarm so he knew there was not a fire. He called the Director and asked if he could silence the alarm. The Director said yes, so he did while the Director remained on the phone.

Staff #3 assisted a few tenants to the dining room and then went to reset the pull station at the door. The fire department arrived within five minutes and then left to help find Tenant #1. Staff #3 had to go to the maintenance room to get an Allen wrench. Staff #3 stated Staff #5 stayed with the tenants. Once the alarm was reset all doors were alarmed. The police arrived with Tenant #1 approximately 15 minutes after the alarm sounded. Tenant #1 went into the office and was on the phone with a family member.

Staff #4 stated she met Tenant #1 the day Tenant #1 moved in to the Program. The following day Tenant #1 was fine until about 2:00 p.m. Tenant #1 kept asking if someone could give Tenant #1 a ride and asked if Tenant #1 could leave. On another day Staff #4 stated Tenant #1 set off the front door alarm when Tenant #1's family came to visit. Tenant #1 wanted to leave and go home.

The Director stated she received a call from Staff #3 around 4:30 p.m. and was told Tenant #1 had pulled the fire alarm by the 300 door and exited. A T-8 screw driver was needed to reset the alarm. The Director had staff conduct a tenant count. Staff #1 and Staff #2 were outside with Tenant #1. One other staff member was left on the floor. The Director called the Program 15 minutes later and spoke to Staff #2. Staff #2 and Tenant #1 rode in the police car and the police called Tenant #1's family member. The Director called Tenant #1's family. A family member and the Director came into the Program. Family members were with Tenant #1 in the apartment. The Director informed the family that 1:1caregivers would be needed every afternoon from 4:00 p.m. to 9:00 p.m. The Director called a private caregiver service that stated they would start the following day.

On 6-9-13 the Director called the Program at 10:00 a.m. and was told Tenant #1 had set off the alarmed front door when Tenant #1 saw a family member arriving. Tenant #1 pushed the family member, stating Tenant #1 did not want the things the family member was bringing and didn't want to stay at the Program.

On 6-10-13 the Director was at work and around 10:00 a.m. noticed Tenant #1 started getting anxious. An as needed medication was given. Tenant #1 participated in activities, exercises and Bingo at 2:00 p.m. Family arrived at 3:00 p.m. After 5:00 p.m. Tenant #1 was tearful at the dining room table. Tenant #1 called the Director over and wanted to know who the person with her was. The Director informed her it was a private caregiver. The Director was called at 7:30 p.m. and was told by Staff #8 that Tenant #1 was hitting the salon door with a shoe. Staff tried to redirect Tenant #1. A nurse was called. Staff took Tenant #1 into the dining room. Tenant #1 wanted to call the police as Tenant #1 stated Tenant #1 was being held against Tenant #1's will. The nurse called the doctor and received an order to increase the Ativan and to give one immediately.

According to an incident report dated 6-11-13 at 2:45 a.m., at 2:20 a.m. an ER nurse called the Program and said she thought she had a tenant of the Program. Staff immediately went to Tenant #1's room and found Tenant #1 gone and the screen was kicked out. Staff called the Director and reported the incident. The tenant was last checked at 1:50 a.m. Tenant #1 was wearing pajama bottoms and a red shirt.

Staff #7 stated a tenant called for an as needed medication before 2:00 a.m. On the way to give the as needed medication, Staff #7 stopped at Tenant #1's apartment at 1:50 a.m. Tenant #1 was watching television and requested a 3:00 a.m. wake up call. Tenant #1 was wearing a red shirt and pajamas. At 2:20 a.m. an ER nurse called and stated Tenant #1 was in the ER. Staff #7 ran down the hall from the dining room where she had been cleaning and found the window open. She couldn't find the screen and noticed Tenant #1's purse was gone. The blinds were down. The bed was covered with clothes. Staff #7 called the Director to inform her of what occurred.

Staff #9 stated Staff #7 gave medications to someone and then checked on Tenant #1 a little before 2:00 a.m. Tenant #1 was wearing a white blouse and red sweat pants. Staff #7 received a phone call from the ER stating Tenant #1 was there. Tenant #1's family member called and stated the family member would go to the ER to pick up Tenant #1. Staff #9 went to Tenant #1's apartment and noticed the blinds were closed and down and the window was open. Staff #9 went outside and couldn't find the screen. The bed was covered with things Tenant #1 had packed. Staff #9 noticed the screen was under the bed. Tenant #1 returned wearing a hospital gown. The Director was there and told Staff #9 to assist Tenant #1 with a shower.

The Director stated she received a phone call on 6-11-13 at approximately 2:45 a.m. Staff #7 informed the Director the ER called and had Tenant #1. The window was open and the screen was down. Tenant #1 returned to the Program at 4:30 a.m. Staff assisted Tenant #1 with a shower and the Director told the family they needed to provide 24 hour per day coverage. A Wander Guard monitoring watch was placed on Tenant #1 around 4:00 p.m. On 6-12-13 the family arrived around 11:00 a.m. and took Tenant #1 to the hospital for a psychiatric evaluation. Later the family called and stated Tenant #1 was being admitted to the hospital.

The RNC stated she had been out of town and did not meet Tenant #1 until 6-10-13. The RNC spoke to Staff #6 and received report regarding Tenant #1 pulling the fire alarm and leaving the building. Staff #6 reported Tenant #1 had behavior issues and Staff #6 came in and played cribbage with Tenant #1. On 6-11-13 the Director told the RNC she had been at the Program since 4:00 a.m. and had asked Tenant #1's family to find 24 hour a day care until placement could be found due to Tenant #1 leaving out the window. On 6-12-13 Tenant #1 went to the hospital for a psychiatric evaluation and was kept overnight for observation. The RNC contacted Tenant #1's physician for a scheduled dose of Ativan instead of the as needed dose. Tenant #1 returned to the Program at 5:20 p.m. on 6-13-13 and the family made arrangements for 24 hour a day care.

During a physician appointment the next day the psychiatric hospital called and stated Tenant #1 could come immediately.

The 24 Hour Supervision Policy indicated 24 hour supervision would be provided by certified caregivers on each shift, 7 days a week. The caregivers would be awake and on duty and monitor the tenants as indicated in their service plan.

According to a Missing Tenant policy, upon becoming aware of a missing tenant, immediately summon the assistance of the other employees on duty. One employee would immediately search the entire inside of the building including all apartments. While one employee was checking the inside of the building, another employee would simultaneously check the immediate outside vicinity of the building, including courtyard, carports, parking lot and the building property.

A layout of the Program was obtained. Tenant #1's apartment was located off the front hallway, near the front door with a street view.

According to the State Climatologist, on 6-8-13 at 4:52 a.m. at the Davenport airport, there were clear skies, winds from the south at 8 miles per hour, 76 degrees and dry. On 6-11-13 at 1:52 a.m. at the Davenport airport it was 63 degrees with winds from the southwest at 5 miles per hour, mostly cloudy and dry with dew forming.

Incident reports were completed and the Department was notified.

Review of Tenant #1's file, staff interviews, interview with the Director and RNC, review of incident reports and review of policies indicated Tenant #1 left the Program on two occasions without staff knowledge. On 6-8-13, Tenant #1 was not easily re-directed and needed police assistance to return to the Program. On 6-11-13, Tenant #1 left the Program and was taken to the ER by an unknown person. The Program did not meet Tenant #1's identified needs.

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

B. Evaluation

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

- Monitoring Observation: Tenant #1 exited the building on 6-8-13 and 6-11-13.

  Tenant #1 was admitted to the Program on 6-8-13. According to the Progress Notes, at 2:00 p.m. Tenant #1 moved into an apartment, was ambulatory and independent with minimal assistance and cuing due to memory loss. Cognitive and health evaluations were completed on 6-7-13 and a functional evaluation was completed on 6-8-13 prior to admission.

According to an incident report dated 6-8-13 at 4:30 p.m., Tenant #1 pulled a fire alarm by the 200 hallway and went out the door. Staff #1 went after Tenant #1 and found Tenant #1 in the back field. Staff #2 also went out to help. Tenant #1 was with Staff #1. Staff #2 and Staff #1 followed Tenant #1 and tried to get Tenant #1 to stop. Finally was able to stop Tenant #1 on a busy road. Firemen came to assist with Tenant #1. The firemen called 911 to assist with Tenant #1. The police escorted Tenant #1 back to the Program and a family member was called.

According to the Progress Notes dated 6-10-13 at 7:00 p.m., staff called Staff #6. Tenant #1 was very agitated, hitting staff, trying doors and hitting a window. Staff attempted to redirect. All as needed medications were given with no result. The physician was called and a new order to give 0.5 mg of Lorazepam immediately and increase to three times per day was ordered. At 8:00 p.m. Staff #6 came to the Program to assess the situation and attempted to assist with redirection by offering to play cribbage. Another tenant gave Tenant #1 a cell phone and Tenant #1 called family. The family stated they would come to the program. At 8:45 p.m. a family member called staff to inform Tenant #1 family would not be coming. Tenant #1 was upset but becoming very tired. Tenant #1 was gently persuaded to go to Tenant #1's apartment with a staff member and go to bed. At 9:00 p.m. Tenant #1 was resting in bed.

According to an incident report dated 6-11-13 at 2:45 a.m., at 2:20 a.m. an ER nurse called the Program and said she thought she had a tenant of the Program. Staff immediately went to Tenant #1's room and found Tenant #1 gone and the screen was kicked out. Staff called the Director and reported the incident. The tenant was last checked at 1:50 a.m. Tenant #1 was wearing pajama bottoms and a red shirt.

According to the Progress Notes dated 6-11-13 at 12:00 p.m., an entry by the Director (not a human service professional) indicated she received a call at approximately 2:45 a.m. from Staff #7. The ER called to report they had Tenant #1. Staff went to Tenant #1's apartment and discovered the screen out and window open. The Director was called and came to work. Family returned with Tenant #1 at approximately 4:30 a.m. Family would sit with Tenant #1 for 24 hours per day until possible placement in a geriatric psychiatric hospital.

According to Progress Notes dated 6-11-12, 12:10 p.m., that morning at 10:50 a.m. the RNC contacted Tenant #1's physician office and reported incident of Tenant #1 setting off fire alarm on 6-8-11 as well as elopement in early morning. The RNC requested an order for Ativan 0.5 mg orally three times a day and for the Nitro Patch Tenant #1 was using prior to admission at the Program. On 6-11-13 at 1:35 p.m. physician orders were received as requested. On 6-12-13 at 5:05 p.m. family members took Tenant #1 to the ER for a psychiatric evaluation. Tenant #1 was admitted overnight for observation. On 6-13-13 at 5:20 p.m., Tenant #1 returned from the hospital accompanied by a family member. Tenant #1 was tearful at times but went to Tenant #1's apartment to lie down and rest.

Supervision would be provided 24 hours per day; from 5:00 a.m. to 10:00 p.m. by family and from 10:00 p.m. to 5:00 a.m. by private caregivers. Staff was to provide one hour checks and document. On 6-14-13 a call was received from a psychiatric hospital indicating a bed opened. The Director notified family and they transported Tenant #1 for admission. Evaluations were not completed as needed with significant change.

Review of Tenant #1's file indicated functional, cognitive and health evaluations were not completed as needed with significant changes.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change.
(IAC r. 481-69.22(2))

C. Service Plans

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

- Monitoring Observation: Tenant #1 exited the building on 6-8-13 and 6-11-13.

Tenant #1 was admitted to the Program on 6-8-13. According to the Progress Notes, at 2:00 p.m. Tenant #1 moved into an apartment, was ambulatory and independent with minimal assistance and cuing due to memory loss. A service plan dated 6-8-13 indicated Tenant #1 was oriented to person, disoriented to time and place. Staff was to provide frequent reminders to day's events, activities and meals. Behavior was appropriate and Tenant #1 was independent with mobility.

According to an incident report dated 6-8-13 at 4:30 p.m., Tenant #1 pulled a fire alarm by the 200 hallway and went out the door. Staff #1 went after Tenant #1 and found Tenant #1 in the back field. Staff #2 also went out to help. Tenant #1 was with Staff #1. Staff #2 and Staff #1 followed Tenant #1 and tried to get Tenant #1 to stop. Finally was able to stop Tenant #1 on a busy road. Firemen came to assist with Tenant #1. The firemen called 911 to assist with Tenant #1. The police escorted Tenant #1 back to the Program and a family member was called.

The service plan was updated on 6-8-13 by the Director (not a human services professional) indicated Tenant #1 alarmed the 300 fire alarm and walked outside with staff following, redirected to return until police arrived. Director requested 1:1 caregivers from 4:00 p.m. to 9:00 p.m. since this seemed to be Tenant #1's exit seeking time.

According to the Progress Notes dated 6-10-13 at 7:00 p.m., staff called Staff #6. Tenant #1 was very agitated, hitting staff, trying doors and hitting window. Staff attempted to redirect. All as needed medications were given with no result. The physician was called and a new order to give 0.5 mg Lorazepam immediately and increase to three times per day was ordered. At 8:00 p.m. Staff #6 came to the Program to assess the situation and attempted to assist with redirection by offering to play cribbage. Another tenant gave Tenant #1 a cell phone and Tenant #1 called family. The family stated they would come to the program. At 8:45 p.m. a family member called staff to inform Tenant #1 family would not be coming. Tenant #1 was upset but becoming very tired. Tenant #1 was gently persuaded to go to apartment with a staff member and go to bed. At 9:00 p.m. Tenant #1 was resting in bed. The service plan was not updated as needed and did not reflect the identified needs of Tenant #1.

According to the Progress Notes dated 6-11-13 at 12:00 p.m., an entry by the Director (not a human service professional) indicated she received a call at approximately 2:45 a.m. from Staff #7. The ER called to report they had Tenant #1. Staff went to Tenant #1's apartment and discovered screen out and window open. Director was called and came to work. Family returned with Tenant #1 at approximately 4:30 a.m. Family would sit with Tenant #1 for 24 hours per day until possible placement in a geriatric psychiatric hospital.

The service plan was updated on 6-11-13 by the Director (not a human service professional) that indicated Tenant #1 pulled screen out and went out window. Director requested 1:1 family presence 24 hours per day. A Wander Guard monitoring watch was initiated.

According to Progress Notes dated 6-11-12, 12:10 p.m., that morning at 10:50 a.m. the RNC contacted Tenant #1's physician office and reported incident of Tenant #1 setting off fire alarm on 6-8-11 as well as elopement in early morning. The RNC requested an order for Ativan 0.5 mg orally three times a day and for the Nitro Patch Tenant #1 was using prior to admission at the Program. On 6-11-13 at 1:35 p.m. physician orders were received as requested. On 6-12-13 at 5:05 p.m. family members took Tenant #1 to the ER for a psychiatric evaluation. Tenant #1 was admitted overnight for observation. On 6-13-13 at 5:20 p.m., Tenant #1 returned from the hospital accompanied by a family member. Tenant #1 was tearful at times but went to Tenant #1's apartment to lie down and rest. Supervision would be provided 24 hours per day; from 5:00 a.m. to 10:00 p.m. by family and from 10:00 p.m. to 5:00 a.m. by private caregivers. Staff was to provide one hour checks and document. On 6-14-13 a call was received from a psychiatric hospital indicating a bed opened. The Director notified family and they transported Tenant #1 for admission.

The service plan was updated on 6-13-13 by the RNC which indicated hourly checks were initiated. A document was provided that reflected hourly checks were completed from 5:45 p.m. on 6-13-13 through 8:35 a.m. on 6-14-13 when Tenant #1 left the Program with family members.

The service plan did not reflect the initiation of private caregivers, behaviors or exit seeking tendencies and interventions. The service plan was not updated as needed with significant change: the tenant's identified needs and the presence of other providers.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (a)The tenant's identified needs and preferences for assistance; (c) The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy and physical therapy. (IAC r. 481-69.26(4)(a,c))

D. Nurse Review

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

- Monitoring Observation: Tenant #1 exited the Program on 6-8-13 and 6-11-13.

  According to the Progress Notes dated 6-10-13 at 7:00 p.m., staff called Staff #6. Tenant #1 was very agitated, hitting staff, trying doors and hitting a window. Staff attempted to redirect. All has needed medications were given with no result. The physician was called and a new order to give 0.5 mg Lorazepam immediately and increase to three times per day was ordered. At 8:00 p.m. Staff #6 came to the Program to assess the situation and attempt to assist with redirection by offering to play cribbage. Another tenant gave Tenant #1 a cell phone and Tenant #1 called family. The family stated they would come to the program. At 8:45 p.m. a family member called staff to inform Tenant #1 family would not be coming. Tenant #1 was upset but becoming very tired. Tenant #1 was gently persuaded to go to apartment with a staff member and go to bed. At 9:00 Tenant #1 was resting in bed.

  According to the Progress Notes dated 6-11-13 at 12 p.m., an entry by the Director (who was not a human service professional) indicated she received a call at approximately 2:45 a.m. from Staff #7. The ER called to report they had Tenant #1. Staff went to Tenant #1's apartment and discovered the screen out and window open. Director was called and came to work. Family returned with Tenant #1 at approximately 4:30 a.m. Family would sit with Tenant #1 24 hours per day until possible placement in a geriatric psychiatric hospital.

  According to Progress Notes dated 6-11-12, 12:10 p.m., this morning at 10:50 a.m. the RNC contacted Tenant #1's physician's office and reported incident of Tenant #1 setting off fire alarm on 6-8-11 as well as elopement in early morning.

The RNC requested an order for Ativan 0.5 mg orally three times a day and for the Nitro Patch Tenant #1 was using prior to admission at the Program. On 6-11-13 at 1:35 p.m. physician orders were received as requested. On 6-12-13 at 5:05 p.m. family members took Tenant #1 to the ER for a psychiatric evaluation. Tenant #1 was admitted overnight for observation. On 6-13-13 at 5:20 p.m., Tenant #1 returned from the hospital accompanied by a family member. Tenant #1 was tearful at times but went to Tenant #1's apartment to lie down and rest. Supervision would be provided 24 hours per day; from 5:00 a.m. to 10:00 p.m. by family and from 10:00 p.m. to 5:00 a.m. by private caregivers. Staff would provide one hour checks and document. On 6-14-13 a call was received from a psychiatric hospital indicating a bed opened. The Director notified family and they transported Tenant #1 for admission.

Nurse reviews were not completed as indicated with a significant change.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receivers personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

E. Policy and Procedures

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

- Monitoring Observation: A review of incident reports was completed.

  Two incident reports were provided for Tenant #1 dated 6-8-13 at 4:30 p.m. and 6-11-13 at 2:45 a.m. The incident report dated 6-8-13 did not include vital signs. The incident report dated 6-11-13 did not include location, the name of the person who completed the report or vital signs.

  The Director and/or RNC did not obtain statements from witnesses, investigate the incidents or document the investigation.

  The Incident and Accident Report Policy indicated the person in charge at the time of the incident or accident would prepare and sign the report. Any incident also needed to be documented in the Tenant Progress Notes and vital signs must be taken and documented on each incident report. The report would include statements from all witnesses, if any. The policy indicated the Director and/or RNC would: investigate all incidents or accidents, document investigation and any corrective action and implement corrective action as appropriate.

Review of incident reports and policy review indicated the Program did not follow the policies and procedures established by the Program.

- 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))