IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
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Des Moines, IA 50319-0083
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #: 56804-I

January 14, 2016

Ms. Tammy Olson, Director
Waukee Memory Care, LLC
1505 SE Laurel Street
Waukee, IA 50263

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - WAUKEE MEMORY CARE, LLC
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Olson:

I. Final Complaint/Incident Investigation Report – Waukee Memory Care, LLC, Waukee, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued 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 **January 5 & 6, 2016.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Service Plans, Nurse Review and Structural Requirements.

Waukee Memory Care, LLC ("Program") is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.17(1)(a), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

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.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The determination of a **$1,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, a tenant eloped due to a malfunctioning door.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481−67.17(5). If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the **State of Iowa** in the amount of **six hundred and fifty dollars ($650)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

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.

IV. Conclusion

The Program is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

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
	S0317	A. BUILDING: _____ B. WING _____	C 01/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAUKEE MEMORY CARE LLC	1505 SE LAUREL STREET 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 Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 16 Total Population of Program at time of on-site: 16 TOTAL census of Assisted Living Program: 16 The following regulatory insufficiencies were cited during the investigation of Incident # 56804-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		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 037	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, evaluations of function, cognition and health were not completed with significant changes of condition. 1. Tenant #1, a 97 year-old, was admitted on 7-24-15 and had diagnoses of: worsening memory, kidney disease, hypertension, anxiety, and gout. On 11-13-15, Tenant #1 was staged at four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. A physician report dated 6-22-15, documented Tenant #1 was mildly frail with gait instability. It was advised Tenant #1 should use a walker. A behavior note dated 10-23-15, documented Tenant #1 displayed anxiety and aggression because of the community dog. Tenant #1 threatened to kill the dog and screamed at other tenants The physician was contacted and a new medication (Buspar) was ordered. Staff A, universal worker (UW), was interviewed on 1-6-16, and stated Tenant #1 did not like the dog and threatened to kill the dog at least once daily. When Tenant #1 was agitated, Tenant #1 would chase after the dog and try to kick the dog. A behavior note dated 11-17-15, and an incident report dated 11-16-15, documented Tenant #1 was observed completely naked, sitting on the bed with another tenant in attendance. The behavior note documented Tenant #1 was very agitated and became aggressive with staff. In a written statement dated 11-17-15, Staff D, Universal Worker, documented Tenant #1 stated "Why can't two adults be left alone to screw?"	A 037		

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A 037	Continued From page 2 The incident report dated 11-16 and the behavior note dated 11-17-15 documented the family was notified following the incident. The Program provided documentation of an undated sexual behaviors and intimacy worksheet which revealed the Program had consulted with the family to develop interventions for future behavior. The Program instituted 15 minute checks for three days. The clinical record contained no documentation prior to this entry related to a possible relationship between Tenant #1 and any other tenant. Tenant #1 eloped from the Program on 12-8-15. Tenant #1 was last seen at 6:00 a.m. rounds and was discovered missing at approximately 7:30 a.m. The police department was notified at approximately 8:05 a.m. and at that time the Program given information by the police dispatcher that a nearby car dealership reported a person on the premises. That person was Tenant #1. Tenant #1 was returned to the Program with a body temperature of 97.1 degrees. An internal investigation revealed the main entrance door did not always latch securely if not given force to shut. When not secure, the alarm did not re-set. Tenant #1 exhibited several behaviors that were previously undocumented including sexual behavior and elopement. Interventions were instituted. Evaluations of function, cognition, and health were not completed following the elopement. 2. Tenant #2, an 82 year-old, was admitted on 7-14-15 and had diagnoses of: senile dementia, coronary atherosclerosis, and esophageal reflux.	A 037		

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A 037	Continued From page 3 On 8-14-15 Tenant #2 was staged at four on the GDS, which indicated moderate cognitive decline. A behavior note dated 11-19-15 and an incident report dated 11-16-15 documented Tenant #2 was observed sitting on the bed with another tenant who was naked. Staff D, UW, was interviewed on 1-5-16 and stated she was present at the time of the incident. Staff D stated Tenant #2 seemed confused and kept calling the other tenant by the name of Tenant #2's deceased spouse. Staff E, UW who was also present at the time of the incident, was interviewed on 1-5-16 stated Tenant #2 thought the other tenant was taking him/her "somewhere." According to the behavior note of 11-19-15, the family was notified following the incident. The Program provided documentation of an undated sexual behaviors and intimacy worksheet which revealed the Program had consulted with the family to develop interventions for future behavior. The Program instituted 15 minute checks for three days. The clinical record contained no further documentation of any other instances of intimate contact with another tenant. Evaluations of Tenant #2's mental health and cognitive status was not completed with a change in behavior which resulted in the Program instituting interventions.	A 037		

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A 083	Continued From page 4	A 083		
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 tenant file review, service plans were not based on evaluations and were not updated with changes of condition to meet the specific service needs of individual tenants. 1. Tenant #1, a 97 year-old, was admitted on 7-24-15 and had diagnoses of: worsening memory, kidney disease, hypertension, anxiety, and gout. On 11-13-15 Tenant #1 was staged at four on the GDS,which indicated moderate cognitive decline. A physician report dated 6-22-15 documented Tenant #1 was mildly frail with gait instability. It was advised Tenant #1 should use a walker. A behavior note dated 10-23-15 documented Tenant #1 displayed anxiety and aggression because of the community dog. Tenant #1 threatened to kill the dog and screamed at other tenants. The physician was contacted and a new medication (Buspar) was ordered.	A 083		

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A 083	Continued From page 5 Staff A, UW, was interviewed on 1-6-16 and stated Tenant #1 did not like the dog and threatened to kill the dog at least once daily. When Tenant #1 was agitated, Tenant #1 would chase after the dog and try to kick the dog. A behavior note dated 11-17-15 and an incident report dated 11-16-15 documented Tenant #1 was observed completely naked, sitting on the bed with another tenant in attendance. The behavior note documented Tenant #1 was very agitated and became aggressive with staff. In a written statement dated 11-17-15, Staff D, Universal Worker, documented Tenant #1 stated "Why can't two adults be left alone to screw?" The incident report dated 11-16 and the behavior note dated 11-17-15 documented the family was notified following the incident. The Program provided documentation of an undated sexual behaviors and intimacy worksheet which revealed the Program had consulted with the family to develop interventions for future behavior. The Program instituted 15 minute checks for three days The clinical record contained no documentation prior to this entry related to a possible relationship between Tenant #1 and any other tenant. Tenant #1 eloped from the Program on 12-8-15. Tenant #1 was last seen at 6:00 a.m. rounds and was discovered missing at approximately 7:30 a.m. The police department was notified at approximately 8:05 a.m. and at that time the Program given information by the police dispatcher that a nearby car dealership reported a person on the premises. That person was Tenant #1. Tenant #1 was returned to the	A 083		

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A 083	Continued From page 6 Program with a body temperature of 97.1 degrees. An internal investigation revealed the main entrance door did not always latch securely if not given force to shut. When not secure, the alarm did not re-set. The service plan with a signature date of 7-23-15, was not updated to include interventions related to identified aggression with the community dog, and was not updated in a timely manner to give staff direction when Tenant #1 exhibited sexual behavior. The service plan did not meet the needs of Tenant #1. 2. Tenant #1's service plan was updated on 12-12-15, with interventions for sexual and exit-seeking behavior. Evaluations were not completed at that time. The service plan dated 12-12-15, was updated with major changes and was not based on evaluations. 3. Tenant #2, an 82 year-old, was admitted on 7-14-15 and had diagnoses of: senile dementia, coronary atherosclerosis, and esophageal reflux. On 8-14-15 Tenant #2 was staged at four on the GDS, which indicated moderate cognitive decline. A behavior note dated 11-19-15 and an incident report dated 11-16-15 documented Tenant #2 was observed sitting on the bed with another tenant who was naked. Staff D, UW, was interviewed on 1-5-16 and stated she was present at the time of the incident. Staff D stated Tenant #2 seemed confused and kept calling the other tenant by the name of Tenant #2's deceased spouse. Staff E, UW who was also present at the time of the incident, was interviewed on 1-5-16 stated	A 083		

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A 083	Continued From page 7 Tenant #2 thought the other tenant was taking him/her "somewhere." According to the behavior note of 11-19-15, the family was notified following the incident. The Program provided documentation of an undated sexual behaviors and intimacy worksheet which revealed the Program had consulted with the family to develop interventions for future behavior. The Program instituted 15 minute checks for three days. The clinical record contained no further documentation of any other instances of intimate contact with another tenant. The clinical record contained a service plan with updates made on 10-12-15. The service plan did not identify Tenant #2's interest in another tenant as spouse, and was not updated to give staff direction when Tenant #2 exhibited sexual behavior. The service plan was not updated with changes and did not meet the needs of Tenant #2.	A 083		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(3) To assess and document the health status of each tenant, to make recommendations	A 096		

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A 096	Continued From page 8 and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Based on tenant file review, nurse reviews were not completed with a change of condition to assess and document health status and monitor progress related to previous recommendations. 1. Tenant #1, a 97 year-old, was admitted on 7-24-15 and had diagnoses of: worsening memory, kidney disease, hypertension, anxiety, and gout. On 11-13-15 Tenant #1 was staged at four on the GDS, which indicated moderate cognitive decline. A physician report dated 6-22-15 documented Tenant #1 was mildly frail with gait instability It was advised Tenant #1 should use a walker. A behavior note dated 10-23-15 documented Tenant #1 displayed anxiety and aggression because of the community dog. Tenant #1 threatened to kill the dog and screamed at other tenants. The physician was contacted and a new medication (Buspar) was ordered. A behavior note dated 11-17-15 and an incident report dated 11-16-15 documented Tenant #1 was observed completely naked, sitting on the bed with another tenant in attendance. The behavior note documented Tenant #1 was very agitated and became aggressive with staff, 15 minute checks were begun, and families were notified. The clinical record contained no documentation	A 096		

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A 096	Continued From page 9 prior to this entry related to a possible relationship between Tenant #1 and any other tenant. A nurse review was not completed following aggressive behavior to assess and document the health status of Tenant #1 and to monitor progress related to previous recommendations. 2. An incident report dated 1-3-16 documented Tenant #1 became agitated, hit hand on the wall and received a bruise to the fifth finger. Tenant #1 then sat on the floor hitting arms on the floor resulting in a skin tear to the left elbow. A nurse review was not completed to assess and document the status of Tenant #1's injuries to the hand and elbow.	A 096		
A 154	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the exit door to the dementia program did not always secure upon closure. When not secured, the alarm system did not function. 1. On 12-8-15, the Program appropriately reported to the Department Tenant #1 eloped from the dementia program. The Program identified to the Department the front door did not latch during testing, and the alarm did not sound.	A 154		

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A 154	Continued From page 10 Tenant #1, a 97 year-old, was admitted on 7-24-15 and had diagnoses of: worsening memory, kidney disease, hypertension, anxiety, and gout. On 11-13-15 Tenant #1 was staged at four on the GDS, which indicated moderate cognitive decline. A physician report dated 6-22-15 documented Tenant #1 was mildly frail with gait instability. It was advised Tenant #1 should use a walker. Staff B, UW, reported Tenant #1 usually slept until 8:00 a.m. A quarterly nurse review dated 10-26-15, documented Tenant #1 had dementia and exit seeking behaviors. Tenant #1 "has had attempts to leave." Staff A, Universal Worker (UW) was interviewed on 1-6-16 at 9:19 a.m. Staff A reported on 12-8-15 she came to work and completed rounds on all tenants at 5:55 a.m. Tenant #1 was in bed. The night shift had reported to Staff A that Tenant #1 had been up all night trying to elope. The Overnight Residential Check sheet also documented Tenant #1 was awake on checks between 10:00 p.m. on 12-7-15 and 4:00 a.m. on 12-8-15. Staff A also reported checking the doors and the doors were locked. Staff C, housekeeper, reported she was cleaning the main lobby between 6 45 a.m. and 7:15 a.m. and did not see Tenant #1 leave the building. Staff A reported at approximately 7:30 a.m. she went to give medications to Tenant #1. Tenant #1 was not in the apartment. Staff A checked with Staff B, UW, and Staff C, housekeeper and neither reported seeing Tenant #1. The building	A 154		

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(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 154	Continued From page 11 was searched. Staff B, UW, stated no alarms went off. Staff A reported the RN was notified at 7:44 a.m. Staff A and C proceeded to search outside the building. The Administrator provided documentation dated 12-8-15, which revealed she was notified about 7:50 a.m. on 12-8-15 Tenant #1 was missing. At 8:05 a.m. the Administrator called police. As the Administrator was notifying police, police received a call from the nearby car dealership reporting a person on the premises. It was determined to be Tenant #1. According to the Administrator in an interview on 1-6-15, she stated there was a barbed wire fence between the Program property and the car dealership. She did state there was an opening in the fencing near the dealership. An online maps program was used to determine the distance between the Program and the dealership. Without the exact route known, it was estimated Tenant #1 walked between 800 and 1400 feet. The State Climatologist documented the weather conditions at 6:00 a.m. on 12-8-15 at 35 degrees with a south wind at five miles per hour (mph) resulting in a wind chill of 31 degrees. Skies were cloudy with no precipitation. By 8:00 a.m. the temperature was 37 degrees but winds had increased to 12 mph resulting in a wind chill of 29 degrees. Skies were cloudy. The Administrator reported there was no snow on the ground.	A 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0317	A. BUILDING: _____ B. WING _____	C 01/06/2016

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A 154	Continued From page 12 Staff A reported she went with the RN to pick up Tenant #1 from the car dealership. Staff A stated the person at the car dealership reported opening the used car building at 7:30 a.m. and Tenant #1 came in shortly after that. Tenant #1 was dressed in socks, shoes, pants, shirt, sweatshirt, hat, and jacket. Staff A reported Tenant #1's clothes were clean, but Tenant #1 stated his/her feet hurt. The staff at the car dealership had provided Tenant #1 with a snack. An incident report dated 12-8-15 and completed by the RN documented Tenant #1 had a body temperature of 97.1 degrees. There were no documented injuries. On 1-6-16 in interview the Administrator stated Tenant #1 reported climbing a fence, sleeping in a car, and having breakfast. The Administrator stated on 1-5-16 the patio was observed after Tenant #1 reported climbing a fence. The internal investigation revealed no evidence to suggest Tenant #1 exited the patio and scaled the fence. The Administrator revealed in a statement dated 12-8-15 and confirmed in interview on 1-5-16 the internal investigation revealed the main door may not have latched correctly if not given some force to shut and therefore the alarm was not re-set. As the Administrator was demonstrating the operation of the main door, one occasion was observed where the door did not latch. Tenant #1 eloped from the Program on 12-8-15 Tenant #1 was last seen at 6:00 a.m. rounds and was discovered missing at approximately 7:30 a.m. The police department was notified at	A 154		

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A 154	Continued From page 13 approximately 8:05 a.m. and at that time the Program given information by the police dispatcher that a nearby car dealership reported a person on the premises. That person was Tenant #1. Tenant #1 was returned to the Program with a body temperature of 97.1 degrees. An internal investigation revealed the main entrance door did not always latch securely if not given force to shut. When not secure, the alarm did not re-set.	A 154		

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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 Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 16 Total Population of Program at time of on-site: 16 TOTAL census of Assisted Living Program: 16 The following regulatory insufficiencies were cited during the investigation of Incident # 56804-I:	A 000	F 000 This plan of correction constitutes our credible Allegation of Compliance. Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provision of the federal and state laws.	
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 evaluation and service plan are maintained according to regulations. 1) Resident #1 evaluation was completed and service plan has been update Resident # 2 evaluation was completed service plan has been updated. 2) On 1/11/2016 Program Director was re-educated on the regulations pertaining to occupancy, admissions, service plan, and evaluation policies and procedures.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Ober	Executive Director	1/29/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 037	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, evaluations of function, cognition and health were not completed with significant changes of condition. 1. Tenant #1, a 97 year-old, was admitted on 7-24-15 and had diagnoses of: worsening memory, kidney disease, hypertension, anxiety, and gout. On 11-13-15, Tenant #1 was staged at four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. A physician report dated 6-22-15, documented Tenant #1 was mildly frail with gait instability. It was advised Tenant #1 should use a walker. A behavior note dated 10-23-15, documented Tenant #1 displayed anxiety and aggression because of the community dog. Tenant #1 threatened to kill the dog and screamed at other tenants The physician was contacted and a new medication (Buspar) was ordered. Staff A, universal worker (UW), was interviewed on 1-6-16, and stated Tenant #1 did not like the dog and threatened to kill the dog at least once daily. When Tenant #1 was agitated, Tenant #1 would chase after the dog and try to kick the dog. A behavior note dated 11-17-15, and an incident report dated 11-16-15, documented Tenant #1 was observed completely naked, sitting on the bed with another tenant in attendance. The behavior note documented Tenant #1 was very agitated and became aggressive with staff. In a written statement dated 11-17-15, Staff D, Universal Worker, documented Tenant #1 stated "Why can't two adults be left alone to screw?"	A 037	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 will have 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: 2/08/2016	

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A 037	Continued From page 2 The incident report dated 11-16 and the behavior note dated 11-17-15 documented the family was notified following the incident. The Program provided documentation of an undated sexual behaviors and intimacy worksheet which revealed the Program had consulted with the family to develop interventions for future behavior. The Program instituted 15 minute checks for three days. The clinical record contained no documentation prior to this entry related to a possible relationship between Tenant #1 and any other tenant. Tenant #1 eloped from the Program on 12-8-15. Tenant #1 was last seen at 6:00 a.m. rounds and was discovered missing at approximately 7:30 a.m. The police department was notified at approximately 8:05 a.m. and at that time the Program given information by the police dispatcher that a nearby car dealership reported a person on the premises. That person was Tenant #1. Tenant #1 was returned to the Program with a body temperature of 97.1 degrees. An internal investigation revealed the main entrance door did not always latch securely if not given force to shut. When not secure, the alarm did not re-set. Tenant #1 exhibited several behaviors that were previously undocumented including sexual behavior and elopement. Interventions were instituted. Evaluations of function, cognition, and health were not completed following the elopement. 2. Tenant #2, an 82 year-old, was admitted on 7-14-15 and had diagnoses of: senile dementia, coronary atherosclerosis, and esophageal reflux.	A 037		

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A 037	Continued From page 3 On 8-14-15 Tenant #2 was staged at four on the GDS, which indicated moderate cognitive decline. A behavior note dated 11-19-15 and an incident report dated 11-16-15 documented Tenant #2 was observed sitting on the bed with another tenant who was naked. Staff D, UW, was interviewed on 1-5-16 and stated she was present at the time of the incident. Staff D stated Tenant #2 seemed confused and kept calling the other tenant by the name of Tenant #2's deceased spouse. Staff E, UW who was also present at the time of the incident, was interviewed on 1-5-16 stated Tenant #2 thought the other tenant was taking him/her "somewhere." According to the behavior note of 11-19-15, the family was notified following the incident. The Program provided documentation of an undated sexual behaviors and intimacy worksheet which revealed the Program had consulted with the family to develop interventions for future behavior. The Program instituted 15 minute checks for three days. The clinical record contained no further documentation of any other instances of intimate contact with another tenant. Evaluations of Tenant #2's mental health and cognitive status was not completed with a change in behavior which resulted in the Program instituting interventions.	A 037		

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A 083	Continued From page 4	A 083		
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 tenant file review, service plans were not based on evaluations and were not updated with changes of condition to meet the specific service needs of individual tenants. 1. Tenant #1, a 97 year-old, was admitted on 7-24-15 and had diagnoses of: worsening memory, kidney disease, hypertension, anxiety, and gout. On 11-13-15 Tenant #1 was staged at four on the GDS,which indicated moderate cognitive decline. A physician report dated 6-22-15 documented Tenant #1 was mildly frail with gait instability. It was advised Tenant #1 should use a walker. A behavior note dated 10-23-15 documented Tenant #1 displayed anxiety and aggression because of the community dog. Tenant #1 threatened to kill the dog and screamed at other tenants. The physician was contacted and a new medication (Buspar) was ordered.	A 083	A 083 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 #1 service plan has been update Resident #2 service plan has been updated. 2) On 1/11/2016 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 will have 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:02/08/2016	

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A 083	Continued From page 5 Staff A, UW, was interviewed on 1-6-16 and stated Tenant #1 did not like the dog and threatened to kill the dog at least once daily. When Tenant #1 was agitated, Tenant #1 would chase after the dog and try to kick the dog. A behavior note dated 11-17-15 and an incident report dated 11-16-15 documented Tenant #1 was observed completely naked, sitting on the bed with another tenant in attendance. The behavior note documented Tenant #1 was very agitated and became aggressive with staff. In a written statement dated 11-17-15, Staff D, Universal Worker, documented Tenant #1 stated "Why can't two adults be left alone to screw?" The incident report dated 11-16 and the behavior note dated 11-17-15 documented the family was notified following the incident. The Program provided documentation of an undated sexual behaviors and intimacy worksheet which revealed the Program had consulted with the family to develop interventions for future behavior. The Program instituted 15 minute checks for three days The clinical record contained no documentation prior to this entry related to a possible relationship between Tenant #1 and any other tenant. Tenant #1 eloped from the Program on 12-8-15. Tenant #1 was last seen at 6:00 a.m. rounds and was discovered missing at approximately 7:30 a.m. The police department was notified at approximately 8:05 a.m. and at that time the Program given information by the police dispatcher that a nearby car dealership reported a person on the premises. That person was Tenant #1. Tenant #1 was returned to the	A 083		

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A 083	Continued From page 6 Program with a body temperature of 97.1 degrees. An internal investigation revealed the main entrance door did not always latch securely if not given force to shut. When not secure, the alarm did not re-set. The service plan with a signature date of 7-23-15, was not updated to include interventions related to identified aggression with the community dog, and was not updated in a timely manner to give staff direction when Tenant #1 exhibited sexual behavior. The service plan did not meet the needs of Tenant #1. 2. Tenant #1's service plan was updated on 12-12-15, with interventions for sexual and exit-seeking behavior. Evaluations were not completed at that time. The service plan dated 12-12-15, was updated with major changes and was not based on evaluations. 3. Tenant #2, an 82 year-old, was admitted on 7-14-15 and had diagnoses of: senile dementia, coronary atherosclerosis, and esophageal reflux. On 8-14-15 Tenant #2 was staged at four on the GDS, which indicated moderate cognitive decline. A behavior note dated 11-19-15 and an incident report dated 11-16-15 documented Tenant #2 was observed sitting on the bed with another tenant who was naked. Staff D, UW, was interviewed on 1-5-16 and stated she was present at the time of the incident. Staff D stated Tenant #2 seemed confused and kept calling the other tenant by the name of Tenant #2's deceased spouse. Staff E, UW who was also present at the time of the incident, was interviewed on 1-5-16 stated	A 083		

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A 083	Continued From page 7 Tenant #2 thought the other tenant was taking him/her "somewhere." According to the behavior note of 11-19-15, the family was notified following the incident. The Program provided documentation of an undated sexual behaviors and intimacy worksheet which revealed the Program had consulted with the family to develop interventions for future behavior. The Program instituted 15 minute checks for three days. The clinical record contained no further documentation of any other instances of intimate contact with another tenant. The clinical record contained a service plan with updates made on 10-12-15. The service plan did not identify Tenant #2's interest in another tenant as spouse, and was not updated to give staff direction when Tenant #2 exhibited sexual behavior. The service plan was not updated with changes and did not meet the needs of Tenant #2.	A 083		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(3) To assess and document the health status of each tenant, to make recommendations	A 096	A 096 The facility does and will continue to ensure that a resident or resident's receives a nurse review every 90 days or as needed with a significant change according to regulations. 1) Resident #1 a nurse review has been completed	

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A 096	Continued From page 8 and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Based on tenant file review, nurse reviews were not completed with a change of condition to assess and document health status and monitor progress related to previous recommendations. 1. Tenant #1, a 97 year-old, was admitted on 7-24-15 and had diagnoses of: worsening memory, kidney disease, hypertension, anxiety, and gout. On 11-13-15 Tenant #1 was staged at four on the GDS, which indicated moderate cognitive decline. A physician report dated 6-22-15 documented Tenant #1 was mildly frail with gait instability It was advised Tenant #1 should use a walker. A behavior note dated 10-23-15 documented Tenant #1 displayed anxiety and aggression because of the community dog. Tenant #1 threatened to kill the dog and screamed at other tenants. The physician was contacted and a new medication (Buspar) was ordered. A behavior note dated 11-17-15 and an incident report dated 11-16-15 documented Tenant #1 was observed completely naked, sitting on the bed with another tenant in attendance. The behavior note documented Tenant #1 was very agitated and became aggressive with staff, 15 minute checks were begun, and families were notified. The clinical record contained no documentation	A 096	2) On 1/11/2016 Program Director was re-educated on the regulations pertaining to nurse reviews, updating service plans, and evaluation policies and procedures. The assessment check list was reviewed with the Program Director to ensure nurse reviews and evaluations are completed timely and to ensure all significant changes are entered timely with updated service plans as needed. Residents residing in the community will have their nurse reviews completed every 90 days or as needed with a significant change. 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: 02/08/2016	

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A 096	Continued From page 9 prior to this entry related to a possible relationship between Tenant #1 and any other tenant. A nurse review was not completed following aggressive behavior to assess and document the health status of Tenant #1 and to monitor progress related to previous recommendations. 2. An incident report dated 1-3-16 documented Tenant #1 became agitated, hit hand on the wall and received a bruise to the fifth finger. Tenant #1 then sat on the floor hitting arms on the floor resulting in a skin tear to the left elbow. A nurse review was not completed to assess and document the status of Tenant #1's injuries to the hand and elbow.	A 096		
A 154	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the exit door to the dementia program did not always secure upon closure. When not secured, the alarm system did not function. 1. On 12-8-15, the Program appropriately reported to the Department Tenant #1 eloped from the dementia program. The Program identified to the Department the front door did not latch during testing, and the alarm did not sound.	A 154	A 154 The facility will maintain the structural requirements for the community in accordance with the regulations. 1) All entrance and exit doors were inspected for proper functioning. 2) The Administrator contacted a review of all the entrance and exit doors with the Facility Maintenance Director. Recess / Roger's Door Company was notified to replace the door panic release bar on the front and patio door of the community.	

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	S0317	A. BUILDING _____ B. WING _____	C 01/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAUKEE MEMORY CARE LLC	1505 SE LAUREL STREET 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 154	Continued From page 10 Tenant #1, a 97 year-old, was admitted on 7-24-15 and had diagnoses of: worsening memory, kidney disease, hypertension, anxiety, and gout. On 11-13-15 Tenant #1 was staged at four on the GDS, which indicated moderate cognitive decline. A physician report dated 6-22-15 documented Tenant #1 was mildly frail with gait instability. It was advised Tenant #1 should use a walker. Staff B, UW, reported Tenant #1 usually slept until 8:00 a.m. A quarterly nurse review dated 10-26-15, documented Tenant #1 had dementia and exit seeking behaviors. Tenant #1 "has had attempts to leave." Staff A, Universal Worker (UW) was interviewed on 1-6-16 at 9:19 a.m. Staff A reported on 12-8-15 she came to work and completed rounds on all tenants at 5:55 a.m. Tenant #1 was in bed. The night shift had reported to Staff A that Tenant #1 had been up all night trying to elope. The Overnight Residential Check sheet also documented Tenant #1 was awake on checks between 10:00 p.m. on 12-7-15 and 4:00 a.m. on 12-8-15. Staff A also reported checking the doors and the doors were locked. Staff C, housekeeper, reported she was cleaning the main lobby between 6:45 a.m. and 7:15 a.m. and did not see Tenant #1 leave the building. Staff A reported at approximately 7:30 a.m. she went to give medications to Tenant #1. Tenant #1 was not in the apartment. Staff A checked with Staff B, UW, and Staff C, housekeeper and neither reported seeing Tenant #1. The building	A 154	3) The Administrator will monitor for completion. • Program Director will review door logs and periodic checks to ensure proper functioning of doors. • Associates educated to inform Program Director or Administrator of any concerns with door alarms and closure of doors to ensure proper functioning. • Administrator / Facility Director will conduct periodic inspections to ensure compliance. 4) Responsible Persons: Program Director, Administrator, Facility Director Alleged Date of Compliance: As soon as locks arrive, Feb 2016.	

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
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A 154	Continued From page 11 was searched. Staff B, UW, stated no alarms went off. Staff A reported the RN was notified at 7:44 a.m. Staff A and C proceeded to search outside the building. The Administrator provided documentation dated 12-8-15, which revealed she was notified about 7:50 a.m. on 12-8-15 Tenant #1 was missing. At 8:05 a.m. the Administrator called police. As the Administrator was notifying police, police received a call from the nearby car dealership reporting a person on the premises. It was determined to be Tenant #1. According to the Administrator in an interview on 1-6-15, she stated there was a barbed wire fence between the Program property and the car dealership. She did state there was an opening in the fencing near the dealership. An online maps program was used to determine the distance between the Program and the dealership. Without the exact route known, it was estimated Tenant #1 walked between 800 and 1400 feet. The State Climatologist documented the weather conditions at 6:00 a.m. on 12-8-15 at 35 degrees with a south wind at five miles per hour (mph) resulting in a wind chill of 31 degrees. Skies were cloudy with no precipitation. By 8:00 a.m. the temperature was 37 degrees but winds had increased to 12 mph resulting in a wind chill of 29 degrees. Skies were cloudy. The Administrator reported there was no snow on the ground.	A 154		

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
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A 154	Continued From page 12 Staff A reported she went with the RN to pick up Tenant #1 from the car dealership. Staff A stated the person at the car dealership reported opening the used car building at 7:30 a.m. and Tenant #1 came in shortly after that. Tenant #1 was dressed in socks, shoes, pants, shirt, sweatshirt, hat, and jacket. Staff A reported Tenant #1's clothes were clean, but Tenant #1 stated his/her feet hurt. The staff at the car dealership had provided Tenant #1 with a snack. An incident report dated 12-8-15 and completed by the RN documented Tenant #1 had a body temperature of 97.1 degrees. There were no documented injuries. On 1-6-16 in interview the Administrator stated Tenant #1 reported climbing a fence, sleeping in a car, and having breakfast. The Administrator stated on 1-5-16 the patio was observed after Tenant #1 reported climbing a fence. The internal investigation revealed no evidence to suggest Tenant #1 exited the patio and scaled the fence. The Administrator revealed in a statement dated 12-8-15 and confirmed in interview on 1-5-16 the internal investigation revealed the main door may not have latched correctly if not given some force to shut and therefore the alarm was not re-set. As the Administrator was demonstrating the operation of the main door, one occasion was observed where the door did not latch. Tenant #1 eloped from the Program on 12-8-15 Tenant #1 was last seen at 6:00 a.m. rounds and was discovered missing at approximately 7:30 a.m. The police department was notified at	A 154		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 154	Continued From page 13 approximately 8:05 a.m. and at that time the Program given information by the police dispatcher that a nearby car dealership reported a person on the premises. That person was Tenant #1. Tenant #1 was returned to the Program with a body temperature of 97.1 degrees. An internal investigation revealed the main entrance door did not always latch securely if not given force to shut. When not secure, the alarm did not re-set.	A 154		