IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 45101-C
45278-C
44432-CR1
44725-IR1

December 26, 2013

Ms. Mary Katherine Harris, RN Manager
Oakwood Place Assisted Living
4126 Northwest Blvd.
Davenport, IA 52806

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

Dear Ms. Harris:

I. Final First Revisit and Complaint/Incident Investigation Report – Oakwood Place Assisted Living, Davenport, IA

Enclosed is the **Final First Revisit and 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 **October 28 & 29, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Criteria for Admission and Retention, Tenant Rights, Evaluations and Service Plans..

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

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

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

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

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of Criteria for Admission and Retention, Tenant Rights, Evaluations and Service Plans.

The determination of a **$2,500 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Criteria for Admission and Retention, Tenant Rights, Evaluation, Service Plans, Compliance with Plan of Correction, and Structural Requirements. As the enclosed Report details, the Program failed to comply with regulatory requirements in the areas of Criteria for Admission and Retention, Tenant Rights, and Service Plans for Tenant #3. The Program has also failed to follow regulatory requirements in the area of Evaluations for Tenants #5 and #8.

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 **one thousand six hundred twenty five dollars ($1,625)** within 30 days after the notice or service of this demand letter.

III. Appeals/Hearings

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

IV. Conclusion

The Program is being assessed a **$2,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Plan of Correction (POC) submitted on December 5, 2013, has been reviewed and will constitute the final POC related to the on-site visit of October 28 & 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 First Revisit and Complaint/Incident Investigation Report

Assisted Living Program:

Mary Katherine Harris, RN Manager
Oakwood Place Assisted Living
4126 Northwest Blvd.
Davenport, Iowa 52806

Complaint/Incident Intake #:

45101-C
45278-C
44432-CR1
44725-IR1

Date of Complaint/Incident Investigation:

October 28 and 29, 2013

Monitor(s):

Maribeth Freland RN
Margaret Kaltefleiter RN

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

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

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

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

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	34
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	38

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	10
Total Population of Program at time of on-site	11
TOTAL census of Assisted Living Program	49

Program History – The program received regulatory insufficiencies in the area of Food Service, Evaluations, Service Plans, Nurse Review, Criteria for Admission and Retention and Life Safety, Tenant Rights, Policy Procedure, Structural and Following the Plan of Correction during this certification period.

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

A. Criteria for Admission and Retention

Complaint/Incident Allegation: 45278-C- It was alleged a tenant resided in the program's secured dementia unit and exhibited chronic elopement attempts and physically aggressive behaviors toward staff members and other tenants that had been occurring for longer than one month. 45101-C- It was alleged a tenant resided in the program's secured dementia unit and exhibited chronic elopement attempts and physically aggressive behaviors toward staff members and other tenants that had been occurring for longer than one month. It was also alleged the RN Manager had been admitting tenants who required assistance with bathing, toileting, dressing and ambulation. It was also alleged the RN Manager was allowing tenants to reside in the program who were incontinent of urine and bowel movements and that tenants resided in the dementia unit who required the use of a wheelchair.

- Monitoring Observation: Tenants who require assistance with bathing, toileting, dressing and ambulation meet the level of care allowable for an assisted living and may reside in an assisted living. Incontinent tenants and tenants who require the use of a wheelchair meet the level of care allowable for an assisted living and may reside in both a general population area and in a dementia unit of an assisted living.

During interviews, Staff #1, #2, #3 and #4 identified Tenants #2 and #3, two cognitively impaired tenants currently residing in the dementia unit, as tenants who chronically wander throughout the secured unit, going into other tenant apartments uninvited. Staff #1, #2, #3 and #4 reported Tenants #2 and #3 did not exhibit physically aggressive behaviors toward other tenants or staff members. The four staff members reported Tenants #2 and #3 pushed on the egress bars located on the exit doors in the dementia unit, sounding the alarms but did not routinely keep pushing on the egress bar in an attempt to actually exit the unit.

During interviews, Staff #1, #2, #3 and #4 identified Tenant #15 was recently admitted to hospice services and three days before had become very lethargic, showing increased dependence with activities of daily living, requiring two person assistance with all transfers, exhibited an inability to ambulate and required repositioning every two hours when in bed. The staff members identified no other tenants who required two person transfers routinely and no tenants who were completely dependent with activities of daily living.

During interviews, Staff #1, #3 and #4 reported Tenant #4, a cognitively impaired tenant who was discharged from the program in September 2013, chronically went out the exit doors in the dementia unit, causing staff members to follow Tenant #4 in an attempt to redirect him/her back into the unit. All three staff members reported Tenant #4 had become progressively physically aggressive with staff members and other tenants prior to discharge.

The monitors reviewed the clinical records of Tenants #2, #3, #4 and #15 for level of care concerns noting the following:

Tenant #2 had exhibited wandering throughout the secured dementia unit and exhibited exit seeking behavior for approximately two to three weeks. During the time of the behaviors, Tenant #2's spouse was hospitalized and was unable to visit on the usual routine basis. Tenant #2 also had a urinary tract infection (UTI) that was identified during the time of the behaviors that was treated with antibiotic therapy. Tenant #2's behaviors decreased to an appropriate and manageable level on 8-15-13. Tenant #2 did not exceed assisted living level of care.

Tenant #15 had begun exhibiting complete dependence with activities of daily living and routine transfer assistance by two staff members three days before the initiation of the monitoring visit. Tenant #15 was recently admitted to hospice services and the Registered Nurse (RN) Manager completed evaluations and update to the service plan due to Tenant #15's significant change of condition. As Tenant #15 had not been exhibiting the above stated changes for greater than 21 days, Tenant #15 did not exceed assisted living level of care.

Tenant #4, an 80 year old, was admitted to the program's dementia unit on 8-29-12 and moved from the program voluntarily on 9-13-13. Tenant #4 had diagnoses of Dementia, Depression and Rheumatoid Arthritis. Tenant #4 scored a 5 on the Global Deterioration Scale (GDS) completed on 8-26-13, indicating moderately severe cognitive decline. Tenant #4's clinical record indicated Tenant #4 was exit seeking and made multiple attempts to elope from the program.

Tenant #4 pushed on the egress bars on the secured exit door going from the dementia unit to the general population area on multiple occasions. Tenant #4 never made it out of the program without staff members being present with Tenant #4. During interview, Staff #1, #2, #3 and #4, all direct care workers, reported Tenant #4 exhibited aggressive physical behaviors (hitting, pinching, kicking, scratching and biting) toward staff members for approximately one month before Tenant #4 moved from the program. Incident reports indicated Tenant #4 slapped Tenant #2's hands once and pushed on Tenant #2's shoulder once. Both incidents resulted in no injury to Tenant #2. The RN Manager contacted the physician multiple times and medications used to control behaviors were adjusted multiple times with ineffective results.

On 9-5-13 the RN Manager called a meeting with Tenant #4's legal representative to discuss Tenant #4's behaviors. It was decided that Tenant #4 exceeded assisted living level of care and would need to move. Tenant #4's legal representative agreed to move Tenant #4 and did so on 9-13-13. Tenant #4 did exceed the assisted living level of care; however, the RN Manager had addressed the level of care issue prior to the monitor's visit and Tenant #4 had already moved from the program.

Tenant #3, a 74 year old, was admitted to the program on 9-16-13 and currently resided in the program's secured dementia unit. Tenant #3 had diagnoses of Lewey Body Type Dementia, Parkinson's Disease, Depression, Rheumatoid Arthritis and Osteoporosis. Tenant #3 scored a 4 on the GDS completed on 9-12-13, indicating moderate cognitive decline, scored a 5 on the GDS completed on 10-2-13, indicating moderately severe cognitively decline and scored a 6 on the GDS completed on 10-10-13, indicating severe cognitive decline.

Notes written by direct care workers and nurse notes included the following:

9-24-13- Staff members reported to the nurse that Tenant #3 had been "on the edge", going in and out of other tenant apartments, yelling/cursing in the common areas seemingly at no one and very restless.
9-29-13- Tenant #3 going in other tenant apartments and insisting one of the tenants was Tenant #3's family member (was not).
10-1-13- Tenant #3 going in other tenant apartments throughout entire day, removing the other tenants personal belongings and took the items to Tenant #3's apartment. Turned on the shower in another tenant's apartment, the shower overflowed water onto the bathroom floor.
10-2-13- Tenant #3 going in other tenant apartments. Tried to take the program's telephone and attempted to call 911. Tenant #3 kept attempting to open fire doors.
10-5-13- Tenant #3 going in other tenant apartments. Tenant #3 set off door alarms three times during one shift and was very difficult to redirect.
10-6-13- Tenant #3 was very agitated, verbally threatening staff members. Tenant #3 kept going into other tenant apartments and was setting off the door alarms.
10-9-13- Tenant #3 going into other tenant apartments, having hallucinations and talking to people not there, set off door alarms multiple times during the day. Tenant #3 entered the common areas of the dementia unit without pants or underwear on, put three pieces of clothing in the toilet causing it to plug and overflow. Tenant #3 was very difficult to redirect and punched the staff member in the stomach.

10-10-13- Tenant #3 was going into other tenant apartments. Tenant #3 pushed on the egress bar and exited into the enclosed courtyard off of the unit, was hallucinating and talking to people who weren't there, removed all clothes and stood in the middle of his/her apartment crying. Tenant #3 took his/her personal belongings to other tenant apartments and removed other tenants' personal belongings to Tenant #3's apartment. Tenant #3 went into Tenant #15's apartment while naked from the waist up while Tenant #15's family was visiting.
10-11-13- Tenant #3 turned on the shower in his/her apartment- flooded onto the bathroom floor, kept setting off the door alarms and kept going into other tenant apartments removing personal items not belonging to Tenant #3. Tenant #3 was difficult to redirect, becoming aggressive with staff members. Tenant #3 took pants down and urinated in the hallway in front of Tenant #12's apartment.
10-12-13- Tenant #3 urinated on the floor of his/her apartment and in the closet later in the day. Tenant #3 took his/her pants down in an empty apartment and was getting ready to urinate on the floor. Staff members found Tenant #3 in Tenant #19's apartment- Tenant #3's hands were on Tenant #19 and Tenant #3 was pushing Tenant #19 away.
Tenant #3 kept going into other tenant apartments.
10-14-13- Note was placed on document directing all other staff members to keep Tenant #3 away from Tenant #19 as they had been arguing verbally. Tenant #3 kept going in other tenant apartments, entering Tenant #18's apartment and upsetting Tenant #18.
10-18-13- Tenant #3 was emptying out his/her dresser drawers, throwing the clothes in the garbage. Tenant #3 kept going into other tenant apartments.
10-19-13- Tenant #3 going into other tenant apartments. Staff members found Tenant #16's belongings in Tenant #3's room. Tenant #3 kept trying to enter empty apartments that had been locked and was going into other tenant apartments throughout evening "making the other tenants unhappy when in their rooms" and undressed twice in the common dining room area.
10-20-13- Tenant #3 going into other tenant apartments, removing personal items that were not Tenant #3's and placed clothing in his/her own toilet.
10-21-13- Tenant #3 entered Tenant #15's apartment and grabbed Tenant #15's spouse's hand and began pulling on it.
10-23-13- Tenant #3 hanging over other tenants in the common dining room area yelling for a person not present. Tenant #3 going into other tenant apartments, focusing on Tenant #2's apartment particularly.
10-24-13- Tenant #3 was going into other tenant apartments.
10-25-13- Tenant #3 was going into other tenant apartments.
10-26-13- Tenant #3 going into other tenant apartments, particularly Tenant #18's, #15's and #2's. Tenant #3 got onto hands and knees picking at the floor in the common areas.
10-29-13- Tenant #3 entered Tenant #15's apartment and began accusing Tenant #15 of exposing his/herself to Tenant #3's "little children".

Physician orders indicated the RN Manager contacted Tenant #3's physician to report Tenant #3's behaviors on 10-2-13 and 10-14-13, resulting in medication (Seroquel and Xanax) dosage increases. The increase in medication dosages was not effective with decreasing Tenant #3's behaviors.

September and October 2013 Medication Administration Records (MARs) documented staff members administered Xanax to Tenant #3 on an as needed basis for anxiety one or more times on 9-25 and 29-13 and 10-1,4,5,6,8,9,10,11,12,18,19,20,21,22,23,24,25,26,27,28 and 29-13.

The monitor made multiple observations of Tenant #3 during the on-site visit. Tenant #3 paced continuously. Staff members had difficulty getting Tenant #3 to sit down to rest or eat meals.

Tenant #3 exhibited behaviors that were disruptive to other tenants residing in the program's secured dementia unit on almost a daily basis, urinated in unusual places in the common areas of the program, frequently entered other tenant apartments in an un-clothed state, frequently set off the exit door alarms, experienced hallucinations and delusions and exhibited aggression toward staff members, other tenants and other tenant family members. Tenant #3 continued to reside at the program despite the multiple behaviors listed above. The program had not identified Tenant #3 as exceeding assisted living level of care and not given any notice of discharge to Tenant #3's legal representative to remove Tenant #3 from residing at the program.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk. (IAC r. 481-69.23(1)c.(1)(2))

B. Tenant Rights

Complaint/Incident Allegation: 45101-C- It was alleged tenants residing in the memory care unit were upset by and afraid of tenants who frequently wandered into their apartments.

- Monitoring Observation: During the July 2013 complaint/incident investigation, the program received a regulatory insufficiency for failure to adequately assess and seek medical evaluation in a timely basis for Tenant #1 following a fall that resulted in a fracture. Tenant #1 no longer resided at the program. The monitors reviewed the clinical records of Tenants #12, a tenant who fell and had a suspected fracture of the hip, and Tenants #17, a tenant who fell, resulting in a fractured scapula. Both Tenant #12 and Tenant #17's clinical records and associated incident reports indicated both tenants were assessed by a nurse in a timely manner and both were sent to the local emergency room for medical evaluation in a timely manner.

  Tenant #3 had diagnoses of Lewey Body Type Dementia, Parkinson's Disease, Depression, Rheumatoid Arthritis and Osteoporosis. Tenant #3 scored a 4 on the GDS completed on 9-12-13, indicating moderate cognitive decline, scored a 5 on the GDS completed on 10-2-13, indicating moderately severe cognitively decline and scored a 6 on the GDS completed on 10-10-13, indicating severe cognitive decline.

Notes written by direct care workers and nurse notes included the following:

9-24-13- Staff members reported to the nurse that Tenant #3 had been "on the edge", going in and out of other tenant apartments, yelling/cursing in the common areas seemingly at no one and very restless.
9-29-13- Tenant #3 going in other tenant apartments and insisting one of the tenants was Tenant #3's family member (was not).
10-1-13- Tenant #3 going in other tenant apartments throughout entire day, removing the other tenants personal belongings and took the items to Tenant #3's apartment. Turned on the shower in another tenant's apartment, the shower overflowed water onto the bathroom floor.
10-2-13- Tenant #3 going in other tenant apartments. Tried to take the program's telephone and attempted to call 911. Tenant #3 kept attempting to open fire doors.
10-5-13- Tenant #3 going in other tenant apartments. Tenant #3 set off door alarms three times during one shift and was very difficult to redirect.
10-6-13- Tenant #3 was very agitated, verbally threatening staff members. Tenant #3 kept going into other tenant apartments and was setting off the door alarms.
10-9-13- Tenant #3 going into other tenant apartments, having hallucinations and talking to people not there, set off door alarms multiple times during the day. Tenant #3 entered the common areas of the dementia unit without pants or underwear on, put three pieces of clothing in the toilet causing it to plug and overflow. Tenant #3 was very difficult to redirect and punched the staff member in the stomach.
10-10-13- Tenant #3 was going into other tenant apartments. Tenant #3 pushed on the egress bar and exited into the enclosed courtyard off of the unit, was hallucinating and talking to people who weren't there, removed all clothes and stood in the middle of his/her apartment crying. Tenant #3 took his/her personal belongings to other tenant apartments and removed other tenants' personal belongings to Tenant #3's apartment. Tenant #3 went into Tenant #15's apartment while naked from the waist up while Tenant #15's family was visiting.
10-11-13- Tenant #3 turned on the shower in his/her apartment- flooded onto the bathroom floor, kept setting off the door alarms and kept going into other tenant apartments removing personal items not belonging to Tenant #3. Tenant #3 was difficult to redirect, becoming aggressive with staff members. Tenant #3 took pants down and urinated in the hallway in front of Tenant #12's apartment.
10-12-13- Tenant #3 urinated on the floor of his/her apartment and in the closet later in the day. Tenant #3 took his/her pants down in an empty apartment and was getting ready to urinate on the floor. Staff members found Tenant #3 in Tenant #19's apartment- Tenant #3's hands were on Tenant #19 and Tenant #3 was pushing Tenant #19 away.
Tenant #3 kept going into other tenant apartments.
10-14-13- Note was placed on document directing all other staff members to keep Tenant #3 away from Tenant #19 as they had been arguing verbally. Tenant #3 kept going in other tenant apartments, entering Tenant #18's apartment and upsetting Tenant #18.
10-18-13- Tenant #3 was emptying out his/her dresser drawers, throwing the clothes in the garbage. Tenant #3 kept going into other tenant apartments.
10-19-13- Tenant #3 going into other tenant apartments. Staff members found Tenant #16's belongings in Tenant #3's room.

Tenant #3 kept trying to enter empty apartments that had been locked and was going into other tenant apartments throughout evening "making the other tenants unhappy when in their rooms" and undressed twice in the common dining room area.
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10-23-13- Tenant #3 hanging over other tenants in the common dining room area yelling for a person not present. Tenant #3 going into other tenant apartments, focusing on Tenant #2's apartment particularly.
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10-29-13- Tenant #3 entered Tenant #15's apartment and began accusing Tenant #15 of exposing his/herself to Tenant #3's "little children".

Physician orders indicated the RN Manager contacted Tenant #3's physician to report Tenant #3's behaviors on 10-2-13 and 10-14-13, resulting in medication (Seroquel and Xanax) dosage increases. The increase in medication dosages was not effective with decreasing Tenant #3's behaviors.

September and October 2013 Medication Administration Records (MARs) documented staff members administered Xanax to Tenant #3 on an as needed basis for anxiety one or more times on 9-25 and 29-13 and 10-1,4,5,6,8,9,10,11,12,18,19,20,21,22,23,24,25,26,27,28 and 29-13.

During interview, Staff #1, #2, #3 and #4, all direct care workers, reported Tenant #3 often got into verbal arguments with other tenants when Tenant #3 entered other tenant apartments without permission.

During interview, Tenant #18, a cognitively intact tenant who resided in the secured memory care unit, reported he/she resided in the unit because his/her spouse had required a secured dementia unit in the past. Tenant #18 lived in the unit with his/her spouse until the spouse died. Tenant #18 stayed residing in the apartment as he/she did not wish to move. Tenant #18 reported having concerns with Tenant #3 frequently entering his/her apartment without permission multiple times on almost a daily basis. Tenant #18 denied being afraid of Tenant #3 but felt intruded upon when Tenant #3 entered the apartment. Tenant #3 reportedly came into the apartment, used the bathroom and touched personal items. Tenant #18 reported the program placed a sign on Tenant #18's door stating "closed for cleaning" with very little success in keeping Tenant #3 out. Tenant #18 reported Tenant #18 had ever been physically aggressive but stated "just babbles and can't understand when I say get out."

Tenant #3 exhibited behaviors that were disruptive to other tenants residing in the program's secured dementia unit on almost a daily basis, urinated in unusual places in the common areas of the program, frequently entered other tenant apartments in an un-clothed state, frequently set off the exit door alarms, verbally acted on hallucinations and delusions toward other tenants and exhibited aggression toward staff members, other tenants and other tenant family members. Tenant #18 felt intruded upon when Tenant #3 repeatedly entered Tenant #18's apartment.

- Regulatory Insufficiency: All tenants have the right to be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

C. Nurse Review

- Monitoring Observation: During the July 2013 on-site complaint/incident investigation, the program received a regulatory insufficiency for failure to complete a nurse review for Tenants #5 and #6 following a change in conditions. Tenant #6 no longer resided at the program. The program reviewed the clinical records of Tenants #2, #3, #4, #5, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16 and #17, finding no nurse review concerns for Tenants #2, #3, #4, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16 and #17.

  Tenant #5, a 79 year old, was admitted to the program on 11-28-11 and currently resided in the program's general population area of the building. Tenant #5 had diagnoses of Chronic Renal Disease, Congestive Heart Failure (CHF), Hypertension (HTN), Atrial Fibrillation and Depression. Tenant #5 answered all but one question correctly on the program's cognitive assessment tool completed on 8-23-13, indicating no to mild cognitive impairment.

  Tenant #5 was hospitalized on 7-3-13 and went to a long term care facility for rehabilitation following the hospitalization, returning to the assisted living on 8-15-13 at 2:30 p.m. On 8-16-13 at 4:15 a.m., Tenant #5 reported experiencing shortness of breath, audible respiratory wheezing, 3+ pitting edema in both lower extremities and a feeling of pressure in his/her chest. Tenant #5 was sent to the emergency room for medical evaluation and was subsequently admitted to the hospital. Tenant #5 was hospitalized for 12 days. Tenant #5 was hospitalized twice within six weeks.

  According to the program's Assessment Tool, the registered nurse documented Tenant #5's physical health changed from a stable chronic condition to an unstable chronic condition. Tenant #5's clinical record lacked documentation of a nurse review following Tenant #5's return from the hospital on 8-27-13 to determine if there was any significant change of health, functional or cognitive status due to the unstable health condition.

  While a deviation from the requirements of the rules was found, it did not meet the standard set forth in the rule 67.10(3) for determining that a regulatory insufficiency exits.

- Regulatory Insufficiency: None noted.

D. Evaluation

- Monitoring Observation: During the July 2013 complaint/incident investigation, the program received a regulatory insufficiency for failure to complete an evaluation of health, functional and cognitive status with changes in condition for Tenants #5 and #6. The program also received a regulatory insufficiency for failure to complete a GDS with the next subsequent cognitive evaluation for Tenants #8 and #10 after scoring on the program's cognitive assessment indicated moderate cognitive decline. Tenant #6 no longer resided at the program. The program completed a GDS for Tenant #8 on 7-31-13 and completed a GDS for Tenant #10 on 8-14-13. The monitors found no other tenants who required completion of the GDS subsequent to identification of moderate cognitive decline on a previous cognitive evaluation using the program's cognitive tool.

  The monitors reviewed the clinical records of Tenants #2, #3, #4, #5, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16 and #17, finding Tenants #7, #9, #10, #11, #16 and #17 had no significant changes in health, functional or cognitive status since the program's plan of correction. Tenants #2, #3, #4, #7, #12, #13, #14 and #15 did experience significant changes in health, cognitive and functional status and the RN completed evaluations as required by regulation.

  Tenant #5 was hospitalized on 7-3-13 and went to a long term care facility for rehabilitation following the hospitalization, returning to the assisted living on 8-15-13 at 2:30 p.m. The RN Manager immediately completed an evaluation of Tenant #5's health, cognitive and functional status upon Tenant #5's return from the hospital.

  On 8-16-13 at 4:15 a.m., Tenant #5 reported experiencing shortness of breath, audible respiratory wheezing, 3+ pitting edema in both lower extremities and a feeling of pressure in his/her chest. Tenant #5 was sent to the emergency room for medical evaluation and was subsequently admitted to the hospital. On 8-23-13, while Tenant #5 was still hospitalized, the RN Manager went to the hospital to evaluate Tenant #5. According to the evaluation notes, dated 8-23-13, Tenant #5 was told his/her cardiac mitral valve was not functioning properly and would require surgery to correct. Tenant #5 chose not to elect surgery due to his/her high risk status. Tenant #5 also refused to go to a nursing home for rehabilitation when discharged from the hospital. The RN Manager documented concerns that Tenant #5 may exceed the level of care allowable for an assisted living when discharged from the hospital. Tenant #5 remained hospitalized another four days after the RN Manager's evaluation visit, totaling 12 days. Tenant #5 returned to the assisted living on 8-27-13.

  Tenant #5 was hospitalized twice within six weeks. According to the program's Assessment Tool, dated 8-23-13, the RN Manager documented Tenant #5's physical health changed from a stable chronic condition to an unstable chronic condition. Tenant #5's clinical record lacked documentation of an evaluation of health, functional or cognitive status following Tenant #5's return from the hospital on 8-27-13 to determine if there were any significant changes in health, functional or cognitive status as previously suspected by the RN Manager due to Tenant #5's unstable health condition.

Tenant #8, an 89 year old, was admitted on 6-12-13 and resided in the program's general population area of the building. Tenant #8 had diagnoses of Diabetes, HTN, Neuropathic Pain and Arthritis. Tenant #8 scored a 3 on the GDS completed on 7-31-13, indicating mild cognitive decline. Tenant #8's service plan, dated 7-10-13, indicated Tenant #8 was independent with medication administration.

According to nurse notes, dated 8-14-13, the RN Manager visited Tenant #8's apartment to discuss medication concerns. The RN Manager documented recently finding "piles of medications set up in plastic medication cups lying around the apartment" and noted pills being "stashed" by Tenant #8. The RN Manager documented concerns that Tenant #8 was no longer able to handle medication administration independently. Tenant #8 did not wish to give responsibility for medication administration to the program. Tenant #8's roommate was willing to set Tenant #8's medications up for Tenant #8. The RN Manager obtained a medication planner and worked with the roommate to assure the roommate's competency with Tenant #8's medication set up. The RN returned to visit Tenant #8 on 8-19-13, determining Tenant #8's roommate was competent with the medication set up.

Tenant #8's clinical record lacked documentation of the RN Manager's completion of a health, functional and cognitive status upon Tenant #8's significant change in functional status when he/she went from being independent with medication administration to requiring assistance of medication set up.

The program failed to complete the required health, functional and cognitive status evaluations with identified significant changes for Tenants #5 and #8.

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

E. Service Plans

Complaint/Incident Allegation: 45278-C- It was alleged the program did not transport a tenant to visit his/her spouse in the attached nursing home as service planned.

- Monitoring Observation: During the July 2013 complaint/incident investigation, the program received a regulatory insufficiency for failing to update service plans to reflect individualized tasks and direction to meet the needs of the tenant for Tenants #5 and #6. Tenant #6 no longer resided at the program. The monitors reviewed the clinical records of Tenants #2, #3, #4, #5, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16 and #17, finding no concerns related to service plans for Tenants #2, #9, #10, #11, #12, #13, #15, #16 and #17. Tenant #14 was identified as the only tenant staff members assisted with transporting to the attached nursing home.

Tenant #14, an 81 year old, was admitted on 2-13-12 and diagnoses included UTI, Generalized Weakness, Dehydration, Coronary Artery Disease, Hyperlipidemia, Benign Prostatic Hyperplasia, HTN, Depression, Gastroesophageal Reflux Disease (GERD), Osteoporosis and Pain. Tenant #14 was staged at a 4 on the GDS which indicated moderate cognitive decline. According to the service plan dated 8-1-13, Tenant #14 was independent with walker in apartment and to and from the dining room. Notify nurse of any increased weakness or fatigue. Offer escort to and from the nursing home to visit spouse in wheelchair. Standby assist with gait belt as needed. According to the Resident Notes dated 9-10-13, the RN Manager spoke to Tenant #14 and Tenant #14's family that there were two rooms open in the nursing home with a shared bathroom. Tenant #14 stated this would be easier as Tenant #14 got tried walking that far and Tenant #14's spouse would be so happy. The social worker would be contacted about a transfer. On 9-24-13 Tenant #14 was transferred to the nursing home.

The LPN stated Tenant #14 went to the nursing home almost daily and would go on own. If staff saw Tenant #14 they'd say wait and they'd get a wheelchair for transport. Tenant #14 didn't ask for help. The LPN stated she was not aware of anyone not providing escort services. The RN Manager stated Tenant #14's spouse resided in the nursing home. Tenant #14 was able to walk to the nursing home alone and knew the best spots to sit along the way. She would see Tenant #14 and would offer a ride. She stated her staff had better not refused to offer Tenant #14 a ride.

Tenant #3 had diagnoses of Lewey Body Type Dementia, Parkinson's Disease, Depression, Rheumatoid Arthritis and Osteoporosis. Tenant #3 scored a 4 on the GDS completed on 9-12-13, indicating moderate cognitive decline, scored a 5 on the GDS completed on 10-2-13, indicating moderately severe cognitively decline and scored a 6 on the GDS completed on 10-10-13, indicating severe cognitive decline.

Notes written by direct care workers and nurse notes included the following:

9-24-13- Staff members reported to the nurse that Tenant #3 had been "on the edge", going in and out of other tenant apartments, yelling/cursing in the common areas seemingly at no one and very restless.
9-29-13- Tenant #3 going in other tenant apartments and insisting one of the tenants was Tenant #3's family member (was not).
10-1-13- Tenant #3 going in other tenant apartments throughout entire day, removing the other tenants personal belongings and took the items to Tenant #3's apartment. Turned on the shower in another tenant's apartment, the shower overflowed water onto the bathroom floor.
10-2-13- Tenant #3 going in other tenant apartments. Tried to take the program's telephone and attempted to call 911. Tenant #3 kept attempting to open fire doors.
10-5-13- Tenant #3 going in other tenant apartments. Tenant #3 set off door alarms three times during one shift and was very difficult to redirect.
10-6-13- Tenant #3 was very agitated, verbally threatening staff members. Tenant #3 kept going into other tenant apartments and was setting off the door alarms.
10-9-13- Tenant #3 going into other tenant apartments, having hallucinations and talking to people not there, set off door alarms multiple times during the day.

Tenant #3 entered the common areas of the dementia unit without pants or underwear on, put three pieces of clothing in the toilet causing it to plug and overflow. Tenant #3 was very difficult to redirect and punched the staff member in the stomach.
10-10-13- Tenant #3 was going into other tenant apartments. Tenant #3 pushed on the egress bar and exited into the enclosed courtyard off of the unit, was hallucinating and talking to people who weren't there, removed all clothes and stood in the middle of his/her apartment crying. Tenant #3 took his/her personal belongings to other tenant apartments and removed other tenants' personal belongings to Tenant #3's apartment. Tenant #3 went into Tenant #15's apartment while naked from the waist up while Tenant #15's family was visiting.
10-11-13- Tenant #3 turned on the shower in his/her apartment- flooded onto the bathroom floor, kept setting off the door alarms and kept going into other tenant apartments removing personal items not belonging to Tenant #3. Tenant #3 was difficult to redirect, becoming aggressive with staff members. Tenant #3 took pants down and urinated in the hallway in front of Tenant #12's apartment.
10-12-13- Tenant #3 urinated on the floor of his/her apartment and in the closet later in the day. Tenant #3 took his/her pants down in an empty apartment and was getting ready to urinate on the floor. Staff members found Tenant #3 in Tenant #19's apartment- Tenant #3's hands were on Tenant #19 and Tenant #3 was pushing Tenant #19 away.
Tenant #3 kept going into other tenant apartments.
10-14-13- Note was placed on document directing all other staff members to keep Tenant #3 away from Tenant #19 as they had been arguing verbally. Tenant #3 kept going in other tenant apartments, entering Tenant #18's apartment and upsetting Tenant #18.
10-18-13- Tenant #3 was emptying out his/her dresser drawers, throwing the clothes in the garbage. Tenant #3 kept going into other tenant apartments.
10-19-13- Tenant #3 going into other tenant apartments. Staff members found Tenant #16's belongings in Tenant #3's room. Tenant #3 kept trying to enter empty apartments that had been locked and was going into other tenant apartments throughout evening "making the other tenants unhappy when in their rooms" and undressed twice in the common dining room area.
10-20-13- Tenant #3 going into other tenant apartments, removing personal items that were not Tenant #3's and placed clothing in his/her own toilet.
10-21-13- Tenant #3 entered Tenant #15's apartment and grabbed Tenant #15's spouse's hand and began pulling on it.
10-23-13- Tenant #3 hanging over other tenants in the common dining room area yelling for a person not present. Tenant #3 going into other tenant apartments, focusing on Tenant #2's apartment particularly.
10-24-13- Tenant #3 was going into other tenant apartments.
10-25-13- Tenant #3 was going into other tenant apartments.
10-26-13- Tenant #3 going into other tenant apartments, particularly Tenant #18's, #15's and #2's. Tenant #3 got onto hands and knees picking at the floor in the common areas.
10-29-13- Tenant #3 entered Tenant #15's apartment and began accusing Tenant #15 of exposing his/herself to Tenant #3's "little children".

The RN Manager did not update Tenant #3's service plan to give direction to staff members on how to deal with Tenant #3's behaviors, what interventions to use for redirection of Tenant #3 when he/she exhibited these behaviors and what to do if unable to redirect Tenant #3.

Tenant #4's clinical record indicated Tenant #4 was exit seeking and made multiple attempts to elope from the program. Tenant #4 pushed on the egress bars on the secured exit door going from the dementia unit to the general population area on multiple occasions. Tenant #4 never made it out of the program without staff members being present with Tenant #4. During interview, Staff #1, #2, #3 and #4, all direct care workers, reported Tenant #4 exhibited aggressive physical behaviors (hitting, pinching, kicking, scratching and biting) toward staff members for approximately one month before Tenant #4 moved from the program. Incident reports indicated Tenant #4 slapped Tenant #2's hands once and pushed on Tenant #2's shoulder once. Both incidents resulted in no injury to Tenant #2. The RN Manager contacted the physician multiple times and medications used to control behaviors were adjusted multiple times with ineffective results.

Tenant #4's service plan had not been updated to reflect Tenant #4's continued exit seeking behaviors, physical aggression toward staff members and other tenants and did not give direction to staff members on how to deal with Tenant #4's behaviors, what interventions to use for redirection of Tenant #4 when he/she exhibited these behaviors and what to do if unable to redirect Tenant #4.

Tenant #5 was hospitalized on 7-3-13 and went to a long term care facility for rehabilitation following the hospitalization, returning to the assisted living on 8-15-13 at 2:30 p.m. The RN Manager immediately completed an evaluation of Tenant #5's health, cognitive and functional status upon Tenant #5's return from the hospital.

On 8-16-13 at 4:15 a.m., Tenant #5 reported experiencing shortness of breath, audible respiratory wheezing, 3+ pitting edema in both lower extremities and a feeling of pressure in his/her chest. Tenant #5 was sent to the emergency room for medical evaluation and was subsequently admitted to the hospital. On 8-23-13, while Tenant #5 was still hospitalized, the RN Manager went to the hospital to evaluate Tenant #5. According to the evaluation notes, dated 8-23-13, Tenant #5 was told his/her cardiac mitral valve was not functioning properly and would require surgery to correct. Tenant #5 chose not to elect surgery due to his/her high risk status. Tenant #5 also refused to go to a nursing home for rehabilitation when discharged from the hospital. The RN Manager documented concerns that Tenant #5 may exceed the level of care allowable for an assisted living when discharged from the hospital. Tenant #5 remained hospitalized another four days after the RN Manager's evaluation visit, totaling 12 days. Tenant #5 returned to the assisted living on 8-27-13.

Tenant #5 was hospitalized twice within six weeks. According to the program's Assessment Tool, dated 8-23-13, the RN Manager documented Tenant #5's physical health changed from a stable chronic condition to an unstable chronic condition.

Tenant #5's clinical record lacked documentation of an evaluation of health, functional or cognitive status following Tenant #5's return from the hospital on 8-27-13 to determine if there were any significant changes in health, functional or cognitive status as previously suspected by the RN Manager due to Tenant #5's un-stable health condition.

The RN Manager completed a service plan, signed by the RN Manager on 8-23-13 and signed by Tenant #5 on 8-27-13 upon his/her return back to the assisted living from the hospital. Tenant #5 was hospitalized from 8-16-13 to 8-27-13. The RN Manager completed the service plan without completing a significant change evaluation upon Tenant #5's return to the assisted living. The service plan would not have been based on Tenant #5's individualized needs post hospitalization.

Tenant #7, an 86 year old, was admitted to the program on 6-5-13 and resided in the program's general population area of the building. Tenant #7 had diagnoses of Alzheimer's Disease, HTN and Osteoarthritis. Tenant #7 scored a 4 on the GDS completed on 7-3-13, indicating moderate cognitive decline. Tenant #7's functional assessment, dated 7-3-13, documented Tenant #7 required staff member assistance with tying shoes, buttoning clothes and zipping clothes. Tenant #7's service plan, dated 7-3-13, indicated Tenant #7 was independent with dressing, requiring no staff member assistance.

Tenant #8's service plan, dated 7-10-13, indicated Tenant #8 was independent with medication administration. According to nurse notes, dated 8-14-13, the RN Manager visited Tenant #8's apartment to discuss medication concerns. The RN Manager documented recently finding "piles of medications set up in plastic medication cups lying around the apartment" and noted pills being "stashed" by Tenant #8. The RN Manager documented concerns that Tenant #8 was no longer able to handle medication administration independently. Tenant #8 did not wish to give responsibility for medication administration to the program. Tenant #8's roommate was willing to set Tenant #8's medications up for Tenant #8. The RN Manager obtained a medication planner and worked with the roommate to assure the roommate's competency with Tenant #8's medication set up. The RN returned to visit Tenant #8 on 8-19-13, determining Tenant #8's roommate was competent with the medication set up.

Tenant #8's clinical record lacked documentation of the RN Manager's completion of a health, functional and cognitive status upon Tenant #8's significant change in functional status when he/she went from being independent with medication administration to requiring assistance of medication set up. Tenant #8's clinical record also lacked documentation of an updated service plan identifying Tenant #8's change from independence with medication administration to requiring assistance from his/her roommate with medication set up.

The program failed to complete updated service plans with identified significant changes for Tenants #5 and #8.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))

F. Other- Registered Nurse Follow up to Changes in Tenant Condition

Complaint/Incident Allegation: 45278-C- It was alleged the program RN failed to assess and treat tenant wounds and failed to follow up in a timely manner when tenants experienced changes in health condition.

- Monitoring Observation: According to the RN Manager, Tenant #11 was the only tenant with a wound. The monitors reviewed the clinical records of Tenants #2, #5, #11, #12 and #13, all tenants who had experienced changes in health condition.

  Tenant #2 experienced a UTI which affected his/her behaviors. The RN Manager contacted Tenant #2's physician to report the changes in behavior in a timely manner, obtained orders for a urinalysis and Tenant #2 was treated appropriately and timely.

  Tenant #5 experienced shortness of breath, tightness in the chest and pedal edema. The RN Manager sent Tenant #5 to the emergency room for medical evaluation immediately. Tenant #5 was subsequently hospitalized and treated for an exacerbation of CHF.

  Tenant #11, an 89 year old, was admitted on 7-31-09 and diagnoses included Diabetes, Constipation, Osteoporosis, Edema, Hyperlipidemia, Hypothyroid and Left Leg Amputee. Tenant #11 scored an 11/11 on the cognitive evaluation, which indicated no or mild impairment. According to the service plan dated 10-14-13, Tenant #11 received right foot and heel treatment completed at the wound clinic. According to Resident Notes dated 9-25-13, Tenant #11 had weekly appointments at the wound clinic for wound to right medial heel. A new skin graft applied, dressing to be changed at wound clinic only. According to Physician Order Details dated 9-25-13, 10-2-13, 10-9-13 and 10-16-13, do not change dressings while graft in place. All dressing changes were to be done at the wound clinic only.

  The RN Manager said wounds were assessed by the RN Manager or the licensed practical nurse (LPN). If the wound was a serious type the LPN provided the care and the RN Manager monitored it. If the wound was minor, staff had been trained to complete wound care. The RN Manager stated Tenant #11 was the only current tenant with a wound. Tenant #11 went to a wound clinic twice a week to receive care. The LPN stated she and the RN Manager assessed wounds. No one was currently providing care for wounds. Tenant #11 had a wound but all cares were done at the wound clinic.

  Review of a tenant file, an interview with the RN Manager and the LPN indicated the wound was assessed as needed.

Tenant #12, a 94 year old, was admitted on 1-27-10 and diagnoses included Depression, Constipation, Mild Dementia, Fractured Left Wrist and Osteoporosis. Tenant #12 was staged at a 4 on the GDS which indicated moderate cognitive decline. According to the Resident Notes dated 9-2-13, a late entry for 8-31-13, Tenant #12 was observed sitting on floor next to bed. Stated fell, denied any injury or pain. Active range of motion was within normal limits on all extremities. Two assist to feet with a gait belt, bears weight and ambulated with walker without difficulty. No pain noted in hands, arms or ribs, used walker without difficulty. On 9-2-13 a superficial abrasion was noted on right elbow. Triple Antibiotic Ointment and a band aid applied. Area was healing. On 9-3-13 noted bruise on right knee and occasional limp, also abrasion on right elbow skin separated and asked physician for treatment. Tenant #12 had brief episode on 8-29-13 of believing fire in home basement. Tenant #12 had some episodes over the weekend of being angry and uncooperative. On 9-3-13 was talking about seeing a rainbow of bugs and children. Tenant #12 was restless, difficult to divert attention, no joining in activities. No temperature, no incontinence of urine or complaints of difficulty of urinating. Tenant #12 was defensive when asked questions. On 9-4-13, physician orders were received for a urinalysis with culture and sensitivity. A urine specimen was obtained and sent to the lab. On 9-5-12 the physician's office notified first results of UA was many bacteria. Tenant #12 complained of feeling tired and generally not feeling well. On 9-6-13 Tenant #12 was lying in bed, complained of pain in right knee and large bruise noted to thigh above the knee. Yellowing bruise noted on one knee and down right leg from the fall on 8-31-13. Tenant #12's family escorted Tenant #12 to a walk in clinic or ER. The right knee was x-rayed and no fracture noted. Tenant #12 returned with a diagnosis of UTI and new orders received for an antibiotic for ten days.

According to the Resident Notes dated 9-26-13, Tenant #12 reported to staff that Tenant #12 had fallen during the night but got self up and did not call for assistance. Tenant #12 was in bed with complaint of right hip pain. A call was placed to the physician's office requesting a mobile x-ray of the right hip. Order received. A result from right hip x-ray received on 9-27-13 at 8:00 a.m. was negative. Tenant #12 was unable to recall the fall, stated not feeling well and not getting up for breakfast. On 9-27-13 at 11:00 a.m. Tenant #12 was getting up for lunch. A Resident Note dated 9-29-13 indicated Tenant #12 was up sitting in the common area on 9-28-13, laughing, stated was all right just a little sore in right hip, didn't want anything for it. On 9-29-13 was refusing to get up for breakfast or lunch. According to the service plan dated 9-17-13, Tenant #12 needed assist of one for transfers and supervision and verbal cuing for locomotion. Used mobility devices of a walker or wheelchair for long distances propelled by others. Staff was to monitor routinely to insure safety and not attempt to transfer independently.

Tenant #13, a 92 year old, was admitted on 12-16-10 and diagnoses included Back Pain, HTN, Dry Eyes, Depression, Constipation, Anxiety and GERD. Tenant #13 was staged at a 4 on the GDS which indicated moderate cognitive decline. According to the service plan dated 8-26-13, monitor room each shift for involuntary stools. Clean soiled areas as needed and remind Tenant #13 to ask for help with clean up. Refer to the MAR for any complaints of constipation or loose stools. Report to nurse if constipation is not resolved. Notify nurse of incontinence of bowel movements (BMs) on floor. Explain to Tenant #13 the need to go to the toilet when first awakened in the morning and sit, as bowels usually moved every morning.

Tenant #13 could then return to bed to rest. Tenant #13's family was to discuss the importance of going to the bathroom prior to bowels moving. Remind Tenant #13 in order to remain in assisted living Tenant #13 needed to have less involuntary BMs on the floor and carpet. According to Resident Notes dated 8-26-13, spoke to Tenant #13's family and explained staff reported increased BM smeared on floor in the bathroom and bedroom. Staff reported it had been a rare occasion however for past week had been a daily occurrence. Tenant #13 did not want to get up in the morning until after 10:00 a.m. Had a BM in brief while lying in bed then walked to bathroom, stool falls out of leg holes on feet. Tenant #13 then took brief off and scrubbed the stool on the floor. On 8-26-13 at 2:30 p.m. Tenant #13's physician was aware of involuntary bowels. On 8-27-13 Tenant #13's family stated had noticed odor with Tenant #13 at times or soiled clothing. Family was asked to discuss problem with Tenant #13. Staff was also concerned with cleanliness and toileting habits. Family stated understanding and if not redirected Tenant #13 would need to transfer to a higher level of care. According to the Resident Notes dated 8-29-13, Tenant #13 had a physician appointment to establish care. New orders were received to decrease Docusate to once daily. A physician order was received on 8-29-13 to decrease Docusate to 100 mg. orally daily. According to Resident Notes dated 9-6-13, Tenant #13 had no involuntary stools or complaints of constipation reported.

The monitors identified no evidence of the RN Manager failing to assess significant changes in health status for Tenants #2, #5, #11, #12 and #13.

- Regulatory Insufficiency: None noted.

G. Program Reporting to the Department

- Monitoring Observation: During the July 2013 on-site complaint/incident investigation, the program received a regulatory insufficiency for failure to report allegations of theft of money or narcotic medications within 24 hours of notification of the allegations for Tenants #6 and #8. Tenant #6 no longer resided at the program during the on-site revisit. Tenant #8 had reported no further allegations of theft of medications or money.

  The program reported there had been no allegations of theft of money, medications or personal property since July 2013.

- Regulatory Insufficiency: None noted.

H. Medications

Complaint/Incident Allegation: It was alleged program staff members used a back pack during medication administration, presenting a sanitation issue. It was also alleged program staff members administered medications to program tenants in the common dining room rather than in tenant apartments.

- Monitoring Observation: Assisted living program are not required by regulation to administer medications solely in tenant apartments. The Department of Inspections and Appeals previously investigated both above stated allegations during a complaint investigation completed on June 10 and 11, 2013 finding no regulatory concerns at that time. The Department identified no sanitation issues with medication administration at the time of the June 2013 investigation and multiple interviewed tenants reported having no issues with medication administration occurring in the common dining room area. The monitors did not investigate these allegations during this on-site visit as the allegations had already been investigated previously.

- Regulatory Insufficiency: None noted.

I. Staffing

Complaint/Incident Allegation: 45101-C- It was alleged the program did not have enough staff members working to meet the needs of the tenants residing at the program. 45278-C It was alleged the program had a tenant residing in the dementia unit that frequently attempted to elope, causing staff members to leave the unit to stay with the eloping tenant for safety, thereby leaving other tenants unsupervised on the night shift or with only one staff member during the day and evening shifts.

- Monitoring Observation: The program reported having three to four staff members covering the day and evening shift in the general population area of the program and two staff members covering the night shift in the general population area of the program. The program reported having two staff members covering the day and evening shift in the secured dementia unit and one staff member covering the night shift in the secured dementia unit.

  During interview, Staff #1, #2, #3, #5 and #6, all direct care workers, reported the program staffing schedules were as stated by the program and all five direct care workers indicated no concerns with staffing numbers, indicating each felt there were enough staff members working each shift to meet the needs of each tenant residing at the program. All staff members carry portable communication devices to contact each other if needed.

  The assisted living rules do not require a specific staff to tenant ratio. The assisted living rules require one or more staff members to be awake and in the proximate area of the dementia unit, which is defined as located within five minutes or less response time.

  Should a staff member on night shift be required to leave the secured memory care unit to stay with an eloping tenant, two other staff members are working in the general population area, are available to assist and respond to tenant needs in the dementia unit and can easily be contacted to assist when needed.

- Regulatory Insufficiency: None noted.

J. Compliance with Plan of Correction

- Monitoring Observation: The program did not resolve the insufficiency in the areas of Tenant Rights, Evaluations and Service Plans received during the July 2013 complaint/incident investigation (44432-C and 44725-I).

- Regulatory Insufficiency: The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. (IAC r. 481-67.10(8))

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

K. Structural Requirements

- Monitoring Observation: During tour of the program's outdoor courtyard located off of the program's secured dementia unit, the monitor noted a tall iron fence surrounded the courtyard. The fence had a keyed iron gate. The gate was locked during the tour.

  During interview, Staff #1, #2, #3 and #4, all direct care workers who routinely work in the dementia unit, denied having a key to the locked courtyard fence gate. On 10-28-13 Staff #1, a day shift employee, and Staff #3, an evening shift employee, took both sets of keys carried by staff members working in the dementia unit to the gate and attempted to open the gate with all keys kept on each set. Neither staff member was able to open the gate with any of the keys.

  During interview, the program's RN Manager, reported all staff members working in the dementia unit carry a key to the locked courtyard gate and thought that all workers would have known they carried the key. On 10-29-13 at approximately 9:00 a.m., the RN Manager accompanied the monitor to the dementia unit. Staff #1, certified medication aide (CMA) and Staff #2, certified nurse aide (CNA) were working during the day shift. Both staff members again indicated a lack of knowledge that they carried a key to open the courtyard gate. The RN Manager and Staff #1 accompanied the monitor to the gate in the courtyard fence. The RN Manager placed the one large key on the set of keys carried by Staff #1 into the lock of the gate and turned it several times back and forth without the gate lock opening. The RN Manager stated "this should be the key". The RN Manager placed her foot under the bottom of the fence gate and lifted the gate with her foot. The RN Manager turned the key in the lock and shook the gate with her foot, eventually opening the gate. The RN Manager reported the fence gate is heavy and needed to be lifted to take the pressure off of the lock in order for the gate to be unlocked. Staff #1 reported she had never been shown how to open the gate. Upon return into the dementia unit, Staff #2 also reported she had never been shown how to open the gate. The RN Manager took Staff #2 to demonstrate opening of the gate with the keys carried by Staff #2.

When a program has a secured gated courtyard, all staff members working in the dementia unit are required to carry a key to the gate to facilitate emergency evacuation from the courtyard in the event of a fire. Staff #1, #2, #3 and #4 did not realize they carried a key to the courtyard gate. The gate did not open easily due to the weight of the gate putting pressure on the lock, preventing unlocking of the gate without lifting the gate with a foot while turning the key in the lock. Staff #1 and #2 had never been shown how to open the gate in this manner. The gate lock did not open easily to facilitate evacuation from the courtyard in the event of a fire and staff members had not been shown how to open the gate if needed for evacuation.

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