IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED

October 1, 2013

Mr. Gary Shebeck, Administrator
Newton Village Assisted Living
122 N. 5th Avenue West
Newton, IA 50208

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – AMENDED FINAL RECERTIFICATION MONITORING EVALUATION REPORT - NEWTON VILLAGE ASSISTED LIVING
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Standard Certification
V. Conclusion

Dear Mr. Shebeck:

I. Amended Final Recertification Monitoring Evaluation Report – Newton Village Assisted Living, Newton, IA

Enclosed is the **Amended Final Recertification Monitoring Evaluation 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 **August 6 & 7, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Structural Requirements, Program Reporting to Department, Service Plans and Medications..

Newton Village Assisted Living ("Program") is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.12(3)(a)(1), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

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 determination of a **$500 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, the Program failed to assure an exit door and courtyard gate in a dementia specific unit were secured, allowing a tenant who was unable to make safe decisions to elope.

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 **Rose Boccella** 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. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0182** with effective dates of **October 6, 2013** through **October 5, 2015**.

V. Conclusion

The Program is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1). The Plan of Correction (POC) submitted on August 27, 2013, has been reviewed and will constitute the final POC related to the on-site visit of August 6 & 7, 2013. The Request for Reconsideration has been reviewed and is denied due to the program failed to update Service Plans timely with significant changes in condition.

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, Rose Boccella, at 515/281-7039.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Amended Final Recertification Monitoring Evaluation Report

Assisted Living Program:

Gary Shebeck, Administrator
Newton Village Assisted Living
122 N 5th Ave. W
Newton, Iowa 50208

Date of Monitoring Visit:

August 6 and 7, 2013

Monitor(s):

Maribeth Freland RN

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

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

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

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

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	39
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	39

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	5
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	9
TOTAL census of Assisted Living Program	48

Tenant/Family Satisfaction Results – A community meeting was held with 35 tenants in attendance. The tenants reported general satisfaction with the program. They reported respectful staff interaction and timely response to calls made using emergency pendants. The tenants reported the food served by the program was palatable and the provision of scheduled activities plentiful. They reported the program's environment to be clean and safe, acknowledging they would recommend it to others.

Program History – The program received regulatory insufficiencies related to service plan, medications, structural environment and failure to report elopements to the Department of Inspections and Appeals during the recertification monitoring visit on August 6 and 7, 2013.

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

A. Structural requirements

Monitoring Observation: Tenant #1, an 85 year old, was admitted to the program's general population unit on 10-7-11 with diagnoses of Hypertension (HTN), Diabetes and Diverticulitis. In early August 2012, Tenant #1 was moved to the program's secured memory care unit and resided in the memory care until his/her discharge on 7-14-13. Tenant #1 scored a 3 on the Global Deterioration Scale (GDS) completed on 4-16-13, indicating mild cognitive decline. Tenant #1 scored a 4 on the GDS completed on 6-6-13, indicating moderate cognitive decline.

According to the service plans, dated 4-17-13, 5-15-13, 6-6-13 and 6-14-13, Tenant #1 was independent with eating, bathing, grooming, dressing and toileting. Tenant #1 was able to transfer and ambulate independently without a device. The program staff members administered medications to Tenant #1.

Tenant #1's clinical record contained documentation of a nurse review, health evaluation, functional evaluation and cognitive evaluation, all dated 8-3-12, which indicated Tenant #1 experienced a significant change cognitively, exhibiting increased confusion and talking of wanting to go home as she believed she didn't live at the program. Nurse notes, dated 8-10-13, documented the program made the decision to move Tenant #1 to the secured memory care unit.

During interview, Tenant #1's family member reported Tenant #1 moved into the program and initially resided in the general population area. Tenant #1 began experiencing increased confusion and became more persistent about wanting to go home. Tenant #1 was having trouble finding his/her apartment, requiring staff members to direct Tenant #1 to the apartment most of the time. The family member indicated the program registered nurse (RN) called a meeting and discussed Tenant #1's changes. The family member reported a decision was made to place Tenant #1 in the secured memory care unit as "she was no longer making good decisions". The family member reported both she and the program RN were afraid that Tenant #1 might try to leave the building unsupervised and get lost.

During interview, the monitor reviewed Tenant #1's family member's recollection of the events leading to Tenant #1's transfer to the memory care unit with the program RN. The program RN stated "I agree" when asked if he agreed with the family member's recollection. The RN stated "It's six of one... half a dozen of another. It was for safety reasons."

The program's general population area was secured at all times to prevent unauthorized entrance to the building from the outside but was not secured, allowing anyone inside the building to exit without restriction. The program's memory care unit was secured to prevent unauthorized exit from the unit. All wanting to exit the memory care unit had to input a code known only by staff members and family members of those residing in the unit into a pad, which temporarily disengaged the alarm system to allow unrestricted exit from the unit. The main door leading from the memory care unit to the general population unit had the alarm system requiring the code attached to it. The door had an egress bar, which when pushed continuously for a few seconds, would sound an audible alarm to alert staff to the attempt at unauthorized exit from the building and then the door would automatically release in 15 seconds. The 15 second egress is necessary for evacuation of the memory care unit in an emergent situation, such as a fire. When the alarm system had been set off, staff members had to reset the alarm system with a key carried by staff members working in the memory care unit.

The memory care unit also had two doors which exited into the program's enclosed courtyard. Neither door leading to the courtyard was alarmed so were to remain locked at all times unless staff members were present in the courtyard to supervise tenants. The courtyard fence had one gate, which was also to be locked at all times to prevent unauthorized exit from the courtyard. All staff members working in the memory care unit, the Administrator and the Head of Maintenance carried a key to unlock both doors and the courtyard gate. Staff members were to check both doors leading to the courtyard and the courtyard gate each shift to assure the doors and gate were locked to prevent unauthorized access to the courtyard when unsupervised and to prevent unauthorized exit from the courtyard area.

Tenant #1 resided in the memory care unit with little changes in condition until mid March 2013. According to a nurse notes, dated 3-12-13, Tenant #1 experienced increased anxiety, walking up and down the hallways of the secured memory care unit, lost his/her balance and fell on 3-11-13, resulting in three fractured ribs. Tenant #1 was admitted to the hospital and remained until his/her discharge on 3-14-13. Tenant #1 returned to the program on 3-14-13.

According to the service plan, dated 3-14-13, Tenant #1 began requiring assistance with bathing, dressing, toileting and ambulating when in the hallways. The same service plan documented Tenant #1 will report "I am moving" or "I want to go home". The service plan directed staff members to show Tenant #1 where his/her apartment was so he/she could find personal items in an attempt to redirect him/her.

Tenant #1's clinical record contained a list of medications, indicating Tenant #1's physician ordered Xanax, an anti-anxiety medication, to be given to Tenant #1 on an as needed basis up to three doses for anxiety on 3-14-13.

During interview, the program RN reported he started noting Tenant #1 began experiencing increased anxiety and exit seeking behaviors following the March 2013 hospitalization for the rib fractures. The RN reported Tenant #1 began pushing on the egress bar on the memory care unit main door and was saying "I need to go home".

During interview, Staff #1, #2, #3, #4, #5 and #6, all care attendants who worked in the memory care unit over the previous four months, reported Tenant #1's anxiety and exit seeking behaviors worsened in the evenings with Tenant #1 saying he/she wanted to go home, needed to care for his/her children and/or was looking for his/her spouse who had died three years prior. Staff #2, #3 and #4 reported Tenant #1's behaviors seemed to worsen in April 2013 following a hospitalization following a fall that had resulted in fractured ribs. Tenant #1 began making multiple attempts on an almost daily basis to exit the doors in the memory care unit and became more anxious, requiring medication to calm him/her. Staff #5 began working at the program on 4-22-13 and reported Tenant #1 had exhibited exit seeking behaviors since Staff #5 had begun employment at the program. Staff ##6 reported she worked with Tenant #1 when he/she lived in the general population area. Staff #6 took a leave of absence to attend school in August 2013 and returned in May 2013. Staff #6 indicated Tenant #1's confusion seemed to have worsened over that time, reporting there had been no elopement attempts when in the general population area and then noting multiple exit seeking behaviors in May 2013.

According to the nurse review, dated 5-3-13, Tenant #1 pushed open the south entrance door in the secured memory care unit setting off the alarm. Staff members responded in time to see Tenant #1 exit through the door. Staff members responded, bringing Tenant #1 back into the building. Tenant #1 remained anxious, talking about going home and wanting to know where the kids were. Staff members administered Xanax to Tenant #1 to calm him/her successfully.

According to the incident report, dated 5-15-13, the nurse review, dated 5-15-13 and the nurse review, dated 6-14-13, Tenant #1 could not be located within the memory care unit at approximately 5:00 p.m. Staff members found Tenant #1 outside the building and off of the program's property. Tenant #1 was returned to the secured memory care unit at

approximately 5:15 p.m. Tenant #1 exhibited an abrasion to the right palm/thumb area and was noted to have small bruising to the right knee and right elbow.

During interview, Staff #3 and #4, both working on the second shift in the memory care unit on 5-15-13, reported Tenant #1 was last seen by staff members at approximately 4:30 p.m. when she was helping to set the table for the supper meal. Both staff members indicated they got busy caring for other tenants and did not see where Tenant #1 went to after leaving the dining room area. At approximately 5:00 p.m. Staff #3 and #4 began gathering tenants for supper and they were unable to locate Tenant #1. Both staff members reported hearing no alarms sounding at that time or anytime between 4:30 and 5:00 p.m. The memory care unit was searched completely. A search was initiated in the general population area with no identification of Tenant #1. Staff #4 went into the enclosed courtyard outside of the memory care unit to look for Tenant #1. Staff #4 found one of the doors leading to the courtyard to be unlocked. Staff #4 reported when she checked the locks at 2:00 p.m. both doors had been secured. Staff #4 reported the Head of Maintenance had been in the courtyard doing lawn work sometime between 2:00 p.m. and 5:00 p.m. Tenant #1 was not in the courtyard. Staff #4 checked the courtyard gate finding the gate to be unlocked. Staff #4 reported at 2:00 p.m. the gate had been secured.

During interview, the Assistant Director reported she was notified at approximately 5:00 p.m. that Tenant #1 was missing. The Assistant Director and all other staff members who were available searched both floors of the general population area without locating Tenant #1. The Assistant Director went out the front of the building and began walking toward the street located at the end of the program's driveway. The Assistant Director noted a pickup truck driving slowly around the area and recognized Tenant #3 sitting in the passenger seat. The Assistant Director was able to stop the driver of truck. The driver reported he had noticed Tenant #1, who had tripped and fallen to the ground, about one and ½ blocks away. The driver stopped to help Tenant #1 who asked for a ride to his/her home. The driver drove Tenant #1 to Tenant #1's residence prior to him/her living at the program, which was about 0.8 miles away. Tenant #1 did not recognize the area or the home when the driver got him/her there so asked to be taken back to where the driver had found him/her. Tenant #1 was unable to tell the driver where he/she lived but the driver indicated he knew there were a nursing home and an assisted living in the area so he began looking for someone who may know where Tenant #1 lived. Tenant #1 was returned back to the program with minimal injuries suffered during the fall.

During interview, the Head of Maintenance verified he had been working in the courtyard mowing the lawn in the afternoon of 5-15-13. The Head of Maintenance indicated he may have inadvertently omitted relocking one of the doors going from the building out into the courtyard and had thought he had locked the gate but on occasion the gate did not lock appropriately if it was windy.

The two doors exiting into the enclosed courtyard were to be locked at all times unless staff members were in the courtyard supervising tenants. One door was left unlocked, allowing access to the courtyard by cognitively impaired tenants and those tenants who no longer exhibited safe decision making abilities. The gate in the courtyard fence was to be locked at all times. The gate was left unlocked, allowing unauthorized exit from the courtyard by cognitively impaired tenants and those tenants who no longer exhibited safe decision making abilities. The two courtyard doors were unalarmed at the time and the alarms on the other doors in the memory care unit did not sound during the time in

question. The program was unable to identify any other way Tenant #1 would have been able to exit the secured memory care area without being noticed by staff members except to assume Tenant #1 exited the property through the unlocked door and gate in the courtyard off of the memory care unit..

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

B. Program Reporting to the Department

Monitoring Observation: Tenant #1 was admitted to the program's general population unit on 10-7-11. In early August 2012, Tenant #1 was moved to the program's secured memory care unit and resided in the memory care until his/her discharge on 7-14-13. Tenant #1 scored a 3 on the Global Deterioration Scale (GDS) completed on 4-16-13, indicating mild cognitive decline. Tenant #1 scored a 4 on the GDS completed on 6-6-13, indicating moderate cognitive decline.

Tenant #1's clinical record contained documentation of a nurse review, health evaluation, functional evaluation and cognitive evaluation, all dated 8-3-12, which indicated Tenant #1 experienced a significant change cognitively, exhibiting increased confusion and talking of wanting to go home as she believed she didn't live at the program. Nurse notes, dated 8-10-13, documented the program made the decision to move Tenant #1 to the secured memory care unit.

During interview, Tenant #1's family member reported Tenant #1 moved into the program and initially resided in the general population area. Tenant #1 began experiencing increased confusion and became more persistent about wanting to go home. Tenant #1 was having trouble finding his/her apartment, requiring staff members to direct Tenant #1 to the apartment most of the time. The family member indicated the program registered nurse (RN) called a meeting and discussed Tenant #1's changes. The family member reported a decision was made to place Tenant #1 in the secured memory care unit as "she was no longer making good decisions". The family member reported both she and the program RN were afraid that Tenant #1 might try to leave the building unsupervised and get lost.

During interview, the monitor reviewed Tenant #1's family member's recollection of the events leading to Tenant #1's transfer to the memory care unit with the program RN. The program RN stated "I agree" when asked if he agreed with the family member's recollection. The RN stated "It's six of one... half a dozen of another. It was for safety reasons."

Tenant #1 resided in the memory care unit with little changes in condition until mid March 2013. According to a nurse notes, dated 3-12-13, Tenant #1 experienced increased anxiety, walking up and down the hallways of the secured memory care unit, lost his/her balance and fell on 3-11-13, resulting in three fractured ribs. Tenant #1 was admitted to the hospital and remained until his/her discharge on 3-14-13. Tenant #1 returned to the program on 3-14-13.

According to the service plan, dated 3-14-13, Tenant #1 began requiring assistance with bathing, dressing, toileting and ambulating when in the hallways. The same service plan

documented Tenant #1 will report "I am moving" or "I want to go home". The service plan directed staff members to show Tenant #1 where his/her apartment was so he/she could find personal items in an attempt to redirect him/her.

Tenant #1's clinical record contained a list of medications, indicating Tenant #1's physician ordered Xanax to be given to Tenant #1 on an as needed basis up to three doses for anxiety on 3-14-13.

During interview, the program RN reported he started noting Tenant #1 began experiencing increased anxiety and exit seeking behaviors following the March 2013 hospitalization for the rib fractures. The RN reported Tenant #1 began pushing on the egress bar on the memory care unit main door and was saying "I need to go home".

During interview, Staff #1, #2, #3, #4, #5 and #6, all care attendants who worked in the memory care unit over the previous four months, reported Tenant #1's anxiety and exit seeking behaviors worsened in the evenings with Tenant #1 saying he/she wanted to go home, needed to care for his/her children and/or was looking for his/her spouse who had died three years prior. Staff #2, #3 and #4 reported Tenant #1's behaviors seemed to worsen in April 2013 following a hospitalization following a fall that had resulted in fractured ribs. Tenant #1 began making multiple attempts on an almost daily basis to exit the doors in the memory care unit and became more anxious, requiring medication to calm him/her. Staff #5 began working at the program on 4-22-13 and reported Tenant #1 had exhibited exit seeking behaviors since Staff #5 had begun employment at the program. Staff ##6 reported she worked with Tenant #1 when he/she lived in the general population area. Staff #6 took a leave of absence to attend school in August 2013 and returned in May 2013. Staff #6 indicated Tenant #1's confusion seemed to have worsened over that time, reporting there had been no elopement attempts when in the general population area and then noting multiple exit seeking behaviors in May 2013.

According to the nurse review, dated 5-3-13, Tenant #1 pushed open the south entrance door in the secured memory care unit setting off the alarm. Staff members responded in time to see Tenant #1 exit through the door. Staff members responded, bringing Tenant #1 back into the building. Tenant #1 remained anxious, talking about going home and wanting to know where the kids were. Staff members administered Xanax to Tenant #1 to calm him/her successfully.

Tenant #1 eloped from the program on 5-15-13 sometime between 4:30 p.m. and was returned to the memory care unit at approximately 5:15 p.m. Tenant #1 was gone from the building without staff member knowledge or supervision for an estimated 15 minutes to 45 minutes. The program determined Tenant #1 most likely exited the memory care unit through a door leading into an enclosed courtyard that had inadvertently been left unlocked and a gate in the courtyard fence that had inadvertently been locked. The doors to leading to the courtyard were unalarmed at that time.

According to the nurse review, dated 5-15-13, Tenant #1's GDS score was a 3, indicating mild cognitive decline, at the time of the incident. The program RN documented a belief the elopement was non-reportable to the Department of Inspections and Appeals as Tenant #1's GDS score was below a 4.

The program was required to report all elopements within 24 hours of the program's knowledge of the incident. The regulations defined elopement as a tenant who has impaired decision making abilities leaves the program without the knowledge or authorization of staff. The regulations further defined impaired decision-making abilities as meaning a lack of capacity to make safe and prudent decisions regarding one's own routine safety as determined by the program manager or nurse or means having a GDS score of 4 or greater.

The program's system to protect against unauthorized exit from the secured memory care unit failed. The two doors exiting into the enclosed courtyard were to be locked at all times unless staff members were in the courtyard supervising tenants. One door was left unlocked, allowing access to the courtyard by cognitively impaired tenants and those tenants who no longer exhibited safe decision making abilities. The gate in the courtyard fence was to be locked at all times. The gate was left unlocked, allowing unauthorized exit from the courtyard by cognitively impaired tenants and those tenants who no longer exhibited safe decision making abilities. The two courtyard doors were unalarmed at the time and the alarms on the other doors in the memory care unit did not sound during the time in question. The program was unable to identify any other way Tenant #1 would have been able to exit the secured memory care area without being noticed by staff members except to assume Tenant #1 exited the property through the unlocked door and gate in the courtyard off of the memory care unit.

Tenant #1 exhibited impaired decision making abilities related to safety. Tenant #1 had expressed a wish to return to his/her home, believed he/she had kids that needed caring for at that home, had exhibited an inability to find his/her own apartment when living in the general population area of the building, had exhibited previous exit seeking behaviors while residing in the secured memory care unit and had moved to the secured memory care unit due to his/her families and the program's RN having concerns that should Tenant #1 leave the unsecured general population area while unsupervised, he/she would get lost. The program should have reported Tenant #1's elopement within 24 hours of the occurrence.

Tenant #1 eloped from the program again approximately 3 weeks later on 6-5-13. During interview, Staff #5 and #6 reported working the evening shift on 6-5-13 in the memory care unit. Tenant #1 was last seen by both staff members folding laundry at one of the dining room tables in the common area of the memory care unit at approximately 7:30 p.m. Both staff members got busy caring for other tenants. At approximately 8:00 p.m. the staff members realized Tenant #1 was no longer in the memory care unit. The staff members elicited the help of Staff #2, who was working in the general population area of the building. Staff #2 searched inside the general population area then went out the main front entrance of the general population area. Staff #2 noticed Tenant #1 standing on the side of the street located at the top of the program drive way. Tenant #1 indicated he/she was awaiting a ride. Staff #2 was able to get Tenant #1 to return to the memory care unit approximately 10 minutes after he/she was noted to be missing.

According to the nurse review and associated cognitive evaluation, dated 6-6-13, Tenant #1's GDS score was determined to be a 4, indicating moderate cognitive decline, at the time of the incident making the elopement reportable to the Department of Inspections and Appeals.

Tenant #1 exhibited impaired decision making abilities related to safety. Tenant #1 had expressed a wish to return to his/her home, believed he/she had kids that needed caring for at that home, had exhibited an inability to find his/her own apartment when living in the general population area of the building, had exhibited previous exit seeking behaviors while residing in the secured memory care unit and had moved to the secured memory care unit due to his/her families and the program's RN having concerns that should Tenant #1 leave the unsecured general population area while unsupervised, he/she would get lost. Tenant #1 was evaluated on 6-6-13 to have a GDS score of 4. The program should have reported Tenant #1's elopement within 24 hours of the occurrence.

Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available when a tenant elopes from a program. (IAC r. 481-67.4(4))

C. Service Plan

Monitoring Observation: Tenant #2, a 90 year old, was admitted to the program on 6-5-09 with diagnoses of Dementia, Depression and Arthritis. Tenant #2 resided in the program's secured memory care unit. Tenant #2 scored a 5 on the GDS completed on 2-11-13 and on 5-13-13, indicating moderately severe cognitive decline.

The service plan, completed on 2-11-13, indicated Tenant #2 was able to transfer and ambulate independently without a device. According to the incident report, dated 5-9-13, Tenant #2 fell while ambulating in the hallway of the memory care unit, resulting in a fracture of his/her pelvis. Tenant #2 was hospitalized from 5-9-13 to 5-13-13. According to the nurse review and the health/functional assessment, dated 5-13-13, Tenant #2 experienced a significant change in conditions following the fall with fracture. Tenant #2 now required the use of a walker with all ambulation, required stand by assistance of one staff member when ambulating in the hallways and required home physical and occupational therapy services.

According to nurse notes and associated incident reports, Tenant #2 fell again on 5-16-13 while attempting to walk from his/her bed to the bathroom. Tenant #2 did not use the walker when ambulating. The fall did not result in any injury. Tenant #2 fell again on 5-18-13 while attempting to walk from his/her bed to the bathroom. Tenant #2 did not use the walker when ambulating. Staff #7, care attendant, documented on the incident report for the 5-16-13 fall that Tenant #2 appeared to be unable to use her walker in a correct way to facilitate ambulation. This fall resulted in a suspected fracture so Tenant #2 was sent out to the hospital and was subsequently admitted. Tenant #2 was transferred to a local nursing home following hospital discharge and had not returned to the program at the time of the monitoring visit.

The clinical record contained a service plan which included the addition of standby assistance with all ambulation in the hallways of the unit but lacked the addition of the requirement for a walker with all ambulation and the need for planned physical and occupational services. The service plan was dated 5-20-13, seven days after the significant changes were identified by the program RN. Tenant #2 had fallen two times between the identification of the significant change needs and when the RN completed the service plan. Tenant #2 did not use the walker when ambulating during that time

period. The service plan was signed by Tenant #2, who had been identified by the RN as exhibiting moderately severe cognitive decline on 5-20-13, 2 days after his/her re-hospitalization.

Tenant #2 would have been unable to participate in the planning of his/her services due to his/her advanced cognitive impairment. The RN did not complete the service plan for significant change in a timely manner following identification of the needed changes.

Tenant #3, a 76 year old, was admitted to the program on 10-12-12 with a diagnosis of Alzheimer's Disease. Tenant #3 was initially admitted to the program's general population area and moved to the program's secured memory care unit on 11-28-12. Tenant #3 currently resided in the program's secured memory care unit. Tenant #3 scored a 5 on the GDS completed on 11-28-12, indicating moderately severe cognitive decline.

The service plan, completed on 11-28-12, indicated Tenant #3 required transfer to the secured memory care unit. The service plan was signed by Tenant #3, who had been identified by the RN as exhibiting moderately severe cognitive decline on 11-28-12.

Tenant #3 would have been unable to participate in the planning of his/her services due to his/her advanced cognitive impairment.

The program failed to update a service plan following a significant change. Tenants identified by the program as moderately to severely cognitively impaired were permitted to sign their service plans.

Regulatory Insufficiency: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. 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. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. (IAC r. 481-69.26(3)a)

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))

D. Medications

Monitoring Observation: Tenant #1's clinical record contained physician's orders, dated 3-14-13, ordering Xanax, an anti-anxiety medication 0.5 milligrams (mg) to be administered by program staff members up to three times daily as needed for anxiety. The physician's order and associated medication administration list lacked direction to staff members on how long the staff members must wait between doses. The program RN did not document clarification on the physician's desired frequency for the administration of the Xanax. Tenant #1's clinical record contained a physician's order,

dated 5-8-13, changing the Xanax order to 0.5 mg. routinely twice daily and Xanax 0.5 mg as needed x 2 doses. The physician's order lacked direction to staff members on how long the staff members must wait between doses. The program RN did not document clarification on the physician's desired frequency for the administration of the Xanax.

Tenant #3's clinical record contained physician's orders, dated 11-4-12, ordering Ativan, an anti-anxiety medication, 0.5 mg to be administered by program staff members up to two times daily as needed for anxiety. The physician's order and associated medication administration list lacked direction to staff members on how long the staff members must wait between doses. The program RN did not document clarification on the physician's desired frequency for the administration of the Ativan.

Tenant #4, an 86 year old, was admitted to the program on 7-24-13 with diagnoses of Dementia, Depression and Coronary Artery Disease. Tenant #4 resided in the program's secured memory care unit. Tenant #4 scored a 4 on the GDS completed on 7-24-13, indicating moderate cognitive decline.

Tenant #4's clinical record contained physician's orders, dated 7-24-13, ordering Milk of Magnesia 30 milliliters to be administered by program staff members as needed for constipation. The physician's order and associated medication administration list lacked direction to staff members on how often Tenant #4 could ingest the milk of magnesia when needed. The program RN did not document clarification on the physician's desired frequency for the administration of the Milk of Magnesia.

Regulatory Insufficiency: When medications are administered traditionally by the program, the administration of medications shall be provided by a registered nurse, a licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6) a)