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INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
47597-C
47800-C

June 25, 2014

Ms. Mary K. Harris, RN Manager
Oakwood Place AL
4126 Northwest Blvd.
Davenport, IA 52806

RE: Final Complaint/Incident Investigation Report, Oakwood Place AL, Davenport, Iowa

Dear Ms. Harris:

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, following an investigation by DIA on **June 5, 9, 10, 11 and 17, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluations and Tenant Documents.

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/emailed to DIA to my attention 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.

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:

Mary K. Harris, RN Manager
Oakwood Place AL
4126 Northwest Blvd
Davenport, IA 52806

Complaint/Incident Intake #: 47597-C
47800-C

Date of Complaint/Incident Investigation:

June 5, 9, 10, 11 and 17, 2014

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:	38
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	40
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	52

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.

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

A. Program Reporting to the Department

Complaint/Incident Allegation #47597-C; 47800-C: It was alleged a tenant eloped and could not be redirected back inside. It was alleged a tenant eloped, was combative and it took multiple staff to get a tenant back in the building.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6). Tenant #1 and Tenant #2 resided in the dementia unit and had incidents where they had left the building.

  Tenant #1, a 91 year old, was admitted on 9-26-11 and diagnoses included: Hypertension (HTN), Dementia, Atrial Fibrillation, Diabetes Mellitus (DM), Coronary Artery Disease (CAD), History of Breast Cancer, Chronic Insomnia, Alzheimer's Disease and Angina. 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.

  According to an Unusual Occurrence report and investigation document, on 5-28-14 at approximately 1:00 p.m. tenants from the dementia unit located on the first floor were being gathered at an alarmed exit door to leave the secure area to go to an activity in the general population area on the first floor.

There were four tenants and two visitors that had gathered. The Activity Director opened the door so tenants and the visitors could exit. Tenant #1 was first to exit. The Activity Director continued to hold the door while the three other tenants and the two visitors exited. The Activity Director then followed the tenants to the music room where the activity was held. The Activity Director noticed immediately that Tenant #1 was not in the area and she stepped out of the music room and asked if anyone had seen Tenant #1. They responded they saw Tenant #1 on the second floor by the dining room. The Activity Director went up the stairs located to the right side of the music room to check the dining room on second floor. The Activity Director was met by the Licensed Practical Nurse (LPN) who said Tenant #1 was not on the second floor. The Activity Director immediately went down the stairs and to the exit door and saw Tenant #1 outside next to the front of a parked van outside the exit doors. The Activity Director asked Tenant #1 to return inside with her. Tenant #1 responded that Tenant #1 was waiting for Tenant #1's family member. The Activity Director explained Tenant #1's family member had just called and told Tenant #1 to wait inside the building. Tenant #1 returned inside with the Activity Director without any difficulty and joined the activity and participated without any attempts to leave or find Tenant #1's family member. Tenant #1 returned to the dementia unit after the activity with staff escort without any difficulty. Tenant #1 was observed by a nurse and had no apparent injury or discomfort. Tenant #1 was wearing shoes, pants, shirt and a light coat. Tenant #1 had not been asking to leave or exiting seeking prior to the incident. Tenant #1 had no reported exit seeking behaviors for six plus months. Tenant #1 normally walked without any balance problem, did not use any walking aid and did not have a history of falls. The approximate time Tenant #1 was not under staff observation was less than two minutes.

According to the State Climatologist, at the Davenport Airport on 5-28-14 at 12:52 p.m. the temperature was 77 degrees, winds were from the northeast at 11 miles per hour (mph), and it was mostly cloudy with no precipitation.

The Program reported the incident to the Department and it was determined no investigation needed to be completed.

Tenant #2, a 79 year old, was admitted on 3-11-14 and diagnoses included: Dementia, Depression, Pain, Gastro Esophageal Reflux Disease (GERD), HTN, Alzheimer's Disease, Agitation and Anxiety. Tenant #2 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #2 resided in the dementia unit and was discharged on 4-15-14.

According to an Unusual Occurrence document, on 3-16-14 Tenant #2 was sitting on the couch with a coat on and Tenant #2 said Tenant #2 was hungry. Staff #7 prepared a snack and asked Tenant #2 to take the coat off and Tenant #2 said Tenant #2 was going to leave it on because Tenant #2 was cold. At 1:15 a.m. Staff #7 was in the common area folding towels at a table when she heard a door alarm. Staff #7 immediately responded to the alarm and saw Tenant #2 outside of the door. Tenant #2 then turned right and went out the gate door following the sidewalk right to the west side of the building. Staff #7 spoke to Tenant #2, asking Tenant #2 to return with her. Tenant #2 agreed without a problem and walked with Staff #7 through the gate back to the double entrance doors. Tenant #2 resisted coming back inside of the building and said Tenant #2 needed to go home.

Tenant #2 stood for less than 10 minutes in the corner by the door that helped shield the wind and snow before re-entering. Tenant #2 returned to Tenant #2's apartment without problems, sitting up until 2:00 a.m. then went to bed at Staff #7's suggestion saying Tenant #2 looked tired. Tenant #2 was wearing a sweat shirt, pants, rain boots, a coat and cap. Tenant #2 did not fall and there was no physical injury noted as frostbite on fingers or feet. Staff #7 responded to alarm immediately, called for help from staff on the general population side and attempted to persuade Tenant #2 to re-enter the Program. The total time spent outside was approximately 15 minutes.

According to staff documentation on 3-16-14 at 1:15 a.m. Tenant #2 set off the door alarm in the back hall leading outside. Tenant #2 was already out of the gate and around the corner when Staff #7 got to Tenant #2. Tenant #2 was cooperative about coming back into the fenced area but did not want to come back inside. Approximately 15 minutes later Staff #7 convinced Tenant #2 to come back in for a hot cup of coffee. Tenant #2 went back to the apartment at 2:00 a.m. and slept in a coat all night.

Staff #7 was working at the time of the incident. At the time of the first checks everyone was okay. She was folding laundry and heard the alarm going off. She thought she would be locked out so she put a bench in the door to prevent being locked out. Tenant #2 was outside approximately 20 to 25 feet and around the gate on the sidewalk. She got Tenant #2 back in the gated area without a problem but could not get Tenant #2 to come inside. She called for other staff to help. After approximately 10 minutes Tenant #2 came back inside. Tenant #2 did not have any injuries and was dressed appropriately including a coat, mittens, boots and a scarf. Tenant #2 ambulated independently.

According to the State Climatologist, at the Davenport Airport on 3-16-14 at 1:13 a.m., the temperature was 30 degrees, winds were from the east at 10 mph, the wind chill was 21 degrees and light snow was falling (½ to 1 inch of accumulation).

According to an Unusual Occurrence document, on 3-16-14 Tenant #2 had been visiting with Tenant #2's spouse through supper. At 6:30 p.m. Tenant #2 spouse said the spouse was going home and put on a coat. Tenant #2 got Tenant #2's coat and put it on and said Tenant #2 was leaving also. Staff and Tenant #2's spouse attempted to explain Tenant #2 needed to stay there and directed Tenant #2's attention elsewhere. Tenant #2 became upset, pushed the spouse several times and stated Tenant #2 was leaving. Tenant #2 then went to the exit door that lead to the elevator in the general population pushing the door handle until it signaled and then exited with staff following Tenant #2. Staff verbally asked Tenant #2 to stop or return without success. Tenant #2 continued to walk down the hall exiting a stairwell door to the outside. Staff walked with Tenant #2 to the circle drive, gave reassurance and encouraged returning to be with the spouse. Tenant #2 verbally refused. Staff notified the Registered Nurse (RN) Manager and followed instructions to call a family member to come and assist. Tenant #2 did agree to return prior to the family member's arrival. Tenant #2 was seated in the entry of the Program by the receptionist desk with the spouse and then with the family member when the family member arrived. Tenant #2 was wearing day clothes, pants, shoes, a coat and hat. Tenant #2 did not fall and there was no physical injury. Staff #8 followed Tenant #2 outside the dementia unit and another staff stayed in the dementia unit.

Security also assisted when outside. The door alarm signaled the handle was being pushed which was responded to immediately by staff. Staff #8 was working when the incident happened. Tenant #2 pushed on the door handle and it released. Tenant #2 went into the hallway and eventually walked outside. Staff #8 was with Tenant #2 at all times when Tenant #2 was outside the dementia unit. Tenant #2 did not have any injuries and another staff stayed in the dementia unit while Staff #8 assisted with Tenant #2. Tenant #2 agreed to come in the main door and sit inside the front doors. Tenant #2 moved to the couch and another family member arrived and Tenant #2 agreed to go back to the dementia unit. Staff #8 said the whole incident was less than 30 minutes.

According to the State Climatologist, at the Davenport Airport on 3-16-14 at 6:52 p.m. the temperature was 25 degrees, winds were from the northeast at 12 mph, the wind chill was 14 degrees the skies were clear and there was an inch of snow on the ground from the previous snowfall.

Tenant #1 had no other elopement attempts documented since the elopement. Tenant #2 was discharged from the Program.

The incident regarding Tenant #1 documented in an Unusual Occurrence report and investigation was reported to the Department and it was determined the incident did not require an investigation. The two incidents regarding Tenant #2 documented in Unusual Occurrence documents were not required to be reported to the Department as staff had knowledge Tenant #2 left the building and the required door alarms functioned and staff responded.

- Regulatory Insufficiency: None noted.

B. Criteria for Admission and Retention

Complaint/Incident Allegation #47507-C: It was alleged a tenant struck out at staff and other tenants, needed one to one care, did not eat and tried to elope.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6). Review of six tenant files indicated none of the current tenant files that were reviewed exceeded the level of care.

  Tenant #1 and Tenant #2 both resided in the dementia unit and had incidents where they had left the building. Tenant #1 had no other elopement attempts documented since the incident on 5-28-14. Tenant #2 was discharged from the Program.

  Tenant #1's file was reviewed. The service plan did not reflect Tenant #1 required one to one care. The service plan indicated Tenant #1's appetite varied during moods. Health evaluations were completed on 5-2-14 and 6-9-14. There was a one pound weight loss reflected from 5-2-14 to 6-9-14.

Tenant #2's file was reviewed. The service plan did not reflect Tenant #2 required one to one care. Resident Notes dated 4-3-14 indicated Tenant #2 had gained two pounds since admission. The service plan reflected Tenant #2 had a poor appetite and provided interventions related to Tenant #2's poor appetite.

Staff #1, #2, #3, #4, #5 and #6 did not identify any tenants that were combative.

The LPN and RN Manager did not identify any tenants that were combative or that exceeded the level of care. The LPN and RN Manager said there were no tenants with significant weight loss.

Review of tenant files, staff interviews and interviews with the LPN and RN Manager did not reveal concerns regarding level of care of current tenants.

- Regulatory Insufficiency: None noted.

C. Medications

Complaint/Incident Allegation #47800-C: It was alleged medications were given by staff without a physician order.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6).

  Staff #1, #2, #5 and #6 said medications were not administered by staff without a physician's order. The LPN said she was not aware of any medications given without a physician's order.

  The RN Manager said Staff #5 was a staff member but was also a family member of Tenant #6. Tenant #6 had lived in independent living before moving into the Program and Staff #5 (family member) monitored Tenant #6's pills there. After Tenant #6 was admitted to the Program Tenant #6 was given one dose of Alprazolam by Staff #5 from Tenant #6's supply. The Program did not have a physician's order at the time it administered. Staff #5 was working at the time it was administered. The RN Manager said it was the correct bottle and it was one dose. The RN Manager said Staff #5 was educated that when she was on the clock she was a staff member and not a family member. The RN Manager said Tenant #6 now had an order and there was no outcome related to the one dose that was administered.

  Tenant #2's file was reviewed. Lunesta 3 milligram (mg) tablet, take one tablet by mouth every day at bedtime was ordered with a prescription date of 3-17-14 and was noted on 3-18-14. Zolpidem 10 mg by mouth every day at bedtime was ordered (may start when current supply of Lunesta was out; would start on 3-27-14). The date ordered was 3-21-14. According to a narcotic record on 3-18-14 at 9:00 p.m. Staff #6 charted she received one tablet of Lunesta from family and it was given. On 3-20-14 staff charted 7 tablets of Lunesta were received from pharmacy. On 3-20-14 at 8:00 p.m. one tablet was given. On 3-27-14 14 Zolpidem Tartrate 10 mg tablets were received. The March 2014 Medication Administration Records (MARs) indicated Lunesta was first documented as given on 3-18-14 at 8:00 p.m.

It was charted as not available on 3-19-14 and was given from 3-20-14 through 3-26-14. On 3-27-14 Zolpidem Tartrate 10 mg tablet was given. Review of Tenant #2's indicated Lunesta was administered consistent with physician orders.

Tenant #6, an 82 year old, was admitted on 5-9-14 and diagnoses included: History of Cerebral Vascular Accident, GERD and HTN. Resident Notes dated 5-9-14 indicated Tenant #6 was admitted and family was to administer medications until Monday except for the antibiotic for a Urinary Tract Infection (UTI). According to Physician's Admission Orders noted on 5-12-14, Tenant #6 had Alprazolam 0.25 mg one tablet by mouth every eight hours as needed for anxiety. The first dose of Alprazolam 0.25 mg one tablet by mouth every eight hours as needed that was documented as administered was on 5-12-14. The Physician's Admission Orders did not list an antibiotic for a UTI. The LPN indicated she received an order for Keflex 500 mg four times daily for 10 days. The LPN said she thought she wrote it on a telephone order but could not find it. The LPN provided a page in a notebook where the order was written. She also provided a document from the physician's office which indicated on 5-9-14 the LPN called regarding Tenant #6's urine results. The family wanted Tenant #6 started on an antibiotic even if results had not returned. Keflex 500 mg one capsule four times daily for 10 days was ordered. The May 2014 MARs indicated Cephalexin (Keflex) 500 mg capsules take one capsule by mouth four times daily for 10 days was administered from 5-9-14 at 8:00 p.m. to 5-19-14 at 4:00 p.m.

Tenant #6 received one dose of medication from Staff #5 who is also a family member. At the time of the administration of the medication the Program did not have a physician's order and Staff #5 was working. Tenant #6 received one dose and Staff #5 was educated by the RN Manager. The LPN received an order for an antibiotic for Tenant #6. Documentation was provided that showed the LPN had called the physician's office and Keflex was ordered; however, at the time of the investigation a telephone order was not found. 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 #47800-C: It was alleged medications were lost.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6).

  Staff #1, #2, #4, #5 and #6 said there were no issues with medications missing and medications were accounted for.

  The LPN said there were no medications unaccounted for and she said there were no issues with Tenant #4's medication. Tenant #4's medications were accounted for and family was very involved.

The RN Manager said there were no medications that were lost. The RN Manager said there were no issues with accounted for medications for Tenant #4. Tenant #4's family said the medications had disappeared. Per the RN Manager's investigation there was nothing missing.

Tenant #4, an 89 year old, was admitted on 6-1-07 and diagnoses included: HTN, Hyperlipidemia and CAD. Tenant #4 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #4 was discharged on 5-11-14. Review of Resident Notes from 1-7-14 to 5-9-14 did not reveal concerns with medications missing or being lost. The service plan updated 2-17-14 indicated Tenant #4's family managed the medications and arranged for automatic reorder/delivery.

Tenant #5, an 88 year old, was admitted on 3-21-11 and diagnoses included: Parkinson's Disease, Osteoporosis, Depression, HTN, Overactive Bladder and Edema. Review of Resident Notes from 3-7-14 to 6-8-14 did not reveal concerns with medications missing or being lost. The service plan indicated staff initialed that medications were left with Tenant #5 to self-administer during a scheduled medication pass. Staff reordered and pharmacy delivered.

Review of tenant files, staff interviews and interviews with the LPN and RN Manager did not reveal concerns regarding missing or lost medications.

- Regulatory Insufficiency: None noted.

D. Staffing

Complaint/Incident Allegation #47800-C: It was alleged a tenant's change in condition was not assessed.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6).

Staff #1, #2, #3, #4, #5 and #6 said if a change in a tenant's condition was reported to the nurses it was followed up on. The RN Manager said if staff reported a change in a tenant's condition she followed up on it.

Tenant #1's file was reviewed. According to Resident Notes dated 6-5-14, Tenant #1 was getting toenails trimmed by an outside provider foot clinic. While trimming the toenails, they cut the side of the great left toe which caused some bleeding and an open area. The area was cleansed and triple antibiotic ointment (TAO) and a band aid were applied. The bleeding subsided. Resident Notes dated 6-9-14 indicated new orders were received for the left great toe. The order was to wash the left great toe with soap and water, rinse, pat dry, apply TAO and band aid every day and as needed until healed.

Cognitive, health and functional evaluations were completed on 6-9-14 and the service plan was updated. The service plan indicated to complete treatments as ordered and to notify the nurse of signs or symptoms or infection (redness, drainage, hot to touch) or if the area failed to heal.

Tenant #3, a 97 year old, was admitted on 5-20-11 and diagnoses included: Insulin Dependent Diabetes Mellitus, Hypothyroid, Hyperlipidemia, HTN, Edema, Left Knee Injury and Constipation. Resident Notes dated 3-25-14 indicated Tenant #3's right eye sclera was red and irritated. There was a small amount of light green drainage noted. It was reported to the physician's nurse. A new order was received for Gentamicin Sulfate Ophthalmic Solution, two drops to both eyes four times daily for five days. Tenant #3 was instructed to stay in the apartment for the next 24 hours due to the diagnosis of conjunctivitis and being contagious. The March 2014 MARs reflected Gentamicin Sulfate Ophthalmic Solution was administered per order. Resident Notes dated 4-3-14 indicated Tenant #3 finished the antibiotic eye drop treatment for conjunctivitis and the eye was completed healed with no redness or drainage noted.

Cognitive, health and functional evaluations were completed as needed on 3-26-14 and the service plan was updated to reflect the conjunctivitis and treatment.

According to Resident Notes dated 3-25-14, Tenant #3 had a six pound weight increase within the past week. Tenant #3 had increased pitting edema to bilateral lower extremities. A physician and family were notified. A new order was received to increase Lasix to 80 mg by mouth three times daily for two days, then 80 mg by mouth twice daily. A basic metabolic panel in one week due to increased edema and weight was also ordered. The March 2014 MARs reflected the change in Lasix orders and indicated the medication was administered consistent with orders.

Resident Notes dated 4-16-14 indicated Tenant #3 had an eight pound weight gain in the past week. Tenant #3 did not have shortness of breath and did not have a cough. Tenant #3 had edema in bilateral lower extremities which was normal for Tenant #3 and it had not gotten worse. Tenant #3 was taking Lasix 80 mg by mouth twice daily. Tenant #3 continued to eat popcorn puffs daily. A call was placed to the physician's nurse to notify of the weight gain and that Tenant #3 was not showing symptoms. The nurse would let the physician know and doubted anything would be changed, according to the Resident Notes.

Tenant #3's service plan reflected Tenant #3 had edema and provided interventions.

Review of tenant files, staff interviews and interviews with LPN and RN Manager did not reveal concerns regarding a lack of assessment with a condition change.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47800-C: It was alleged staff discussed the tenants and cares in a smoking area of the building.

- Monitoring Observation: Staff #1, #2, #3, #4, #5 and #6 said they were not aware of any staff who discussed tenant cares and the tenants where it could be overheard by others. The Administrative Assistant said the doors in the smoking area were locked, there were no tenants there and only people who might be able to hear would be kitchen staff and they would have to have their ears pressed.

The LPN said she was not aware of any staff that discussed tenant cares and the tenants where it could be overheard by visitors, family, vendors and others besides staff. There had been no complaints from tenants or family regarding staff discussing tenant health or personal information. Staff received training on the Health Insurance Portability and Accountability Act (HIPAA).

The RN Manager said she was not aware of any staff who discussed tenant cares and the tenants where it could be overheard by others. The smoking area was by stairwell #2 and only staff went out there for smoking. Visitors, vendors and family did not go out there. It required a key to get back in and the conversations were not audible near the area. The sidewalk went to the back parking lot where staff parked. There were no complaints from tenants or families regarding confidentiality. Staff was trained on HIPPA.

Per staff interviews, an interview with the Administrative Assistant and interviews with the LPN and RN Manager there were no concerns identified regarding staff discussing health care information where it could be overheard by non-staff members.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47800-C: It was alleged the nurse's tasks were all delegated.

- Monitoring Observation: Staff #1, #2, #3, #4, #5 and #6 said they had nurse delegated training on tasks including observation of those tasks. Staff #1, #2, #3, #4, #5 and #6 said they felt comfortable completing the tasks with the training provided.

  The LPN said there had not been any complaints regarding lack of training regarding tasks staff had been asked to do.

  The RN Manager said regarding delegation if staff was not comfortable with the tasks delegated they were instructed to let her know. There were no concerns about lack of training.

  Staff interviews and interviews with the LPN and RN Manager did not reveal concerns regarding tasks that were delegated to staff.

- Regulatory Insufficiency: None noted.

E. Tenant Rights

Complaint/Incident Allegation #47800-C: It was alleged a staff was verbally abusive towards tenants. It was alleged reports of abuse were reported and nothing was done.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6). Review of the tenant files did not reveal concerns regarding staff being verbally abusive towards tenants.

Staff #1, #2, #3, #4, #5 and #6 said staff was not verbally abusive towards the tenants. The LPN and RN Manager said staff was not verbally abusive towards the tenants. They followed up if there were reports or allegations of abuse and there had been no disciplinary action taken regarding staff being verbally abusive towards tenants.

Review of tenant files, staff interviews and interviews with the LPN and RN Manager did not reveal concerns regarding staff being verbally abusive towards tenants.

- Regulatory Insufficiency: None noted.

F. Structural Requirements

Complaint/Incident Allegation #47800-C: It was alleged benches were placed in front of exit doors to keep a tenant from leaving.

- Monitoring Observation: Staff #1, #2, #3, #4, #5 and #6 said none of the exits had been blocked by objects to prevent a tenant from leaving. The LPN said none of the exits had been blocked by objects to prevent a tenant from leaving.

  The RN Manager said there was a time in the dementia unit when staff moved a bench so it was strategically placed in front of two doors. There was no obstruction if an emergency. The benches could be easily moved with one person. The benches were at least two to three feet from the door and a person could walk around the bench. The RN Manager said it was for about a week or so and there were no incidents or harm.

  Per monitor observations on 6-5-14 at approximately 1:35 p.m. and 6-9-14 at approximately 11:34 a.m. there were no objects in front of the exit doors in the dementia unit.

  The intervention implemented to deter a tenant from exit seeking might not be effective; but no regulatory insufficiencies were identified as the item was not obstructing the exit, there was room to walk around it and it could be moved.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47800-C: It was alleged a tenant tried to get out the window, broke the screen and the window was open. It was alleged a tenant could get a leg or head out of the screen. It was alleged maintenance staff put a lock on the window so it could not open.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6).

  Staff #1, #2, #3, #4 and #5 said none of the tenants had removed the screens and left the building. Staff #6 said Tenant #2 had tried to remove the screen.

  The LPN said Tenant #2 removed the screen in the apartment but did not get out through the window. Maintenance was contacted and a block was put on the window.

The RN Manager said Tenant #2 tore a window screen but Tenant #2 did not leave through the window. The RN Manager said Tenant #2 could not get Tenant #2's legs out of the window. She said the windows opened about six inches in the dementia unit. An extra block was put in the window for safety to prevent it from opening more than three to four inches.

Staff #9 said one tenant ripped off a screen. Staff #9 could not remember the tenant's name but said it had been a while ago and the tenant was no longer there. It was torn off and was on the ground on the outside by the window. A tenant would not be able to get out because the window would not open far enough. Staff #9 said the tenant did not get outside that Staff #9 was aware of.

The Director of Maintenance and Security said a screen was pushed out of one of the tenant apartments and it needed a new screen. He put a block on the window so it would not slide open. He thought it was for the same tenant who pushed the screen out.

A tour of Tenant #2's former apartment (which was not occupied at the time of the investigation) revealed a screen was damaged and a window block piece was present on the window.

According to Resident Notes dated 3-18-14, third shift reported Tenant #2 remained in the apartment during the night. During staff rounds it was noted the apartment window had been opened, maximum distance six inches before it was blocked to open further. The screen on the left window was torn. It appeared Tenant #2 reached through and tore the screen. Maintenance was notified and moved the window block up to prevent it from opening.

According to staff documentation on 3-18-14 it was documented third shift staff reported Tenant #2 was asleep all night. Tenant #2 was awake and dressed at 9:15 a.m. A housekeeper was in the room to clean and reported the screen on the window had been torn off and was lying on the bushes outside of the window. The RN Manager was notified and came over to observe.

Per staff interviews, an interview with Director of Maintenance and Security and interviews with the LPN and the RN Manager, Tenant #2 had removed a screen but did not get out of the building through the window. Tenant #2 was discharged and the apartment was vacant at the time of the investigation.

- Regulatory Insufficiency: None noted.

G. Service Plans

Complaint/Incident Allegation #47800-C: It was alleged staff signed service plans but was not given the service plan to review.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6). Review of six tenant files did not reveal concerns with staff signatures on service plans.

  Staff #2, #3, #4, #5 and #6 said they reviewed service plans and were not asked to sign without reviewing them. Staff #1 said she had not yet been asked to sign the service plans but had reviewed them. She said she was never asked to sign anything she was not able to review.

  The LPN said in the general population service plans were kept in the charts in the medication room. A copy was kept in the dementia unit and the service plans were accessible to staff. Staff was asked to sign and they were allowed to read them. They were put on a clipboard and asked to review and sign.

  The RN Manager said service plans were in every tenant chart and were available. In the dementia unit the service plans were kept in a three ring binder. The service plans were accessible to staff. The staff did not sign without reviewing.

  Review of tenant files, staff interviews and interviews with the LPN and RN Manager did not reveal concerns regarding staff signing service plans.

- Regulatory Insufficiency: None noted.

H. Evaluation

Complaint/Incident Allegation #47800-C: It was alleged assessments were not completed appropriately.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6).

  Tenant #1's file was reviewed. According to Resident Notes dated 6-5-14, Tenant #1 was getting toenails trimmed by an outside provider foot clinic. While trimming the toenails, they cut the side of the great left toe which caused some bleeding and an open area. The area was cleansed and TAO and a band aid were applied. The bleeding subsided. Resident Notes dated 6-9-14 indicated new orders were received for the left great toe. The order was to wash the left great toe with soap and water, rinse, pat dry, apply TAO and band aid every day and as needed until healed. Cognitive, health and functional evaluations were completed on 6-9-14 and the service plan was updated. The service plan indicated it was a change of condition for a left toe treatment. The service plan indicated to complete treatments as ordered and to notify the nurse of signs or symptoms or infection (redness, drainage, hot to touch) or if area failed to heal. Tenant #1 had a diagnosis of DM. The LPN completed the evaluations when Tenant #1 exhibited a significant change.

  Tenant #3 file was reviewed. Resident Notes dated 3-25-14 indicated Tenant #3's right eye sclera was red and irritated. There was a small amount of light green drainage noted. It was reported to the physician's nurse.

A new order was received for Gentamicin Sulfate Ophthalmic Solution, two drops to both eyes four times daily for five days. Tenant #3 was instructed to stay in the apartment for the next 24 hours due to the diagnosis of conjunctivitis and being contagious. The March 2014 MARs reflected Gentamicin Sulfate Ophthalmic Solution was administered per order. Cognitive, health and functional evaluations were completed on 3-26-14. The health evaluation indicated it was a change of condition for conjunctivitis. The LPN signed the evaluations 3-26-14 at 11:00 a.m. and the RN Manager signed on 3-26-14 at 11:10 a.m. The evaluations were completed by the LPN when Tenant #3 exhibited a significant change.

Tenant #5's file was reviewed. Cognitive, health and functional evaluations were completed on 3-10-14. The evaluations were completed for a fall/physical therapy services. The LPN signed the evaluations on 3-10-14 at 2:00 and 2:30 p.m. and the RN Manager signed on 3-10-14 at 3:00 p.m. The evaluations were completed by the LPN when Tenant #5 exhibited a significant change.

Evaluations were not completed by a health or human service professional when a tenant exhibited a significant change.

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

I. Tenant Documents

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

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6).

  Tenant #1's file was reviewed. According to an Unusual Occurrence report and investigation document, on 5-28-14 at approximately 1:00 p.m. tenants from the dementia unit located on the first floor were being gathered at an alarmed exit door to leave the secure area to go to an activity in the general population area on the first floor. There were four tenants and two visitors that had gathered. The Activity Director opened the door so tenants and the visitors could exit. Tenant #1 was first to exit. The Activity Director continued to hold the door while the three other tenants and the two visitors exited. The Activity Director then followed the tenants to the music room where the activity was held. The Activity Director noticed immediately that Tenant #1 was not in the area and she stepped out of the music room and asked if anyone had seen Tenant #1. They responded they saw Tenant #1 on the second floor by the dining room. The Activity Director went up the stairs located to the right side of the music room to check the dining room on second floor.

The Activity Director was met by the LPN who said Tenant #1 was not on the second floor. The Activity Director immediately went down the stairs and to the exit door and saw Tenant #1 outside next to the front of a parked van outside the exit doors. The Activity Director asked Tenant #1 to return inside with her. Tenant #1 responded that Tenant #1 was waiting for Tenant #1's family member. The Activity Director explained Tenant #1's family member had just called and told Tenant #1 to wait inside the building. Tenant #1 returned inside with the Activity Director without any difficulty and joined the activity and participated without any attempts to leave or find Tenant #1's family member. Tenant #1 returned to the dementia unit after the activity with staff escort without any difficulty. Tenant #1 was observed by a nurse and had no apparent injury or discomforts. Tenant #1 was wearing shoes, pants, shirt and a light coat. Tenant #1 had not been asking to leave or exiting seeking prior to the incident and Tenant #1 had not had any reported exit seeking behaviors for six plus months. Tenant #1 normally walked without any balance problem, did not use any walking aid and did not have a history of falls. The approximate time Tenant #1 was not under staff observation was less than two minutes.

The Program reported the incident to the Department and it was determined no investigation needed to be completed. An Unusual Occurrence report and investigation was completed; however, an incident report related to the incident was not completed.

Tenant #2's file was reviewed. According to an Unusual Occurrence document, Tenant #2 was sitting on the couch with a coat on and Tenant #2 said Tenant #2 was hungry. Staff #7 prepared a snack and asked Tenant #2 to take the coat off and Tenant #2 said Tenant #2 was going to leave it on because Tenant #2 was cold. At 1:15 a.m. Staff #7 was in the common area folding towels at a table when she heard a door alarm. Staff #7 immediately responded to the alarm and saw Tenant #2 outside of the door. Tenant #2 then turned right and went out the gate door following the sidewalk right to the west side of the building. Staff #7 spoke to Tenant #2, asking Tenant #2 to return with her. Tenant #2 agreed without a problem and then walked with Staff #7 through the gate back to the double entrance doors. Tenant #2 resisted coming back inside of the building and said Tenant #2 needed to go home. Tenant #2 stood for less than 10 minutes in the corner by the door that helped shield the wind and snow before re-entering. Tenant #2 returned to Tenant #2's apartment without problems, sitting up until 2:00 a.m. then went to bed at Staff #7's suggestion saying Tenant #2 looked tired. Tenant #2 was wearing a sweat shirt, pants, rain boots, a coat and cap. Tenant #2 did not fall and there was no physical injury noted as frostbite on fingers or feet. Staff #7 responded to alarm immediately, called for help from staff on the general population side and attempted to persuade Tenant #2 to re-enter the Program. The total time spent outside was approximately 15 minutes.

According to the State Climatologist, at the Davenport Airport on 3-16-14 at 1:13 a.m., the temperature was 30 degrees, winds were from the east at 10 mph, the wind chill was 21 degrees and light snow was falling (½ to 1 inch of accumulation).

According to an Unusual Occurrence document, on 3-16-14 Tenant #2 had been visiting with Tenant #2's spouse through supper. At 6:30 p.m. Tenant #2 spouse said the spouse was going home and put on a coat. Tenant #2 put on Tenant #2's coat and said Tenant #2 was leaving also.

Staff and Tenant #2's spouse attempted to explain Tenant #2 needed to stay there and directed Tenant #2's attention elsewhere. Tenant #2 became upset, pushed the spouse several times and stated Tenant #2 was leaving. Tenant #2 then went to the exit door that lead to the elevator in the general population pushing the door handle until it signaled and then exited with staff following Tenant #2. Staff verbally asked Tenant #2 to stop or return without success. Tenant #2 continued to walk down the hall exiting a stairwell door to the outside. Staff walked with Tenant #2 to the circle drive, gave reassurance and encouraged returning to be with the spouse. Tenant #2 verbally refused. Staff notified the RN Manager and followed instructions to call a family member to come and assist. Tenant #2 did agree to return prior to the family member's arrival. Tenant #2 was seated in the entry of the Program by the receptionist desk with the spouse and then with the family member when the family member arrived. Tenant #2 was wearing day clothes, pants, shoes, a coat and hat. Tenant #2 did not fall and there was no physical injury. Staff #8 followed Tenant #2 outside the dementia unit and another staff stayed in the dementia unit. Security also assisted when outside. The door alarm signaled the handle was being pushed which was responded to immediately by staff.

According to the State Climatologist, at the Davenport Airport on 3-16-14 at 6:52 p.m. the temperature was 25 degrees, winds were from the northeast at 12 mph, the wind chill was 14 degrees the skies were clear and there was an inch of snow on the ground from the previous snowfall.

Unusual Occurrence documents were completed related to both incidents on 3-16-14 with Tenant #2; however incident reports were not completed. The Incident Report form had additional information including vital signs. The Unusual Occurrence documents did not document vital signs. In both incidents on 3-16-14 Tenant #2 was outside and the temperature was 25 and 30 degrees with 14 and 21 degree wind chills. At the time of the 1:15 a.m. incident on 3-16-14 light snow was falling. Tenant #2 refused to come back inside and the estimated time outside was approximately 15 minutes.

According to staff documentation on 3-18-14 it was documented third shift staff reported Tenant #2 was asleep all night. Tenant #2 was awake and dressed at 9:15 a.m. A housekeeper was in the room to clean and reported the screen on the window had been torn off and laying on the bushes outside of the window. The RN Manager was notified and came over to observe.

According to Resident Notes dated 3-18-14, third shift reported Tenant #2 remained in the apartment during the night. During staff rounds it was noted the apartment window had been opened, maximum distance six inches before it was blocked to open further. The screen on the left window was torn. It appeared Tenant #2 reached through and tore the screen. Maintenance was notified and moved the window block up to prevent it from opening. An incident report was not completed regarding the damage of Tenant #2's screen. Tenant #2 had incidents of exit seeking behavior on 3-16-14.

Tenant #6's file was reviewed. According to Resident Notes dated 6-8-14 it was reported Tenant #6 was warming cookies in the apartment microwave and it overheated causing the smoke alarm to signal. The microwave was removed from the apartment and family was made aware. Tenant #6 recalled the incident from earlier that week. Tenant #6 had not asked to have the microwave replaced. The service plan was updated and reflected Tenant #2 was not to have a microwave in the apartment. An incident report was not completed related to the incident.

Incident reports were not completed regarding incident that involved the tenants.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: Incidents reports involving the tenant, including but not limited to those related to medication errors, accidents falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record). (IAC r. 481-69.25(1)(o))