IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
53819-C
53857-I

July 17, 2015

Ms. Tammy Olson, Administrator
Village at Legacy Pointe
1654 SE Holiday Crest Circle
Waukee, IA 50263

RE: Final Complaint/Incident Investigation Report, Village at Legacy Pointe, Waukee, Iowa

Dear Ms. Olson:

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 **July 2 & July 6, 2015.** An investigation of Complaint #53819-C and Incident #53857-I was completed. There were no regulatory insufficiencies identified related to Incident #53857-I. There were regulatory insufficiencies identified related to Complaint #53819-C and during the course of the investigation of Complaint #53819-C and Incident #53857-I. The regulatory insufficiencies are indicated on the enclosed report.

The following allegations were investigated in regards to Complaint #53819-C:

1. Allegation: Admission/Discharge
   Findings: Unsubstantiated
   Comments: Staff interviews, review of tenant files and review of Program documents did not reveal concerns related to admission/discharge.

2. Allegation: Tenant Rights
   Findings: Unsubstantiated
   Comments: Staff interviews, review of tenant files and review of Program documents did not reveal concerns related to tenant rights.

The following allegation was investigated in regards to Incident #53857-I:

1. Allegation: Staffing
   Findings: Unsubstantiated
   Comments: Staff interviews, review of tenant files and review of Program documents did not reveal concerns related to staffing.

The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation, Tenant Documents, Service Plans and Structural Requirements.

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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0257	A. BUILDING _____ B. WING _____	C 07/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT LEGACY POINTE	1654 SE HOLIDAY CREST CIRCLE WAUKEE, IA 50263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 25 Number of tenants with cognitive disorder: 15 Total Population of Program at time of on-site: 40 TOTAL census of Assisted Living Program: 40 Complaint #53819-C and Incident #53857-I were investigated. There were no regulatory insufficiencies identified related to Incident #53857-I. There were regulatory insufficiencies identified related to Complaint #53819-C and during the course of the investigation of Complaint #53819-C and Incident #53857-I.	A 000		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. 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.	A 037		

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A 037	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of tenant files, Program documents and a staff interview, the Program failed to complete cognitive, health and functional evaluations with significant change in condition for two of three tenant files reviewed (Tenants #2 and #3). (During the course of the investigation of Complaint #53819-C and Incident #53857-I) 1. Tenant #2, a 96 year old, was admitted on 6-15-15 and diagnoses included: chronic kidney disease, psychosis, constipation, hypothyroidism, depressive disorder, hypertension (HTN), pneumonia and abnormality of gait. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. The GDS document (which had an effective date of 7-5-15) reflected "NA" for the score; however, stage six had the most check marks indicated. According to 24-Hour Report documents from 6-24-15 to 7-4-15, Tenant #2 was wandering and was found on the floor inside the conference room in the independent living building, Tenant #2 was incontinent of urine, was up during the hours of sleep, Tenant #2 was very disoriented and walked the halls on first and second floor at night. According to Progress Notes from 6-24-15 to 7-3-15, staff checked on Tenant #2 every one to two hours throughout the day and night, Tenant #2 wore a robe over clothing as Tenant #2 felt it needed to be on at all times and Tenant #2 went to a back door when an activity staff was near by,	A 037		

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A 037	Continued From page 2 opened the door and was redirected back inside. Tenant #2 had difficulty remembering where Tenant #2's apartment was and had gone to other doors and opened them. An outside agency providing companionship and one-on-one time with Tenant #2, two hours per day, five days per week was initiated. Tenant #2 complained of constipation and had a large incontinent stool in the middle of Tenant #2's kitchen floor, Tenant #2 went into several other tenant apartments, Tenant #2 pushed Tenant #2's bed away from the window and tried to open the window and screen and Tenant #2 refused medications. Evaluations were completed and had an effective date of 6-21-15. Evaluations were completed after Tenant #2 eloped on 7-5-15 and the effective date of the evaluations was 7-5-15. Cognitive, health and functional evaluations were not completed as needed with significant change for Tenant #2 with behaviors, incontinence, refusals, wandering, leaving the building with staff awareness, attempting to remove the screen from a window and the addition of private caregivers. Evaluations were not completed when Tenant #2 had a significant change in condition. 2. Tenant #3, an 89 year old, was admitted on 7-25-13 and diagnoses included: debility, hyperlipidemia, iron deficiency anemia, leukocytosis, HTN and chronic kidney disease. According to Progress Notes dated 5-12-15, Tenant #3 had weight loss noted that month. Tenant #3 received home care services from an outside service provider and the home care nurse was notified of the weight loss. Tenant #3 was encouraged to continue eating meals and maintaining Tenant #3's diet.	A 037		

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A 037	Continued From page 3 According to an interview with the Program Director on 7-6-15 at 2:18 p.m. and 2:55 p.m., Tenant #3 had made sexually inappropriate comments to staff. Staff was to redirect and tell Tenant #3 that it was inappropriate and report the comments to the Program Director. Cognitive, health and functional evaluations were not completed with significant change when Tenant #3 had noted weight loss and had inappropriate behaviors towards staff. 3. According to the Program's policy regarding evaluations, all tenants would have an initial, 30 day from taking occupancy, every six months, significant change and annual evaluations. The evaluations would be completed timely and accurately along with the service plan.	A 037		
A 077	481-69.25(1)o Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include. o. Incident 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) This REQUIREMENT is not met as evidenced by: Based on review of tenant files, a staff interview and review of Program documents the Program failed to complete an incident report for one of three tenant files reviewed (Tenant #2). Tenant #2, who had been identified as a elopement risk and wanderer, left the building and a staff	A 077		

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A 077	Continued From page 4 observed Tenant #2 leaving the building and responded. An incident report was not completed related to the incident with Tenant #2. (Complaint #53819-C) 1. Tenant #2, a 96 year old, was admitted on 6-15-15 and diagnoses included: chronic kidney disease, psychosis, constipation, hypothyroidism, depressive disorder, hypertension, pneumonia and abnormality of gait. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. The GDS document (which had an effective date of 7-5-15) reflected "NA" for the score; however, stage six had the most check marks indicated. According to Progress Notes dated 7-1-15 (late entry), Tenant #2 went to a back door that morning when an activity staff was near by and opened the back door, looking outside. The activity staff redirected Tenant #2 back inside. The service plan dated 6-15-15 identified Tenant #2 as a elopement risk and wanderer. According to a cognitive evaluation, which had an effective date of 6-21-15, Tenant #2's errors on the Short Mental Status Questionnaire (SMSQ) indicated severe intellectual functioning. 2. According to an interview with Staff B on 7-6-15 at 11:26 a.m., Tenant #2 was going out the door right before the skilled nursing section. Staff B opened the door and asked Tenant #2 where Tenant #2 was going. Tenant #2 said Tenant #2 was looking for Tenant #2's "hut." Staff B saw Tenant #2 walk out the door. Staff B walked with Tenant #2 through the parking lot and back into the independent living part of the building Tenant #2 was dressed appropriately for the weather and had no injuries. Staff B said Tenant #2 was easily	A 077		

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A 077	Continued From page 5 redirectable. Staff B reported it to the Administrator and the Administrator said to walk Tenant #2 to the dementia unit. Staff B learned that Tenant #2 had an appointment and Tenant #2's family would be arriving at the Program to take Tenant #2 to the appointment. Tenant #2 sat with staff and did an activity until family arrived to take Tenant #2 to the appointment. Staff B said she did not complete an incident report related to the incident. 3. According to a weather website, the weather conditions at the airport nearest to the Program on 7-1-15 were as follows: temperature was a high of 76 degrees and a low temperature of 63 degrees and there was a trace amount of precipitation. 4. Review of incident reports for the past three months did not reveal an incident report related to the incident on 7-1-15 with Tenant #2. Tenant #2 left the building and was observed by Staff B. Tenant #2 said Tenant #2 was looking for Tenant #2's "hut." The service plan dated 6-15-15 identified Tenant #2 was an elopement risk and wanderer. According to a cognitive evaluation, which had an effective date of 6-21-15, Tenant #2's errors on the SMSQ indicated severe intellectual functioning. An incident report was not completed as needed regarding the incident with Tenant #2. 5. According to the Program's policy and procedure regarding accident/incident reporting, all accidents or incidents involving tenants, employees, visitors and vendors occurring at the Program must be investigated and reported to the Executive Director. Regardless of how minor an accident/incident might be, including injuries of an unknown origin, it must be reported to the	A 077		

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A 077	Continued From page 6 department supervisor as soon as the information was received of an accident/incident, no later than the end of the shift upon which the accident/incident occurred. Whenever an accident/incident occurred the following step was completed: an accident/incident reported was completed per company policy by the supervisor/department manager.	A 077		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, Program documents and a staff interview the Program failed to update service plans as needed and the service plans did not reflect the service needs of the tenants for three of three tenant files reviewed (Tenants #1, #2 and #3). (During the course of the investigation of Complaint #53819-C and Incident #53857-I) 1. Tenant #1, a 79 year old, was admitted on 1-21-14 and diagnoses included: hypothyroidism, Parkinsonism, rheumatoid arthritis and	A 083		

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A 083	Continued From page 7 osteoporosis. Tenant #1 was discharged on 6-29-15. According to Major Nurse Review document dated 6-17-15, Tenant #1 required total assistance with most activities of daily living (ADLs). The document indicated Tenant #1 had a significant change. Tenant #1 continued to decline in strength and ability to perform ADLs. Tenant #1 had outside caregivers and at times required an additional staff to transfer Tenant #1 with a gait belt if Tenant #1's legs were weak or Tenant #1 was tired. The service plan was not updated as needed to reflect total assistance with most ADLs and a decline in strength and ability to perform ADLs. The service plan was not updated as needed and did not reflect the service needs of Tenant #1. 2. Tenant #2, a 96 year old, was admitted on 6-15-15 and diagnoses included: chronic kidney disease, psychosis, constipation, hypothyroidism, depressive disorder, hypertension (HTN), pneumonia and abnormality of gait. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. The GDS document (which had an effective date of 7-5-15) reflected "NA" for the score; however, stage six had the most check marks indicated. According to 24-Hour Report documents from 6-24-15 to 7-4-15, Tenant #2 was wandering and was found on the floor inside the conference room in the independent living building, Tenant #2 was incontinent of urine, was up during the hours of sleep, Tenant #2 was very disoriented and walked the halls on first and second floor at night. According to Progress Notes from 6-24-15 to 7-3-15, staff checked on Tenant #2 every one to	A 083		

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A 083	Continued From page 8 two hours throughout the day and night, Tenant #2 wore a robe over clothing as Tenant #2 felt it needed to be on at all times and Tenant #2 went to a back door when an activity staff was near by, opened the door and was redirected back inside. Tenant #2 had difficulty remembering where Tenant #2's apartment was and had gone to other doors and opened them. An outside agency providing companionship and one-on-one time with Tenant #2 two hours per day, five days per week was initiated. Tenant #2 complained of constipation and had a large incontinent stool in the middle of Tenant #2's kitchen floor, Tenant #2 went into several other tenant apartments, Tenant #2 pushed Tenant #2's bed away from the window and tried to open the window and screen and Tenant #2 refused medications. The service plan was updated on 6-24-15 and after Tenant #2's elopement on 7-5-15. The service plan was not updated as needed to reflect behaviors, incontinence, refusals, wandering, leaving the building with staff awareness, attempting to remove the screen and the addition of private caregivers. The service plan was not updated as needed and did not reflect the service needs of Tenant #2. 3. Tenant #3, an 89 year old, was admitted 7-25-13 and diagnoses included: debility, hyperlipidemia, iron deficiency anemia, leukocytosis, HTN and chronic kidney disease. According to Progress Notes dated 5-12-15, Tenant #3 had weight loss noted that month. Tenant #3 received home care services from an outside service provider and the home care nurse was notified of the weight loss. Tenant #3 was encouraged to continue eating meals and maintaining Tenant #3's diet.	A 083		

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A 083	Continued From page 9 According to an interview with the Program Director on 7-6-15 at 2:18 p.m. and 2:55 p.m., Tenant #3 had made sexually inappropriate comments to staff. Staff was to redirect and tell Tenant #3 that it was inappropriate and report the comments to the Program Director. The service plan was not updated as needed when Tenant #3 had noted weight loss and inappropriate behaviors towards staff. The service plan did not reflect interventions related to Tenant #'3's behaviors. The service plan was not updated as needed and did not reflect the service needs of Tenant #3. 4. According to the Program policy and procedure regarding service plans, a service plan would be developed on or before taking occupancy, 30 days after taking occupancy, every six months, annually and with each significant change or additional information related to the tenant during the timeframe between the evaluation schedules.	A 083		
A 155	481-69.35(1)c Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. c. Programs shall have private dwelling units with a single-action, lockable entrance door. This REQUIREMENT is not met as evidenced by: Based on observation, a Program document and a staff interview the Program failed to have private dwelling units with a single-action, lockable entrance door. The tenant apartments	A 155		

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A 155	Continued From page 10 did not have a single-action lockable entrance door. (During the course of the investigation of Complaint #53819-C and Incident #53857-I) 1. According to observation on 7-6-15 at approximately 12:09 p.m. and 12:55 p.m., a vacant apartment was observed and the apartment did not have a single-action lockable entrance door. When the apartment entrance door was locked and an attempt to egress from inside the apartment was made the door did not unlock by using the door handle. The door unlocked when the dead bolt lock was unlocked and the door was opened by using the door handle. 2. According to an interview with Staff A on 7-6-15 at 12:07 p.m., if a tenant apartment entrance door was locked and the door needed to be opened the dead bolt would have to be unlocked for the door to open. 3. According to a current copy of the Program's certificate from the Department, the Program had 40 double occupancy dwelling units.	A 155		

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A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 25 Number of tenants with cognitive disorder: 15 Total Population of Program at time of on-site: 40 TOTAL census of Assisted Living Program: 40 Complaint #53819-C and Incident #53857-I were investigated. There were no regulatory insufficiencies identified related to Incident #53857-I. There were regulatory insufficiencies identified related to Complaint #53819-C and during the course of the investigation of Complaint #53819-C and Incident #53857-I.	A 000		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. 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.	A 037	A 037 The facility does and will continue to ensure that a resident or resident's service plan and evaluation are maintained according to regulations. 1) Resident # 2 service plan has been update Resident # 3 service plan has been updated.	

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	S0257	A. BUILDING: _____ B. WING _____	C 07/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT LEGACY POINTE	1654 SE HOLIDAY CREST CIRCLE WAUKEE, IA 50263

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A 037	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of tenant files, Program documents and a staff interview, the Program failed to complete cognitive, health and functional evaluations with significant change in condition for two of three tenant files reviewed (Tenants #2 and #3). (During the course of the investigation of Complaint #53819-C and Incident #53857-I) 1. Tenant #2, a 96 year old, was admitted on 6-15-15 and diagnoses included: chronic kidney disease, psychosis, constipation, hypothyroidism, depressive disorder, hypertension (HTN), pneumonia and abnormality of gait. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. The GDS document (which had an effective date of 7-5-15) reflected "NA" for the score; however, stage six had the most check marks indicated. According to 24-Hour Report documents from 6-24-15 to 7-4-15, Tenant #2 was wandering and was found on the floor inside the conference room in the independent living building, Tenant #2 was incontinent of urine, was up during the hours of sleep, Tenant #2 was very disoriented and walked the halls on first and second floor at night. According to Progress Notes from 6-24-15 to 7-3-15, staff checked on Tenant #2 every one to two hours throughout the day and night, Tenant #2 wore a robe over clothing as Tenant #2 felt it needed to be on at all times and Tenant #2 went to a back door when an activity staff was near by,	A 037	2) On 7/10/2015 Program Director was re-educated on the regulations pertaining to occupancy, admissions, service plan, and evaluation policies and procedures. The assessment check list was reviewed with the Program Director to ensure evaluations are completed timely and to ensure all significant changes are entered timely with updated service plans as needed. Residents residing in the community have had their services plans reviewed. 3) The Administrator will conduct periodic reviews with the Program Director to ensure compliance of the regulations. 4) Responsible Person: Director of Nursing, Alleged Date of Compliance: 7/24/2015	

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A 037	Continued From page 2 opened the door and was redirected back inside. Tenant #2 had difficulty remembering where Tenant #2's apartment was and had gone to other doors and opened them. An outside agency providing companionship and one-on-one time with Tenant #2, two hours per day, five days per week was initiated. Tenant #2 complained of constipation and had a large incontinent stool in the middle of Tenant #2's kitchen floor, Tenant #2 went into several other tenant apartments, Tenant #2 pushed Tenant #2's bed away from the window and tried to open the window and screen and Tenant #2 refused medications. Evaluations were completed and had an effective date of 6-21-15. Evaluations were completed after Tenant #2 eloped on 7-5-15 and the effective date of the evaluations was 7-5-15. Cognitive, health and functional evaluations were not completed as needed with significant change for Tenant #2 with behaviors, incontinence, refusals, wandering, leaving the building with staff awareness, attempting to remove the screen from a window and the addition of private caregivers. Evaluations were not completed when Tenant #2 had a significant change in condition. 2. Tenant #3, an 89 year old, was admitted on 7-25-13 and diagnoses included: debility, hyperlipidemia, iron deficiency anemia, leukocytosis, HTN and chronic kidney disease. According to Progress Notes dated 5-12-15, Tenant #3 had weight loss noted that month. Tenant #3 received home care services from an outside service provider and the home care nurse was notified of the weight loss. Tenant #3 was encouraged to continue eating meals and maintaining Tenant #3's diet.	A 037		

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A 037	Continued From page 3 According to an interview with the Program Director on 7-6-15 at 2:18 p.m. and 2:55 p.m., Tenant #3 had made sexually inappropriate comments to staff. Staff was to redirect and tell Tenant #3 that it was inappropriate and report the comments to the Program Director. Cognitive, health and functional evaluations were not completed with significant change when Tenant #3 had noted weight loss and had inappropriate behaviors towards staff. 3. According to the Program's policy regarding evaluations, all tenants would have an initial, 30 day from taking occupancy, every six months, significant change and annual evaluations. The evaluations would be completed timely and accurately along with the service plan.	A 037		
A 077	481-69.25(1)o Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include. o. Incident 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) This REQUIREMENT is not met as evidenced by: Based on review of tenant files, a staff interview and review of Program documents the Program failed to complete an incident report for one of three tenant files reviewed (Tenant #2). Tenant #2, who had been identified as a elopement risk and wanderer, left the building and a staff	A 077	A 077. 1) Resident # 2 incident report for 7/01/2015 was filled out and recorded. 2) On 7/10/ 2015 Program Director was re-educated on the facilities incident reporting policy and procedures. Associates were in serviced on the facilities policy and procedure for filling out an incident report timely. The Program Director will ensure when reviewing incident reports or maintaining progress notes and reviewing communication log all actionable items are maintained per regulations and facility policy. 3) Administrator to conduct periodic audits to ensure accuracy and completion of incident reports, and accuracy of service plans and assessments. 4) Responsible Person: Program Director Alleged Date of Compliance: 7/24/2015	

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A 077	Continued From page 4 observed Tenant #2 leaving the building and responded. An incident report was not completed related to the incident with Tenant #2. (Complaint #53819-C) 1. Tenant #2, a 96 year old, was admitted on 6-15-15 and diagnoses included: chronic kidney disease, psychosis, constipation, hypothyroidism, depressive disorder, hypertension, pneumonia and abnormality of gait. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. The GDS document (which had an effective date of 7-5-15) reflected "NA" for the score; however, stage six had the most check marks indicated. According to Progress Notes dated 7-1-15 (late entry), Tenant #2 went to a back door that morning when an activity staff was near by and opened the back door, looking outside. The activity staff redirected Tenant #2 back inside. The service plan dated 6-15-15 identified Tenant #2 as a elopement risk and wanderer. According to a cognitive evaluation, which had an effective date of 6-21-15, Tenant #2's errors on the Short Mental Status Questionnaire (SMSQ) indicated severe intellectual functioning. 2. According to an interview with Staff B on 7-6-15 at 11:26 a.m., Tenant #2 was going out the door right before the skilled nursing section. Staff B opened the door and asked Tenant #2 where Tenant #2 was going. Tenant #2 said Tenant #2 was looking for Tenant #2's "hut." Staff B saw Tenant #2 walk out the door. Staff B walked with Tenant #2 through the parking lot and back into the independent living part of the building Tenant #2 was dressed appropriately for the weather and had no injuries. Staff B said Tenant #2 was easily	A 077		

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A 077	Continued From page 5 redirectable. Staff B reported it to the Administrator and the Administrator said to walk Tenant #2 to the dementia unit. Staff B learned that Tenant #2 had an appointment and Tenant #2's family would be arriving at the Program to take Tenant #2 to the appointment. Tenant #2 sat with staff and did an activity until family arrived to take Tenant #2 to the appointment. Staff B said she did not complete an incident report related to the incident. 3. According to a weather website, the weather conditions at the airport nearest to the Program on 7-1-15 were as follows: temperature was a high of 76 degrees and a low temperature of 63 degrees and there was a trace amount of precipitation. 4. Review of incident reports for the past three months did not reveal an incident report related to the incident on 7-1-15 with Tenant #2. Tenant #2 left the building and was observed by Staff B. Tenant #2 said Tenant #2 was looking for Tenant #2's "hut." The service plan dated 6-15-15 identified Tenant #2 was an elopement risk and wanderer. According to a cognitive evaluation, which had an effective date of 6-21-15, Tenant #2's errors on the SMSQ indicated severe intellectual functioning. An incident report was not completed as needed regarding the incident with Tenant #2. 5. According to the Program's policy and procedure regarding accident/incident reporting, all accidents or incidents involving tenants, employees, visitors and vendors occurring at the Program must be investigated and reported to the Executive Director. Regardless of how minor an accident/incident might be, including injuries of an unknown origin, it must be reported to the	A 077		

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A 077	Continued From page 6 department supervisor as soon as the information was received of an accident/incident, no later than the end of the shift upon which the accident/incident occurred. Whenever an accident/incident occurred the following step was completed: an accident/incident reported was completed per company policy by the supervisor/department manager.	A 077		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, Program documents and a staff interview the Program failed to update service plans as needed and the service plans did not reflect the service needs of the tenants for three of three tenant files reviewed (Tenants #1, #2 and #3). (During the course of the investigation of Complaint #53819-C and Incident #53857-I) 1. Tenant #1, a 79 year old, was admitted on 1-21-14 and diagnoses included: hypothyroidism, Parkinsonism, rheumatoid arthritis and	A 083	A 083 1) Resident # 1 was discharged from the community on 6/29/2015 and admitted into the health care center. Residents # 2 and 3 had their service plans updated. 2) The Program Director was re-educated on the regulations and the facilities policy and procedures for maintaining service plans. Residents residing in the facility will have their services plans maintained and updated as needed based on their evaluations to reflect their current ADLS, needs and requests. 3) Administrator to review and monitor service plans and evaluations of residents with Program Director to ensure accuracy and completion. 4) Responsible Person: Program Director Alleged Date of Compliance: 7/24/2015	

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A 083	Continued From page 7 osteoporosis. Tenant #1 was discharged on 6-29-15. According to Major Nurse Review document dated 6-17-15, Tenant #1 required total assistance with most activities of daily living (ADLs). The document indicated Tenant #1 had a significant change. Tenant #1 continued to decline in strength and ability to perform ADLs. Tenant #1 had outside caregivers and at times required an additional staff to transfer Tenant #1 with a gait belt if Tenant #1's legs were weak or Tenant #1 was tired. The service plan was not updated as needed to reflect total assistance with most ADLs and a decline in strength and ability to perform ADLs. The service plan was not updated as needed and did not reflect the service needs of Tenant #1. 2. Tenant #2, a 96 year old, was admitted on 6-15-15 and diagnoses included: chronic kidney disease, psychosis, constipation, hypothyroidism, depressive disorder, hypertension (HTN), pneumonia and abnormality of gait. Tenant #2 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. The GDS document (which had an effective date of 7-5-15) reflected "NA" for the score; however, stage six had the most check marks indicated. According to 24-Hour Report documents from 6-24-15 to 7-4-15, Tenant #2 was wandering and was found on the floor inside the conference room in the independent living building, Tenant #2 was incontinent of urine, was up during the hours of sleep, Tenant #2 was very disoriented and walked the halls on first and second floor at night. According to Progress Notes from 6-24-15 to 7-3-15, staff checked on Tenant #2 every one to	A 083		

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A 083	Continued From page 8 two hours throughout the day and night, Tenant #2 wore a robe over clothing as Tenant #2 felt it needed to be on at all times and Tenant #2 went to a back door when an activity staff was near by, opened the door and was redirected back inside. Tenant #2 had difficulty remembering where Tenant #2's apartment was and had gone to other doors and opened them. An outside agency providing companionship and one-on-one time with Tenant #2 two hours per day, five days per week was initiated. Tenant #2 complained of constipation and had a large incontinent stool in the middle of Tenant #2's kitchen floor, Tenant #2 went into several other tenant apartments, Tenant #2 pushed Tenant #2's bed away from the window and tried to open the window and screen and Tenant #2 refused medications. The service plan was updated on 6-24-15 and after Tenant #2's elopement on 7-5-15. The service plan was not updated as needed to reflect behaviors, incontinence, refusals, wandering, leaving the building with staff awareness, attempting to remove the screen and the addition of private caregivers. The service plan was not updated as needed and did not reflect the service needs of Tenant #2. 3. Tenant #3, an 89 year old, was admitted 7-25-13 and diagnoses included: debility, hyperlipidemia, iron deficiency anemia, leukocytosis, HTN and chronic kidney disease. According to Progress Notes dated 5-12-15, Tenant #3 had weight loss noted that month. Tenant #3 received home care services from an outside service provider and the home care nurse was notified of the weight loss. Tenant #3 was encouraged to continue eating meals and maintaining Tenant #3's diet.	A 083		

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A 083	Continued From page 9 According to an interview with the Program Director on 7-6-15 at 2:18 p.m. and 2:55 p.m., Tenant #3 had made sexually inappropriate comments to staff. Staff was to redirect and tell Tenant #3 that it was inappropriate and report the comments to the Program Director. The service plan was not updated as needed when Tenant #3 had noted weight loss and inappropriate behaviors towards staff. The service plan did not reflect interventions related to Tenant #3's behaviors. The service plan was not updated as needed and did not reflect the service needs of Tenant #3. 4. According to the Program policy and procedure regarding service plans, a service plan would be developed on or before taking occupancy, 30 days after taking occupancy, every six months, annually and with each significant change or additional information related to the tenant during the timeframe between the evaluation schedules.	A 083		
A 155	481-69.35(1)c Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. c. Programs shall have private dwelling units with a single-action, lockable entrance door. This REQUIREMENT is not met as evidenced by: Based on observation, a Program document and a staff interview the Program failed to have private dwelling units with a single-action, lockable entrance door. The tenant apartments	A 155	A 155 1) Resident #2 had the dead bolt removed from his door. All resident apartment doors were inspected for single action locks. 2) The Administrator contacted the State Fire Marshall Office for proper notification. The Facility Director was educated on the proper type of handle to meet regulations. The door locks of all 40 residents will be equipped with the proper handles. The Locksmith Company was notified to place the order for the proper locks.	

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A 155	Continued From page 10 did not have a single-action lockable entrance door. (During the course of the investigation of Complaint #53819-C and Incident #53857-I) 1. According to observation on 7-6-15 at approximately 12:09 p.m. and 12:55 p.m., a vacant apartment was observed and the apartment did not have a single-action lockable entrance door. When the apartment entrance door was locked and an attempt to egress from inside the apartment was made the door did not unlock by using the door handle. The door unlocked when the dead bolt lock was unlocked and the door was opened by using the door handle. 2. According to an interview with Staff A on 7-6-15 at 12:07 p.m., if a tenant apartment entrance door was locked and the door needed to be opened the dead bolt would have to be unlocked for the door to open. 3. According to a current copy of the Program's certificate from the Department, the Program had 40 double occupancy dwelling units.	A 155	3) The Administrator will monitor for completion. Facility Director will ensure proper handles in the future during replacement if needed. Administrator will conduct periodic inspections to ensure compliance. 4) Responsible Person: Administrator, Facility Director. Alleged Date of Compliance: prior to year end of 2015 as soon as locks arrive.	