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
	S0244	A. BUILDING: _____ B. WING _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDHAVEN ASSISTED LIVING CENTER	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

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A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. General Population Number of tenants without cognitive disorder: 73 Number of tenants with cognitive disorder: 7 Memory Care Unit Number of tenants without cognitive disorder: 4 Number of tenants with cognitive disorder: 27 TOTAL Census of Assisted Living Program for People with Dementia: 111 The investigation of self-reported incident #75772-I and complaint #75793-C resulted a regulatory insufficiencies.	A 000		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure tenants received services and cares that were adequate and appropriate, including physician ordered	A 013		

DD 7/16/18

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A 013	Continued From page 1 medications and treatments. This affected 13 of 13 tenants reviewed during the investigation of self-reported incident #75772-I (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13). Findings follow: 1. Record review of the Program's investigation document, dated 4-2-18, revealed 22 tenants experienced a variety of medication issues on 4-1-18. These issues included: medications not documented as administered, medications and treatments not administered as ordered, missing medications and medications not given at the prescribed time. In addition, a tenant had incorrect medication left in a cup in the apartment and another tenant waited two hours for a colostomy bag change. The investigation document indicated on 4-1-18 at approximately 7:45 p.m. the Senior Director of Assisted Living received a call from Staff A who reported Tenant #1 reported he/she had not received supper medications. The supper medications were punched out from the medication card, as well as the bedtime medications. The Senior Director of Assisted Living instructed Staff A to administer bedtime medications from the last day on the medication card, copy the medication administration records (MARs), and put it under her door for further follow up. On 4-2-18 the Senior Director of Assisted Living arrived to find multiple copies of MARs of various tenants that indicated issues with medications not received, including Tenants #1, #2, #4, #7, #8, #12 and #13. It was noted Tenant #11 was very upset when he/she had not received his/her	A 013	Staff D is no longer employed at WHC. Plan to review policy/procedure in regards to medication policies and procedures with all nursing staff by July 28, 2018 Will audit nursing staff and medication pass by July 28, 2018	

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A 013	Continued From page 2	A 013		

Lovenox injection by noon as it was scheduled for breakfast. On 4-2-18 Tenant #7 spoke with the Senior Director of Assisted Living and reported he/she did not receive the lunch medications prior to go to the dining room, but did find them left in his/her apartment at 2:00 p.m. Tenant #7 paged for supper medications at 4:00 p.m. and Staff D told Tenant #7 the medications could not be found. Staff A reported Tenant #7's two missing pills were punched out of the medication cards, but other 7:00 p.m. and bedtime medications were in the medication cards. Tenant #7 said he/she was hesitant to call for Staff D, as Staff D did not "like it" when Tenant #7 put on the call light to ask for medications.

At approximately 8:30 a.m. on 4-2-18 staff reported more inconsistencies affecting Tenants #2, #3, #5, #6, #7, #8 and #12.

Staff A's typed statement, dated 4-2-18, reflected she found supper medications for two tenants (unnamed tenants) not administered. Tenants #1, #2 and #8 had bedtime medications punched out and not signed for. Tenants #1 and #2 had bedtime medications punched out, but both reported not receiving them. Tenant #7 reported not receiving supper medications, but had two of the bedtime pills punched out. The narcotic book was "messed up" and Staff D did not sign for hardly any supper medications. Tenant #9 said it took Staff D two hours from when he/she called to come and change his/her colostomy bag.

Staff B's typed statement, dated 4-3-18, reflected Staff B wrote Staff D a slip to remind Staff D that Tenant #11 needed his/her Lovenox injection. Staff B reminded Staff D about four times and Staff D said the tenant could wait, as she was

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A 013	Continued From page 3 "sick of them always thinking it was their time." Staff D gave the injection at 12:30 p.m. Tenant #11 was very upset about the wait for the Lovenox injection. Staff B called an off duty nurse to ask for help during a medication pass because Staff D could not be found for awhile. Staff D did not answer on the walkie talkie when called and could not be located by Staff B. On 3-31-18 Staff B witnessed Staff D sitting on a sofa in a tenant apartment. Staff D had chips, soda, her phone, the television remote and MARs. The tenant was asleep in his/her recliner. When Staff B walked in Staff D said, "You found my hiding spot." Staff C's typed statement dated 4-2-18 indicated between 3:15 p.m. to 3:30 p.m. staff reported to Staff D Tenant #9 needed his/her colostomy bag changed. A staff reported later in the shift that Tenant #9 waited two hours for Staff D to change his/her colostomy bag. At approximately 7:45 p.m. to 8:00 p.m. Staff A called Staff C to review the MARs. Tenant #1's supper and bedtime medications were punched out of the card but Tenant #1 reported not receiving either set of medications. Staff A said Tenant #1 was not the first tenant to report it. Staff A and Staff C looked over the MARs and found that none of the supper or bedtime medication/treatments had been signed off even thought they had been punched out of the card prior to Staff A beginning the medication pass. Copies of the MARs in question and notes were left for the Senior Director of Assisted Living. Review of Medication Error Reports for Tenants #1, #2, #3, #4, #5, #6, #7, #8 and #10 indicated Staff D was noted as the staff making the errors. Medication Error Reports were not found for	A 013		

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A 013	Continued From page 4 Tenants #9, #11, #12 and #13. 2. Record Review of Tenant #1's file revealed a Medication Error Report indicated on 4-1-18. According to the report, Tenant #1 did not receive supper or bedtime medications; however, they were not in the medication cards. A missed dose and preparation error were listed as the type of variance occurring. April 2018 MARs revealed the following medications not documented as administered at supper on 4-1-18: Prosight tablet, take one tablet orally, twice daily, Calcitrate 200 milligram (mg) tablet, take one tablet orally, three times per day with meals and Requip 0.25 mg, take one tablet orally, daily. Continued review of MARs revealed a note reflecting bedtime medications were punched out, but Tenant #1 said he/she did not receive the medication. Staff administered the bedtime medication from another day on the medication card. The MARs reflected an order for Requip 0.25 mg tablet, two tablets by mouth at bedtime daily. The Requip 0.25 mg at bedtime was not in the medication card when staff administered the medication. 3. Record review of Tenant #2's file revealed a Medication Error Report indicated on 4-1-18. According to the report, Tenant #2 did not receive bedtime medications and the medications were missing from the medication card. Staff gave Tenant #2 the medications from the spare dose. A missed dose and preparation error were listed as the type of variance occurring.	A 013		

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A 013	Continued From page 5 Review of April 2018 MARs included a note that indicated all bedtime medications were punched out and Tenant #2 said he/she did not receive the medication. Staff administered bedtime medications from another day on the medication card. The MARs reflected the following bedtime medications that were missing: Ativan 0.5 mg tablet, take one tablet orally, three times per day, Ditropan XL 5 mg tablet, take one tablet orally, daily, Zocor 20 mg tablet, take one tablet orally, daily, Seroquel 25 mg tablet, take one tablet orally, daily and Flomax 0.4 mg capsule, take one capsule orally, daily. Continued review of MARs revealed the following medications were not signed as administered at supper on 4-1-18: Acetaminophen 500 mg, take one tablet orally, twice daily, Colace 100 mg, take two capsules orally, twice daily, Ativan 0.5 mg tablet, take one tablet orally, three times per day. 4. Record review of Tenant #3's file revealed a Medication Error Report indicated on 4-1-18. According to the report, Tenant #3 reported not receiving a supper medication. The medication was missing from the medication card. A missed dose and preparation error were listed as the type of variance that occurred. The April 2018 MARs included a note that Tenant #3 reported not receiving his/her supper medications, which included Glucophage 500 mg tablet, 1/2 tablet. The medication was missing from the medication card. The MARs revealed the following medications	A 013		

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A 013	Continued From page 6 not documented as administered on 4-1-18: Cardizem CD 180 mg capsule, one capsule by mouth daily; Lasix 20 mg tablet, 1 1/2 tablets by mouth daily; Synthroid 75 microgram (mcg) tablet, one tablet by mouth daily; Potassium CL 10 milliequivalent (MEQ) capsules, two capsules by mouth daily; Prosight tablet, one tablet by mouth daily; Colace 100 mg capsule, one capsule by mouth twice daily (breakfast dose); Eliquis 2.5 mg tablet, one tablet by mouth twice daily (breakfast dose); Metoprolol Succinate ER 200 mg tablet, one tablet by mouth daily; and Glucophage 500 mg tablet, 1/2 tablet by mouth three times daily (breakfast, lunch and supper doses). 5. Record review of Tenant #4's file revealed a Medication Error Report indicated on 4-1-18 Tenant #4 reported not receiving supper medications. A missed dose and preparation error were listed as the type of variance that occurred. The severity of the error was noted as significant. April 2018 MARs revealed the following medications and treatments not documented as administered and Tenant #4 reported not receiving on 4-1-18: Novolog 100 units/mililiters (ml) Pen, 0-14 units injected subcutaneous four times daily per sliding scale (supper dose); Pulmicort 0.5 mg/2 ml, one vial nebulized twice daily (supper dose); Calcium 600 + D 400 tablet, one tablet by mouth twice daily (supper dose); Eliquis 5 mg tablet, one tablet by mouth twice daily (supper dose); Probiotic capsule, one capsule by mouth twice daily (supper dose); and Systane Balance 0.6% eye drop, one drop instilled in both eyes three times daily (supper	A 013		

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A 013	Continued From page 7 dose). Tenant #4's MARs reflected blood sugar checks four times daily (which were recorded on a monthly log). A note on the MARs reflected the blood sugar check was not completed at supper on 4-1-18 and the log and machine were checked to verify. The April log did not reflect a recorded blood glucose reading for supper on 4-1-18. A note on the MARs reflected the lunch blood sugar on 4-1-18 was inaccurately documented at 160 and the machine history indicated a reading of 157. The MARs also reflected staff initialed the completion of Brovana 15 mcg/2 ml solution, one vial nebulized at breakfast. The MAR reflected the medication was not available and could not have administered when Staff D initialed for the completion of the treatment. Further record review revealed the Program's investigation document, dated 4-2-18, indicated a cup of crushed medications was found in Tenant #4's apartment and remnants of a blue coating of a pill were found. Tenant #4 did not receive any blue pills. 6. Record review of Tenant #5's file revealed a Medication Error Report indicated on 3-31-18 and 4-1-18 Tenant #5 reported he/she did not receive a nasal spray. The variance was indicated as a missed dose. Review of March and April 2018 MARs revealed an order for Flonase 0.05% nasal spray, one spray in each nostril daily, not documented as completed on 3-31-18 and 4-1-18.	A 013		

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A 013	Continued From page 8 Continued review of Tenant #5's April MARs included a note regarding Tenant #5's report of not receiving the nasal spray all weekend. 7. Record review of Tenant #6's file revealed a Medication Error Report indicated Tenant #6 reported not receiving a B12 injection as ordered on 4-1-18. A missed dose was listed as the type of variance that occurred. The April 2018 MARs reflected an order for Cyanocobalamin 1000 mcg/ml, one ml intramuscularly every month on the 1st was not documented as administered. Tenant #6 reported not receiving the injection on 4-1-18. Additional review of Tenant #6's MARs also reflected the following medications not documented as administered at breakfast on 4-1-18: Fiber capsule, one capsule by mouth daily; Xanax 0.25 mg tablet, one tablet by mouth daily; Calcium 600 + D 400 tablet, one tablet by mouth daily; I-Vite tablet, one tablet by mouth daily; Lamotrigine 200 mg tablet, one tablet by mouth daily; Synthroid 75 mcg tablet, one tablet by mouth daily; Meloxicam 7.5 mg tablet, one tablet by mouth daily; multivitamin tablet, one tablet by mouth daily; and Prilosec 20 mg capsule, one capsule by mouth daily. 8. Record review of Tenant #7's file revealed a Medication Error Report indicated on 4-1-18 Tenant #7 reported two medications not administered at 7:00 p.m. The medications were not left in the medication card. A missed dose and preparation error were listed as the type of	A 013		

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A 013	Continued From page 9 variance that occurred. The April 2018 MARs indicated the following medications not documented as administered on 4-1-18: Buspar 10 mg tablet, one tablet by mouth three times daily (7:00 p.m. dose); Abilify 10 mg tablet, 1/2 tablet by mouth daily (along with 2.5 mg to make 7.5 mg); and Abilify 5 mg tablet, 1/2 tablet by mouth daily (along with 5 mg to make 7.5 mg). Continued review of Tenant #7's MARs included a note documenting Buspar and Abilify were punched out, but Tenant #7 said he/she did not receive them. The note indicated possibly Metformin was not received also. The MAR reflected an order for Metformin 500 mg tablet, one tablet with lunch and supper, not documented as administered on 4-1-18 at supper. Copies of the Metformin 500 mg tablet (lunch) medication card and Buspar 10 mg tablet (lunch) medication card reflected doses on 4-2-18 missing. 9. Record review of Tenant #8's file revealed a Medication Error Report indicated on 4-1-18 Tenant #8 reported not receiving eye drops as ordered and Tylenol in the afternoon. A missed dose and preparation error were listed as the type of variance that occurred. The April 2018 MARs reflected the following medications and treatments not documented as administered and on 4-1-18: Tylenol Arthritis 650 mg tablet, take two tablets orally, every eight hours (afternoon dose) and Artificial Tears 1.4 % eye drops, instill one drop into both eyes, four times daily	A 013		

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A 013	Continued From page 10 (breakfast, lunch and supper doses). Additional review of Tenant #8's April 2018 MARs reflected the following medications and treatments not documented as administered on 4-1-18: Flonase 50 mcg nasal spray, one spray in each nostril daily; Cranberry Extract 250 mg, one capsule by mouth twice daily (supper dose); Duoneb 0.5-2.5 mg/3 ml, one vial nebulized twice daily (supper dose); Prilosec 20 mg capsule, take one capsule by mouth twice daily (supper dose); Betapace 80 mg tablet, one tablet by mouth twice daily (supper dose); Metamucil Powder Orange, one tablespoon mixed in adequate fluid daily; Ativan 0.5 mg tablet, by mouth daily; and Myrbetriq ER 50 mg tablet, one tablet by mouth daily. The MAR included a note that indicated bedtime medications were punched out and staff was unsure if he/she received all bedtime medications. Bedtime medications included: Ativan 0.5 mg tablet, take orally, daily and Myrbetriq ER 50 mg tablet, take one tablet orally, daily, which were not documented as administered on 4-1-18. The Controlled Utilization Record for Tenant #8's Ativan reflected the count was reduced by two (half) tablets despite lack of documentation of the administration of the medication at bedtime on 4-1-18. 10. Record review of Tenant #9's file revealed the April 2018 MARs. Further review of the MARs indicated the following medications not documented as given on 4-1-18: aspirin 325 mg tablet, one tablet by mouth daily; Meloxicam 7.5	A 013		

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mg tablet, one tablet by mouth daily; Metoprolol Succinate ER 25 mg tablet, one tablet by mouth daily; Prilosec 40 mg capsule, one capsule by mouth daily; Miralax Powder 17 gram (gm), one capful with eight ounces of liquid daily; Senna Laxative 8.6 mg tablet, two tablets by mouth daily; and Lasix 40 mg tablet, one tablet by mouth twice daily (breakfast and lunch doses).

Additional review of Tenant #9's April 2018 MARs also reflected an order for Hydrocodone-APAP 5/325 mg tablet, two tablets by mouth three times daily at 5:00 a.m., 1:00 p.m. and 9:00 p.m. The 1:00 p.m. dose on 4-1-18 was not signed out on the MAR. The Control Utilization Record for the Hydrocodone-APAP reflected on 4-1-18 at 8:30 a.m. two tablets were administered. The time reflected on the Control Utilization Record was not the prescribed time the medication was ordered to be administered.

As indicated above Staff A and Staff C's statements indicated Tenant #9 waited two hours for Staff D to change his/her colostomy bag on 4-1-18. The April 2018 MARs reflected to change the ostomy weekly on Saturday and as needed. The MAR did not reflect a documented entry for the completion of the ostomy change as needed on 4-1-18.

11. Record review of Tenant #10's file revealed a Medication Error Report indicated on 4-1-18 Tenant #10 reported not receiving two medications at supper. The medications were not signed out. A missed dose and preparation error were listed as the type of variance that occurred.

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A 013	Continued From page 12 Review of Tenant #10's April 2018 MARs reflected the medication Tenant #10 reported not receiving on 4-1-18 were not documented as administered. These medications included: Betapace 120 mg tablet, 1/2 tablet by mouth twice daily (supper dose) and Neurontin 100 mg capsule, two capsules by mouth three times daily (supper dose). Continued review of Tenant #10's April MARs indicated the following medications and treatments were not documented as administered at breakfast on 4-1-18: Zyloprim 300 mg tablet, 1/2 tablet by mouth daily; aspirin 81 mg chew tablet, two tablets by mouth daily; Colace 100 mg capsule, one capsule by mouth daily; Prozac 20 mg capsule, one capsule by mouth daily; Lasix 20 mg tablet, 1/2 tablet by mouth daily; Miralax Powder 17 gm, one capful with 8 ounces of liquid daily; and Neurontin 100 mg capsule, two capsules by mouth three times daily. 12. Record review of Tenant #11's file revealed April 2018 MARs reflected an order for Lovenox 1.5 mg/kilograms daily at breakfast not documented as administered on 4-1-18. A note on the MAR reflected Tenant #11 received the injection; however, it was given after lunch. Tenant #11's Lovenox injection was not administered in the prescribed timeframe and was not documented as administered. 13. Record review of Tenant #12's file revealed a note on the April 2018 MARs indicated all medications were out of the medication cards	A 013		

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and Tenant #12 did not think he/she was missing any medications on 4-1-18.

Continued review of Tenant #12's April 2018 MARs reflected none of the medications and treatments to be administered at breakfast, lunch or supper were documented as administered on 4-1-18. Medications and treatments included: Artificial Tears 1.4% drops, one drop into both eyes twice daily; Xiidra 5% eye drops, one drop into both eyes, twice daily; Aspercreme Lidocaine 4% applied topically to right side of abdomen daily, on for 12 hours off for 12 hours (breakfast dose); Ensure 8 ounces of milk at each meal (breakfast, lunch and supper); aspirin 81 mg EC tablet, one tablet by mouth daily; Atentolol 25 mg tablet, one tablet by mouth daily; Biotin 5000 mcg capsule, two capsules by mouth daily; Zytrec 10 mg tablet, one tablet by mouth daily; Metamucil capsule, one capsule by mouth daily; Thera-M Enhanced tablet, one tablet by mouth daily; Vitamin D3 5,000 unit capsule, one capsule by mouth daily; Xanax 0.25 mg tablet, 1/2 tablet by mouth twice daily (breakfast and supper doses); Bentyl 20 mg tablet, one tablet by mouth twice daily (breakfast and supper doses); Colace 100 mg capsule, one capsule by mouth twice daily (breakfast and supper doses); Flonase 50 mcg nasal spray, one spray in each nostril 1 or 2 times daily (breakfast and supper doses); Tylenol Extra-Strength 500 mg tablets, two tablets by mouth three times daily (breakfast and lunch doses); Calcium Citrate 250 mg, one tablet by mouth three times daily (breakfast, lunch and supper); Florajen Acidophilus capsule, one capsule orally daily; Macrodantin 50 mg capsule, one capsule orally daily; Ditropan XL 10 mg tablet, one tablet orally, daily; Protonix 40 mg EC tablet, one tablet orally daily; and Paxil 40 mg

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A 013	Continued From page 14 tablet, one tablet orally daily. 14. Record review of Tenant #13's file revealed a note on the April 2018 MARs indicated all bedtime medications were punched out and not signed for and staff was unsure if Tenant #13 received the medications. Another note on the MARs revealed Tenant #13 was interviewed and reported he/she did not recall getting the medications. Continued review of Tenant #13's April 2018 MARs reflected the following medications were not documented as administered at bedtime and Tenant #13 reported not receiving on 4-1-18: Namenda 10 mg tablet, one tablet orally twice daily; Neurontin 100 mg capsule, one capsule orally three times daily; Aricept 10 mg tablet, one tablet orally daily; and Trazodone 50 mg tablet, one tablet orally daily. 15. When interviewed on 6-13-18 at 3:58 p.m. the Senior Director of Assisted Living confirmed the above findings related to medications and treatments for Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13.	A 013		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance	A 089		

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A 089	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans to reflect the identified needs of tenants. This pertained to 4 of 8 tenants reviewed during the investigation of complaint #75793-C (Tenants #1, #4, #5 and #7). Findings follow: 1. When interviewed on 6-19-18 at 3:15 p.m. Staff A reported Tenant #1 consumed alcohol when she lived at the Program. Family asked staff to administer scotch to Tenant #1. When interviewed on 6-19-18 at 3:32 p.m. Staff B reported Tenant #1 consumed alcohol daily (she had moved out of the Program). A nurse would administer alcohol and her family would also give her alcohol. Tenant #1 had been intoxicated when her family was in town. Record review of Tenant #1's file revealed Progress Notes indicated following: a. On 6-8-18 family had an early birthday celebration for Tenant #1. Tenant #1 was "very intoxicated" and could "barely respond to directions" regarding cares for bed. It typically took one staff to assist Tenant #1 to get ready for bed and that night it took two staff to assist. One staff had to physically put Tenant #1's arms into the pajama shirt as she was unable to do it independently per usual. Tenant #1 was "unable to keep her eyes open or hold her head up nor could she sit up by herself." Tenant #1 could	A 089	Tenant #1 was discharged from the program on 5/14/18 Tenant #4 was discharged from the program on 6/7/18. Tenant #5 was discharged from the program on 6/13/18 Tenant# 7 currently in skilled level of care. Remaining resident's service plans will be audited for individualized cares/services by July 28, 2018. Upon competition of significant change, 30 day review, Quarterly and annually assessments service plans will be individualized and reviewed by senior director or designee.	

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A 089	Continued From page 16 usually stand to get her pajama bottoms on but that night she was not able to bear weight long enough to complete the task of putting on her pants. Two staff physically lifted Tenant #1 into bed that night. b. On 6-9-18 it Tenant #1 reported not feeling well and complained of a stomach ache. Tenant #1 was slow to respond to questions and unable to keep her eyes open. Staff had to physically hold her arm up to place the blood pressure cuff on her arm to obtain a blood pressure. There was an odor of alcohol noted on Tenant #1's breath. Continued record review revealed treatment administration records (TARs) reflected the following: a. January 2018 TARs noted "per family" 3/4 shot of scotch twice per day not before 3:00 p.m. It was documented as given four times by staff and one entry stated "FAM." b. February 2018 TARs noted may have 3/4 ounce (20 mililiters) shot of scotch, twice daily after 3:00 p.m. It was documented as given 11 times. c. March 2018 TARs noted the above instructions and to give it in a small glass. It was documented as given 17 times. d. April 2018 TARs noted the above instructions. It was documented as given 20 times. e. May 2018 TARs noted the above instructions. It was documented as given 20 times.	A 089		

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A 089	Continued From page 17 f. June 2018 TARs noted the above instructions. It was documented as given 6 times. Additional record review revealed Tenant #1's service plan, dated 3-9-18, reflected Tenant #1 "may request occasional alcoholic drink." The service plan failed to reflect the family request to offer alcohol twice daily after 3:00 p.m., the frequency of the alcohol consumption, and at times Tenant #1's lack of participation in activities of daily living (ADLs) related to the alcohol consumption. 2. Record review of Tenant #4's file reflected a diagnosis of C2 (vertebrae) fracture and hypersomnia (excessive sleepiness). Continued record review revealed Progress Notes indicated the following: a. On 4-6-18 at 12:00 p.m. staff was called to the apartment and Tenant #4 was found sitting on the bathroom floor. Tenant #4 reported she fell out of the wheelchair because she fell asleep. b. On 4-6-18 at 1:01 p.m. Tenant #4 was seated in the wheelchair with her head down and reported "falling asleep again." c. On 4-7-18 staff was called to the apartment and found Tenant #4 on the floor in her bedroom. Tenant #4 reported she feel asleep in the wheelchair, slipped out, and landed on her face. Tenant #4 sustained an abrasion on the bridge of her nose with mild bleeding noted. d. On 4-23-18 a diagnosis of hypersomnia was noted and a home sleep study ordered.	A 089		

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A 089	Continued From page 18 e. On 5-7-18 Tenant #4 called for assistance and staff observed her on the floor in the kitchen. Tenant #4 wore a hard cervical collar. Bleeding from her nostrils and an abrasion/swelling to the forehead were noted. Tenant #4 reported she fell asleep in the wheelchair and fell out of the wheelchair onto the floor. f. On 5-8-18 Tenant #4 wore dark glasses, which were removed for an assessment. Upon removal of the glasses, new dark purple bruising and swelling surrounding both eyes was noted. Tenant #4 had difficulty opening her eyes due to swelling. A call was placed to update the physician and family. Family requested Tenant #4 go to the emergency room (ER) for an evaluation. An additional note on 5-8-18 documented Tenant #4 admitted to the hospital. Tenant #4 was diagnosed with a nasal bone fracture and soft tissue swelling in the nasal cavity, as well as cellulitis in the left knee. Tenant #4 received intravenous (IV) fluids and antibiotics. g. On 5-31-18 an annual/significant change review was completed after Tenant #4's 5-8-18 to 5-31-18 hospitalization with subsequent skilled nursing stay for a recurrent falls and a closed nasal bone fracture. Tenant #4 was discharged to the Program on 5-31-18. The review noted resumption of level two services for stand by assistance (SBA) with ADLs and limited ambulation, independent with stand-pivot transfers. i. On 6-2-18 staff was called to Tenant #4's apartment and found her on the floor in the bathroom. Tenant #4 reported she did not know what happened but said she must have fallen	A 089		

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asleep while trying to put a roll of toilet paper on the holder. Tenant #4 said she was tired at lunch and should have come back and went to bed. A laceration above the right eyebrow was noted. Tenant #4 complained of head pain, but declined to be seen.

Further record review revealed Tenant #4's service plan, dated 1-22-18, reflected chronic C2 fracture and soft, hard and waterproof cervical collars worn by Tenant #4. The service plan reflected a history of falls and included falls from the wheelchair.

Tenant #4's service plan, updated post hospitalization and skilled nursing stay (undated and unsigned) reflected a closed nasal bone fracture. The plan noted resumption of level two services for SBA with ADLs and limited ambulation with stand-pivot transfers (might request SBA). The plan also reflected a lap tray for the wheelchair implemented while at the nursing facility for fall prevention, which Tenant #4 managed independently. Continued review of the plan revealed the plan failed to reflect Tenant #4 falling asleep in the wheelchair and falling out of the chair, despite falls with injuries related to falling out of the wheelchair.

3. Record review of Tenant #5's file revealed the tenant's diagnoses included: diarrhea, irritable bowel syndrome, bladder incontinence and dementia. Tenant #5 was staged at six on the Global Deterioration Scale, which indicated severe cognitive decline.

Review of Progress Notes indicated Tenant #5 had twelve incidents of bowel and/or bladder

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incontinence in April 2018, and four in May 2018, which required staff assistance.

Additional record review revealed Tenant #5's service plan, dated 5-9-18, reflected staff assisted with toileting needs and noted Tenant #5 had "intermittent bladder and bowel incontinency." The service plan directed staff to remind Tenant #5 to toilet periodically and report episodes of incontinence to the the nurse. The service plan failed to reflect the extent of Tenant #5's incontinency and related interventions.

4. Record review of Tenant #7's file revealed a diagnosis of history of a decubitus ulcer.

Review of Progress Notes indicated the following:

a. On 5-15-18 a dark blood blister to the left outer leg was noted. Tenant #7 said she hit it on the wheelchair all the time. The blister as noted to be 2 centimeters (cm) long and 1.5 cm wide. The anti-embolism hose was left off the left leg.

b. On 5-16-18 Tenant #7's family called the physician and instructions were given to keep it covered for protection and it should resolve in 7 to 10 days. Tenant #7 agreed to have her leg wrapped with dressing for protection. There was a noted increase in discoloration to the leg and bruising around the blister area.

c. On 5-20-18 Tenant #7 was directed not to wear anti-embolism hose to the left leg due to the blister.

d. On 5-25-18 no change in size of the blister but

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A 089	Continued From page 21 a color change was noted. The area was black in color and there was an open area to lower midline of the leg. There was red drainage from the open area. e. On 5-30-18 a referral was made to the wound clinic. f. On 6-7-18 wound care ordered Mepilex AG and 3M lite compression wrap, and directed not to remove the wrap. g. On 6-11-18 at 3:00 p.m. Tenant #7 was observed on the floor. Tenant #7 lost her balance when she stood up and fell to the floor. Tenant #7 had a 1 cm skin tear to the right elbow. h. On 6-11-18 at 8:15 p.m. the dressing was changed to the right elbow. The old dressing was "soaked" with a large amount of blood. i. On 6-14-18 wound clinic gave a diagnosis of traumatic wound to left lateral ankle and right elbow. Orders included: application of Silver foam to left lateral ankle every other day; Size E tubigrips on the left leg; keep left foot elevated while sitting; Xeroform and Mepilex border dressing applied every other day.; and cleanse wounds with wound spray, pat to dry. Further record review revealed May 2018 TARs reflected a dressing change to the left outer leg, and directed staff to cover the blister with pad and gauze per Tenant #7's and family request. June 2018 TARs reflected a dressing change to the right outer leg, and directed to cover blister with pad/gauze per Tenant #7's request. These orders were discontinued and wound clinic orders were added to the TAR on 6-14-18.	A 089		

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A 089	Continued From page 22 Continued record review revealed Tenant #7's service plan, dated 2-12-18, reflected the tenant's history of impaired skin integrity, including a decubitus ulcer. The service plan noted if impaired skin integrity occurred the nurses should notify the physician and follow treatments as ordered. The service plan failed to reflect Tenant #7's wounds, treatment, and referral to the wound clinic. The service plan reflected assistance with dressing/undressing of lower extremities, including socks, shoes and toe cushion. The service plan failed to reflect the anti-embolism hose and tubigrips. 5. When interviewed on 6-21-18 at approximately 2:50 p.m. the Senior Director of Assisted Living confirmed the above findings.	A 089		