IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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March 11, 2014

Complaint Intake #'s: 44432-CR2
44725-IR2
45101-CR
45278-CR
46375-C
47139-C

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

RE: Final Complaint Investigations, Complaint/Incident Revisits & Recertification Monitoring Evaluation Report – Oakwood Place Assisted Living, Davenport, IA

Dear Ms. Harris:

Enclosed is the **Final Complaint Investigations, Complaint/Incident Revisits & Recertification Monitoring Evaluation 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, following a survey by DIA on **February 11, 13, 18 and 19, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Service Plan and Staffing.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted to DIA within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Also enclosed you will find the Assisted Living Program Certificate **S0139** with effective dates of **March 9, 2014** through **March 8, 2016**.

If you have any questions in regard to this report, please contact me at 515/281-7039 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 Investigations & Complaint/Incident Investigation Revisits & Recertification Monitoring Evaluation Report

Assisted Living Program:

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

Complaint/Incident Intake #: 44432-CR2
44725-IR2
45101-CR
45278-CR
46375-C
47139-C

Date of Complaint/Incident Investigations & Complaint/Incident Investigation Revisits & Monitoring Visit:

February 11, 13, 18 and 19, 2014

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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:	43
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	44

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	10
TOTAL census of Assisted Living Program	54

Tenant/Family Satisfaction Results – A community meeting with 16 tenants, two tenant interviews and one family interview were held. Housekeeping services were completed to their satisfaction and there were no issues with housekeeping, maintenance or laundry. Nursing services were available and staff responded within five to ten minutes when tenants requested assistance. The tenants received the services expected when the occupancy agreement was signed. Staff treated the tenants with respect and they received the services requested. There was a variety of foods served and there was enough food served. Cold foods were served cold. Hot foods were not always served hot; however, staff would warm up the food if requested. The tenants reported the food was too spicy; however, it was reported there was a new chef and the issue was being addressed. The vegetables including green beans, carrots and peas were at times overcooked and at times undercooked. The meat at times was tough and the chicken was dry. There were enough activities offered and they said the activity staff did a good job. There were no suggestions for additional activities and the tenants received a schedule of activities. There were a good variety of activities offered and activity supplies were available. There was a suggestion for closed caption viewing on the television across from the country kitchen. There was a comment regarding it would be helpful to be able to differentiate between a pendant call for emergency services and a pendant call for routine care needs. There was an isolated incident with a whirlpool bath; however, the staff no longer provided the tenant with bathing services and no other tenants expressed concerns with bathing. The tenants felt safe and made their own decisions. The tenants would recommend the Program to others. The tenants could go to Administrative staff with concerns.

Program History – During the course of the complaint investigations, complaint/incident investigations revisits and recertification conducted on February 11, 13, 18 and 19, 2014 the Program received regulatory insufficiencies in the areas of: Service Plan and Staffing.

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

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

A. Criteria for Admission and Retention

The Program received a regulatory insufficiency at the time of the October 28 and 29, 2013 complaint investigations (45101-C; 45278-C) and complaint/incident investigation revisits (44432-CR; 44725-IR) regarding Tenant #3 related to knowingly admitting or retaining a tenant who was dangerous to self or others tenants or staff, including but not limited to a tenant who despite intervention chronically eloped, was sexually aggressive or abusive or displayed unmanageable verbal abuse or aggression or displayed behavior that places another tenant at risk.

- Monitoring Observation: Tenant #3 was discharged on 11-7-13. Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24). Tenants #2, #9, #23 and #24 had been discharged from the Program to a higher level of care. Tenants #5, #8, #11, #18, #20 and #21 were current tenants and did not exceed the criteria for admission and retention.

  The RN Manager was interviewed and stated there were no tenants who wandered, urinated outside of the bathroom, exhibited behaviors or exceeded level of care. The LPN and Staffs #1, #2, #6, #7 and #13 stated there were no tenants who wandered, urinated outside of the bathroom, exhibited behaviors, required routine two person assist or exceeded level of care.

  Review of tenant files, staff interviews, an interview with the LPN and RN Manager did not reveal concerns regarding criteria for admission and retention.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #46375-C: It was alleged there were tenants that did not meet the requirements for assisted living. It was alleged tenants needed two to one care, could not ambulate, were incontinent, had behaviors, went into other tenant rooms and bathrooms and was verbally abusive towards staff and some other tenants. It was alleged it was more care than could be provided.

- Monitoring Observation: Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24). Tenants #2, #9, #23 and #24 had been discharged from the Program to a higher level of care. Tenants #5, #8, #11, #18, #20 and #21 were current tenants and did not exceed the criteria for admission and retention.

  Tenant #2, a 77 year old, was admitted on 8-10-12 and diagnoses included: Dementia, Glaucoma, Acid Reflux, Anxiety, Alzheimer's Disease, Sleep Apnea, Joint and Muscle Pain and Depression. Tenant #2 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #2 resided in the dementia unit. Tenant #2 was discharged on 2-3-14. According to Resident Notes dated 1-20-14, there was a discussion with family regarding Tenant #2's increased assistance with activities of daily living and going into other apartments. Family agreed Tenant #2 needed more assistance and would contact the rest of the family and talk with the social worker at the nursing facility about a transfer. The doctors were notified of the condition and the future transfer. According to Resident Notes dated 1-23-14, there were plans to transfer Tenant #2 to a private room and family would come on 2-1-14 to transfer. Resident Notes dated 2-3-14 indicated Tenant #2 went home on the weekend with family and returned on 2-3-14 and was taken to the new apartment by family. Evaluations and the service plan were updated on 1-18-14.

  Tenant #23, a 91 year old, was admitted on 11-22-13 and diagnoses included: Diabetes, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Coronary Artery Disease (CAD), Anemia, Nerve Pain, Hypertension (HTN), Hyperlipidemia, Constipation, Glaucoma and Asthma. According to a service plan dated 11-21-13, Tenant #23 requested assistance with medications, assistance in and out of the shower/tub, assistance with oral care, one assist with dressing, transfers, mobility, toileting, housekeeping and laundry services. Tenant #23 was independent in eating. According to Resident Notes dated 11-30-13 staff reported Tenant #23 had been incontinent of bowel and bladder. On 12-1-13 a message was left for Tenant #23's family regarding concerns with complaints of back hurting, low motivation and incontinence. Tenant #23's physician was updated. According to Resident Notes dated 12-5-13, Tenant #23 had an appointment with Tenant #23's physician. A call was received from the hospital that Tenant #23 had been admitted directly from the physician's office for dark stools. On 12-6-13 Tenant #23's family reported due to changes and weakness that Tenant #23 would be transferred to a higher level of care upon discharge. Tenant #23 was discharged on 12-6-13.

  Tenant #24, an 81 year old, was admitted on 11-12-13 and diagnoses included: Osteoporosis, Circulation, Glaucoma, Constipation, Congestive Heart Failure, Hyperlipidemia, HTN, Depression, Gastro Esophageal Reflux Disease (GERD) and Inflammation. According to a service plan dated 12-11-13, Tenant #24 requested assistance with medication, assistance in and out of the shower/tub, one assist with dressing, transfers, housekeeping services and laundry. Tenant #24 was independent with hygiene and grooming, walking, toileting and eating.

According to Resident Notes dated 12-16-13, Tenant #24 used the emergency call system around 8:45 a.m. to call for help. Tenant #24 was observed lying on their back on the floor in the apartment. Vitals were taken and a large bump was noted to the right side of head and small abrasion noted to right elbow. Also Tenant #24 complained of back pain. Medics were called and Tenant #24 was transported to the ER. Tenant #24's family and physician were notified. Tenant #24 was admitted to the hospital. On 12-19-13 Tenant #24's family was at the Program and reported Tenant #24 was transferred to a skilled unit. On 1-10-14 Tenant #24 was admitted to a higher level of care and discharged from the Program.

The RN Manager was interviewed and stated there were no tenants who wandered, urinated outside of the bathroom, exhibited behaviors or exceeded level of care. The LPN and Staffs #1, #2, #6, #7 and #13 stated there were no tenants who wandered, urinated outside of the bathroom, exhibited behaviors, required routine two person assist or exceeded level of care.

Monitor observations in the dementia unit did not indicate any current tenants wandered.

Review of tenant files, staff interviews, an interview with the LPN and RN Manager did not reveal concerns regarding criteria for admission and retention.

- Regulatory Insufficiency: None noted.

B. Tenant Rights

The Program received a regulatory insufficiency at the time of the October 28 and 29, 2013 complaint investigations (45101-C; 45278-C) and complaint/incident investigation revisits (44432-CR; 44725-IR) regarding Tenant #3 and Tenant #18 related to all tenants not having the right to be treated with consideration, respect, and full recognition of personal dignity and autonomy.

- Monitoring Observation: Tenant #3 was discharged on 11-7-13. Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24).

  Tenant #18, an 88 year old was admitted on 2-13-07 and diagnoses included: Osteoporosis, Pain, HTN, Insomnia, Constipation, Edema, Anxiety, Hypokalemia, Indigestion and Depression. Tenant #18 scored an 11/11 on the cognitive tool, which indicated no or mild impairment. Tenant #18 resided in the dementia unit. Resident Notes from 12-6-13 to 1-24-14 did not reflect any concerns with other tenants entering Tenant #18's apartment. The service plan reflected staff monitored locations of other tenants to prevent them from entering Tenant #18's apartment. Tenant #18 was to push the call button if another tenant entered Tenant #18's apartment.

Staff was to respond promptly and escort the other tenant from Tenant #18's apartment. When another tenant was seen walking towards Tenant #18's apartment staff was to redirect to a different direction. Tenant #18's apartment door could be locked to prevent others from entering on bad days when tenants were wandering or when Tenant #18 was napping or at night. Tenant #18 was able to exit from the inside without using a key. Tenant #18 had made a sign to hang across the door to keep out.

Tenant #18 was interviewed and stated Tenant #18 had no more concerns regarding tenants entering Tenant #18's apartment. All tenants who wandered had left. Staff locked her apartment when there were tenants who wandered in and out but now there was no need to lock the apartment.

The RN Manager was interviewed and stated there were no tenants who wandered, urinated outside of the bathroom, exhibited behaviors or exceeded level of care. The LPN and Staffs #1, #2, #6, #7 and #13 stated there were no tenants who wandered, urinated outside of the bathroom, exhibited behaviors, required routine two person assist or exceeded level of care.

Monitor observations in the dementia unit did not indicate any current tenants wandered.

The Resident's Bill of Rights was provided and indicated the Program maintained policies, procedures and ongoing programs to ensure that the rights listed of each tenant were protected by all personnel.

Review of tenant files, an interview with Tenant #18, staff interviews, an interview with the LPN and the RN Manager did not reveal concerns regarding tenant rights related to tenants going into other tenant apartments.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47139-C: It was alleged tenants were rushed by staff in the dining room and were told they were late for meals when they still had time. It was alleged tables were wiped off in front of tenants and reset. It was alleged tenants were not given enough time to eat. It was alleged staff did not answer tenant requests in a timely manner at meals and ignored the tenants.

- Monitoring Observation: A community meeting with 16 tenants, two tenant interviews and one family interview were held. The tenants did not voice any concerns with the dining experience and described it as pleasant. The tenants did not have any concerns with being rushed at meals and said they had time to eat. The tenants did not voice any concerns with the tables being cleared or reset and said the process was completed appropriately. The tenants reported staff accommodated their requests at meals. The tenants said staff was responsive to the tenants at meals. Staff served them appropriately at meals.

The monitor observed a lunch meal. The lunch hour was from 11:30 a.m. to 12:30 p.m. Several tenants arrived early, they were greeted by staff, asked what they would like to drink and were given a salad if desired. Tenants came and left during the hour and time was provided for the tenants to take as much time as needed to consume their meal. The monitor observed staff removing a dirty plate from tenants once all food was consumed. After the tenants left the table, used glasses, silverware, placemat and napkins were removed. Other tenants were observed sitting at the tables where their dining partners had already left. No tables were reset while tenants were sitting at the tables. Staff responded to all requests during the dining experience and staff was attentive to tenant needs.

The RN Manager was interviewed and stated tenants had better not be rushed in the dining room, she stated the tables were cleared once the tenant left the table and tenants were absolutely given enough time to eat their meals. She stated staff did answer tenant requests in a timely manner during meals. The RN Manager stated staff sitting at a table during meal times was a concern the tenants raised at the February Resident Council Meeting and since then the table had been removed.

The LPN was interviewed and stated the tenants were not rushed in the dining room; tables were being wiped off in front of tenants and reset at empty spots. She stated the tenants were given enough time to eat. She stated staff answered tenant requests in a timely manner during meals, staff did not sit at tables in the dining room and never intentionally ignored the tenants during meals.

Staff #6 stated meals in the dining room was served from 7:30 a.m. to 8:30 a.m., 11:30 a.m. to 12:30 p.m. and 4:30 p.m. to 5:30 a.m. Some tenants came to the dining room at 11:00 a.m. to socialize and get their drinks. She stated about 45 minutes into the meal time she would call the apartments of tenants who had not yet arrived to see if they were planning to come to the meal. Tables were wiped off in front of tenants if it was close to the end of the hour. She stated tenants were not ignored during the meal, tenants were given enough time to eat and requests were answered in a timely manner.

Staff #13 stated tenants were not rushed in the dining room and tables were sometimes wiped off and reset in front of tenants. She stated staff had been told that staff and dietary workers were on a schedule that needed to be kept so it was necessary to reset the tables in front of tenants. She stated tenants were given enough time to eat their meals. She stated there was no longer a table for staff to sit at and no one ignored tenants if a hand was raised.

Eight staff files were reviewed (Staff #2, #6, #7, #8, #9, #10, #11 and #12). Staff had nurse delegations for Cleaning the Dining Room after a Meal. The delegation indicated tables needed to be cleared promptly after a meal had been completed; staff needed to ensure the table had been cleaned with the appropriate disinfectant and there were no spilled areas remaining.

When resetting the table with water pitchers, clean plates, cups, glasses and eating utensils it was to be observed the items were clean and free from dried food or stains and attention to the plate the water pitcher sat on also. Soiled items were returned to the kitchen for proper cleaning. The chair set and arms was to be wiped off as needed for spills with disinfectant. The Cleaning the Dining Room after a Meal delegation was completed for Staff #2, #6, #7, #8, #9, #10, #11 and #12.

Per the community meeting, staff interviews, the LPN interview, the RN Manager interview, monitor observation and review of staff delegations for cleaning the dining room after a meal did not reveal any concerns related to tenants being rushed at meals, tenants not given enough time to eat, lack of staff response at meals or having tables cleared and reset.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47139-C: It was alleged a staff was verbally abusive to a tenant, mocked a tenant and ignored a tenant when assistance was requested. It was alleged when a tenant asked for something a staff was rude.

- Monitoring Observation: There was an allegation related to a respite tenant. Tenant #22 was identified by the Program as a respite tenant. Tenant #22 was admitted for respite care on 1-13-14 and was discharged on 2-11-14. There were no administrative rules for respite in Chapter 67 or Chapter 69 at the time of the investigation; therefore the complaint allegation was not investigated.

  The RN Manager, the LPN and Staff #13 stated they had not observed any coworkers being rude to tenants. Staff #1 stated sometimes coworkers were rude to tenants. She stated Tenant #19 resided in the dementia unit and asked for water a lot and she witnessed Staff #2 bang her hand on the counter. Staff #2 was also impatient with Tenant #2 not being able to find Tenant #2's room. Staff #1 spoke with the RN Manager about two months ago and asked to no longer be assigned to work with Staff #2. Staff #2 stated she had never observed any staff being rude to tenants.

  According to interviews with Staffs #2, #6, #7 and #13 they were not aware of any tenants that had been abused.

  The monitor observed interactions between staff and tenants in the dementia unit and did not witness any staff being rude to tenants.

  A community meeting with 16 tenants, two tenant interviews and one family interview were held. The tenants received the services expected when the occupancy agreement was signed. Staff treated the tenants with respect and received the services requested.

Review of tenant files, a community meeting, an interview with the RN Manager and the LPN did not reveal concerns regarding staff being rude to tenants. Staff #1 said Staff #2 was impatient and she had asked not to work with Staff #2.

- Regulatory Insufficiency: None noted.

C. Evaluation

The Program received a regulatory insufficiency at the time of the October 28 and 29, 2013 complaint investigations (45101-C; 45278-C) and complaint/incident investigation revisits (44432-CR; 44725-IR) regarding Tenants #5 and #8 related to not evaluating 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 to determine any changes to services needed. The evaluation shall be conducted by a health or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant had not exhibited a significant change.

- Monitoring Observation: Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24).

  Tenant #5, a 79 year old, was admitted on 11-28-11 and diagnoses included: Anemia, Gastrointestinal (GI) Bleed, GERD, Hyperlipidemia, Atrial Fibrillation, Benign Prostate Hypertrophy, Depression, HTN and Gout. Cognitive, health and functional evaluations were completed on 12-5-13. Evaluations were completed as needed.

  Tenant #8, a 90 year old, was admitted on 6-12-13 and diagnoses included: HTN, Diabetes, Arthritis, Anxiety, Constipation, Depression and Pancreatic Insufficiency. Cognitive, health and functional evaluations were completed on 12-4-13. Evaluations were completed as needed.

  Review of tenant files indicated cognitive, health and functional evaluations were completed as needed.

- Regulatory Insufficiency: None noted.

D. Service Plans

The Program received a regulatory insufficiency at the time of the October 28 and 29, 2013 complaint investigations (45101-C; 45278-C) and complaint/incident investigation revisits (44432-CR; 44725-IR) regarding Tenants #3, #4, #5, #7 and #8 related to not developing a service plan 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.

- Monitoring Observation: Tenant #3 was discharged on 11-7-13. Tenant #4 was discharged on 9-13-13. Tenant #7 was discharged on 1-8-14. Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24).

  Tenant #5's file was reviewed. A service plan was completed on 12-5-13. The service plan was updated needed with significant change and was based on evaluations.

  Tenant #8's file was reviewed. A service plan was completed on 12-4-13. The service plan was updated needed with significant change and was based on evaluations.

  Review of tenant files indicated service plans were updated as needed with significant change and were based on evaluations.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24).

  Tenant #2's file was reviewed. According to Resident Notes dated 12-26-13, Tenant #2's family member reported Tenant #2 had urinary frequency, urgency and burning. New orders were received for a Urinalysis (UA) with Culture and Sensitivity if indicated and also start Cipro 500 milligrams twice daily for seven days (start after UA was collected). The service plan did not reflect Tenant #2's urinary frequency, urgency, burning and antibiotic therapy. The service plan did not reflect the tenant's identified needs and preferences.

  Tenant #5's file was reviewed. On 1-31-14 daily weights were discontinued and weekly weights were ordered. A nurse review was completed in Resident Notes on 1-31-14. The service plan reflected daily weights were discontinued on 1-31-14. Weekly weights were not added to the service plan. The February 2014 Treatment Administration Record (TAR) indicated Tenant #5's weight was obtained as ordered. The service plan did not reflect the tenant's identified needs and preferences.

  Tenant #21, a 76 year old, was admitted on 7-28-12 and diagnoses included: Alzheimer's Disease, Depression, Hyperlipidemia, HTN, Status/Post Right Hip Pinning, Dementia and Atrial Fibrillation. According to Resident Notes dated 12-10-13, Tenant #21 had red, irritated, right upper eye lid and a stye to inside corner. On 12-13-13 the Resident Notes indicated Tenant #21's right upper eye lid continued to be red, irritated and Tenant #21 complained of burning. New orders were received for Polytrim drops one drop to right eye four times daily for seven days. The redness, irritation and stye on Tenant #21's eye and eye drops were not reflected on the service plan.

The December 2013 Medication Administration Record (MAR) reflected eye drops were documented as administered. On 2-15-14 a minor discretionary change was added to service plan that reflected Tenant #21 might ask to help look for rings. Verbal reassurance was to be provided that Tenant #21's family had the rings getting them cleaned or repaired. It also reflected to get Tenant #21 involved with an activity or task. A nurse review was completed on 2-15-14; however, did not address the issue with the rings. The minor discretionary change was added to the service plan; however, a nurse review related to the issue was not completed.

- Regulatory Insufficiency: When a tenant needs personal care of health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan (IAC r. 481-69.26(3)(b))

- 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))

E. Medications

Complaint/Incident Allegation #47139-C: It was alleged a staff member used medication cases that were put in a back pack which was a contamination issue.

Monitoring Observation: An interview with the RN Manager indicated Staff #5 used a back pack but left it in the medication room. She stated white plastic medication containers had been given out during marketing events.

The LPN was interviewed and stated some medications were kept in the medication room. The tenant's room number was written on the envelope to transport the medications to the tenant's room. She stated there were plastic containers with the Program's name and tenant room number. She had seen them in a drawer upstairs by the television. Staff #5 used a backpack but did not take it into tenant rooms. Staff #5 did not use a purse but used a backpack instead. The monitor accompanied the LPN upstairs to see if there were plastic containers in the drawer and none were found.

A written statement provided by Staff #5 indicated she used plastic pill cases for the good of the environment (instead of using paper envelopes). The containers were marked with the tenant specific apartment numbers so only those tenants' medications were placed in that container. She did place the containers in the top part of her work bag because she was afraid they would come missing. She used them to save on the cost of the envelopes.

Her backpack was for work only, had a blood pressure cuff, stethoscope, sewing kits and denture repair kit inside. She indicated she used alcohol to clean the containers weekly and as needed.

The RN Manager provided a written statement dated 2-15-14 that indicated she met with Staff #5 regarding the use of plastic pill containers for medication passing. Staff #5 stated she was trying to be "green" and not use the pill envelopes just to be put in the trash. Staff #5 stated she used one container for the tenant which was marked with the tenant's room number. She stated she never put another tenants' pills in a different marked container or two tenants' pills in different areas of one container at the same time. Staff #5 stated she routinely cleaned the containers inside and out with alcohol swabs. Staff #5 stated she kept the pill containers in a pocket inside of her backpack. She did not routinely keep them in a drawer at work as in the past they had been thrown away. When she was done using the pill containers for the day she placed them in her backpack. The backpack went in her vehicle at the end of the shift. Staff #5 stated she had never left work with pills or a single pill in the container with her. Staff #5 explained her backpack was her work bag, held her own stethoscope, blood pressure cuff and sewing kit, things she used at work. She stated it was no different than what other staff did with their bags except hers was a backpack. The RN Manager explained to Staff #5 this may be a concern to others that she might be taking medication from the tenants. They discussed cleanliness and that Staff #5 was to use pill envelopes when taking medications from the apartments or medication room to the tenant with their room number written on the envelope and then dispose the envelope.

The RN Manager stated the practice of using the plastic containers was discontinued on 2-15-14 and Staff #5 now used the envelopes.

Review of the RN Manager's statement and Staff #5's statement indicated Staff #5 used pill cases to administer medications. The practice occurred with one staff and was discontinued on 2-15-14. While a deviation from requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47139-C: It was alleged a tenant was in need of a medication and there was no order for the medication. It was alleged a tenant had fallen.

- Monitoring Observation: Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24). Review of Tenant #20's file indicated Tenant #20 had a fall.

Tenant #20, a 90 year old, was admitted on 2-1-13 and diagnoses included HTN, Hyperlipidemia, Macular Degeneration and CAD. Tenant #20 was staged at a four on the GDS, which indicated moderate cognitive decline.

According to an Incident Report dated 1-18-14, Tenant #20 came out of apartment and yelled at staff for not having breakfast ready, sat at another table and told another tenant to pick up something from the floor. Tenant #20 preferred to have oatmeal ready for breakfast when Tenant #20 came out in the morning. Staff reassured Tenant #20 and provided the oatmeal right away. There was no further yelling. Staff reported Tenant #20 had attempted to flush a pad down the toilet which the staff removed and the toilet did not run over. The RN Manager spoke to Tenant #20 about behaviors and actions. Tenant #20 smiled and responded that he/she wouldn't do anything like that. The RN Manager discussed with staff to monitor Tenant #20 and report any behaviors; staff was reminded to use interventions and try other interventions and then notify the nurse. According to an Incident Report dated 2-4-14, Tenant #20 was walking with one shoe on and lost balance and fell down. Tenant #20 had a skin tear on right elbow and a band aide was provided. There was swelling and a bruise on right side of head, with head pain and right elbow pain. On 2-5-14 the RN Manager documented activity as usual, no change in level of care and band aid intact to elbow, no swelling or drainage. There was swelling and a purple bruise to right hand and no complaints of pain. There were no new orders for anxiety medications indicated in Tenant #20's file.

The RN Manager and LPN were interviewed and stated medications and orders for anxiety medications were obtained as needed. The LPN stated she was not aware of any tenants who requested anxiety medications be ordered.

Review of tenant files, an interview with the RN Manager and LPN did not reveal concerns regarding obtaining orders for anxiety medications and falls.

- Regulatory Insufficiency: None noted.

F. Staffing

Complaint/Incident Allegation #47139-C: It was alleged staff slept on third shift.

Monitoring Observation: The RN Manager was interviewed and stated there had not be any staff sleeping on third shift and she couldn't imagine any third shift staff sleeping. She had not initiated any disciplinary action for staff sleeping on duty. The LPN was interviewed and stated she hoped no staff slept on third shift and she had not heard of anyone sleeping. Staff #13 stated she had never heard of anyone sleeping on the job.

The LPN and Staffs #2 and #7 indicated there was enough staff to meet the needs of the tenants.

According to the ALP Monitoring Entrance Form, on third shift there was two staff assigned in the general population and one in the dementia unit.

A community meeting with 16 tenants, two tenant interviews and one family interview were held. Nursing services were available and staff responded within five to ten minutes when tenants requested assistance. The tenants received the services expected when the occupancy agreement was signed. Staff treated the tenants with respect and received the services requested. The tenants said there were no issues with staff response on third shift.

Per interviews with the RN Manager and LPN and a community meeting there were no issues with staff sleeping on third shift.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47139-C: It was alleged the nurse did not help out when short.

- Monitoring Observation: The RN Manager was interviewed and stated when staff called off work she would ask others to come in. She kept a log and would work to find coverage. The LPN would help out by working on the floor. The RN Manager would answer lights and monitor an area as needed. The LPN stated she helped out a lot when staff called off work; she would come in early and did whatever it took. She had even worked holidays.

  The LPN and Staffs #2 and #7 indicated there was enough staff to meet the needs of the tenants.

  A community meeting with 16 tenants, two tenant interviews and one family interview were held. Nursing services were available and staff responded within five to ten minutes when tenants requested assistance. The tenants received the services expected when the occupancy agreement was signed. Staff treated the tenants with respect and received the services requested.

  Per interviews with staff, the LPN and RN Manager and a community meeting there were no issues with staffing as it related to tenant services.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47139-C: It was alleged a tenant was incontinent and staff did not provide bathroom reminders.

- Monitoring Observation: Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24). Review of Tenant #21's file indicated Tenant #21 received toileting reminders.

  Tenant #21's file was reviewed. The service plan indicated in regards to toileting that Tenant #21 was awoken at least twice at night (midnight and 4:00 a.m.) and reminded to toilet and help change soiled linen/clothing as needed. Soiled items were removed during the night and washed. A protective mattress cover was reapplied before making the bed with clean sheets. The bed mattress was to never go without the protective cover. According to a daily report sheet, on the night shift there were two checks consistently documented from 1-19-14 to 2-8-14.

  The RN Manager stated bathroom reminders were provided as indicated on the service plan. Check marks on the task sheets indicated staff did the checks. She stated Tenant #21 had not complained to her that bathroom reminders were not being provided. The LPN stated Tenant #21 was scheduled for two bathroom reminders during the night. The task sheets reflected the bathroom checks were completed and there had not been any complaints of Tenant #21 not getting the reminders.

  A community meeting with 16 tenants, two tenant interviews and one family interview were held. Nursing services were available and staff responded within five to ten minutes when tenants requested assistance. The tenants received the services expected when the occupancy agreement was signed. Staff treated the tenants with respect and received the services requested.

  Review of tenant files, an interview with the LPN and RN Manager and a community meeting did not reveal concerns regarding lack of services provided including toileting reminders.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24). Tenant #11 was identified as the only current tenant that received wound care. The RN Manager indicated Tenant #11 had a right heel wound. Tenant #11 was going to the wound clinic for all treatment on the wound. Due to the extreme cold and snow Tenant #11 was currently going to the wound clinic on Wednesday. The Program's nurses were completing the wound care two days per week.

Tenant #11, an 89 year old was admitted on 7-31-09 and diagnoses included: Diabetes, Constipation, Osteoporosis, Edema, Hyperlipidemia and Hypothyroid. Tenant #11 scored an 11/11 on the Cognitive Tool, which indicated no or mild impairment.

According to the December 2013 TAR Tenant #11 had an order for cleanse wound and peri-wound to right medial heel with wound cleanser, apply puracol dressing to wound, apply Betadine to peri-wound cover with opti-foam and secure with mediapore tape and kling gauze every other day and as needed. The TAR reflected the treatment was completed on 12-6-13, 12-8-13 and 12-10-13 by Staff #8.

Staff #8 had a delegation for lotion, creams and ointments dated 2-12-14. Staff #8 had delegations for topical medications and skin tears. Staff #8 was a CMA/CNA and did not have delegations regarding Tenant #11's wound treatment.

- Regulatory Insufficiency: The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of the tenants. Nurse delegation shall, at a minimum, include the following: Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. (IAC r. 481-67.9(4)(d))

G. Nurse Review

Complaint/Incident Allegation #46375-C: It was alleged the nurse did not look at tenants' skin or assess wounds. It was alleged the nurse did not complete any skin treatments.

Complaint/Incident Allegation #47139-C: It was alleged wounds were not assessed by the nurses.

- Monitoring Observation: Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24). Tenant #11 was identified as the only current tenant that received wound care. The RN Manager indicated Tenant #11 had a right heel wound. Tenant #11 was going to the wound clinic for all treatment on the wound. Due to the extreme cold and snow Tenant #11 was currently going to the wound clinic on Wednesday. The Program's nurses were completing the wound care two days per week.

  Tenant #11's file was reviewed. Tenant #11's service plan reflected Tenant #11 had a right foot/heel treatment being completed at the wound clinic or as ordered.

Review of Resident Notes from 12-5-13 to 2-6-14 indicated there was documentation regarding Tenant #11's wounds. On 12-5-13 Resident Notes indicated Tenant #11 had an appointment at the wound clinic for a wound on the right medial heel. Tenant #11 was previously treated with skin graft and dressing only changed at the wound clinic. New treatment orders were received to cleanse wound and periwound to right medial heel with wound cleanser, pat dry, apply optifoam dressing and apply Betadine to periwound. Cover with mediapore tape and kling gauze, every other day and as needed. Tenant #11 was aware of the orders and the TAR was updated. Resident Notes dated 12-13-13 indicated Tenant #11 was seen at the wound clinic on 12-11-13. Skin graft was put into place. The previous optifoam dressing was discontinued. Dressings were only to be done at the wound clinic. Resident Notes dated 12-18-13 indicated Tenant #11 had routine appointment at the wound clinic for wound on right heel. Skin graft was in place. Dressings were changed only at the wound clinic. Resident Notes dated 12-20-13 indicated Tenant #11 cancelled the appointment at the wound clinic to have dressing changed due to weather. Orders were received from wound clinic for dressing change to right heel. The orders were to change on 12-20-13 and on 12-23-13 if not able to make it to the wound clinic and to not wash. A call was received from the wound clinic and orders were received to change the dressing to right heel and do not cleanse area, wound veil in place. Cover with puracol then opti-foam and secure with tape, according to Resident Notes dated 12-30-13.

On 1-2-14 Tenant #11 had an appointment at the wound clinic and the dressing was done at the clinic. Orders were received not to remove dressing or get wet. According to Resident Notes dated 1-8-14, Tenant #11 had an appointment at the wound clinic for wound to the right heel. Dressings were only to be done at the wound clinic on Monday and Wednesday. Tenant #11 had an appointment scheduled 1-15-14 at the wound clinic. Dressings were to be changed at the wound clinic. According to Resident Notes dated 1-23-14, Tenant #11 had an appointment at the wound clinic and was to continue to have dressings changed every Monday and Wednesday at the wound clinic. Tenant #11 had an appointment at the wound clinic on 1-29-14 and new orders were received to change dressing to right heel on Friday and Monday. Dressing would be changed on Wednesday at the wound clinic, according to Resident Notes dated 1-30-14.

According to Resident Notes dated 2-6-14, Tenant #11 had a scheduled appointment at the wound clinic and new orders were received for dressing to right heel. RN or LPN to change dressing on Monday and Friday and as needed. Dressing was to be changed on Wednesday at wound clinic. Those entries from 12-5-13 to 2-6-14 were completed by the LPN. The RN Manager completed in nurse review in Resident Notes on 1-31-14. The nurse review indicated the area was pink with moderate amount of serous drainage, no granulation was noted. The edges were white and the surrounding skin was pink. The foot was warm to touch, the treatment was completed and there was no pain.

According to the December 2013 TAR, Tenant #11 had an order for cleanse wound and peri-wound to right medial heel with wound cleanser, apply puracol dressing to wound, apply Betadine to peri--wound cover with optifoam and secure with mediapore tape and kling gauze every other day and as needed. The TAR reflected the treatment was completed on 12-6-13, 12-8-13 and 12-10-13 by Staff #8. Staff #8 was a CNA/CMA. The January and February TARs reflected the treatments completed at the Program were documented as completed by the LPN.

Resident Notes from 12-5-13 to 2-6-14 reflected documentation regarding Tenant #11's wound. The documentation was completed by the LPN and RN Manager. The service plan reflected the wound and treatment at the wound clinic or as ordered. The TARs reflected Staff #8 completed a treatment for Tenant #11's three times in December. The TARs and Resident Notes indicated the treatments besides the three in December were completed by the LPN or at the wound clinic.

The RN Manager and LPN were interviewed and stated the nurses did assess the wounds. Staff #1 stated most tenants with wounds went to the wound clinic. She had been trained to do whatever was listed on the MAR for wound care and the RN Manager would show her how to do the cares. She would tell the nurses if she was not comfortable and then the LPN would do the treatment. Staff #2 stated she had not yet been trained on wound cares and she called the LPN who provided follow-up. Staff #6 stated she had been trained to do whatever the MAR indicated. Tenants went to the wound clinic and she would call the LPN or RN Manager for follow-up and they responded immediately. Staff #7 said if it was a big wound the nurses took care of it. If not, the instructions were on the MAR and she would do whatever it indicated. She stated the nurses provided follow-up to wound care if needed. Staff #13 stated the LPN went over the wound cares and showed her the first time she provided wound care and it was explained on the MAR. She stated the nurses provided follow-up to wound care if needed.

Review of tenant files, staff interviews, an interview with the LPN and an interview with the RN Manager did not reveal any concerns regarding wound care or assessment of wounds.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation 46375-C: It was alleged there was not appropriate nurse follow up regarding a change in a tenant's condition.

- Monitoring Observation: Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24). Review of Tenant #9's file indicated Tenant #9 had a change in condition and was hospitalized.

  Tenant #9, a 96 year old, was admitted on 6-5-13 and diagnoses included Dementia, Alzheimer's, HTN, Atrial Fibrillation, Pain and Edema. Tenant #9 was staged at a four on the GDS, which indicated moderate cognitive decline.

According to the Resident Notes dated 12-2-13 at 1:00 p.m., Tenant #9 had an episode on way to lunch where he/she got very weak, short of breath and stumbled to bench in the hallway and sat down. Speech was very mumbled and unable to understand what Tenant #9 was saying. Face was very red; Blood Pressure was 130/58. Tenant #9 could not sit up straight. Within one to two minutes of the episode, Tenant #9 was talking normally, sitting upright on the bench and was still very short of breath. Tenant #9 was escorted back to apartment, still weak. Staff and family reported that Tenant #9 had increased confusion, shortness of breath and general malaise through the weekend and an appointment was scheduled with Tenant #9's physician. The LPN spoke with the family to update on the episode. The family arrived to take Tenant #9 to the emergency room (ER). The LPN spoke with family at 5:00 p.m. who stated Tenant #9 was admitted to the hospital and no diagnosis at that time. The RN Manager noted in the Resident Notes on 12-5-13 that Tenant #9's family reported tests showed decreased heart function. Tenant #9 physically improved after a blood transfusion however the decision was made for no aggressive treatment and Tenant #9 would be transferred to a higher level of care.

The RN Manager stated Tenant #9 was walking in the hall, became weak and was lowered to a bench. Tenant #9 had cardiac problems and was transported to the ER. Family stated they would come to the Program and take Tenant #9 to the ER. The LPN stated it was at lunch time and Tenant #9 was walking and stumbled, was short of breath and sat on a bench in the hall. Vital signs were taken and the RN Manager came up and went with Tenant #9 back to Tenant #9's apartment. The RN Manager called Tenant #9's family who came right in. Tenant #9 was stabilized. It was discussed whether to send Tenant #9 to the ER or to a doctor's appointment. The family took Tenant #9 to the ER.

Review of tenant files, an interview with the LPN and RN Manager indicated no there were concerns identified with a tenant's change in condition and nurse follow up.

- Regulatory Insufficiency: None noted.

H. Activities

Complaint/Incident Allegation #47139-C: It was alleged activity staff did not complete activities in the dementia unit and did not interact with the tenants. It was alleged the dementia unit was not supplied with activity supplies that would interest the tenants and staff brought in supplies. It was alleged tenants from the dementia unit were not escorted to an activity outside of the unit by activity staff.

- Monitoring Observation: A community meeting with 16 tenants, two tenant interviews and one family interview were held. There were enough activities offered and they said the activity staff did a good job. There were no suggestions for additional activities and the tenants received a schedule of activities. There were a good variety of activities offered and activity supplies were available.

  Staff #1 stated she had brought baking goods and crafts in for the dementia tenants. She had asked the Activity Director (AD) but the AD didn't bring in appropriate items. She stated the day before the AD told her to bring in receipts for the items she purchased. Staff #2 stated the AD created the activity calendar but most of the time staff did the activities. The AD helped with baking and recently made Valentines. For music programs outside the unit the staff took the tenants out and stayed with them. Staff #2 stated there were not enough activity supplies and she had seen some staff purchase supplies to bring in and hang on the walls or for projects. Staff #7 stated the AD completed the activity calendar but most of the time the staff did the activities. The AD did come into the dementia unit and helped, she did a lot of cooking with the tenants. The AD made Valentines with the tenants and came in two to three times per week; she would stop in and out daily. Staff #7 stated supplies were available sometimes and she had brought supplies in from home when tenants wanted to do something different. Staff #13 stated there really weren't enough supplies for activities in the dementia unit. She stated there were staff members who brought in things but it had stopped now. The AD told staff she needed a receipt or a statement that she didn't ask staff to bring the supplies.

  The AD stated she asked staff who worked in the dementia unit for ideas of favorite things the tenants liked to do. The tenants liked to bake and the AD helped in the dementia unit twice a week with baking and crafts. She stated staff escorted the tenants to the music room and activity room for those activities and staff stayed with the tenants. No tenants or their families had expressed any complaints about activities. The AD stated she checked with the staff for what supplies they needed and she went to the store once a month and would go in between if needed. Some staff had told her they bought supplies and she told them to bring in a receipt and they'd be reimbursed but no staff had done so. She had even told families if it was for a group activity they should bring in the receipt.

  The RN Manager stated the AD performed activities in the dementia unit and there were plenty of activity supplies available. She did have some staff bring in their own supplies and she had told them to not do so or to bring in a receipt for the supplies. The LPN stated there were some staff that brought in items to be used for activity supplies but they were never asked to provide supplies.

  Activity calendars for the general population and the dementia unit for the month of February 2014 were provided. Multiple activities were provided every day of the month.

According to the Activity Policy, the Program employed an AD to develop a comprehensive activity program. The programming should be appropriate for each tenant and should reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skill by providing opportunities for a variety of types and levels of involvement. Activities should be planned to support the tenant's service plan and should be consistent with occupancy policies. A written schedule of activities should be developed at least monthly and made available to tenants and their representatives. Tenants should be given the opportunity to choose their level of participation in all activities offered in the program. For activities in dementia-specific Program, the tenants would be provided opportunities for leisure education and independent living skills. Individualized programing would be available on the service plan.

Review of the activity calendar, activity policy, comments from the community meeting, staff interviews, an interview with the LPN, an interview with RN Manager and the AD did not reveal concerns with the activities provided.

- Regulatory Insufficiency: None noted.

I. Structural Requirements

The Program received a regulatory insufficiency at the time of the October 28 and 29, 2013 complaint investigations (45101-C; 45278-C) and complaint/incident investigation revisits (44432-CR; 44725-IR) relating to not having buildings and grounds that were well-maintained, clean, safe and sanitary.

- Monitoring Observation: There was an inspection by a Deputy Fire Marshal. According to a document, it was asked the exiting component requirements within the dementia unit be evaluated. It was to be determined if the two delay exit doors to the courtyard were considered "Required Exits." The RN Manager indicated she asked that be considered a Required Exit for the dementia unit. The lock (gate) was unlocked on 12-17-13 and the sidewalk was cleared from snow.

  Prior to the inspection from the SFM, nurse delegations for Gardens Exit Gate were completed. The delegation indicated each staff in the dementia unit area was to carry a key that unlocked the gate. The key needed to be on their person at all times, if there was only one staff on duty the spare key was to be kept in the drawer under the upper locked medication cabinets. The gate was to be locked at all times except in an emergency as a fire while tenants were being escorted to a safe area. The key should not be given to other departments to be used and if keys were taken home accidently it was expected they be returned as soon as possible and was not to wait until the next day. Missing keys were to be reported to the nurse immediately and a search was to be started. Eight staff files were reviewed (Staff #2, #6, #7, #8, #9, #10, #11 and #12) and had delegations completed related to the exit gate.

The RN Manager was interviewed and stated the gate outside the dementia unit was unlocked and the sidewalk was kept clear at all times. The LPN, Staffs #1, #2, #7 and #13 stated the gate outside of the dementia unit was unlocked and the sidewalks were kept clear at all times.

The monitor observed the unlocked gate and the sidewalk leading to the gate was free of snow and debris.

The Program asked the exit be considered a Required Exit which required the gate be unlocked and the sidewalk clear. Prior to the change with the exit and gate, nurse delegations were completed regarding the exit gate. Per interviews with staff, the LPN and the RN Manager and monitor observation the gate was unlocked and the sidewalk was clear.

- Regulatory Insufficiency: None noted.

J. Other

Complaint/Incident Allegation #47139-C: It was alleged documents were back dated.

- Monitoring Observation: Ten tenant files were reviewed (Tenants #2, #5, #8, #9, #11, #18, #20, #21, #23 and #24). Review of tenant files did not reveal any documents had been back dated.

  The RN Manager was interviewed and stated she had never asked staff to back date any documents and service plans were not back dated due to the service plans not being completed. The LPN stated she had never been asked to back date any documents and she had not seen any service plans back dated due to not being completed. Staffs # 1, #2, #7 and #13 stated they had not been asked to back date any documents. Staff #13 stated she was not aware of any service plans being back dated due to the service plan not being completed.

  Review of tenant files, staff interviews, an interview with the LPN and the RN Manager did not reveal concerns regarding back dating of documents.

- Regulatory Insufficiency: None noted.

K. Compliance with Plan of Correction

During the course of complaint investigations, complaint/incident investigations revisits and recertification the following information was obtained:

- Monitoring Observation: The Program's Plan of Correction (POC) included a plan to correct the cited insufficiencies related to criteria for admission and retention, tenant rights, evaluation, service plans and structural requirements. During the course of the complaint investigations, complaint/incident investigations revisits and recertification there were no regulatory insufficiencies found in the areas of criteria for admission and retention, tenant rights, evaluation and structural requirements. In regards to service plans the Program followed the POC; however, regulatory insufficiencies that were not previously cited were identified related to service plans.

- Regulatory Insufficiency: None noted.