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

Complaint/Incident Intake #:
45990-I
46095-C

January 8, 2013

Mr. Dan Collins, Manager
Grand Haven
201 East Franklin Street
Eldridge, IA 52748

RE: Final Complaint/Incident Investigation Report, Grand Haven, Eldridge, Iowa

Dear Mr. Collins:

Enclosed is the **Final Complaint/Incident Investigation Report** completed 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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116 or James.Berkley@dia.iowa.gov

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Dan Collins, Manager
Grand Haven
201 East Franklin Street
Eldridge, IA 52748

Complaint/Incident Intake #: 45990-I
46095-C

Date of Complaint/Incident Investigation:

December 2, 3 and 5, 2013

Monitor(s):

Stephanie Cummins, MA

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:	79
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	83

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	12
TOTAL census of Assisted Living Program	95

Program History – The program received regulatory insufficiencies in the area of Record Checks, Service Plans, Policy and Procedure during this certification period.

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

A. Policies and Procedures

Complaint/Incident Allegation #45990-I: The Program reported a tenant eloped.

- Monitoring Observation: Tenant #1 eloped on 10-24-13.

  Tenant #1, a 76 year old, was admitted on 10-14-13 and diagnoses included: Hypertension (HTN), Hypercholesterolemia, Alzheimer's Disease, Seizures, Plantar Fasciitis and Gastro Esophageal Reflux Disease. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit. Cognitive, health and functional evaluations were completed and the service plan was updated on 10-24-13, after the elopement. The service plan reflected Tenant #1 was independent with mobility and did not use any assistive devices. The service plan updated on 10-24-13 reflected Tenant #1 eloped on 10-24-13 exiting from the southwest door (at end of tenant hallway). A second door alarm was ordered that would be placed on both southwest exterior doors and interior doors. Signs would be posted on the southwest exterior doors that indicated door alarmed when opened. On 10-31-13 the service plan was updated and indicated the door alarms were installed. On 11-7-13 the service plan was updated and indicated there was a sticker placed on the southwest exterior doors that said alarm would sound when door was opened.

According to an incident report, on 10-24-13 at approximately 3:45 p.m. Tenant #1 left the dementia unit via the southwest exterior door and walked next door to a medical clinic and sat in the waiting room. Tenant #1 was able to tell medical clinic staff Tenant #1's first name when questioned. It was observed that Tenant #1 was wearing an Alzheimer's bracelet. The number on the bracelet was called which was Tenant #1's spouse. Tenant #1's spouse informed the caller Tenant #1 resided in the dementia unit at the Program. Medical clinic staff then called the Manager. The Manager and the Director of Nursing (DON) went to pick up Tenant #1 and returned Tenant #1 to the dementia unit. Tenant #1 was calm when they arrived. No injuries were noted. Tenant #1 was dressed appropriately in street clothes and wearing a winter coat. The temperature outside was approximately 55 degrees.

According to Nurse's/Care Notes dated 10-24-13, Tenant #1 left the dementia unit via the southwest exterior door and walked next door to the medical clinic and sat down in the waiting room. Tenant #1 told medical clinic staff Tenant #1's first name and then medical clinic staff noticed Tenant #1 was wearing an Alzheimer's bracelet. Tenant #1's spouse was notified. Tenant #1's spouse informed the caller Tenant #1 resided in the dementia unit at the Program. Medical clinic staff then called the Manager. The Manager and the DON went to get Tenant #1. Tenant #1 was seated in the lobby, dressed appropriately and wearing a winter coat. Tenant #1 was returned to the Program via the van and the DON escorted Tenant #1 back to the dementia unit. Staff was educated on door alarms. The southwest exterior door Tenant #1 exited was checked. The panic bar was pushed and did not alarm. The alarm was reset and then functioned. Staff was in-serviced on dementia unit door alarms and procedure when door alarms went off. A call was placed to Tenant #1's spouse to reassure Tenant #1 was safe and back in the building.

According to Staff #1's written statement, Staff #1 was sitting at the table playing cards with several tenants. Staff #2 had just taken a tenant to check the tenant's blood sugar before supper. Tenant #1 and another tenant followed. Staff #1's pager went off at approximately 3:30 p.m. and it showed the south wing door. Staff #1 did a visual check on all doors and did not see anyone near the doors. Staff #1 finished the card game and began getting tenants ready for supper.

Staff #1 was interviewed. Staff #1 was sitting in the common area in the dementia unit. Staff #2 had gotten up to take another tenant to the room to give medications. Tenant #1 and another tenant went down the hall. A page went off, Staff #1 did not recognize the door and it was a page Staff #1 had not seen before and it indicated one of the doors was opened. Staff #1 did not get up and check the doors but did visualize the doors from where Staff #1 was seated. Staff #1 said she visualized the doors and there was nothing unusual at the doors. Staff #1 did not know it went to pager because the doors had an audible alarm and staff had to go and shut off the alarm. Staff #1 said the Manager and the DON asked if they were missing anyone and asked about a head count and said Tenant #1 was at the office. The Manager went and brought Tenant #1 back. Tenant #1 did not sustain any injuries. Tenant #1 was independent with mobility. From the time Staff #1 last saw Tenant #1 and the time the page was received was approximately two minutes. Staff #1 said Tenant #1 went to the doors frequently and some days would set off the alarm and other days would not set off the alarm.

In the dementia unit Tenant #1 had visual checks every hour and staff kept a constant eye on Tenant #1. At the time of the elopements checks were completed appropriately. Staff #1 said there was enough staff to meet the needs of the tenants.

According to Staff #2's written statement, Staff #1 was playing cards with a group of tenants at the table and Staff #2 had finished folding napkins with Tenant #1. It was approximately 3:30 p.m. when Staff #2 went with another tenant to the tenant's apartment to check the tenant's blood sugar before supper. Tenant #1 and another tenant were also in the hallway. When Staff #2 was in the tenant's apartment a door signal came across the pager but not an alarm. When Staff #2 left the tenant's apartment there was no one in the hallway and Staff #2 went to another tenant's apartment to assist with toileting. Minutes later she went to the other end of the hall to talk with staff as to what needed to be done before supper. At that time the Manager came and reported Tenant #1 missing.

Staff #2 was interviewed. She said it was 3:30 p.m. and Staff #2 walked another tenant to the tenant's room to take a blood sugar. Staff #1 was at the dining room table and was doing an activity with other tenants. Staff #2 was checking the other tenant's blood sugar. Staff #2 did not physically look at the pager Staff #2 had gloves on. Staff #2 said it sounded like someone coming in the doors. Staff #2 was done with the blood sugar, Staff #1 was in with another tenant and there was a family member for one of the tenants and Staff #2 believed that was who came in. Staff #2 went to where Staff #1 was and then the Manager came in. It was approximately 15 minutes from when the page went off until the Manager came in. The light on the door was green and the door did not alarm. Tenant #1 did not have any injuries and the visual checks were completed regarding Tenant #1. There had been no prior or subsequent elopements with Tenant #1. Tenant #1 was wearing a coat; however, it was not sure if it was Tenant #1's coat. Tenant #1's pattern was to walk the halls and Tenant #1 had set off the alarm.

The DON said she was in the Manager's office and a telephone called was received regarding one of the Program's tenants at the medical clinic. Tenant #1 told the medical clinic staff Tenant #1's first name and Tenant #1's Alzheimer's bracelet was noticed. The bracelet had Tenant #1's spouse's name and number. The spouse was contacted and the spouse told them Tenant #1 resided at the Program. The DON and Manager brought Tenant #1 back to the Program. The DON escorted Tenant #1 to the dementia unit. Tenant #1 was wearing street clothes, shoes and winter coat. Tenant #1 was independent with mobility and did not require assistance of another person or assistive device. The southwest exit door did not alarm but it did go to the pager. The DON and Manager turned the key on the alarm and it was activated and alarmed. Staff #1 saw the pager and went to the door and did not see anyone at that point. Staff was in-serviced on the door alarm. A second door alarm was ordered and signs were placed the doors. Tenant #1 had one hour visual checks and the checks were completely appropriately. Tenant #1 did not have any prior or subsequent elopements. Since the elopement the door alarms had functioned appropriately.

The Manager said regarding the elopement that it was windy that day and there were power surges. Power surges happened frequently. The page went to the pager; however, the alarm malfunctioned.

Staff was aware that every door went to the pagers. There had been no prior or subsequent elopements with Tenant #1. After the elopement, battery alarms and signs were added to the doors, staff was re-educated on door alarm policy and policy and procedures when door pages went off and an elopement pack was developed. The Manager said there was sufficient staff to meet the needs of the tenants.

A document was completed by the DON and the Manager regarding the elopement with Tenant #1. At approximately 3:58 p.m. on 10-24-13 the Manager received a telephone call from next door medical clinic staff that one of the Program's tenants was there and seemed confused. The medical clinic staff asked the tenant's name and the tenant identified himself/herself as Tenant #1. The Manager told the medical clinic staff they would be right over to get Tenant #1 and bring Tenant #1 back to the Program. The Manager got the keys to the van and the Manager and DON went to the medical clinic. They observed Tenant #1 in the waiting room of the clinic in a coat. Tenant #1 was calm. Tenant #1 reported Tenant #1 took a walk and could not figure out how to get back in to the building and ended up next door. The DON asked if Tenant #1 wanted to come back to the Program for supper and Tenant #1 agreed without hesitation. Tenant #1 was brought back in the van and the DON and Tenant #1 walked back into the building with no redirection needed. The DON escorted Tenant #1 to the dementia unit where Tenant #1 took off the coat and sat down quietly.

According to the document, the Manager and DON checked every door in the dementia unit. The southwest door audio alarm did not work when the panic bar was pushed. They used the keys and reset the alarm and it then functioned appropriately. The door was tested several times and it worked every time after the alarm on the door was reset. The pagers were checked and the pager showed a southwest door page at 3:46 p.m. When Staff #1 was asked if Staff #1 received a page of a door alarm, Staff #1 said that she had, and got up from the table and did a visual check of the southwest door and did not see anyone by or outside the door. Staff #1 then looked at all the outside doors to make sure she was looking at the right door and did not note anything out of the ordinary. The door was tested on the morning of 10-25-13 and it tested correctly and there was no issues with the door alarm working properly. It was tried three times throughout the day and the door did not duplicate any issues. The alarm sounded every time it was tested and the magnet engaged every time it was reset.

According to the document, the plan of action included to re-educate staff of the door alarm policy, re-educate staff of policy and procedures when a door page went off, check all exit doors every shift until second audio alarm was installed and order and install a second audible alarm on all outside doors in the dementia unit.

Staff #1 and Staff #2 received Counseling/Warning Reports regarding not checking dementia unit door alarms as oncoming staff. The southwest door showed on the pager but staff did not follow the door alarm policy.

There were two doors in the dementia unit that went to the exterior of the building, one door that went to the secured courtyard and two interior doors that went to the general population.

The two exterior exit doors were 15 second egress doors and also had a battery alarm. At the time of the elopement the doors did not have a battery alarm. At the time of the investigation the doors alarms were checked and functioned appropriately. The door alarm records indicated the southwest door was opened at 3:46 p.m. and was reset in eight seconds.

The dementia unit door alarm policy indicated the procedure was at the start of second shift staff was to check the three exterior alarmed doors by checking the light above the door. The light should be red on all doors. If the indicator lights showing proper function were not red to notify the Manager immediately. All staff dedicated to the dementia unit area was to check and wear company provided pagers during the shift. The program required staff to respond if any door alarm sounded or a page came across the pager for the dementia unit door alarm to check all doors promptly. The alarmed doors would open within 15 seconds in case there was a fire. Thoroughly check inside and outside areas triggered by the alarm. A tenant check was to be completed to make sure all tenants were accounted for.

The elopement procedure indicated to watch for signs of wandering and confusion, if any door alarm sounded, check alarms promptly. Thoroughly check inside and outside areas triggered by the alarm. If a potential elopement had occurred and the tenant was not seen, notify the Nurse and or Manager and check all apartments, offices, closets, bathrooms and common areas. The Manager or Nurse would call family to see if the tenant was with them. An outside search would also be conducted. If the tenant was still not found the Manager or Nurse would notify local law enforcement. The Manager or Nurse would notify the family, once the tenant was found. An incident report was to be filled out and document on any elopement or attempted elopement.

According to a statement from the Manager, the exterior and interior doors in the dementia unit had visual and system checks to make sure the doors were alarmed and locked from 10-25-13 to 10-31-13 at least once daily. The doors did not duplicate any issues or malfunctions. The Manager installed the second audio alarm on exterior doors at 11:00 a.m. on 10-31-13.

An in-service was held on 11-13-13 and the elopement policy was reviewed.

Hourly visual checks were consistently documented as completed for Tenant #1 on 10-24-13.

According to the Program's Monthly Inspection Forms, when inspected in September, October and November 2013 door alarms and key pads were checked and there were no concerns identified.

The path Tenant #1 took from the Program to the medical clinic was not witnessed; however, possible terrain included: sidewalk, grass and streets. Tenant #1 would have crossed a city street with a 25 mile per hour (mph) speed limit.

According to the State Climatologist, on 10-24-13 at 3:52 p.m. at the Davenport Airport the conditions were as follows: temperature 39 degrees, winds were from the west at 14 mph, the wind chill was 31 degrees; there were cloudy skies and no precipitation near at that time.

The Program reported the elopement to the Department. An incident report was completed. An investigation was completed. Additional battery alarms were added and signs were added to the exterior doors. Evaluations were completed after the elopement and the service plan was updated. Visual checks were documented as completed on 10-24-13. After the elopement there was an in-service and the elopement policy was reviewed. An elopement kit was developed.

Policies and procedures were not followed regarding Tenant #1's elopement. Staff did not at the start of second shift check the exterior alarmed doors by checking the light above the door for proper function notification. Staff did not check all doors promptly if any door alarm sounded or a page came across the pager for the dementia unit doors. Staff did not thoroughly check inside and outside areas triggered by the alarm. A tenant check was not completed to make sure all tenants were accounted for. The Program's policies and procedures were not followed regarding Tenant #1's elopement.

- 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)

B. Service Plans

Complaint/Incident Allegation #46095-C: It was alleged a tenant fell and sustained an injury.

- Monitoring Observation: Tenants #2, #3, #4 and #5 fell and sustained fractures.

Tenant #2, an 82 year old, was admitted on 6-4-12 and diagnoses included: HTN, Osteoporosis, Glaucoma, Depression and Expressive Aphasia. Tenant #2 was staged a five on the GDS, which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit.

According to an incident report, on 9-8-13 at 4:00 p.m. staff walked into Tenant #2's apartment and observed Tenant #2 on the floor. Tenant #2 was lying on the floor with head and shoulders in between the television and desk. Tenant #2 reported Tenant #2's right hip hurt. Staff put a pillow under Tenant #2's head, then called the nurse on call and called 911 and family as directed by the nurse. Tenant #2 was in a lot pain holding the right hip and was very restless trying to relieve the pain.

According to Nurse's/Care Notes dated 9-9-13, when staff entered the apartment they observed Tenant #2 on the floor with head and shoulders in between the television and desk. The fall was unobserved. Tenant #2 reported the right hip really hurt.

Staff placed a pillow under Tenant #2's head and placed a call to 911 and notified family. Tenant #2 was independent with mobility using the wheeled walker. Tenant #2 was transferred to the hospital for evaluation. Tenant #2's family called and reported Tenant #2's right hip was broken. Nurse's/Care Notes dated 10-21-13 indicated it was planned to discharge Tenant #2 from a nursing home back to the Program on 10-28-13.

According to an incident report, on 11-9-13 at approximately 4:30 a.m. Tenant #2 pushed the pendant and staff responded. Tenant #2 was observed on the floor at the end of the bed with the walker in front of Tenant #2 and was asking for help. Staff called another staff to assist and reassure Tenant #2 as staff called the DON. Staff called 911 and sat with Tenant #2 until Emergency Medical Services (EMS) arrived. Tenant #2 was in good spirits and reported "My legs hurt and my back and bottom."

According to Nurse's/Care Notes dated 11-11-13, staff called the DON on 11-9-13 and reported Tenant #2 pushed the pendant and staff responded and observed Tenant #2 sitting on the floor with Tenant #2's walker in front of Tenant #2 asking for help. Tenant #2 complained of leg and back pain. The DON instructed staff to call 911, not move Tenant #2, take vital signs, contact family and send Tenant #2 to the Emergency Room (ER) to be evaluated. Tenant #2 returned later that day and all X-Rays were normal. A Urinalysis showed positive for a Urinary Tract Infection (UTI). Tenant #2 was started on Bactrim DS one tablet by mouth for five days. Tenant #2 received 500 milliliters intravenous fluids in the ER. Tenant #2 remained independent with mobility with wheeled walker. Tenant #2 had a history of UTIs and Urinary Retention noted on the service plan.

According to an incident report, on 11-11-13 at 7:20 p.m. staff was doing room checks and heard Tenant #2 calling from the room. Staff observed Tenant #2 lying face down approximately 10 feet inside the door. The walker was turned over. The right arm was beside Tenant #2 with the left arm under Tenant #2. The DON, medic and family was called. Staff stayed with Tenant #2 until medics arrived. Tenant #2 was calm and complained of pain in the upper arm/shoulder. On 11-12-13 Tenant #2 was sent back out on 11-12-13 by EMS.

According to Nurse's/Care Notes dated 11-12-13, on 11-11-13 at approximately 7:20 p.m. staff called the DON to report when doing room checks they heard Tenant #2 calling from the apartment. Staff observed Tenant #2 lying face down approximately 10 feet inside the door with the walker turned over. Tenant #2's right arm was beside Tenant #2 and the left arm was under Tenant #2. Tenant #2 complained of pain in left upper arm/shoulder. Tenant #2 returned to the Program. Staff attempted to get Tenant #2 dressed but Tenant #2 complained of pain in the left arm/shoulder. The area was swollen, purple and discoloration was noted. A decision was made to have Tenant #2 transferred back to the ER via EMS.

Staff #2 said she was doing some checks, going down the hall and heard Tenant #2 calling from the room. Tenant #2 was lying on the floor, Staff #2 called other staff and the DON was called. The DON said to call Emergency Medical Technicians (EMTs). Family was notified. Tenant #2 said Tenant #2 was hurting. The walker was lying on the side. Tenant #2 was sent out.

According to Nurse's/Care Notes dated 11-18-13 and 11-19-13, Tenant #2 had a fall on 11-11-13 that resulted in a left shoulder fracture. Tenant #2 was independent with mobility with the wheeled walker. Tenant #2 was hospitalized on 11-12-13 for uncontrolled pain related to left shoulder fracture. During the hospital stay Tenant #2 had difficulty swallowing and requested no feeding tube per living will. Tenant #2 was placed on hospice. Tenant #2 returned from the hospital on 11-18-13. Tenant #2 was bed bound, was repositioned approximately every two hours, incontinent care and oral care was provided approximately every two hours. Tenant #2 was able to verbalize need with one to two words and hand gestures. The Program applied for a waiver of administrative rule from the Department for Tenant #2.

The service plan in place at the time of the incident on 9-9-13 indicated Tenant #2 was independent with mobility with use of wheeled walker. Evaluations and the service plan were updated on 10-21-13 prior to Tenant #2's return post hip fracture. The 10-21-13 service plan indicated staff assisted with mobility using a gait belt and wheeled walker. Tenant #2 was independent with transfers from bed to/from wheelchair. Tenant #2 walked with a drop left foot. Tenant #2 had a history of falls. Evaluations and the service plan were updated on 11-4-13. According to the Subsequent Health/Functional Assessment, Tenant #2 and family requested Tenant #2 to return to independent with ambulation with the use the walker and could use a wheelchair for distances. The service plan reflected Tenant #2 was independent with mobility in the dementia unit with the use of the wheeled walker. Tenant #2 might request staff assistance by wheelchair for longer distance. Evaluations and the service plan was updated on 11-18-13, post left shoulder fracture, placement on hospice and return to the Program.

Tenant #2 fell and sustained a fracture on 9-9-13. An incident report was completed. Tenant #2 was independent with mobility with a wheeled walker. Evaluations were completed and the service plan was updated post fracture and with Tenant #2's return to the Program. On 11-11-12 Tenant #2 fell and fractured a shoulder. An incident report was completed. Tenant #2 was sent back due to the ER on 11-12-13 for uncontrolled pain, was hospitalized and started on hospice. Evaluations and the service plan were updated. The Program applied for a waiver of administrative rule for Tenant #2.

Tenant #3, an 89 year old was admitted on 12-14-08 and diagnoses included: HTN, Insulin Dependent Diabetes Mellitus, Peripheral Vascular Disease, Severe Arthritis, Cataract Surgery and Right Shoulder Replacement. Tenant #3 scored a value that indicated normal mental functioning on the cognitive evaluation.

According to an incident report, on 10-11-13 at 12:15 a.m. Tenant #3 activated the pendant and staff responded. Staff attempted to put a gait belt on Tenant #3 and Tenant #3 refused and stated it hurt Tenant #3's ribs. Staff assisted on both sides of Tenant #3 to stand up. Tenant #3 started to turn right with pivoting Tenant #3's feet. One staff moved over three to four steps. Tenant #3 was being assisted by other staff. Tenant #3 then fell over landing on Tenant #3's side. Staff observed a large open area on Tenant #3's forehead and side of the face. There were skin tears on the right and left legs and left arm. There was a raised area on the forehead. The nurse and 911 was called.

Tenant #3 was uncomfortable on Tenant #3's side and kept asking to be turned over. They "log rolled" Tenant #3 over to Tenant #3's back and placed a pillow under the head. Pressure was applied to the forehead and skin tears as instructed by the 911 operator until ambulance/fire rescue arrived. Tenant #3 complained of left arm and leg pain. Tenant #3 wanted to turn on Tenant #3's back.

According to a Nurse Review dated 10-11-13, the nurse received a call at home at 12:15 a.m. from universal workers who reported Tenant #3 had fallen and had a laceration to Tenant #3's forehead. The nurse instructed staff not to move Tenant #3 and call 911 and then Tenant #3's family. Staff called back at 3:37 a.m. and said Tenant #3 had a neck fracture. When the incident report was reviewed it indicated two staff assisted Tenant #3 up from bed to get into Tenant #3's electric wheelchair to use the bathroom. Staff indicated Tenant #3 refused the use of the gait belt because it hurt Tenant #3's ribs. As Tenant #3 was turning to sit in the chair Tenant #3 fell. Tenant #3 was sent to the ER by EMS and family was notified. Tenant #3 sustained a C2 break with no cord involvement and was going to be treated by putting Tenant #3 in a brace.

Nurse's/Care Notes dated 10-11-13 indicated Tenant #3 had a C2 fracture, multiple abrasions and facial swelling.

The service plan in place at the time of the incident indicated Tenant #3 requested assistance with mobility using the rolling walker in the apartment to and from the bathroom. Staff was to use a gait belt for transfers and mobility. Tenant #3 was independent with mobility when Tenant #3 used the electric wheelchair. Tenant #3 was able to bear minimal weight to the left knee. The service plan also reflected Tenant #3 had very fragile skin and staff was to use caution with cares and notify the nurse of any new skin issues.

Tenant #3 had not returned to the Program at the time of investigation.

The Program reported the incident to the Department. The Program completed an investigation regarding the incident with Tenant #3. According to the Investigation Report, Tenant #3 was alert and oriented times four. Tenant #3 was a one to one minimal assist with transfers, mostly helping Tenant #3 up from the sitting position. Tenant #3 had no falls in the past six months and had not received Physical Therapy/Occupational Therapy (PT/OT) in the past six months. Staff #3 assisted Tenant #3 to a sitting position on the side of the bed. Tenant #3 requested the assistance of one but since Tenant #3 refused to let Staff #3 put the gait belt on so two staff assisted Tenant #3. Tenant #3 stood up without difficulty, was in the process of pivot and turning to set down in the wheelchair when the fall occurred. Tenant #3 was wearing non-skid slipper socks and a night clothes. Tenant #3 did not verbalize any new complaints to Staff #3. Staff #6 worked with Staff #3 that night. Staff #6 positioned the wheelchair next to the bed and assisted Tenant #3 along with Staff #3 in getting up so Tenant #3 could turn and sit down in the wheelchair. After speaking with the staff involved working with Tenant #3 there was nothing to alert them that Tenant #3 was not feeling well or unsteady on Tenant #3's feet.

Staff #3 had a written statement. Tenant #3 was sitting on the side of the bed, Staff #3 and the other staff offered a gait belt and Tenant #3 refused. They assisted Tenant #3 to stand up and Tenant #3 was turning around. Staff #3 stepped back a few steps as Tenant #3 turned the other staff was next to Tenant #3. As Tenant #3 turned Tenant #3 fell over to the floor landing on the front of the body on the floor. After contacting the nurse, they logged rolled Tenant #3 over to Tenant #3's back and applied pressure to the open wounds per instructions of the 911 operator until the ambulance and fire rescue arrived.

Staff #6 had a written statement. Staff #6 entered the apartment at around 12:10 a.m. after responding to a pendant. Tenant #3 was lying in bed a gait belt was offered by Staff #3 but was told it hurt Tenant #3. Both staff assisted Tenant #3 in standing up and the electric wheelchair was placed close to Tenant #3, allowing Tenant #3 to turn around and pivot into it. Tenant #3 attempted to turn around and sit in the wheelchair. Staff #3 had turned to ensure the walkway was clear. As Tenant #3 turned Tenant #3 lost Tenant #3's balance and fell away from Staff #6. There was no way either of the staff could catch Tenant #3 or even assist in Tenant #3's fall. Tenant #3 landed face down with the left arm appearing to be stuck under the tenant.

Staff #3 said Tenant #3 refused the gait belt on a daily basis when Staff #3 worked. Staff #4 said Tenant #3 used a gait belt and did not refuse to use the gait belt. In the afternoon Staff #4 walked with Tenant #3 using a gait belt to the chair. Staff #5 said she used a gait belt to walk Tenant #3 back and forth to the bathroom but did not use it when transferring from the bed to the wheelchair or from the chair to the wheelchair. Staff #5 said Tenant #3 was a one person transfer and did not refuse the gait belt. The DON said Tenant #3 was assisted with mobility to and from the bathroom. Tenant #3 was a transfer assist with a gait belt to and from the bathroom. The gait belt was refused on the night of the incident with Tenant #3. From the bed to the wheelchair a gait belt was not required for the transfer. The DON said she felt like staff handled the situation well regarding rolling Tenant #3 over as Tenant #3 could have done harm to self and Tenant #3 calmed down after being rolled over and was comfortable.

The service plan in place at the time of the incident indicated Tenant #3 requested assistance with mobility using the rolling walker in the apartment to and from the bathroom. Staff was to use a gait belt for transfers and mobility. Tenant #3 was independent with mobility when Tenant #3 used the electric wheelchair. Tenant #3 was able to bear minimal weight to the left knee. The service plan also reflected Tenant #3 had very fragile skin and staff was to use caution with cares and notify the nurse of any new skin issues. The service plan did not reflect Tenant #3's refusal of the gait belt and other possible transfer techniques or options due to the refusals. Tenant #3 fell and sustained a fracture. At the time of the fall Tenant #3 had refused to use the gait belt. Tenant #3's service plan did not reflect the identified needs and preferences for assistance.

Tenant #4, a 90 year old, was admitted on 10-31-12 and diagnoses included: Recent Cerebral Vascular Accident, Bilateral Knee Replacement, Bilateral Cataracts, Hemiparesis, Depression, Weakness and Gall Bladder Stones. Tenant #4 scored a value that indicated normal mental functioning on the cognitive evaluation.

According to an incident report, on 10-15-13 at 2:40 p.m. Tenant #4 pushed the pendant and was found on the floor next to the chair. Tenant #4 reported Tenant #4's right leg hurt and Tenant #4 was sent to the hospital by ambulance.

According to a nurse review dated 10-15-13, staff responded to a pendant call and Tenant #4 was found on the floor. Staff called for a nurse to come to the apartment. The nurse assessed Tenant #4 and Tenant #4 complained of pain to the right knee. The staff activated EMS and Tenant #4 was not moved by staff related to pain in the knee. Family was notified of the transfer to the ER for evaluation.

According to Nurse's/Care Notes dated 10-16-13 Tenant #4 was admitted to the hospital with a fracture for observation. Nurse's/Care notes dated 10-18-13, Tenant #4 was admitted to nursing home for rehabilitation related to a break above the ankle. Tenant #4 returned to the Program on 12-2-13. Evaluations were completed and the service plan was updated regarding Tenant #4's return to the Program.

According to a nurse review dated 10-10-13, Tenant #4 was independent with mobility in the apartment with the use of a walker. Staff assisted Tenant #4 for distance mobility using the wheelchair and Tenant #4 would push the pendant when assistance was needed. Tenant #4 was discharged from PT on 10-4-13 with goals met.

The service plan in place at the time of the fall and fracture indicated Tenant #4 was independent with mobility in Tenant #4's apartment with the use of a walker. Tenant #4 would activate the pendant if Tenant #4 needed assistance. Staff assisted Tenant #4 to and from meals and activities via wheelchair. Family provided a hospital bed with rails for increased bed mobility. The service plan was updated after the fracture and reflected Tenant #4 was independent with mobility in Tenant #4's apartment with the use of the walker if Tenant #4 needed assistance Tenant #4 would activate the pendant. Tenant #4 requested to be independent with mobility to and from the bathroom. Tenant #4 was to wear immobilizer boot when ambulating. Tenant #4 used a wheelchair to and from meals. Family provided a hospital bed with rails and trapeze bar for increased bed mobility.

Tenant #4 fell and sustained a fracture. An incident report was completed. Tenant #4 was independent in ambulation in the apartment with a wheeled walker at the time of the fall. Tenant #4's occurred in Tenant #4's apartment. Evaluations were completed and the service plan was updated post fracture and with Tenant #4's return to the Program.

Tenant #5, a 94 year old, was admitted on 8-12-12 and diagnoses included: Atrial Fibrillation, HTN, Pacemaker, Hypercholesterolemia, Hypothyroidism, Rhinitis and Overactive Bladder. Tenant #5 was staged at a three on the GDS, which indicated mild cognitive decline.

According to an incident report, on 9-14-13 at 5:30 p.m. staff observed Tenant #5 fall but could not see Tenant #5 fall, just feet in the air. Tenant #5 complained of the right shoulder hurting and staff did not move Tenant #5. Tenant #5 was sent to the ER and was admitted to the hospital for a broken humorous. Tenant #5 reported Tenant #5 tripped over Tenant #5's feet.

According to a nurse review dated 9-15-13, Tenant #5 was in the main dining room for supper on 9-14-13 when Tenant #5 got up and fell. Staff observed Tenant #5 lying on the floor, Tenant #5 complained of right arm shoulder pain. Staff instructed Tenant #5 to lay still and wait for help. Staff called the nurse and was instructed to call 911 and not to move Tenant #5. The nurse called the hospital for report and was told Tenant #5 had a broken humorous and was going to require surgical repair to fix it. Tenant #5 was admitted to the hospital.

Staff #5 said she saw Tenant #5's feet; however, did not see Tenant #5 fall. At the time of the fall Tenant #5 did not require any assistance to and from the dining room. Staff #5 went over and Tenant #5 was on Tenant #5's back and said the shoulder hurt. Staff #5 called 911, called the nurse and called the family. Tenant #5 was not moved until the EMTs arrived.

According to Nurse's/Care Notes dated 10-16-13, Tenant #5 returned to the Program. Evaluations were completed and the service plan was updated prior to Tenant #5's return to the Program.

The evaluation in place at the time of the fall indicated Tenant #5 was independent with ambulation using a wheeled walker. The service plan was updated on 10-11-13 prior to Tenant #5's return to the Program and on 11-13-13 and 11-20-13. An update to the service plan dated 11-26-13 reflected Tenant #5 was discharged from PT due to goals met and Tenant #5 was independent with wheeled walker in the apartment and in the community.

Tenant #5 fell and sustained a fracture. An incident report was completed. Tenant #5 was independent in ambulation with a wheeled walker. Evaluations were completed and the service plan was updated post fracture and with Tenant #5's return to the Program.

Staff #1, #2, #3, #4, #5 and #6 had nurse delegated training on using a gait belt, ambulation with a walker and transferring from bed to chair.

Tenants #2, #3, #4 and #5 sustained fractures and incident reports were completed related to the incidents. Tenant #3's service plan did not reflect the identified needs and preferences for assistance.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))