IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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DEMAND LETTER
CERTIFIED

Complaint Intake #: 44432-C
44725-I
44433-M

September 17, 2013

Ms. Mary Kathleen Harris, Director
Oakwood Place Assisted Living
4130 Northwest Blvd.
Davenport, IA 52806

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

Dear Ms. Harris:

I. Final Complaint/Incident Investigation Report – Oakwood Place Assisted Living, 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 **July 29 - 31, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights, Program Reporting to Department, Nurse Review, Evaluation and Service Plans.

Oakwood Place Assisted Living ("Program") is being assessed a **$1,500 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 Regulatory Insufficiencies in the areas of Tenant Rights, Evaluations, Nurse Reviews and Service Plans.

The determination of a **$1,500 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Tenant Rights, Nurse Review, Evaluation and Service Plans. As the enclosed Report details, the program failed to protect Tenant #1's rights. The program failed to evaluate four tenants with significant changes in condition and failed to perform Nurse Reviews and update Service Plans for two 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 **nine hundred seventy five dollars ($975)** 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 **$1,500 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 August 30, 2013, has been reviewed and will constitute the final POC related to the on-site visit of July 29 - 31, 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 Kathleen Harris, Director Oakwood Place
Oakwood Place Assisted Living
4130 Northwest Blvd.
Davenport, Iowa 52806

Complaint/Incident Intake #:

44432-C
44725-I
44433-M

Date of Complaint/Incident Investigation:

July 29, 30 and 31, 2013

Monitor(s):

Maribeth Freland RN
Joyce Kix 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:	36
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	38
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	3
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	10
TOTAL census of Assisted Living Program	48

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, Tenant Rights, Policy Procedure 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: 44432-C-It was alleged a tenant fell, fracturing his/her pelvis. The tenant requested nurse evaluation and the program nurse did not evaluate the tenant in a timely manner.

- Monitoring Observation: The monitors reviewed the program's incident reports from the previous three month period noting only one tenant with a fracture. (Tenant #1)

  The monitor reviewed Tenant #1's clinical record, noting the following:

  Tenant #1, a 95 year old, was admitted to the program on 11-30-11 with diagnoses of Dementia, Depression and Glaucoma. Tenant #1 resided in the program's secured memory care unit. Tenant #1 scored a 4 on the Global Deterioration Scale (GDS) completed on 4-19-13, indicating moderate cognitive decline.

  According to the service plan, dated 4-19-13, Tenant #1 was independent with eating, grooming, dressing, toileting, transfers and ambulation utilizing a walker. Tenant #1 required staff member assistance with bathing and medication administration.

According to the incident report, dated 7-2-13, Tenant #1 sought out Staff #1, certified nursing assistant (CNA) at approximately 4:50 a.m. reporting he/she had fallen while going to the bathroom, was experiencing right leg/groin pain and needed to see a nurse. Tenant #1 was ambulating without a walker at the time of the incident. The incident report documented Tenant #1 had swelling in the right groin area. The incident report documented Staff #1 took Tenant #1's vital signs, noting Tenant #1's blood pressure to be 158/94.

During interview, Staff #1 reported she arrived at work at 9:45 p.m. on 7-1-13 and worked until approximately 5:45 a.m. Staff #1 reported Tenant #1 entered the main common area of the secured memory care unit at approximately 4:30 a.m., reporting he/she had fallen and needed to be seen by a nurse. Staff #1 reported Tenant #1 kept going room to room looking for a nurse and refused to sit down. Staff #1 reported this behavior to be unusual; therefore, Staff #1 "knew something wasn't right". Staff #1 attempted to call the nurse at the health care center attached to the assisted living program. The nurse at the health care center reported she was very busy and was the only staff person available at the time so was unable to respond right away. Staff #1 was unable to remember the name of the nurse contacted. Staff #1 "knew something wasn't right and didn't know what to do" so immediately contacted the Director of Oakwood Place who is also a registered nurse (RN). Staff #1 reported Tenant #1's condition to the Director/RN. Staff #1 reported the Director/RN told her if Tenant #1 was up walking around Tenant #1 could wait until the morning for an assessment. The Director/RN reportedly told Staff #1 to call a "pretend" nurse to pacify Tenant #1. Staff #1 reported calling Staff 2, CNA, who was working in the general population area of the program. Staff #1 reported she told Staff #2 that the Director/RN wanted someone to act like a nurse to pacify Tenant #1. Both staff members attempted to pacify Tenant #1. Staff #1 gave Tenant #1 two Tylenol. Staff #1 reported the Director/RN told her not to fill out an incident report as the fall was not witnessed but Staff #1 reported feeling uncomfortable with the direction and initiated an incident report anyway. Staff #1 reported the health care center nurse called back at approximately 5:30 a.m. to report she was able to come to assess Tenant #1 but Staff #1 told the health care center nurse she was no longer needed as the Director/RN had already given direction. Staff #1 reported the health care center nurse usually responded to requests for assessment in a timely manner and the Director/RN had never before given direction to call a "pretend" nurse.

During interview, Staff #2 reported receiving a call from Staff #1 at approximately 5:00 a.m. on 7-2-13 requesting assistance. Staff #1 reported the Director/RN told her to have someone pretend to be a nurse as Tenant #1 was requesting to see a nurse. Staff #1 asked Staff #2 to pretend. Staff #2 reported Tenant #1 was familiar with her and knew she was not a nurse so refused. Staff #2 reported she attempted to assist Tenant #1 as best she could. Tenant #1 was seated in a chair in the main common area of the secured memory care unit when Staff #2 arrived to assist. Tenant #1 was reporting pain in the right hip area. Staff #2 reported Staff #1 gave Tenant #1 two Tylenol and Tenant #1 sipped on some hot chocolate. Staff #2 stayed with Tenant #2 for approximately 45 minutes. Tenant #1 attempted to stand several times but each time Tenant #1 attempted to bear weight on his/her right leg, Tenant #1 would express increased pain and would immediately sit back down on the chair. Staff #2 reported Tenant #1 did not walk during the 45 minutes she observed.

Staff #2 reported this behavior to be unusual for Tenant #1 and felt Tenant #1 needed assessed by a nurse as Tenant #1 was expressing pain, especially when standing and this was not usual for Tenant #1. Staff #2 reported the health care center nurse usually responded to requests for assessment in a timely manner and the Director/RN had never before given direction to call a "pretend" nurse.

According to the program policy, titled Accident and Emergency Response Policy, when staff members become aware of a resident medical emergency when the program RN was not present in the building, the resident associate assigned to the area was to respond, assess the situation and, if possible medical care was required, call the health center nurse who was to respond.

During interview, Staff #3, certified medication assistant (CMA), reported she arrived at work at 5:45 a.m. on 7-2-13. Staff #3 reported Tenant #1 was seated at a table in the main common area of the secured memory care unit upon Staff #3's arrival. Staff #1 told Staff #3 Tenant #1 had fallen about one hour previously and was complaining of pain, wanting to see a nurse. Tenant #1 complained of pain radiating around to his/her back. Staff #3 did not administer any medications to Tenant #1. At sometime during the morning, Tenant #1 indicated he/she needed to use the toilet. Staff #3 reported each time Tenant #1 attempted to stand he/she was in "tremendous" pain. Staff #3 attempted to get Tenant #1 to sit in a wheelchair for transport into his/her apartment but Tenant #1 refused. Another CNA working in the memory care unit assisted Tenant #1 to his/her apartment with Tenant #1 walking in his/her usual gait. Once Tenant #1 got to the room, he/she had to sit down to rest and then was unable to get back up again to go to the toilet. Staff #3 reported this behavior to be unusual for Tenant #1 and felt Tenant #1 needed to be evaluated by a nurse or medical professional as she was experiencing pain while standing. Staff #3 reported attempting to reach the Director/RN at approximately 8:00 a.m. with no answer. Staff #3 then contacted Tenant #1's family member who indicated a wish to have Tenant #1 sent to the emergency room for medical evaluation. Staff #3 called the emergency transport service requesting transport of Tenant #1 to a local emergency room for evaluation. Staff #3 reported the emergency transport service arrived and took Tenant #1 to the hospital. Staff #3 reported the Director/RN had not yet arrived at work when Tenant #1 left the program.

According to the emergency transport system on 7-2-13 at 8:09 a.m. the emergency transport call was received and dispatched at 8:10 a.m. The emergency transport system arrived at the program at 8:20 a.m. and was at Tenant #1's side at 8:21 a.m. Emergency personnel found Tenant #1 standing in his/her room. Upon assessment, Tenant #1 stated he/she got up around 4:30 a.m. to go to the bathroom and fell. Both Tenant #1 and program staff members reported Tenant #1 walked to the nursing station and his/her right leg started hurting. Tenant #1 denied any neck or back pain but did complain of right leg pain. Tenant #1 described the right leg pain as steady and dull non-radiating pain that was intensified with exertion. Tenant #1 rated the pain at a 7 on a 1-10 scale with 10 being the worst pain ever experienced and indicated the pain had been present for approximately 1 to 3 hours. Tenant #1 stood and sat on a cot for transport. Tenant #1 left the program with emergency personnel at 8:31a.m. Tenant #1 was later diagnosed with a fractured pelvis.

According to Nurse Notes, dated 7-1-13 and timed at 8:30 a.m., the Director/RN documented receiving a telephone call at 5:15 a.m. from staff members reporting Tenant #1 was upset and pacing the halls. Staff members reported Tenant #1 fell "sometime, was unable to be specific and wants to see a nurse." The Director/RN documented Tenant #1 denied pain, gait was steady and fast, there was no swelling or bruising. The Director documented knowledge that the health care center nurse was unavailable to assess Tenant #1. The Director documented she instructed staff members to talk to Tenant #1 calmly, tell Tenant #1 that the nurse was aware of his/her concerns and would assess Tenant #1 first thing when she arrived. The Director/RN reported these interventions were effective until 8:00 a.m. when Tenant #1 began complaining of right groin pain and was unable to stand. The Director/RN documented no redness, bruising or swelling identified.

During interview, the Director/RN reported she did receive a call from staff members during the early morning hours of 7-2-13. The Director/RN reported receiving a report from Staff #1 that Tenant #1 had indicated he/she fell, un-witnessed, and wished to see a nurse. The Director/RN reported Staff #1 had reported Tenant #1 was experiencing groin pain. "That is why I asked her how she was walking." The Director reported she was told Tenant #1 was walking around the secured memory care unit without difficulty but was insistent on getting to see a nurse. The Director/RN reported telling Staff #1 to "act like a nurse until I can get there." The Director/RN reported she was not told of any swelling or bruising to the groin area or about the elevated blood pressure. The Director/RN denied telling Staff #1 not to fill out an incident report. The Director/RN reported she did not get to the program until after Tenant #1 had been transported to the emergency room, indicating she usually came to work between 8:30 a.m. and 8:45 a.m.

According to nurse notes, the Director/RN received a telephone call from the hospital on 7-1-13 11:00 a.m. to report Tenant #1 would be admitted to a long term care setting following discharge from the emergency room. On 7-9-13, the Director/RN documented Tenant #1 fell while at the health center (resulted in a fractured hip) and was sent to the hospital. Tenant #1 would be moving to a different town to be closer to his/her family member when discharged from the hospital without returning to the assisted living program.

Tenant #1 reported he/she had fallen, was in pain and requested nurse evaluation. The program staff members attempted to get the health care center nurse to evaluate Tenant #1 as directed per policy. The health center nurse was not able to respond immediately. The staff member contacted the program Director/RN via telephone. The Director/RN reported she was aware that Tenant #1 was experiencing pain and aware that the health center nurse was unable to respond immediately. The Director/RN told staff members to "act like a nurse until I can get there" but did not arrive to assess Tenant #1 in excess of four hours later, after Tenant #1 was already sent out to be evaluated at the emergency room. Staff members reported Tenant #1 complained of pain from the time of occurrence until transport to the emergency room. Staff members made one other attempt to reach the Director/RN by telephone unsuccessfully. The Director/RN's documentation was dated on the wrong day, timed as documented at a time prior to her arrival at the building.

- Regulatory Insufficiency: All tenants have the right to receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

- Regulatory Insufficiency: All tenants have the right to receive from the manager and staff of the program a reasonable response to all requests. (IAC r. 481-67.3(5))

B. Medications

Complaint/Incident Allegation: 44725-I- The program reported a tenant alleged he/she had missing narcotics.

- Monitoring Observation: The program reported 18 tenants who the program administered medications for that had physician's orders to take narcotic medications and 3 tenants who self-administered medications that had physician's orders to take narcotic medication. The monitors reviewed the Medication Administration Records (MARs) for Tenant #2, #8, #9 and #11. The monitors found documentation of narcotic counts matched the number of medications kept by the program for Tenants #2, #9 and #11.

  Tenant #8, a 90 year old, was admitted to the general population on 6-12-13 with diagnoses of Hypertension (HTN), Diabetes, Arthritis, Depression, Neuropathic pain, and Pancreatic Insufficiency. The program's cognitive tool dated 5-21-13 indicated Tenant #8 missed three questions out of eleven indicating moderately advanced impairment. The service plan dated 7-10-13 directed Tenant #8 stored medications in the apartment, reordered medications as needed and self-medicated. The Physician's Order signed 7-23-13 documented an order for Oxycodone-Acetaminophen 10/325 milligrams, one tablet as needed every four hours for pain. The Nurse's Note dated 7-9-13 documented Tenant #8 reported that over 60 tablets of Oxycodone were missing from the bottle of 180 delivered 7-3-13. The Director counted the tablets and found 102 tablets in the prescription bottle and two tablets in a blue bag. The Director also noted that Tenant #8 lived with a roommate and refused to set up the medications in a planner for tracking when the medication was taken. Tenant #8 stated during interview 7-30-12 that he/she took one tablet every four hours while awake at least five tablets every day. The monitor observed several medication cups sitting out on a small table filled with tablets of multiple kinds. Tenant #8 reported that some of the cups belonged to her roommate and some to her. According to the pharmacy, the new bottle of 180 tablets was delivered 7-3-13 and was opened for use that day and the bottle locked in the medication drawer in the kitchen area. Tenant #8 reported opening the bottle on 7-9-13 and noticing that half the bottle was already gone so the Director was notified of potential theft. If Tenant #8 took five pills per day only 30 pills had been ingested so potentially 46 tablets were unaccounted for. The Director reported there are five sets of keys to the medication drawers in the tenant's rooms. The keys are passed from the staff person working to the next one coming on. According to the schedule, there were at least 17 staff people who had access to the key and potentially the medication during the six days in question. Staff #4, #5, #6, #8, #9 and #10, all CMAs, who were responsible for medication administration and had access to the keys, were interviewed. All reported they had not seen anything suspicious or any staff members entering tenant's rooms when the tenant was not present.

Tenant #8 is responsible for self- medication so the program does not complete a count of the narcotics. Tenant #8 has moderate advanced cognitive impairment and lived with a roommate. Seventeen staff members had access to the key to the medication drawer during the time period from 7-3 to 7-9-13. It could not be determined exactly how many tablets were actually missing or who was responsible.

- Regulatory Insufficiency: None noted.

C. Other

Complaint/Incident Allegation: 44433-M- The program reported multiple tenants alleged items, including money, gift cards and jewelry, were missing from their apartments.

- Monitoring Observation: The program identified eight tenants who had alleged money, jewelry or gift cards were missing from each tenant's apartment. (Tenants #2, #3, #4, #6, #7, #9, #10 and #11) The program notified the local police department, who subsequently identified a suspected perpetrator in multiple thefts involving tenants residing at the program. The suspected perpetrator confessed to some of the alleged thefts and the police had pictures of some jewelry that had been taken to area stores for cash. All jewelry items had been melted down for the gold prior to the police investigation but the police were able to obtain pictures of some of the jewelry that had been sold by the suspected perpetrator.

  After investigating, the monitors were able to identify Tenants #3, #9 and #11 as victims of potential theft of money by a staff member. A separate dependent adult abuse report was completed per protocol for the three tenants.

  The monitors identified the following for Tenants #2, #4, #6, #7 and #10:

  Tenant #2, a 96 year old, was admitted to the program on 11-23-12 with the diagnoses of Osteoarthritis, Anemia and Gastro-Esophageal Reflux Disease. Tenant #2 resided in the general population area of the building. Tenant #2 answered all questions correctly on the program's Cognitive Tool completed on 7-12-13, indicating no cognitive impairment.

  According to Nurse Notes, dated 7-29-13, Tenant #2 reported he/she was unable to locate three rings and one necklace, believing the items to have been stolen. The local police department was contacted by program administration to report the missing jewelry.

  During interview, Tenant #2 reported approximately three weeks prior to reporting to program administration he/she found an empty jewelry box which had previously contained a ring. Upon close examination of his/her jewelry, Tenant #2 identified three rings and one necklace missing from his/her apartment. Tenant #2 did not immediately report the missing jewelry to program administration. Tenant #2 was unable to remember when he/she last saw the missing jewelry. Tenant #2 reported never locking his/her apartment door prior to the identification of the missing jewelry and had not noticed any unauthorized persons in or around his/her apartment.

On 7-30-13 Tenant #2 reviewed all of the police pictures of jewelry taken by the alleged perpetrator and was unable to identify any of the jewelry as his/hers.

The program completed an investigation into Tenant #2's allegations of missing jewelry and reported the allegations to the Department of Inspections and Appeals as required by regulation on 7-29-13. The monitors were unable to tie Tenant #2's missing jewelry to the alleged perpetrator of thefts within the building.

Tenant #4, a 90 year old, was admitted to the program on 5-1-13 with the diagnoses of Osteoporosis, Arthritis and Depression. Tenant #4 resided in the general population area of the building. Tenant #4 answered all questions correctly on the program's Cognitive Tool completed on 6-12-13, indicating no cognitive impairment.

According to Nurse Notes, dated 7-1-13, Tenant #4 reported he/she cashed a check for cash on 6-19-13 for $200.00 and was now unable to locate only $10.00 and some change. Tenant #4 believed the money was not spent and should still be in the apartment. Tenant #4 also reported two check books were also missing from his/her apartment. Program administration assisted Tenant #4 in searching the apartment, finding both of the check books and "some of the money". The local police department was contacted by program administration to report the missing cash.

According to Nurse Notes, dated 7-3-13, Tenant #4 reported he/she had found the remaining missing cash in his her apartment after searching more thoroughly.

The program completed an investigation into Tenant #4's allegations of missing money and reported the allegations to the Department of Inspections and Appeals as required by regulation on 7-2-13. Tenant #4 found all of the missing cash prior to the monitors' investigation.

Tenant #6, a 94 year old, was admitted to the program on 5-17-13 with the diagnoses of Chronic Edema, Chronic Obstructive Pulmonary Disease, Degenerative Joint Disease, HTN and Macular Degeneration. Tenant #6 resided in the general population area of the building. Tenant #6 answered all but one question correctly on the program's Cognitive Tool completed on 5-7-13, indicating no too little cognitive impairment.

According to Nurse Notes, dated 7-2-13, Tenant #6's family member reported he/she noticed Tenant #6's wallet was empty. Tenant #6 usually kept a "small amount of cash" in the wallet. Tenant #6's family could not be certain of the amount that may have been in the wallet prior to noticing the missing cash. The local police department was contacted by program administration. Tenant #6 no longer resided at the program so was unable to be interviewed.

The program completed an investigation into Tenant #6's allegations of missing money and reported the allegations to the Department of Inspections and Appeals on 7-24-13, exceeding the required 24 hour reporting time period allowed by regulation. The monitors were unable to determine the amount of money missing and were unable to tie Tenant #6's missing money to the alleged perpetrator of thefts within the building.

Tenant #7, a 76 year old, was admitted to the program on 7-28-12 with the diagnoses of Alzheimer's Dementia, Depression, HTN, and Atrial Fibrillation. Tenant #7 resided in the general population area of the building. Tenant #7 scored a 3 on the GDS completed on 8-24-12, indicating mild cognitive decline.

According to Nurse Notes, dated 7-24-13, Tenant #7 and his/her family member reported Tenant #7 was missing three rings and a watch, believing the items to have been stolen. The local police department was contacted by program administration.

On 7-30-13, Tenant #7 reviewed all of the police pictures of jewelry taken by the alleged perpetrator and was unable to identify any of the jewelry as his/hers. Tenant #7 reported never locking his/her apartment door prior to the identification of the missing jewelry but now locked the door each time when leaving.

The program completed an investigation into Tenant #7's allegations of missing jewelry and reported the allegations to the Department of Inspections and Appeals as required by regulation on 7-24-13. The monitors were unable to tie Tenant #7's missing jewelry to the alleged perpetrator of thefts within the building.

Tenant #10, an 87 year old, was admitted to the program on 4-19-13 with the diagnoses of Hypertension, Diabetes, Osteoporosis and Osteoarthritis. Tenant #10 resided in the general population area of the building. Tenant #10 answered all but three questions correctly on the program's Cognitive Tool completed on 5-17-13, indicating moderately advanced cognitive impairment.

According to Nurse Notes, dated 7-3-13, Tenant #10 reported missing three Walgreen's gift cards he/she had been given in May 2013. Tenant #10's family member reported Tenant #10 did have three gift cards for Walgreens. The local police department was contacted by program administration to report the missing cash.

During interview, Tenant #10 reported he/she had two Walgreen's gift cards that were given as gifts in May 2013. Tenant #10 reported keeping the gift cards in a purse and stored the purse in a cupboard in his/her apartment. About two weeks after being given the gifts, Tenant #10 went to Walgreens to shop and when paying for items noted the gift cards were no longer in the purse. Tenant #10 had to pay for the items with a check.

During interview, Tenant #10's family member reported Tenant #10 had three Walgreens gift cards- two for $30.00 and one for $15.00. Tenant #10 was given the gift cards in May 2013. Tenant #10's family member initially still had receipts for the gift cards and called the tracking number on the receipt. Tenant #10's family member reported he/she was told that all three cards totaling $75.00 were spent on 6-3-13 at an unspecified Walgreens store. Tenant #10's family member no longer could locate the receipts with the tracking numbers.

The program completed an investigation into Tenant #10's allegations of missing money and reported the allegations to the Department of Inspections and Appeals as required by regulation on 7-3-13. Further tracking to determine who used the gift cards could not be completed as the receipts for the cards were unavailable.

The monitors could not tie Tenant #10's missing gift cards to the alleged perpetrator of thefts in the building.

The program followed appropriate protocol when investigating the allegations of theft as described above.

- Regulatory Insufficiency: None noted. (Determination of no insufficiency does not indicate the thefts did not occur. The monitors were not able to tie the alleged thefts to the alleged perpetrator after thoroughly investigating each case.)

During the course of the investigation, the monitors identified the following:

D. Program Reporting to the Department

- Monitoring Observation: Tenant #6's Nurse Notes, dated 7-2-13, documented Tenant #6's family member reported he/she noticed Tenant #6's wallet was empty. Tenant #6 usually kept a "small amount of cash" in the wallet. Tenant #6's family could not be certain of the amount that may have been in the wallet prior to noticing the missing cash. The local police department was contacted by program administration.

  The program completed an investigation into Tenant #6's allegations of missing money and reported the allegations to the Department of Inspections and Appeals on 7-24-13, exceeding the required 24 hour reporting time period allowed by regulation.

  Tenant #8's Nurse Notes, dated 7-9-13, documented Tenant #8, a tenant who administered his/her own medications, reported missing narcotic medications from his/her apartment. The local police department was contacted by program administration.

  The program completed an investigation into Tenant #8's allegations of missing narcotics and reported the allegations to the Department of Inspections and Appeals on 7-24-13, exceeding the required 24 hour reporting time period allowed by regulation.

- Regulatory Insufficiency: A staff member or employee of a facility or program who, in the course of employment, examines, attends, counsels, or treats a dependent adult in a facility or program and reasonably believes the dependent adult has suffered abuse, shall report the suspected adult abuse to the department. If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged abuser, the staff member shall directly report the abuse to the department within twenty-four hours. (IAC r. 235 E, 2 and 3 a.)

E. Nurse Review

- Monitoring Observation: Tenant #5, a 79 year old, was admitted to the general population 11-28-11 with diagnoses of HTN, Benign Prostatic Hypertrophy, Alzheimer's, Atrial Fibrillation, Anemia, Gastro-Esophageal Reflux Disease (GERD), and Depression. Tenant #5 answered all questions correctly on the program's Cognitive Tool completed on 6-22-13, indicating no cognitive decline.

  Tenant #5's comprehensive health, cognitive and functional evaluations were last completed 6-22-12. The most recent nurse review had been completed 3-22-13. The program provided Incident Reports of falls, both witnessed and un-witnessed , sustained by Tenant #5 on 5-17, 5-27, 5-29, 6-8, 6-16, 6-22, and 7-2-13. The clinical record lacked a nurse review completed regarding repeated falls.

  Tenant #6's comprehensive health, cognitive and functional evaluations were last completed 5-7-13 prior to admission. The program provided Incident Reports of falls dated 6-14, 6-16, and 6-30-13. The Nurse's Note dated 7-2-13 documented Tenant #6 was experiencing increased confusion, unsteady gait, and an increase in falls. Tenant #6 was requesting staff assistance with a wheelchair and required maximal staff assistance with dressing and transfers. Tenant #6 was transferred to the attached nursing home on 7-3-13 due to declining condition. The clinical record lacked a nurse review completed regarding repeated falls and declining health and physical condition.

- Regulatory Insufficiency: If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r. 481-69.27(1))

F. Evaluation

- Monitoring Observation: Tenant #5's comprehensive health, cognitive and functional evaluations were last completed on 6-22-12. The most recent nurse review had been completed 3-22-13. The program provided Incident Reports of falls, both witnessed and un-witnessed , sustained by Tenant #5 on 5-17, 5-27, 5-29, 6-8, 6-16, 6-22, and 7-2-13. The Nurse's Note dated 6-11-13 documented Tenant #5 had not been usual self for past two weeks. Tenant #5 had not been attending activities and was not making conversation with others as in the past. The physician was notified requesting an increase in dosage of the antidepressant medication. The clinical record lacked documentation of completion of health, cognitive or functional evaluations with the repeated falls, change in behavior or required annual review. The Director concurred that she had not completed evaluations for Tenant #5 as of 7-31-13.

Tenant #6's comprehensive health, cognitive and functional evaluations were last completed on 5-7-13 prior to admission. The program provided Incident Reports of falls dated 6-14, 6-16, and 6-30-13. The Nurse's Note dated 7-2-13 documented Tenant #6 was experiencing increased confusion, unsteady gait, and an increase in falls. Tenant #6 was requesting staff assistance with a wheelchair and required maximal staff assistance with dressing and transfers. Tenant #6 was transferred to the attached nursing home on 7-3-13 due to declining condition. The clinical record lacked evidence of completion of health, cognitive, and functional evaluations at the required 30 day time-frame or with the changes in Tenant #6's condition.

Tenant #8's clinical record included documentation of the program's Preadmission Cognitive Tool form, dated 5-21-13, which documented Tenant #8 answered 7 of 11 questions correctly, resulting in a score of 8, which indicated moderately advanced impairment. The clinical record included documentation of the program's 30 Day Cognitive Tool form, dated 7-10-13, which documented Tenant #8 answered 7 of 11 questions correctly, resulting in a score of 7, which indicated moderately advanced impairment. The RN did not complete a GDS assessment with the subsequent cognitive evaluation on 7-10-13, despite identification of moderate cognitive decline on 5-21-13 when utilizing the program's scored objective tool.

Tenant #10's clinical record included documentation of the program's Preadmission Cognitive Tool form, dated 4-16-13, which documented Tenant #10 answered 8 of 11 questions correctly, resulting in a score of 8, which indicated moderately advanced impairment. The clinical record included documentation of the program's 30 Day Cognitive Tool form, dated 5-17-13, which documented Tenant #10 answered 8 of 11 questions correctly, resulting in a score of 8, which indicated moderately advanced impairment. The RN did not complete a GDS assessment with the subsequent cognitive evaluation on 5-17-13, despite identification of moderate cognitive decline on 4-16-13 when utilizing the program's scored objective tool.

- 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))

- 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))

G. Service Plans

- Monitoring Observation: Tenant #5's Service Plan was last completed 6-22-12 and indicated Tenant #5 was independent with transferring and ambulation. The program provided Incident Reports of falls, both witnessed and un-witnessed , sustained by Tenant #5 on 5-17, 5-27, 5-29, 6-8, 6-16, 6-22, and 7-2-13. The Nurse's Note dated 6-11-13 documented Tenant #5 had not been usual self for past two weeks. Tenant #5 had not been attending activities and was not making conversation with others as in the past. The physician was notified requesting an increase in dosage of the antidepressant medication. The clinical record lacked documentation of an up-dated annual service plan with interventions for repeated falls and the change in behavior. The Director concurred that she had not completed a service plan for Tenant #5 as of 7-31-13.

  Tenant #6's Service Plan was last completed 5-8-13 prior to admission and indicated Tenant #6 was independent with transfers, ambulation, grooming, dressing, toileting and medication administration. The program provided Incident Reports of falls dated 6-14, 6-16, and 6-30-13. The Nurse's Note dated 7-2-13 documented Tenant #6 was experiencing increased confusion, unsteady gait, and an increase in falls. Tenant #6 was requesting staff assistance with a wheelchair and required maximal staff assistance with dressing and transfers. Tenant #6 was transferred to the attached nursing home on 7-3-13 due to declining condition. The clinical record lacked documentation of an up-date to the service plan at the required 30 day interval or with interventions for the repeated falls and changes in condition. The Director concurred that she had not completed a service plan for Tenant #6 at any time before the transfer to the nursing home.

- 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))