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 #: 44976-A**

October 24, 2013

Ms. Kim Stodgel, Administrator
Lakeside Village Assisted Living
2067 Highway 4
Panora, IA 50716

**RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL RECERTIFICATION & COMPLAINT/INCIDENT INVESTIGATION REPORT - LAKESIDE VILLAGE ASSISTED LIVING**
**II. Reduction of Civil Penalty**
**III. Appeals/Hearings**
**IV. Standard Certification**
**V. Conclusion**

Dear Ms. Stodgel:

**I. Final Recertification & Complaint/Incident Investigation Report – Lakeside Village Assisted Living, Panora, IA**

Enclosed is the **Final Recertification & 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 **August 22, 26-29, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Service Plan, Tenant Rights, Structural Requirements, Policies and Procedures, Tenant Documents and Life Safety.

**Lakeside Village Assisted Living** ("Program") is being assessed a **$7,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC 67.12(3)(a)(1)(2).

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.

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 determination of a **$7,000 civil penalty** is based upon repeated Regulatory Insufficiencies in the areas of Evaluation of Tenant, Service Plan, Tenant Rights, Structural Requirements, Policies and Procedures, Tenant Documents and Life Safety; and for noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, The Program failed to properly perform evaluations, update service plans and maintain complete documentation for Tenant #1 with a progressing decubitus ulcer on bilateral buttocks and coccyx area that eventually developed into a Stage IV decubitus ulcer upon admission to the local hospital. The Program also had chemicals accessible to tenants in the dementia unit. The Program failed to perform appropriate evaluations and update service plans for Tenant #3 and Tenant #4 exhibiting physical and sexual type behaviors.

## 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 **four thousand five hundred and fifty dollars ($4,550)** 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 **S0264** with effective dates of **November 8, 2013** through **November 7, 2015**.

## V. Conclusion

The Program is being assessed a **$7,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a), (b) and 481 IAC 67.12(3)(a)(1), (2). The Plan of Correction (POC) submitted on October 8, 2013, has been reviewed and will constitute the final POC related to the on-site visit of August 22, 26-29, 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 Recertification & Complaint/Incident Investigation Report

**Assisted Living Program:**

Kim Stodgel, Administrator
Lakeside Village Assisted Living
2067 Highway 4
Panora, IA 50716

**Complaint/Incident Intake #:** 44976-A

**Date of Monitoring Visit:**

August 22, 26-29, 2013

**Monitor(s):**

Hal L. Chase, RN BSN MPH
Jim Berkley, RN BS

**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: | 30 |
| Number of tenants with cognitive disorder: | 0 |
| Total Population of Program at time of on-site | 30 |

| **Dementia-Specific Program by Dedication** | |
|---|---|
| Number of tenants without cognitive disorder: | 0 |
| Number of tenants with cognitive disorder: | 3 |
| Total Population of Program at time of on-site | 3 |
| **TOTAL census of Assisted Living Program** | 33 |

**Tenant/Family Satisfaction Results** – A community meeting was held with 26 tenants in attendance. Tenants reported the Program was their home and enjoyed living there. Housekeeping services were completed to each tenant's satisfaction and the building and grounds were clean, safe and sanitary. Nursing services were available when needed and staff was always polite, courteous and respectful. Staff knew what services each tenant needed and responded to their calls for assistance within fifteen minutes.

Tenants reported they enjoyed the activities offered. The food was good and a variety of meats, vegetables and desserts were offered. Tenants felt safe and comfortable and would recommend the Program to anyone looking for a place to live.

**Program History** – The Program received regulatory insufficiencies in the areas of Evaluation, Service Plans, Tenant Rights, Structural, Policy and Procedures, Tenant Documents and Life Safety during this certification period.

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

**A. Evaluation of Tenant**

Complaint/Incident Allegation #44976-A: It was alleged the Program notified Tenant #1's health care provider Tenant #1 had a two-by-two centimeter (cm) pressure area on his/her coccyx. The health care provider assessed Tenant #1's coccyx and discovered a Stage IV ulcer with deep tissue damage and tunneling

Monitoring Observation: During this course of this investigation it was determined there was sufficient cause to conduct a dependent adult abuse investigation in tandem with the recertification and complaint investigation.

Tenant #1, a 75 year old, was admitted on 2-22-12 and had diagnoses of: Dementia, Bipolar Affective Disorder, Venous Stasis Ulcers, history of Deep Vein Thrombosis, Urinary and Fecal Incontinence, Hyperglycemia, Hypokalemia, Chronic Kidney Disease Stage II, Hyperlipidemia, Osteoarthritis, Chronic Venous Insufficiency, Depression, Depression, Obesity, Hypertension (HTN), Hyperlipidemia Behavioral Problems including Hallucinations, Osteoarthrosis and Osteoporosis.

A Global Deterioration Scale (GDS) was completed on 8-5-13 and staged Tenant #1 at six, which indicated severe cognitive decline. Tenant #1 resided in the dementia unit.

Service notes of 1-23-13 through 6-2-13 indicated no entries related to a change in condition to Tenant #1's buttocks. Tenant #1 was prescribed Calmoseptine ointment on 2-21-11 – apply topically to buttock as needed for redness. Pharmacy records indicated Calmoseptine ointment was ordered and delivered on 4-2-13, 6-18-13 and 6-27-13. Medication Administration Records (MARs) for June through August, 2013 indicated Calmoseptine ointment had not been administered.

Service notes of 6-3-13 indicated Tenant #1 became shaky and appeared weak. A functional evaluation of 6-3-13 indicated Tenant #1was independent with activities of daily living (ADLs) including, ambulation, transfer, dressing, grooming and eating, was incontinent of urine and needed assistance with toileting. A physical evaluation of the same date indicated Tenant #1's skin integrity was clammy, moist and intact. No other entries were noted related to additional care needs.

Service notes of 6-3-13 indicated Tenant #1 was transported by emergency medical services (EMS) to a hospital emergency room and was later admitted for 23-hour observation. Service notes of 6-4-13 indicated Tenant #1 returned to the Program the next day. Service notes of the same entry indicated Tenant #1 continued to have discoloration to buttocks. A physical evaluation of 6-4-13 indicated Tenant #1's skin integrity was fragile, dry and the buttocks was breaking down. A cognitive evaluation of 6-4-13 indicated a GDS of five, which indicated moderately severe cognitive decline. No other entries related to skin care was noted.

An incident report of 6-20-13 indicated Tenant #1 was found on the floor and had an orange size hematoma located on the forehead. EMS was called and Tenant #1 was transported to hospital emergency room for evaluation and treatment. Hospital emergency records indicated Tenant #1 was treated for a closed head injury and returned to the Program. The attending physician ordered Tylenol and ice packs to be applied to the hematoma. The attending physician also notified the Program of Tenant #1's skin breakdown to the coccyx area

A physical evaluation was completed on 6-20-13 and indicated edema to lower extremities and Tenant #1's skin was dry, but the buttocks were discolored, fragile with scattered superficial open areas. Calmoseptine as needed (prn) was noted as applied. A functional evaluation of the same dated indicated a change in functional status, as Tenant #1 needed assistance with ADLs, including assistance with dressing, grooming, was incontinent occasionally two or more times per week and needed assistance with toileting, was one-staff assist with transfer and assistance with eating, but was independent with ambulation. No other entries related to skin care was noted.

Service notes of 7-9-13 indicated Tenant #1 had superficial open area on buttocks. A physical evaluation of 7-9-13 indicated Tenant #1's buttocks were reddened with two areas (one on each side of the buttocks) less than one centimeter in diameter which was superficial. A functional evaluation of the same date indicated a change in functional status as Tenant #1 required routine two-staff assist with transfers, was independent with ambulation and was incontinent daily. No other entries related to skin care was noted.

A physical evaluation completed on 7-11-13 at 2:00 p.m. indicated Tenant #1's buttocks were reddened and four superficial open areas on right buttocks – four centimeters in diameter and three open areas on the left buttocks – six centimeters in diameter. It was also noted that Duoderm was applied.

MARs for July 2013 indicated Duoderm was transcribed and dated 7-16-13 by the Program nurse. Pharmacy records indicated the Program received two boxes-containing five each of 4x4 centimeter patches on 7-15-13 and 7-24-13. MARs for July, 2013 indicated Duoderm was initially applied on 7-16-13.

Tenant #1's file indicated a physician's telephone order was completed by the Program nurse on 7-11-13 at 2:30 p.m. The telephone order listed the primary provider as an advanced registered nurse practitioner (ARNP), and instructed to apply Duoderm to open area and change every three days and prn. This telephone order was voided and a second telephone order was completed by the Program nurse. The second telephone order written included the same elements as the first.

The ARNP was interviewed and reported her last contact with the Program was 5-3-13 related to drawing blood samples for an appointment with a geriatric physician. The ARNP reported she had no recollection of giving a phone order for Duoderm placement. She had also reviewed the task list (which identifies any correspondence) from the medical records and none was noted.

The Program nurse reported it was the Program's policy to send telephone orders to the physician/provider for their signature after the telephone order was given. The telephone order written by the Program nurse on 7-11-13 had not been signed by the ARNP. No explanation was given as to why the order from the ARNP for Duoderm had not been sent to the ARNP for her signature.

Service notes of 7-29-13 indicated evaluations were completed as Tenant #1 had an elevated temperature of 100.4 degrees Farenheit (F) and had experienced "extra" weakness. A physical evaluation of 7-29-13 indicated Tenant #1 was unable to communicate needs and had opened areas that were superficial. A functional evaluation was completed on the same day and indicated Tenant #1 needed supervision with ambulation.

Service notes of 7-29-13 indicated Tenant #1 was not able to stand independently and was sent a hospital emergency room for evaluation. Hospital emergency records indicated the Program reported Tenant #1 had not voided for the last eight hours and was unable to ambulate the last couple of days. Tenant #1 returned to the program the same day.

Service notes o 7-30-13 indicated the Program nurse spoke to a skilled nursing facility for possible evaluation and placement. Service notes of 8-1-13 indicated Tenant #1 was evaluated by a skilled nursing facility and would be admitted once an opening existed. A physical evaluation of 8-5-13 noted a pressure area was on the left coccyx, approximately two centimeters by two centimeters by one centimeter in size, with smooth educes, no swelling or heat noted at site. An "interior wound bed red," with "string of slough noted." A functional evaluation of 8-5-13 indicated Tenant #1 was no longer ambulatory, used a wheel-chair and staff was to transport. Tenant #1 required total care with dressing, grooming and toileting and required two staff to routinely transfer. A cognitive evaluation of the same date indicated Tenant #1's GDS was staged at six, which indicated severe cognitive decline.

Service notes of 8-5-13 indicated the Program nurse changed the Duoderm on Tenant #1's buttocks earlier in the day and noted a small slit – approximately .4 centimeters x .1 centimeters on left side of buttocks and blood was present on a disposable brief. Tenant #1 continued to be incontinent of bowel and bladder.

Later the same day, staff reported Tenant #1's Duoderm was off. The Program nurse noted Tenant #1 had an opened area approximately two centimeters by two centimeters by two centimeters in size. The Program nurse called Tenant #1's ARNP and "voiced concern that Tenant #1's wound may be tunneling and undermining." Service notes of the same entry reported the ARNP would evaluate the following day.

Service notes of the same entry indicated Tenant #1 was resting in bed on his/her right side without pressure to the coccyx. The bed was at the lowest position possible and a large body pillow and comforter was placed on each side of the bed. "Tenant #1 was to "stay off coccyx with frequent position changes."

Service notes of 8-6-13 indicated Tenant #1's wounds on buttocks had opened to approximately nine centimeters by five centimeters and wound bed was pink. "Bloody drainage noted on diaper." No odor, swelling or heat was noted. Tenant #1's ARNP arrived and reported Tenant #1 needed intravenous antibiotics and further assessment at a hospital. Tenant #1 was transported by ambulance to a hospital emergency room for evaluation.

Hospital records of 8-6-13 indicated a large Decubitus Ulcer was noted over the coccyx. A superficial Erythematous area measured approximately eight centimeters in diameter with open central area which was one-and a-quarter inch in length and one-half inch deep with one-inch tunneling located at 12-oclock. Hospital laboratory results indicated Tenant #1 was positive for Methicillin Resistance Staphylococcus Aureus (MRSA). Tenant #1 was admitted to the hospital with admitting diagnoses of Fever, Decubitus Ulcer/Pressure Ulcer in the Sacral area, Antibiotic Therapy and a Urinary Tract Infection.

Tenant #1's ARNP was interviewed and reported as a registered nurse and an advanced registered nurse practitioner Tenant #1's wound developed over several weeks and would have expected to be sooner when the wound was developing. Pressure ulcers develop due to lack of turning and/or the lack of changing incontinent briefs. Tenant #1 did not have the mental capacity to care for himself/herself and relied on staff to assist with his/her needs. The ARNP reported prior to her visit of 8-6-13, she last saw Tenant #1 on 5-3-13.

Hospital registered nurse (RN) – (HRN#1), certified in wound care was interviewed and reported the following. Tenant #1's wounds were located on the coccyx and sacrum and extended to bilateral buttocks, covering tissue where Tenant #1 would have pressure due to prolonged sitting as the wound area extended to the entire sitting area. It was noted there was peeling skin anterior and medial to the large open wound, indicating Tenant #1 was sitting on feces and urine for extended periods of time. Tenant #1 had eight wounds medial to left buttock (not including the large wound noted earlier) with slough noted in these areas progress to one large opening. This area was considered an unstageable Decubitus area.

Medial, anterior to this area located on the left buttock was an open stage four Decubitus wound which was surrounded by reddened tissue, anterior to bony prominence located anterior to the open wound, extending skin breakdown to bilateral buttocks. The open wound had yellow thick adhering slouth coming out of the wound, covering 100% of the wound. These wounds indicated Tenant #1 was having skin breakdown for at least four to six weeks or longer.

HRN #1 reported Tenant #1's wounds indicated he/she was not provided with a standard of care which would have included daily frequent repositioning, fluid intake, and assistance with eating, incontinence care and daily skin assessment.

Tenant #1 was admitted to hospice with admitting diagnoses of Decubitus Ulcer and Dementia while hospitalized and was discharged from the hospital on 8-9-13 to a skilled nursing facility,

The Program nurse completed evaluations which initially indicated skin breakdown beginning 6-3-13, degradation of skin integrity on 6-20-13, 7-11-13, 7-29-13 and 8-5-13 in addition to a change in status related to ADLs, including the need for two staff to routinely transfer Tenant #1 beginning 7-29-13. The Program nurse completed evaluations, documenting a significant change in health status but did not evaluate eligibility to reside at the Program related to whether the Program could provide the needed cares and did not adequately provide additional services as needed by referring to Tenant #1's provider for assessment related to the open wounds on the buttocks.

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

Monitoring Observation: Seven tenant files were reviewed (including Tenant #1). No issues were found related to evaluations for Tenants #2, #5, #6 and #7.

During staff interviews, Staff #2 reported Tenant #3 and #4 had been "sexual together", but couldn't be specific as she had not witnessed any events. Staff #4 was interviewed and reported Tenant #3 and #4 would often sit together and hold hands. Staff #5 was interviewed and reported Tenant #4 was flirting and sexually inappropriate with the opposite sex. She was directed to check where Tenant #3 and #4 were during daytime hours and Tenant #3 and #4 were not to have any personal time together. Both Staff #2 and #5 had no additional information.

The Administrator was interviewed and reported the Program nurse had reported staff had found Tenant #3 was Tenant #4 lying together in Tenant #3's bed.

The Administrator was unsure of when this incident occurred. She reported she understood both Tenant #3 and #4 had wanted to engage in sexual intercourse. Staff had reported that both tenants had been seen holding hands frequently while in the common area. Two staff had been assigned for both the day and evening shift after this incident occurred. Staff was to check on each tenant's whereabouts during this time.

The Program nurse was interviewed and reported around 6-4-13 staff had called her regarding concerns of an incident or sexual behavior between Tenant #3 and Tenant #4. She arrived to find Tenant #3 with his/her pants pulled down and his/her genitals were seen. Tenant #4's pants were down and Tenant #4 was lying adjacent to Tenant #3. Tenant #4 was attempting to get on top.

The Program nurse assisted Tenant #4 out of bed and staff escorted Tenant #4 to his/her apartment. Following this incident two staff were scheduled for the day and evening shift. Staff was directed to be diligent with watching both tenants. At times Tenant #3's apartment was locked to keep Tenant #4 from going into Tenant #3's apartment.

Tenant #3, an 87 year old, was admitted on 3-13-13 and had diagnoses of: Dementia, HTN, A history of a Hip Fracture, Hiatal Hernia and Benign Prostatic Hypertrophy. A GDS was completed on 6-11-13 and staged Tenant #3 at four, which indicated moderate cognitive impairment. Tenant #3 was independent with most ADLs, needing assistance with grooming and dressing. Tenant #3 resided in the dementia unit.

Service notes of 4-29-13 and 5-6-13 indicated Tenant #3 was wandering throughout the unit and was exit seeking. Evaluations of 5-3-13 indicated Tenant #3 was wandering but did not address incidents of exit seeking and inappropriate sexual behavior. On 6-11-13 Tenant #3's family sought placement in another facility.

Tenant #4, a 78 year old, was admitted on 10-7-11 and had diagnoses of: Congestive Heart Failure, Dementia and Hyperlipidemia. A GDS completed on 7-8-13 staged Tenant #4 at three, which indicated mild cognitive decline. Tenant #4 resided in the dementia unit. Tenant #4 was independent with most ADLs but needed assistance with bathing.

A functional evaluation of 7-8-13 indicated Tenant #4 was verbally and physically aggressive one to three times weekly. A review of service notes and staff interviews noted to incidents of physical aggression.

Service notes indicated a late entry was made on 6-28-13 and indicated Tenant #4 was exit seeking. Evaluations of 7-8-13 did not address incidents of exit seeking and inappropriate sexual behavior. On 8-1-13 Tenant #4 was discharged from the program.

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 services 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))

**B. Service Plan**

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

Monitoring Observation: Seven tenant files were reviewed and no issues were found related to service plans for Tenant #5, #6 and #7.

Tenant #1's service notes of 6-3-13 indicated Tenant #1 became shaky and appeared weak. Tenant #1's service notes of 6-3-13 indicated Tenant #1 was transported by EMS to a hospital emergency room and was later admitted for 23-hour observation. Service notes of 6-4-13 indicated Tenant #1 continued to have discoloration to buttocks.

A physical evaluation of 6-4-13 indicated Tenant #1's skin integrity was fragile, dry and the buttocks were breaking down. No other entries related to skin care was noted. A cognitive evaluation of 6-4-13 indicated a GDS of five, which indicated moderately severe cognitive decline.

The service plan of 2-21-13 was updated on 2-28-13 to include staff assist with indicated Tenant #1 required staff assistance with ADLs, including bathing, dressing and intermittent assistance with toileting but could be left alone. The service plan did not establish interventions related to skin breakdown of the buttocks and a change in cognition. The service plan was not signed by Tenant #1 or by Tenant #1's representative.

An incident report of 6-20-13 indicated Tenant #1 was found on the floor and had an orange size hematoma located on the forehead. EMS was called and Tenant #1 was transported to hospital emergency room for evaluation and treatment. Hospital emergency records indicated Tenant #1 was treated for a closed head injury and returned to the Program. The attending physician ordered Tylenol and ice packs to be applied to the hematoma. The attending physician also notified the Program of Tenant #1's skin breakdown to the coccyx area

A physical evaluation was completed on 6-20-13 and indicated edema to lower extremities and Tenant #1's skin was dry, but the buttocks were discolored, fragile with scattered superficial open areas. Calmoseptine was noted to be used prn. A functional evaluation of the same dated indicated a change in functional status, as Tenant #1 needed assistance with ADLs, including assistance with dressing, grooming, was incontinent occasionally two or more times per week and needed assistance with toileting, one-staff assist with transfer and assistance with eating. No other entries related to skin care was noted.

The service plan of 2-28-13 was updated on 6-20-13 and directed staff to apply an ice pack to the forehead three-to-four times daily for swelling, but did not establish interventions related to one-staff assist with transfer, assistance with eating and skin care to the buttocks. The service plan was not signed by Tenant #1 or Tenant #1's representative.

Service notes of 7-9-13 indicated Tenant #1 had superficial open area on buttocks. A physical evaluation of 7-9-13 indicated Tenant #1's buttocks were reddened with two areas (one on each side of the buttocks) less than one centimeter in diameter which was superficial. A functional evaluation of the same date indicated a change in functional status as Tenant #1 required routine two-staff assist with transfer, was independent with ambulation and was incontinent daily. No other entries related to skin care was noted.

A physical evaluation was completed on 7-11-13 at 2:00 p.m. and indicated Tenant #1's buttocks were reddened and four superficial open areas on right buttocks – four centimeters in diameter and three open areas on the left buttocks – six centimeters in diameter. It was also noted that Duoderm was applied.

The service plan of 6-20-13 was updated on 7-9-13 and included interventions directing staff to toilet Tenant #1 every two-to-three hours, to stand and move every one-to-two hours for prevention of skin breakdown, but did not establish interventions to provide routine two-staff assist with transfer. The Program was not able to provide documentation of staff toileting Tenant #1 every two-to-three hours.

Tenant #1's file indicated a physician's telephone order was completed by the Program nurse on 7-11-13 at 2:30 p.m. and instructed to apply Duoderm to open area and change every three days and prn. MARs for July, 2013 indicated Duoderm was initially applied on 7-16-13.

A physical evaluation of 7-29-13 indicated Tenant #1 was unable to communicate needs and had opened areas to the buttocks that were superficial. A functional evaluation was completed on the same day and indicated Tenant #1 needed two-staff assist with transfer and used a wheelchair for mobility.

Service notes of 7-29-13 indicated Tenant #1 was not able to stand independently and was sent a hospital emergency room for evaluation. Hospital emergency records indicated the Program reported Tenant #1 had not voided for the last eight hours and was unable to ambulate the last couple of days. Tenant #1 returned to the program the same day.

The service plan of 7-9-13 was not updated to include interventions directing staff to use a wheelchair for mobility, to provide routine two-staff assist with transfer and to report incidents of infrequent urination.

Service notes of 8-5-13 indicated the Program nurse changed the Duoderm on Tenant #1's buttocks earlier in the day and noted a small slit – approximately .4 centimeters x .1 centimeters on left side of buttocks and blood was present on a disposable brief. Tenant #1 continued to be incontinent of bowel and bladder.

A physical evaluation of 8-5-13 noted a pressure area was on the left coccyx, approximately two centimeters by two centimeters by one centimeter in size, with smooth educes, no swelling or heat noted at site. An "interior wound bed red," with "string of slough noted." A functional evaluation of 8-5-13 indicated Tenant #1 was no longer ambulatory, used a wheel-chair and staff was to transport. Tenant #1 required total care with dressing, grooming and toileting and required two staff to routinely transfer.

A cognitive evaluation of the same date indicated Tenant #1's GDS was staged at six, which indicated severe cognitive decline.

Later the same day, staff reported Tenant #1's Duoderm was off. The Program nurse noted Tenant #1 had an opened area approximately two centimeters by two centimeters by two centimeters in size. The Program nurse called Tenant #1's ARNP and "voiced concerns that Tenant #1's wound may be tunneling and undermining." Service notes of the same entry reported the ARNP would evaluate the following day.

Service notes of 8-5-13 indicated Tenant #1 was resting in bed on his/her right side without pressure to the coccyx. The bed was at the lowest position possible and a large body pillow and comforter was placed on each side of the bed. "Tenant #1 was to "stay off coccyx with frequent position changes."

Service notes of 8-6-13 indicated Tenant #1's wounds on buttocks had opened to approximately nine centimeters by five centimeters and wound bed was pink. "Bloody drainage noted on diaper." No odor, swelling or heat noted. Tenant #1's ARNP arrived and reported Tenant #1 needed intravenous antibiotics and further assessment at a hospital. Tenant #1 was transported by ambulance to a hospital emergency room for evaluation.

The service plan of 7-9-13 was not updated to include interventions related to ambulatory status, total care with most ADLs; two staff assistance with transfer and frequent repositioning. The Program was not able to provide documentation when staff provided frequent position changes.

Tenant #2, a 76 year old, was admitted on 5-17-13 and had diagnoses of: Dementia, Anxiety and a History of Urinary Tract Infections. A GDS was completed on 8-23-13 and staged Tenant #2 at four, which indicated moderate cognitive decline. Tenant #2 resided in the dementia unit.

Service notes of 8-19-13 indicated staff reported Tenant #2 had increased anxiety and confusion. A urinalysis (UA) was ordered and results obtained on 8-20-13 indicated a urinary tract infection (UTI). Antibiotic (ATB) therapy 250mg daily for 10 days was initiated on 8-23-13.

Service notes of 8-23-13 indicated Tenant #2 had increased incontinence, confusion and anxiety. A functional evaluation was completed on 8-23-13 and indicated Tenant #2 was incontinent routinely and required intermittent assistance with toileting. Tenant #2 wandered one to three times weekly.

Tenant #2's service plan was updated on 8-23-13 and indicated Tenant #2 was on ATB therapy, for staff encourage Tenant #2 to drink more fluids and to take Tenant #2's temperature daily. The service plan indicated Tenant #2 was independent with toileting. Staff #1, #2, #3 and #4 reported Tenant #2 wandered throughout the Program looking for his/her spouse.

The service plan of 8-23-13 established interventions related to ATB therapy and for staff to monitor temperature and increase fluid intake. However, the service plan did not establish interventions related to monitoring for increased confusion and anxiety and wandering. The service plan indicated Tenant #2 was independent with toileting despite an evaluation which indicated Tenant #2 needed assistance with toileting. The service plan was signed by the nurse but was not signed by Tenant #2 or his/her legal representative.

During staff interviews, Staff #2 reported Tenant #3 and #4 had been sexual together, but couldn't be specific as she had not witnessed any events. Staff #4 was interviewed and reported Tenant #3 and #4 would often sit together and hold hands. Staff #5 was interviewed and reported Tenant #4 was flirting and sexually inappropriate with the opposite sex. She was directed to check where Tenant #3 and #4 were during daytime hours and Tenant #3 and #4 were not to have any personal time together. Both Staff #2 and #5 had no additional information.

The Administrator was interviewed and reported the Program nurse had reported staff had found Tenant #3 with Tenant #4 lying together in Tenant #3's bed. The Administrator was unsure of when this incident occurred. She reported she understood both Tenant #3 and #4 had wanted to engage in sexual intercourse. Staff had reported that both tenants had been seen holding hands frequently while in the common area. Two staff had been assigned for the both the day and evening shift after this incident occurred. Staff was to check on each tenant's whereabouts during this time.

The Program nurse was interviewed and reported around 6-4-13 staff had called her regarding concerns of an incident or sexual behavior between Tenant #3 and Tenant #4. She arrived to find Tenant #3 with his/her pants pulled down and his/her genitals were seen. Tenant #4's pants were down and Tenant #4 was lying adjacent to Tenant #3 and attempting to get on top.

The Program nurse assisted Tenant #4 out of bed and staff escorted Tenant #4 to his/her apartment. Following this incident two staff were scheduled for the day and evening shift. Staff was directed to be diligent with watching both tenants. At times Tenant #3's apartment was locked to keep Tenant #4 from going into Tenant #3's apartment.

Tenant #3's service notes of 4-29-13 and 5-6-13 indicated Tenant #3 was wandering throughout the unit and was exit seeking. Evaluations of 5-3-13 indicated Tenant #3 was wandering but did not address incidents of exit seeking and inappropriate sexual behavior. The service plan of 5-3-13 and 6-11-13 did not include interventions related to behaviors of wandering, exit seeking or the inappropriate sexual behavior.

Tenant #4's functional evaluation of 7-8-13 indicated Tenant #4 was verbally and physically aggressive one to three times weekly. Service notes indicated a late entry was made on 6-28-13 and indicated Tenant #4 was exit seeking. The service plan of 4-12-13 was not updated to include interventions related to exit seeking and inappropriate sexual behavior.

Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30days 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. (IAC r. 481-69.26(4) (a))

**C. Tenant Rights**

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

Monitoring Observation: Seven tenant files were reviewed and no issues were found related to tenant rights for Tenants #2, #5, #6 and #7.

Tenant #1's evaluations of 6-3-13, 6-20-13, 7-11-13, 7-29-13 and 8-5-13 indicated a degradation of skin integrity of Tenant #1's buttocks, resulting a significant change in status. A telephone order of 7-11-13 ordering Duoderm to be placed on Tenant #1's buttocks every three days was not substantiated by the ARNP. The ARNP was interviewed and reported she was not aware of nor did records indicated an order for Duoderm had been given.

Service notes of 8-6-13 indicated Tenant #1's wounds on buttocks had opened to approximately nine centimeters by five centimeters and wound bed was pink. "Bloody drainage noted on diaper." No odor, swelling or heat noted. Tenant #1's ARNP arrived and reported Tenant #1 needed intravenous antibiotics and further assessment at a hospital. Tenant #1 was transported by ambulance to a hospital emergency room for evaluation.

The service plan of 2-28-13 was updated on 6-20-13, but didn't include interventions related the skin breakdown on Tenant #1's buttocks. The service plan of 7-9-13 was not updated to include interventions related to ambulatory status, total care with most ADLs; two staff assisted with transfer and frequent repositioning as documented in service notes. The Program was not able to provide documentation when staff provided frequent position changes.

Tenant #1 was prescribed Calmoseptine ointment on 2-21-11 – apply topically to buttock as needed for redness. Pharmacy records indicated Calmoseptine ointment was ordered and delivered on 4-2-13, 6-18-13 and 6-27-13. Medication Administration Records (MARs) for June through August, 2013 indicated Calmoseptine ointment had not been administered.

Hospital records of 8-6-13 indicated a large Decubitus Ulcer was noted over the coccyx. A superficial Erythematous area measured approximately eight centimeters in diameter with open central area which was one-and a-quarter inch in length and one-half inch deep with one-inch tunneling located at 12-oclock. Hospital laboratory results indicated Tenant #1 was positive for Methicillin Resistance Staphylococcus Aureus (MRSA). Tenant #1 was admitted to the hospital with admitting diagnoses of Fever, Decubitus Ulcer/Pressure Ulcer in the Sacral area, Antibiotic Therapy and a Urinary Tract Infection.

Tenant #1's ARNP was interviewed and reported as a registered nurse and an advanced registered nurse practitioner Tenant #1's wound developed over several weeks and would have expected to be sooner when the wound was developing.

Pressure ulcers develop due to lack of turning and/or the lack of changing incontinent briefs. Tenant #1 did not have the mental capacity to care for himself/herself and relied on staff to assist with his/her needs. The ARNP reported prior to her visit of 8-6-13, she last saw Tenant #1 on 5-3-13.

Hospital registered nurse (RN) – (HRN#1), certified in wound care was interviewed and reported the following. Tenant #1's wounds were located on the coccyx and sacrum and extended to bilateral buttocks, covering tissue where Tenant #1 would have pressure due to prolonged sitting as the wound area extended to the entire sitting area. It was noted there was peeling skin anterior and medial to the large open wound, indicating Tenant #1 was sitting on feces and urine for extended periods of time. Tenant #1 had eight wounds medial to left buttock (not including the large wound noted earlier) with slough noted in these areas progress to one large opening. This area was considered an unstageable Decubitus area.

Medial, anterior to this area located on the left buttock was an open stage four Decubitus wound which was surrounded by reddened tissue, anterior to bony prominence located anterior to the open wound, extending skin breakdown to bilateral buttocks. The open wound had yellow thick adhering slouth coming out of the wound, covering 100% of the wound. These wounds indicated Tenant #1 was having skin breakdown for at least four to six weeks or longer.

HRN #1 reported Tenant #1's wounds indicated he/she was not provided with a standard of care which would have included daily frequent repositioning, fluid intake, and assistance with eating, incontinence care and daily skin assessment.

The Program did not receive appropriate care and treatment related to his/her degradation of skin integrity leading to a Stage four Decubitis Ulcer. The Program did not receive services which were adequate and appropriate.

Tenant #3 and #4 resided in the dementia unit. Tenant #3 had a GDS of four, which indicated moderate cognitive decline. Tenant #4 had a GDS of three, which indicated mild cognitive impairment.

During staff interviews, Staff #2 reported Tenant #3 and #4 had been sexual together, but couldn't be specific as she had not witnessed any events. Staff #4 was interviewed and reported Tenant #3 and #4 would often sit together and hold hands. Staff #5 was interviewed and reported Tenant #4 was flirting and sexually inappropriate with the opposite sex.

The Administrator reported staff had found Tenant #3 with Tenant #4 lying together in Tenant #3's bed. The Administrator was unsure of when this incident occurred. She reported she understood both Tenant #3 and #4 had wanted to engage in sexual intercourse. Staff had reported that both tenants had been seen holding hands frequently while in the common area.

The Program nurse was interviewed and reported around 6-4-13 staff had called her regarding concerns of an incident or sexual behavior between Tenant #3 and Tenant #4. She arrived to find Tenant #3 with his/her pants pulled down and his/her genitals were seen. Tenant #4's pants were down and Tenant #4 was lying adjacent to Tenant #3 and attempting to get on top.

Tenant #3's and #4's cognitive impairment was unequal and the Program did not ensure either tenant's safety related to each tenant's sexual behavior.

Regulatory Insufficiency: All tenants have the following rights: 1. to receive care, treatment and services which are adequate and appropriate. (IAC r. 481.67(1))

Regulatory Insufficiency: All tenants have the following rights. 1. To be treated with consideration, respect and full recognition of personal dignity and autonomy. 4. To be free from mental and physical abuse. (IAC r. 481-67.3 (1)(4))

**D. Structural requirements**

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

Monitoring Observation: A tour of the dementia unit on 8-22-13 revealed the monitors observed the dementia unit medication room door was unlocked and accessible to tenants located in the dementia unit. Inside the medication room another door leading to a maintenance closet was propped open with a cleaning cart. The cleaning cart had bottles of cleaning chemicals accessible to tenants with dementia.

Apartment 265 was unlocked and vacant. Upon inspection a bottle of Betadine was found in the bathroom.

Apartment 263 was unlocked and vacant. Upon inspection a bottle of Lysol spray was found in the bathroom.

Chemicals unsecured in the maintenance closet included the following:

| Chemical | Material Safety Data Sheet Warning |
|---|---|
| Ethyl Alcohol 16% Hand sanitizer | Eye irritant, harmful if swallowed |
| One bottle of Isopropyl Alcohol 70% | Vapor irritant to respiratory and CNS depression |
| Three bottles of Foamy Mac 4 Cleaner | Burning upon contact, Harmful or fatal if swallowed |
| One bottle Pet Formula Upholstery Cleaner | No MSDS was available |
| One bottle of Century Q256 – Disinfectant Cleaner | Corrosive, Irreversible eye damage and harmful or fatal if swallowed |
| Two bottles Ready to use All Purpose Cleaner | Alkaline cleaner Hazardous to eyes and skin |
| Provon foaming hand soap | Causes eye irritation Can cause upset stomach and nausea |
| One can of GTS Foaming Disinfectant Spray | Can cause Pneumonitis if aspirated into lungs May cause asphyxia, anesthetic effect and possible unconsciousness |
| Four bottles of Multi-clean Multi-shine | Harmful if swallowed, Skin irritation upon |

| | |
|---|---|
| Glass and Window Cleaner | contact |
| Two cans of Clorox Disinfectant Spray | Vapors harmful or fatal Minor irritation to mouth. Ingestion may result in ethanol intoxication |
| One bottle of 950 Bowel Cleaner | Causes severe burns to eyes and skin Harmful or fatal if swallowed |
| One spray bottle of Stainless Steel Cleaner and Polish | Severe irritation to eyes, skin |
| One bottle of Soft Soap (hand soap) | No MSDS sheet available |
| One can of Hair Spray | No MSDS sheet available |
| One box of Tide Laundry Detergent | Gastrointestinal irritation, vomiting, diarrhea. May cause stinging, tearing, itching and swelling of they eyes |
| Lysol Brand Disinfectant Spray | Contains denatured ethanol- if swallowed may result in ethanol poisoning. Causes moderate eye irritation |
| Betadine Antiseptic Solution | Contains Iodine and Glycerol – Harmful if swallowed |

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

**E. Policies and Procedures**

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

Monitoring Observation: A tour of the dementia unit on 8-22-13 revealed the monitors observed the dementia unit medication room door was unlocked and accessible to tenants located in the dementia unit. Inside the medication room another door leading to a maintenance closet was propped open with a cleaning cart. The cleaning cart had bottles of cleaning chemicals accessible to tenants with dementia.

Staff #1 was working in the dementia unit and reported she had unlocked the medication room door during her shift. The Administrator reported the Program did not have a policy or procedure related to keeping the medication room secured.

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(1))

**F. Tenant Documents**

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

Monitoring Observation: Review of Tenant #1's clinical record revealed a physical evaluation was completed on 6-20-13 and noted Tenant #1's buttocks were discolored, fragile with scattered superficial open areas. Calmoseptine was noted as applied to Tenant #1's buttocks.

Calmoseptine ointment was prescribed on 2-21-11 and was to be applied topically to buttock as needed for redness. Pharmacy records indicated Calmoseptine ointment was ordered and delivered on 4-2-13, 6-18-13 and 6-27-13. Medication Administration Records (MARs) for June through August, 2013 indicated Calmoseptine ointment had not been administered.

An incident report of 6-20-13 indicated Tenant #1 was found on the floor and had an orange size hematoma located on the forehead. EMS was called and Tenant #1 was transported to hospital emergency room for evaluation and treatment. Hospital emergency records indicated Tenant #1 was treated for a closed head injury and returned to the Program. The attending physician ordered Tylenol and ice packs to be applied to the hematoma. No documentation was found which indicated ice packs were applied.

A physical evaluation completed on 7-11-13 at 2:00 p.m. indicated Tenant #1's buttocks were reddened and four superficial open areas on right buttocks – four centimeters in diameter and three open areas on the left buttocks – six centimeters in diameter. It was noted that Duoderm was applied.

MARs for July 2013 indicated Duoderm was transcribed and dated 7-16-13 by the Program nurse. Pharmacy records indicated the Program received two boxes-containing five each of 4x4 centimeter patches on 7-15-13 and 7-24-13. MARs for July, 2013 indicated Duoderm was initially applied on 7-16-13. No documentation was found which indicated Duoderm had been applied on 7-11-13.

Service notes of 8-5-13 indicated Tenant #1 was resting in bed on his/her right side without pressure to the coccyx. The bed was at the lowest position possible and a large body pillow and comforter was placed on each side of the bed. "Tenant #1 was to "stay off coccyx with frequent position changes." No documentation was found which indicated Tenant #1 was repositioned.

During staff interviews, Staff #2 reported Tenant #3 and #4 had been sexual together, but couldn't be specific as she had not witnessed any events. Staff #4 was interviewed and reported Tenant #3 and #4 would often sit together and hold hands. Staff #5 was interviewed and reported Tenant #4 was flirting and sexually inappropriate with the opposite sex.

The Administrator reported staff had found Tenant #3 with Tenant #4 lying together in Tenant #3's bed. The Administrator was unsure of when this incident occurred. She reported she understood both Tenant #3 and #4 had wanted to engage in sexual intercourse. Staff had reported that both tenants had been seen holding hands frequently while in the common area.

The Program nurse was interviewed and reported around 6-4-13 staff had called her regarding concerns of an incident or sexual behavior between Tenant #3 and Tenant #4. She arrived to find Tenant #3 with his/her pants pulled down and his/her genitals were seen. Tenant #4's pants were down and Tenant #4 was lying adjacent to Tenant #3 and attempting to get on top. A review of program records indicated an incident report had not been completed related to the incident involving Tenant #3 and #4.

Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record. q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs.) (IAC r.481-69.25(1)(o,q))

**G. Life Safety**

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

Monitoring Observation: During a tour of the dementia unit on 8-22-13, at approximately 11:00 a.m. monitors noted the exit doors in the dementia unit were not locked and did not have a delay egress. The Administrator reported the exit doors to the dementia unit had never been alarmed and the delayed egress had never worked.

It was later determined the Program used a Wander Guard system, whereas, each tenant residing in the dementia unit wore a pendant which activated the exit door locks and delayed egress and staff were notified via pagers of a tenant who attempted to leave the unit through an exit door. Upon inspection of the exit doors to the courtyard there was no Wander Guard system in place to alarm when tenants attempted to go into the courtyard. Tenants were able to get outside into the courtyard without staff's knowledge.

The dementia unit had an external courtyard with an exit gate. The exit gate was locked with a combination lock. Staff #1, #2, #3, #4 and #5 reported they didn't know the combination to unlock the gate.

As monitors were leaving the unit through an exit door Tenant #2 walked within 10 feet from the exit door but the Wander guard did not activate. Both monitors were able to exit the unit, as the exit door did not lock and the delayed egress did not engage. Staff immediately redirected Tenant #2 away from the exit door.

The Administrator reported the Program did not have a policy or procedure for routinely monitoring the exterior door alarms and paging systems. The Program did not have a policy or procedure establishing guidelines when staff was to check placement and activation of the Wander-guard security devices tenant's wore.

Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have: written procedures regarding alarm systems and appropriate staff response when a tenant's service plan indicates a risk of elopement or a tenant exhibits wandering behavior. (IAC r.481-69.32(2)(a))