IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
48391-C
49446-I
49532-C

September 8, 2014

Ms. Alice Comer, Director
Bickford Cottage Iowa City
3500 Lower West Branch Road
Iowa City, IA 52245

RE: Final Complaint/Incident Investigation Report, Bickford Cottage Iowa City, Iowa City, Iowa

Dear Ms. Comer:

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 **August 18, 19, 20 and 25, 2014.** The Report notes a Regulatory Insufficiency in the area(s) of: Service Plans.

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 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Complaint/Incident Intake #: 48391-C
49446-I
49532-C

Alice Comer, Director
Bickford Cottage Iowa City
3500 Lower West Branch Road
Iowa City, IA 52245

Date of Complaint/Incident Investigation:

August 18, 19, 20 and 25, 2014

Monitor(s):

Stephanie Cummins, MA
Stephanie Radabaugh, PhD

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

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

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

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

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a

Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	34
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	37
TOTAL census of Assisted Living Program	37

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

A. Service Plans

Complaint/Incident Allegation #49446-I: The Program reported a tenant eloped.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7).

  Tenant #3, an 85 year old, was admitted on 7-14-14 and diagnoses included: Hypertension (HTN), Hypothyroidism, Dementia, Congestive Heart Failure, Atrial Fibrillation, Chronic Renal Disease and Chronic Anemia. Tenant #3 was staged at three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline.

  According to an incident report, on 8-2-14 at 1:46 p.m. a person came to the front door and said there was a tenant who had eloped standing along a street under a tree. Staff went outside and noted Tenant #3 standing under a tree along a city street with Tenant #3's slippers. RN #1 was notified. Staff escorted Tenant #3 back into the building and vitals were taken. Vitals were as follows: blood pressure 114/78, temperature 98.4, pulse 71 and respirations 16. Tenant #3 was wearing a black long sleeved shirt and denim jeans. Staff went to Tenant #3's apartment and noted the window was open and the screen lying in the grass. There were no wandering monitoring system alarms or door alarms noted on the pager/wandering monitoring system. Tenant #3 was wearing a wandering monitoring system wrist watch. The physician and family were notified. RN #1's follow up on the incident report dated 8-2-14 indicated Tenant #3 appeared to have removed the screen from the window and exited the building. Tenant #3 was noted to be standing in the yard by a passerby. Staff escorted Tenant #3 back into the building without difficulty. There were no injuries or complaints. An assessment was completed and there were no physical

concerns noted. The service plan was updated, a family meeting was scheduled, the window was secured and one to one supervision was put into place.

Staff #1 said another staff reported a person was at the front door and said someone had eloped. She went outside and observed Tenant #3 under a tree along the sidewalk (on the same side of the sidewalk as the building). Staff #1 called RN #1 and brought Tenant #3 back into the building. Vitals were taken and were within normal limits and there were no injuries. There was no notification from the computer regarding a missing person or any door alarms. Staff #1 said Tenant #3 pushed the screen out onto the grass and there was no damage to the screen. One to one supervision was provided and the Director and RN #1 arrived. Staff #1 said Tenant #3 was sitting on the couch watching a movie at 1:25 p.m. and at 1:42 p.m. when Staff #1 was assisting another tenant Staff #1 did not recall Tenant #3 sitting on the couch. Tenant #3 ambulated independently and had a steady gait. Tenant #3 was wearing a long sleeved shirt, blue jeans, socks and shoes. The window was opened earlier in the day when Staff #1 collected laundry. Tenant #3 was out of the building with family from 9:00 a.m. to 12:00 p.m. Staff #1 said the wandering monitoring system rechecked itself and if Tenant #3 would have been outside longer it would have acknowledged Tenant #3 was outside. Tenant #3 had no elopements since the elopement on 8-2-14. Staff #1 said Tenant #3 was very pleasant and easily redirected. Interventions included the placement of a window alarm and activities. Staff #1 said Tenant #3 had never tried to exit via the window previously. Staff #1 said staff was trained on the window alarm and the situation was handled appropriately.

RN #1 said she received a telephone call from Staff #1 who said a person knocked on the door and reported one of the tenants was outside. Tenant #3 was standing in shade and did not have any injuries. Staff checked Tenant #3's vitals and there were no areas of concern. There was one to one supervision with Tenant #3. The Director and RN #1 arrived at the building. Assessments were completed and family was notified. Family had been in the building earlier and saw the window open. On Monday (8-4-14) a meeting was held with the family. Interventions included: the blind was shut and turned, a sheet was placed on the rod and two emergency signs were placed. A window alarm was placed and activities were provided. The one to one supervision was stopped on 8-4-14 as there had been no problems and Tenant #3 had not touched the window covering. Tenant #3 did not have any previous elopements and no subsequent elopements. RN #1 said staff followed the policies and procedures and handled the incident appropriately.

According to an incident investigation document signed by RN #1, Tenant #3's wandering monitoring system wrist watch was tested and functioned appropriately. The door alarms and staff pagers were checked and functioned. Through staff interviews it was determined no more than 15 minutes had elapsed between the time Tenant #3 was last seen inside the building and the time Tenant #3 was found in the yard.

The Director said Staff #1 reported Tenant #3 had gotten out of the building. The screen from the apartment window was removed. Tenant #3 had not been outside long enough for the system to recognize Tenant #3 as missing. RN #1 and the Director came to the building. Family was notified and the RN #1 assessed Tenant #3. Tenant #3's family had been at the Program that day and taken Tenant #3 for a

drive. Family said the window was open when family was there. Private duty care was initiated until Monday. There were no other attempts to elope that weekend. A blanket was placed over the window and signs were put up. There were no injuries and no history of exiting via the window. Tenant #3 ambulated independently. Interventions included: more specialized activities and a window alarm. Other families were also approached to see if relocation from an interior apartment to an exterior apartment would be possible; however, all who were asked declined to move. The Director said staff followed the policies and procedures and the incident was handled appropriately.

According to review of incident reports, on 7-23-14 at 7:50 p.m. staff responded to the front door alarm and the wandering monitoring system alarm. Staff noted Tenant #3 exiting the building. There were visitors exiting the building who had held the door open for Tenant #3. On 7-24-14 at 3:40 p.m. Tenant #3 exited the door by following care staff at 12:30 p.m. and 3:40 p.m. In both instances Tenant #3's wandering monitoring system wrist watch functioned appropriately. Tenant #3 was redirected back to an activity within the building. After the elopement on 8-2-14, there was an incident report dated 8-12-14 at 7:30 p.m. According to the incident report, staff was alerted by the wandering monitoring system that Tenant #3 had opened an exterior door. Staff responded immediately and redirected Tenant #3 back into the building.

According to Progress Notes dated 8-2-14, one to one supervision was put into place. The Director and RN #1 were in the building after the elopement. Health, functional and cognitive evaluations were completed. Tenant #3 appeared well hydrated and denied thirst. Tenant #3 ambulated with usual steady gait. No bruising or other injuries were noted. The apartment window was observed and the screen was completely intact lying directly outside the window. Staff noted they had seen the window open with screen fully intact earlier in the day. Family had visited earlier that day and had taken Tenant #3 out for breakfast and a car ride. Progress Notes dated 8-4-14 indicated one to one supervision was maintained through the weekend and Tenant #3 did not make any attempts to exit.

Evaluations were completed on 8-2-14 and the service plan was updated. On 8-4-14 the cognitive and health evaluations were completed and on 8-5-14 the functional evaluation and service plan were completed. The service plan was updated on 8-5-14 reflected on 8-2-14 Tenant #3 pushed the screen out of the window and exited the building. The service plan indicated Tenant #3 had worked outside and liked to spend time outside. The service plan indicated Tenant #3 had previously attempted to exit the building through the front door when visitors had mistaken Tenant #3 for a visitor but Tenant #3 had never attempted to open a window or shown any interest in the windows. The service plan indicated the window was marked with emergency exit only signs and covered with a heavy fabric. There was also a possible arrangement to move to an interior courtyard apartment.

Progress Notes dated 8-15-14 indicated Tenant #3 was holding Tenant #3's chest and appeared pale and less talkative than usual. Tenant #3's hands and feet were cold to touch and mild edema was noted in hands and 2+ pedal edema to lower legs. Tenant #3 was sent to the emergency room and was admitted to a hospital. Tenant #3 had

internal bleeding of unknown cause and would receive a transfusion of five units of blood.

Tenant #3 returned from the hospital and a service plan was completed dated 8-20-14. The service plan reflected a window alarm had been added at the top of the window that would sound an audible alarm if the window was opened. A receipt dated 8-8-14 showed the purchase of an alarm from a home improvement store. RN #1 said the window alarm was installed on the date the alarm was purchased.

The wandering monitoring system was checked at the time of the investigation and functioned appropriately. One of the exit doors was checked at the time of the investigation and the door and alarm functioned appropriately. Review of the wandering monitoring system records for 8-2-14 from 1:00 p.m. to 2:00 p.m. did not reflect any alarms or notifications for Tenant #3. The windows in the building including Tenant #3's apartment window were not a part of the wandering monitoring system. The exit doors were monitored as a part of the wandering monitoring system.

The Exit Door Inspections policy indicated maintenance would inspect the exit doors weekly to ensure they functioned appropriately. The inspections completed on 8-1-14, 8-8-14 and 8-15-14 indicated the exit doors functioned appropriately.

The area and terrain Tenant #3 possibly traveled was observed. The area outside of the window was grass and the trees Tenant #3's was standing under when observed were located near a sidewalk.

According to the State Climatologist, at the Iowa City Airport on 8-2-14 at 1:52 p.m. the weather conditions were as follows: temperature was 83 degrees, winds were calm, there were partly cloudy skies, the heat index was 85 degrees and there was no precipitation.

The window alarm was placed as intervention on the service plan dated 8-20-14. The window alarm was installed on the window on 8-8-14; however, the service plan was not updated to reflect the window alarm until the service plan update on 8-20-14. On 8-12-14 Tenant #3 set off the alarms on the front door and was redirect back to the building. It was after the elopement on 8-2-14 and before the window alarm was reflected on the service plan. The service plan did not reflect the identified needs and preferences for Tenant #3.

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

Tenant #4, an 80 year old, was admitted on 8-5-08 and diagnoses included: Expressive Aphasia, Hyperlipidemia, Parkinson's Disease and Vascular Dementia. Tenant #4 was staged at a three on the GDS, which indicated mild cognitive decline. According to Physician's Orders, Tenant #4 had diet orders for no added salt, small portions and to grind meat. The service plan reflected the no added salt diet and smaller portions for weight control per physician's order. The service plan did not reflect the order to grind meat. The service plan did not reflect the identified needs and preferences for Tenant #4.

Review of tenant files indicated the service plans did not reflect the identified needs and preferences for assistance.

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

Complaint/Incident Allegation #48391-C: It was alleged when a tenant received hospice services the service plan and notes were not available to staff. It was alleged the services to be provided were not clear.

- Monitoring Observation: The ALP Monitoring Entrance form indicated Tenant #1 and Tenant #2 received hospice services.

  Tenant #1, a 100 year old, was admitted on 3-1-14 and diagnosis included: Esophageal Perforation, Atrial Fibrillation, HTN, Macular Degeneration and Pacemaker. Tenant #1 received hospice services. Review of Tenant #1's file indicated a hospice care plan was in the file. The Program's service plan reflected hospice services including: health monitoring, provision of health supplies, bathing twice a week and selected medication provision. Review of Tenant #1's file indicated the service plan reflected hospice as an outside service provider and hospice documentation was also provided in the file.

  Tenant #2, an 85 year old, was admitted on 8-5-07 and diagnoses included: Cerebral Palsy, Gastro Esophageal Reflux Disease and Recurrent Urinary Tract Infection. Tenant #2 received hospice services. Review of Tenant #2's file indicated a hospice care plan and notes were in the file. The Program's service plan reflected hospice services including: nursing visits a minimum of one to two times weekly for wound care and assessment, nursing aide services once to twice weekly with personal care services and chaplain, music therapy and social work services as requested by Tenant #2. The nurse would coordinate services between hospice and the Program to prevent duplication of services. The phone number for hospice was provided. The service plan also listed instructions for whom to call if a medical concern arose. Review of Tenant #2's file indicated the service plan reflected hospice as an outside service provider and hospice documentation was also provided in the file.

  Staff #1, Staff #2, RN #1, RN #2 and the Director said hospice documentation was available for tenants who received hospice services.

  Review of tenant files and staff interviews did not reveal concerns regarding clarity of hospice services or availability of hospice documentation.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48391-C: It was alleged tenants' mail was screened before they could receive it and there was no mention of it on the service plan.

- Monitoring Observation: The Program identified Tenants #4, #8, #9, #10 and #11 had mail that was sorted.

Tenant #4's file was reviewed. The service plan dated 7-1-14 indicated Tenant #4 requested the mail be held in the mail cart for Tenant #4's family to pick up and go through when they visited. The request for held mail was reflected on Tenant #4's service plan.

Tenant #8, a 78 year old, was admitted on 9-16-13 and had a diagnosis of Cognitive Impairment with Short Term Memory Loss. Tenant #8 was staged at three on the GDS, which indicated mild cognitive decline. The service plan did not reflect Tenant #8's mail was sorted.

Tenant #9, an 84 year old, was admitted on 11-1-10 and diagnoses included: Dementia and Hyperlipidemia. Tenant #9 was staged at a three on the GDS, which indicated mild cognitive decline. The service plan did not reflect Tenant #9's mail was sorted.

Tenant #10, a 79 year old, was admitted on 6-17-11 and diagnoses included: Dementia and History of HTN. Tenant #10 was staged at three on the GDS, which indicated mild cognitive decline. The service plan did not reflect Tenant #10's mail was sorted.

Tenant #11, an 83 year old, was admitted 5-10-12 and diagnoses included: Osteoporosis, Chronic Disequilibrium, HTN, Depression, Urinary Frequency and Scoliosis. Tenant #11 was staged at a three on the GDS, which indicated mild cognitive decline. The service plan did not reflect Tenant #11's mail was sorted.

The Life Enrichment Coordinator said the mail was delivered six days per week. The time of mail delivery was always different and she was assigned to deliver it to the tenants. She said if she worked on Saturday the mail was delivered and if not it was delivered on Monday. There were tenants who had mail sorted and the mail was kept in a filing cabinet. There were no complaints from tenants regarding having mail sorted.

RN #1 said generally the Life Enrichment Coordinator delivered the mail. The Life Enrichment Coordinator got it out of the main mail box and sorted it by apartments. RN #1 said there were four to five tenants that had mail held. There were no complaints.

The Director said mail was delivered to the large mail box. The mail was delivered at different times. Once the mail was at the building the Life Enrichment Coordinator sorted the mail and passed the mail. There were no complaints from tenants regarding having the mail sorted.

A community meeting with 11 tenants was held. The tenants did not voice any concerns regarding privacy. There was comment made regarding not receiving mail on Saturday or Wednesday when the Life Enrichment Coordinator was not there.

There were no complaints from tenants at the community meeting regarding privacy. A review of tenant files indicated the service plans for Tenants #8, #9, #10 and #11 did not reflect the mail was sorted. 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 #48391-C: It was alleged evaluations were not completed prior to the development of the service plan.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7).

Tenant #1's file was reviewed. The file for Tenant #1 revealed evaluations were completed prior to the development of the service plan.

Tenant #2's file was reviewed. The file for Tenant #2 revealed evaluations were completed prior to the development of the service plan.

Tenant #3's file was reviewed. The file for Tenant #3 revealed evaluations were completed prior to the development of the service plan.

Tenant #4's file was reviewed. The file for Tenant #4 revealed evaluations were completed prior to the development of the service plan.

Tenant #5, a 70 year old, was admitted on 12-2-13 and diagnosis included: Dementia, Glaucoma, Depression and Anxiety. The file for Tenant #5 revealed evaluations were completed prior to the development of the service plan.

Tenant #6, a 79 year old, was admitted on 5-2-11 and diagnosis included: Dementia, Moderate Alzheimer's Disease and Depression. The file for Tenant #6 revealed evaluations were completed prior to the development of the service plan.

Tenant #7, an 81 year old, was admitted on 7-24-11 and diagnosis included: Mild Dementia, Memory Disturbance, Polymyalgia Rheumatica, History of Giant Cell Arteritis, Hyperlipidemia, Well Controlled Type II Diabetes and Partial Small Bowel Obstruction. The file for Tenant #7 revealed evaluations were completed prior to the development of the service plan.

RN #1, RN #2 and the Director said evaluations were completed prior to the development of the service plan.

Review of tenant files and staff interviews did not reveal concerns regarding the completion of evaluations and the development of service plans.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48391-C: It was alleged the service plans did not reflect the cares that are provided. It was alleged the care checklists were not accurate and cares were missed as a result of the inaccuracies.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). Review of the seven tenant files indicated the cares reflected on the Resident Services Summary were reflected on the service plans. The Resident Services Summary provided a basic list of tasks to be completed for the tenants for example: a.m. and p.m. cares, escorts, meal and activity reminders, toileting assistance, safety checks, pet care and wake up calls. The service plans also reflected those tasks; however, appeared to provide more specificity than the Resident Care Summaries.

  A community meeting was held with 11 tenants. The tenants stated they received the cares they requested.

  Staff #1, Staff #2, RN #1, RN #2 and the Director indicated the service plans reflected the cares provided and the care checklists were accurate.

  Review of tenant files, staff interviews and a community meeting with tenants did not reveal concerns regarding the care checklists, cares provided or the reflection of cares on the service plan.

- Regulatory Insufficiency: None noted.

B. Policies and Procedures

Complaint/Incident Allegation #48391-C: It was alleged incident reports were not followed up on in a prompt manner.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7).

  The Program's Incident and Accident Report policy indicated staff completed the top portion of the Fall Investigation Tool immediately after a fall and the nurse would complete the bottom portion of the Fall Investigation Tool within 24 hours or the next workday.

  Incident reports for August 2014 (to the time of the investigation were reviewed). The follow up or further action noted on incident reports was completed per the Program's policy regarding incident reports.

  Staff #1, Staff #2, RN #1, RN #2 and the Director said incident reports were followed up on in a prompt manner.

  Review of a policy, tenant files and staff interviews did not reveal concerns regarding follow up on incident reports.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48391-C: It was alleged tenants' code status indicated in the charts were not consistent with the code status designated in the apartments.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7).

  Tenant #1's file was reviewed. The Resident Emergency Code Status document indicated no resuscitation should be attempted. The code status indicator sticker on the outside of Tenant #1's file reflected do not resuscitate (DNR) which was consistent with the code status indicator sticker on the inside of Tenant #1's apartment door which revealed a DNR status.

  Tenant #2's file was reviewed. The Resident Emergency Code Status document indicated no resuscitation should be attempted. The code status indicator sticker on the outside of Tenant #2's file reflected DNR which was consistent with the code status indicator sticker on the inside of Tenant #2's apartment door which revealed a DNR status.

  Tenant #3's file was reviewed. The Resident Emergency Code Status document indicated no resuscitation should be attempted. The code status indicator sticker on the outside of Tenant #3's file reflected DNR which was consistent with the code status indicator sticker on the inside of Tenant #3's apartment door which revealed a DNR status.

  Tenant #4's file was reviewed. The Resident Emergency Code Status document indicated no resuscitation should be attempted. The code status indicator sticker on the outside of Tenant #4's file reflected DNR which was consistent with the code status indicator sticker on the inside of Tenant #4's apartment door which revealed a DNR status.

  Tenant #5's file was reviewed. The Resident Emergency Code Status document indicated no resuscitation should be attempted. The code status indicator sticker on the outside of Tenant #5's file reflected DNR which was consistent with the code status indicator sticker on the inside of Tenant #5's apartment door which revealed a DNR status.

  Tenant #6's file was reviewed. The Resident Emergency Code Status document indicated no resuscitation should be attempted. The code status indicator sticker on the outside of Tenant #6's file revealed DNR which was consistent with the code status indicator sticker on the inside of Tenant #6's apartment door which revealed a DNR status.

  Tenant #7's file was reviewed. The Resident Emergency Code Status document indicated no resuscitation should be attempted. The code status indicator sticker on the outside of Tenant #7's file reflected DNR order which was consistent with the code status indicator sticker on the inside of Tenant #7's apartment door which revealed a DNR status.

  The Program's Do Not Resuscitate Orders policy outlined that when a tenant had signed and dated the Code Status form, the code status would be noted on the outside cover of the tenant file and on the tenant's apartment door using an indicator sticker.

Staff #1, Staff #2, RN #1, RN #2 and the Director stated the code status indicator stickers on tenant files matched the code status indicator stickers on the tenant apartment doors.

Review of tenant files, staff interviews and observations did not reveal concerns regarding the code status indicators in tenant files and tenant apartments.

- Regulatory Insufficiency: None noted.

C. Medications

Complaint/Incident Allegation #48391-C: It was alleged there were discharged tenant medications kept in a location accessible to tenants that were not securely stored.

- Monitoring Observation: On 8-18-14 no medications were observed within administrative offices during the initial tour of the building or during investigative discussions with staff.

  The Program's Medication Record Maintenance policy outlined that upon the discharge of a tenant, unit dose medication would be returned to the pharmacy, if applicable.

  Staff #1, RN #1, RN #2 and the Director stated that discontinued or unused medications were not stored in administrative offices. RN #1 said full card medications were returned to the pharmacy. Narcotic medications were destroyed per policy and non-narcotic medications were packaged and sent to a medication recycling program.

  Staff interviews, observations and review of a policy did not reveal concerns regarding storage of medications in a location accessible to tenants.

- Regulatory Insufficiency: None noted.

D. Staffing

Complaint/Incident Allegation #49532-C: It was alleged showers were not getting completed despite asking for assistance.

- Monitoring Observation: A community meeting was held with 11 tenants. The tenants stated they received the cares they requested.

  Staff #1, Staff #2, RN #1, RN #2 and the Director felt there was enough staff to meet the identified needs of the tenants and all cares were given including showers. Staff #1, Staff #2, RN #1, RN #2 and the Director said the service plans reflected the needs of the tenants.

  A community meeting with tenants and staff interviews did not reveal concerns regarding the completion of cares including showers.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48391-C: It was alleged staff did not get instructions in a prompt manner to keep tenants safe including tenants that were falling, wandering and those threatening suicide.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). Review of the seven tenant files did not reveal any tenants that currently exceeded the level of care.

  A community meeting was held with 11 tenants. The tenants described staff as terrific and noted pendant response was immediate over the pendant intercom system. The tenants stated they received the cares they requested.

  Staff #1, Staff #2, RN #1, RN #2 and the Director said staff received instructions to keep tenants safe including tenants that were wandering or falling.

  Staff #1, Staff #2, RN#1, RN #2 and the Director did not identify any tenants that had suicidal ideations.

  Review of tenant files, a community meeting with tenants and staff interviews did not reveal concerns regarding level of care or staff instructions to ensure tenant safety.

  - Regulatory Insufficiency: None noted.

  Complaint/Incident Allegation #48391-C: It was alleged delegations were signed with minimal training from a nurse.

- Monitoring Observation: Staff files were reviewed. Staff #1, #4, #5 and #6 had nurse delegations completed for assigned tasks. Staff #1 and Staff #2 said they were delegated by RN #1. RN #2 stated all staff was delegated by RN #1. RN #1said nurse delegations were completed.

  A community meeting was held with 11 tenants. The tenants stated they received the cares they requested.

  A community with tenants, staff interviews and review of staff files did not reveal concerns regarding nurse delegation.

  - Regulatory Insufficiency: None noted.

F. Tenant Documents

Complaint/Incident Allegation #48391-C: It was alleged meal order forms were not completed and updated.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7).

Tenant #1's file was reviewed. Tenant #1 had a general diet and the meal order form indicated Tenant #1 had a general diet.

Tenant #2's file was reviewed. An altered texture diet was recommended; however, Tenant #2 had a regular diet. The meal order form indicated Tenant #2 had a general diet.

Tenant #3's file was reviewed. Tenant #3 had a no added salt diet. The meal order form indicated Tenant #3 had a no added salt diet.

Tenant #4's file was reviewed. Tenant #4's diet included no added salt, grind meats and small portions. The meal order form indicated Tenant #4 had a no added salt diet, small portions and to grind meats.

Tenant #5's file was reviewed. Tenant #5 had a general diet. The meal order form indicated no diet orders.

Tenant #6's file was reviewed. Tenant #6 had a regular diet. The meal order form indicated Tenant #6 had a regular diet.

Tenant #7's file was reviewed. Tenant #7 had a low concentrated sweets diet. The meal order form indicated Tenant #7 had a no sugar diet.

Staff #1, Staff #2, RN #1, RN #2, the Kitchen Manager and the Director said meal order forms were updated as needed.

Review of tenant files, meal order forms and staff interviews did not reveal concerns regarding diet orders and meal order forms.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48391-C: It was alleged staff could not document in tenant files. It was alleged there was a communication book that was shredded.

- Monitoring Observation: Staff #1 said anyone could document in tenant files in the Progress Notes and there was a communication book in the office.

  RN #1 said staff documented in the tenant files if something was unusual. RN #1 said there was also a communication book which was retained for seven days.

  RN #2 said staff documented in Progress Notes and there was a communication book.

  The Director said staff could document in the tenant files and there was communication book which was kept for a certain amount of time.

  According to the Program's Documentation policy, documentation was by exception, the communication book was to be utilized appropriately per policy and any staff could document in Progress Notes.

Staff interviews and review of a policy did not reveal concerns regarding staff documentation.

- Regulatory Insufficiency: None noted.

G. Nurse Review

Complaint/Incident Allegation #48391-C: It was alleged physician orders were not entered and followed up in a prompt manner. It was alleged medications were delayed and medication errors were covered up.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). Review of the seven tenant files indicated physician orders were noted and medications were added to the medication administration records.

  Staff #1, RN #1, RN#2 and the Director said physician orders were followed up in a timely manner and medication errors were not covered up.

  Review of tenant files and staff interviews did not reveal concerns regarding physician orders, medication administration or medication errors.

- Regulatory Insufficiency: None noted.

H. Food Service

Complaint/Incident Allegation #49532-C: It was alleged the cook was off and a meal was cooked/prepped by nursing staff on shift that were to be caring for tenants. It was alleged there were concerns nutritional needs might not be getting met, the changes on the menu were not communicated and a tenant was still hungry after a meal was served.

- Monitoring Observation: The Director said on 8-14-14, Staff #3 requested to have 8-16-14 off. The administrative team planned a meal for tenants which included premade food items from a local grocery store. The Director noted menu substitutions were similar in nature. In example, the lunch menu for 8-16-14 contained the following food items: Caesar salad, meatloaf (or) baked macaroni and cheese, mashed potatoes and gravy with green beans (or) a broiled tomato half, baked roll and ginger cookie. The meal planned and served by the Program was Caesar salad, meatloaf, macaroni salad, wheat roll, fresh tomato slice and a bakery cookie.

  RN #1 said there was one tenant complaint after the breakfast meal regarding a hardboiled egg. There were no complaints at the lunch meal. RN #1 was present for both the breakfast and lunch meals served on 8-16-14. RN #1 went over the supper menu with staff.

  A Food and Resident Council Meeting was held on 8-18-14. Tenants described the substituted 8-16-14 meal as kind of fun and good.

  A community meeting with 11 tenants was held. The tenants said there was enough food served at meals.

Food items served during two meal observations on 8-19-14 and a noon meal on 8-20-14 were consistent with foods listed on the advance menu and menu board.

Review of the menus, council meeting minutes, observations, staff interviews and a community meeting with tenants did not reveal concerns regarding nutritional needs.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48391-C: It was alleged dietician serving sizes were not followed and staff gave half portions to tenants with no documented reason for the half portions.

- Monitoring Observation: Food items served during two meal observations on 8-19-14 and a noon meal on 8-20-14 were consistent with foods and food portions listed on the advance menu.

  Staff #1, Staff #2, RN #1, RN #2, the Kitchen Manager and the Director stated that tenants received full portion sizes unless ordered otherwise by a physician.

  A community meeting with 11 tenants was held. The tenants said there was enough food served at meals.

  Staff interviews, observations and a community meeting with tenants did not reveal concerns regarding the food portions served to the tenants.

- Regulatory Insufficiency: None noted.

I. Life Safety

Complaint/Incident Allegation #49532-C: It was alleged a fire alarm went off in the night and staff could not silence the alarm while tenants were sleeping. It was alleged staff did not know what to do and tried to call management for some time before anyone answered.

- Monitoring Observation: Staff files were reviewed. Staff #1, #4, #5, #6 and #7 had training on emergency procedures.

  A community meeting with 11 tenants was held. The tenants did not voice any concerns with privacy or with fire alarms.

  Staff #1 said staff was trained on emergency procedures including fire alarms. Staff #1 said there was an issue in June with a non-fire alarm and it was repaired. Staff #1 said management staff responded to staff telephone calls.

  Staff #2 said staff was trained on the emergency procedures including fire alarms. Staff #2 said there had not been any issues with a fire alarm going off and staff not being able to silence the alarms. Staff #2 said usually she did not call management; however, she had not heard of any issues.

RN #1 said staff was trained on emergency procedures including fire alarms. RN #1 said there had not been any issues with a fire alarm going off and staff not being able to silence the alarms. RN#1 said management staff responded to staff telephone calls.

RN #2 said staff was trained on emergency procedures including fire alarms. RN #2 said there had not been any issues with a fire alarm going off and staff not being able to silence the alarms. RN #2 said management staff responded to staff telephone calls.

The Director said staff was trained on emergency procedures including fire alarms. The Director said there had not been any issues with fire alarms going off and staff not being able to silence the alarms. The Director said on 7-12-14 there was a storm in the area and the front door alarm went off at 5:30 a.m. Staff called the Director. The Maintenance Director called staff and verbally walked staff through repairing the issue. It was approximately one hour until it was repaired and one staff stayed at the door to ensure it was secured. The Director said there were no complaints from tenants regarding that situation. The Director said management staff responded to staff telephone calls.

Staff interviews, review of staff files and a community meeting with tenants did not reveal concerns regarding staff training on emergency procedures or with management staff response.

- Regulatory Insufficiency: None noted.

J. Activities

Complaint/Incident Allegation #48391-C: It was alleged spontaneous activity forms for tenants with dementing illness were not available for staff to use.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). The ALP Monitoring Entrance Form and tenant list provided by the Program identified three tenants had a GDS of 4 or greater (Tenants #5, #6 and #7). Tenants #5, #6 and #7 had an individualized spontaneous activity document for staff to utilize as needed.

  Staff #1, RN #1, RN #2 and the Director said spontaneous activity forms were available for staff to use.

  Review of spontaneous activity forms, tenant files and staff interviews did not reveal concerns regarding the availability of spontaneous activity forms.

- Regulatory Insufficiency: None noted.

K. Other

Complaint/Incident Allegation #48391-C: It was alleged documentation was falsified including postdating documentation and filling in information after the fact.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). Review of the seven tenant files revealed no concerns of postdated documentation or falsified records.

  Staff #1, Staff #2, RN #1, RN #2 and the Director said incident reports were followed up on in a timely manner. RN #1, RN #2 and the Director said documentation was not postdated or falsified.

  Review of tenant files and staff interviews did not reveal concerns regarding postdated documentation or falsified records.

  - Regulatory Insufficiency: None noted.