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
	S0029	A. BUILDING: _____ B. WING _____	C 10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE MARION	1100 LINDEN DR MARION, IA 52302

(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	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. 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. Number of tenants without cognitive impairment: 27 Number of tenants with cognitive impairment: 11 Total census: 38 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program and the investigation of Complaint #101953-C:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policies and procedures regarding incident reporting. This pertained to 2 of 5 current tenants reviewed (Tenants #3 and #4) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 10-4-22 of Tenant #2's file revealed Communication Log documents indicated the following:	A 150		

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A 150	Continued From page 1 -On 8-16-22 Tenant #2 removed his clothing and walked around after supper. He tried to push doors to leave outside. -On 8-19-22 Tenant #2 removed his clothing in the dining room. -On 9-23-22 Tenant #2 tried to hit another tenant. -On 9-27-22 Tenant #2 was irritated. He pushed staff into the kitchen while he screamed. He attempted to go into another tenant's apartment and "got mad" when redirected. Continued record review revealed incident reports were not completed related to incidents noted above with Tenant #2. 2. Record review on 10-5-22 of Tenant #4's file revealed Communication Log documents indicated the following: -On 8-12-22 Tenant #4 was very upset all shift, "lots of elopement behavior", he cried and used "abusive language" when redirected. An as needed medication was given. -On 9-20-22 Tenant #4 had "bad behaviors today", refused "everything" and urinated on the dining room floor. Continued record review revealed incident reports were not completed related tot eh incidents noted above with Tenant #4. 3. Record review on 10-4-22 of Tenant C1's file revealed Progress Notes indicated the following: -On 1-10-22 Tenant C1 was sent to the ER twice	A 150		

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A 150	Continued From page 2 over the weekend, once on Friday evening and once on Saturday evening for behaviors. Tenant C1 was verbally aggressive and threw shoes and dishes. Tenant C1 threw water and as medications at staff. No changes were made at the hospital and she was not admitted. -On 1-31-22 on 1-30-22 Tenant C1 was combative with staff and attempted to "go after staff." She threw herself on the floor from the wheelchair and kicked another tenant's walker. She refused assistance from staff and screamed and hit the floor. She was transferred to the hospital via ambulance. Continued record review revealed incident reports were not completed related to the incidents noted above with Tenant C1. 4. Record review of the Program's policy and procedure regarding Incident and Accident Reports indicated tenant, staff or visitor incidents or accidents were to be reported and documented immediately. Incidents or accidents would be documented on the incident report form. The person in charge at the time would complete the incident report form and would include witness statements from all witnesses. Incidents included but were not limited to medication errors, injuries to staff, visitors or tenants and tenant falls. 5. When interviewed on 10-13-22 at 10:04 a.m. the Director confirmed all incident reports for the tenants listed above were provided.	A 150		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights:	A 155		

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A 155	Continued From page 3 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure a tenant was treated with respect, consideration and dignity related to an emergency room (ER) visit and return to the Program. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review of Tenant C1's file revealed a 30 day notice for discharge, dated 1-11-22, indicated Tenant C1 exceeded the criteria to be retained based on being dangerous to self or others and having aggressive behavior. Transfer needed to occur no later than 2-10-22. The Program provided a 2-19-22 discharge date for Tenant C1. Continued record review revealed an Unusual Occurrence Report indicated on 12-4-21 Tenant C1 was "extremely agitated" and staff was unable to redirect her. Tenant C1 grabbed knives off the dining room tables and threatened staff and threw knives at them. Several other tenants observed her throwing knives and were upset and wanted the police called. Tenant C1 was sent to the ER. Further record review revealed Progress Notes indicated the following: -On 12-8-21 the nurse evaluated Tenant C1 at the hospital and discharge was planned for 12-9-21.	A 155		

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-On 12-9-21 Tenant C1 arrived via transport service and she was "very aggressive and combative" with the driver and staff. An ambulance was called and she was sent back to the hospital. It was noted she was also combative and aggressive with ambulance staff. Tenant C1 was taken back to the hospital.

-On 1-10-22 Tenant C1 was sent to the ER twice over the weekend, once on Friday evening and once on Saturday evening for behaviors. Tenant C1 was verbally aggressive and threw shoes and dishes. Tenant C1 threw water and as medications at staff. No changes were made at the hospital and she was not admitted.

-On 1-11-22 a decision was made to issue a 30 day notice for discharge to Tenant C1 related to level of care.

-On 1-31-22 on 1-30-22 Tenant C1 was combative with staff and attempted to "go after staff." She threw herself on the floor from the wheelchair and kicked another tenant's walker. She refused assistance from staff and screamed and hit the floor. She was transferred to the hospital via ambulance. "Per RNC on call and Divisional RN" Tenant C1 could not return until one to one care was in place.

-On 2-1-22 at 7:45 p.m. Tenant C1 returned from the hospital. There was a outside caregiver to provide one to one care until alternative placement was secured.

Continued record review revealed a Physician Order Fax form dated 2-2-22 indicated Tenant C1 returned from the ER at about 7:45 p.m. on 2-1-22. She was gone for nearly 48 hours the physician orders for her needed to be resigned.

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The ER indicated no new orders but a medication list was not provided. It was requested the provider signed the attached medication list to reactivate Tenant C1 in the pharmacy system.

An After Visit Summary for the 1-30-22 to 2-1-22 ER visit was not located in Tenant C1's file.

Further record review of hospital records indicated Tenant C1 was admitted in the ER on 1-30-22 and discharged from the ER on 2-1-22. It was reported Tenant C1 had an altercation with staff and slid out of her wheelchair. Tenant C1 complained of low back pain. At 9:38 p.m. on 1-30-22 it was noted Tenant C1 was ready for discharge but hospital staff was informed the Program would not take her back. They had given her a 30 day notice and if the hospital discharged her, they would call 911 and send her back. The notes indicated from a fall perspective, Tenant C1 was stable, calm and at her baseline. The Program would not take her back. It was noted there was no resolution that night she would be "boarded" in the ER. Hospital staff talked with Tenant C1's family about it and family was "surprised by this news." Hospital notes indicated Tenant C1's family spoke with Program staff and was told the Program would not take her back until family hired one to one care for Tenant C1. A ED Note dated 2-1-22 at 7:01 p.m. indicated a one to one caregiver arrived at the Program and they were ready for Tenant C1 to return. Tenant C1's family was made aware of her discharge to the Program.

2. When interviewed on 10-13-22 at 10:04 a.m. the Director said the last time that she could recall Tenant C1 being sent out to the hospital there were issues with getting transportation to bring her back. One of the outside transportation

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services declined to transport her because she was aggressive towards to the driver. Other outside transportation companies would also not transport. A 30 day notice was issued due to Tenant C1's behavior. She was not involved in decisions regarding tenants returning from the hospital. She said the Program's nurse and the Divisional RN would be involved in those decisions.

When interviewed on 10-12-22 at 11:29 a.m. the Divisional Director of Resident Services said previously she was a traveling nurse for the corporation and was in the building once per week. She said Tenant C1 had a lot of behaviors. She said did not know of the specific situation regarding Tenant C1 in the ER for nearly 48 hours. She said Tenant C1 was not denied to come back to the Program. She could not recall if she spoke with hospital staff at that time.

3. In summary, Tenant C1 who had behaviors and had been given a 30 day notice dated 1-11-22 for transfer with transfer on or before 2-10-22. On 1-30-22 Tenant C1 was transferred out of the building via ambulance to the ER after an incident that occurred at the Program. On 1-30-22 at 9:38 p.m. the medical team at the hospital determined Tenant C1 was stable from the fall perspective, was calm and at her baseline. She was ready for discharge from the ER. Program staff informed the hospital staff they would not take Tenant C1 back, she had been given a 30 day notice and if the hospital discharged her they would call 911 and send her back to the hospital. Hospital staff shared that information with Tenant C1's family and it was noted that they were surprised. Family contacted Program staff and was told they had to secure a one to one caregiver for Tenant C1 to be able to

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A 155	Continued From page 7 return. On 2-1-22 at 7:01 p.m. the hospital prepared to discharge Tenant C1 from the ER. Program records indicated Tenant C1 returned at about 7:45 p.m. on 2-1-22 and the Program had to obtain new signed medication orders for Tenant C1 as she had been out to the ER for nearly 48 hours. Tenant C1 was not allowed to return to the Program despite the hospital determination she was stable and ready for discharge. Tenant C1 remained in the ER for nearly 48 hours, when the Program accepted her back with one to one care arranged by the family until her permanent discharge on 2-19-22. Tenant C1 was not treated with consideration, respect and full recognition of her personal dignity.	A 155		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received nurse delegated training within 30 days of employment. This pertained to 1 of 6 non-licensed staff employed greater than 30 days (Staff A, B, C and D). Findings follow: 1. Record review on 10-3-22 and 10-422 of Staff	A 345		

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A 345	Continued From page 8 A's training documented revealed a hire date of 8-29-22. Nurse delegation training was not completed until 9-30-22, which was greater than 30 days from Staff A's hire date. 2. Record review on 10-3-22 and 10-4-22 of Staff B's training documents revealed a hire date of 5-9-22 and a start date of 5-20-22. Nurse delegated training was not completed until 9-10-22, which was greater than 30 days from Staff B's hire date. 3. Record review of the ALP/ADS/EEG Monitoring Entrance Form revealed the Nurse was hired on 7-13-22. The Former Nurse had a termination date of 4-30-22. 4. When interviewed on 10-13-22 at 12:50 p.m. the Director confirmed no additional nurse delegation training documents were found for Staff B.	A 345		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by	A 290		

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A 290	Continued From page 9	A 290		

exception. This pertained to 3 of 5 current tenants reviewed (Tenants #1, #2 and #4) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow:

1. Record review on 10-4-22 of Tenant #1's file revealed the service plan dated 8-27-22 had handwritten updates with a recorded date of 8-9-22. The updates reflected staff would complete weekly housekeeping, which was a change from Tenant #1's family completing housekeeping tasks. It also reflected staff would complete laundry weekly, which was a change from Tenant #1's family completing laundry tasks.

Continued record review of Tenant #1's file revealed Progress Notes did not reflect entries related to the handwritten updates on the service plan for changes to housekeeping and laundry that occurred dated 8-9-22. Nurse's notes were not documented by exception, including with changes of housekeeping and laundry services for Tenant #1.

2. Record review on 10-4-22 of Tenant #2's file revealed Communication Log documents indicated the following:

-On 8-16-22 Tenant #2 removed his clothing and walked around after supper. He tried to push doors to leave outside.

-On 8-19-22 Tenant #2 removed his clothing in the dining room.

-On 9-4-22 Tenant #2 refused his morning medications.

-On 9-5-22 Tenant #2 refused his shower four times.

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A 290	Continued From page 10 -On 9-8-22 Tenant #2 refused his shower and refused lunch. -On 9-10-22 Tenant #2 did not have any laundry to be completed. -On 9-15-22 Tenant #2 tried to get into other tenant apartments. -On 9-16-22 Tenant #2 had been "very irritable" and staff locked everyone's apartments due to his wandering. -On 9-19-22 Tenant #2 refused to put his pants on. -On 9-20-22 Tenant #2 did not get up all day and refused to put his pants on. -On 9-23-22 Tenant #2 tried to hit another tenant. -On 9-27-22 Tenant #2 was irritated. He pushed staff into the kitchen while he screamed. He attempted to go into another tenant's apartment and "got mad" when redirected. -On 9-30-22 Tenant #2 had an odor from his person. "Can be smelled when he walks by." Staff attempted to set up a shower but was unsuccessful. He was in another tenant's bed. Continued record review review revealed the Progress Notes did not reveal any documented entries related to Tenant #2's behavior as noted above. Nurse's notes were not documented by exception, including related to Tenant #2's behaviors. 3. Record review on 10-5-22 of Tenant #4's file	A 290		

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revealed Communication Log documents indicated the following:

-On 8-12-22 Tenant #4 was very upset all shift, "lots of elopement behavior", he cried and used "abusive language" when redirected. An as needed medication was given.

-On 9-12-22 Tenant #3 was "very irritable."

-On 9-15-22 on third shift Tenant #4 was up from 2:30 a.m. to 5:30 a.m. screaming.

-On 9-18-22 Tenant #4 was in pain, was very agitated and took off his brace.

-On 9-19-22 Tenant #4 had behaviors today.

-On 9-20-22 Tenant #4 had "bad behaviors today", refused "everything" and urinated on the dining room floor.

-On 9-30-22 Tenant #4 refused his shower and was agitated.

Continued record review revealed Progress Notes did not reveal any documented entries related to Tenant #4's behavior as noted above. Nurse's notes were not documented by exception, including related to Tenant #4's behaviors.

4. Record review on 10-4-22 of Tenant C1's file revealed an Unusual Occurrence Report indicated on 12-4-21 Tenant C1 was "extremely agitated" and staff was unable to redirect her. Tenant C1 grabbed knives off the dining room tables and threatened staff and threw knives at them. Several other tenants observed her throwing knives and were upset and wanted the

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A 290	Continued From page 12 police called. Tenant C1 was sent to the emergency room (ER). Progress Notes indicated the following: -On 12-8-21 the nurse evaluated Tenant C1 at the hospital and discharge was planned for 12-9-21. -On 12-9-21 Tenant C1 arrived via a transport service and she was "very aggressive and combative" with the driver and staff. An ambulance was called and she was sent back to the hospital. It was noted she was also combative and aggressive with ambulance staff. Tenant C1 was taken back to the hospital. -The next documented entry in Progress Notes was dated 1-10-22. Continued record review revealed an After Visit Summary dated 12-15-21 indicated Tenant C1 was hospitalized from 12-9-21 to 12-15-21 and the diagnosis was major neurocogntive disorder. Further record review revealed a nurse's note was not documented by exception, including when Tenant C1 returned to the Program after the 12-9-21 to 12-15-21 hospitalization. 5. When interviewed on 10-13-22 at 10:04 a.m. the Director confirmed all nurse's notes for the tenants listed above were provided.	A 290		
A 350	481-69.26(1) 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	A 350		

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A 350	Continued From page 13 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 observation, interview and record review the Program failed to update service plans as needed and ensure service plans reflected the identified needs of tenants. This pertained to 5 of 5 current tenants reviewed (Tenants #1, #2, #3, #4 and #5) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 10-4-22 of Tenant #1's file revealed Progress Notes indicated the following: -On 8-1-22 Tenant #1's family would be providing housekeeping and laundry for Tenant #1. Family would also provide prompts to shower and would set up medications he would take independently. -On 8-12-22 Tenant #1's right leg was swollen and his family took him to urgent care. He was diagnosed with a blood clot and new orders were received for Xarelto 20 milligram (mg) twice daily for 21 days and 20 mg daily after the 21 days. Tenant #1 was also to follow up with his primary care provider (PCP) on 8-19-22. Continued record review revealed the August, September and October 2022 medication administration records (MARs) reflected staff initialed for the administration of the Xarelto medication. Further record review revealed the ALP/ADS/EEG Monitoring Entrance Form identified two tenants	A 350		

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wandered. At the time of the entrance meeting on 10-3-22, the Director identified Tenant #1 as one of the tenants wandered.

When observed in the afternoon on 10-4-22, Tenant #1 frequently near the front exit door.

Continued record review revealed the service plan dated 8-1-22 (admission service plan) reflected Tenant #1's family set up medications and Tenant #1 would take them. The service plan dated 8-27-22 reflected Tenant #1 did not typically take medication and was currently taking a medication for a deep vein thrombosis, noted as temporary. Tenant #1's family would set up the medications and Tenant #1 would take them. The current service plan did not reflect assistance provided by staff related to medication administration, it also did not reflect Tenant #1 was prescribed a blood thinning medication or Tenant #1's wandering behavior and interventions.

2. Record review on 10-4-22 of Tenant #2's file revealed Unusual Occurrence Reports indicated the following:

-On 4-8-22 Tenant #2 was agitated with another tenant and he pushed her to the ground, which caused an injury to the other tenant and knelt on top of her and was going to hit her until staff intervened. Tenant #2 was sent to the hospital.

-On 6-10-22 staff assisted Tenant #2 with a shower and he shoved the staff against the grab bar and "used all of his weight to pin the CMA in place." Tenant #2 bit the staff on the neck and then punched, hit, and put his knee into the staff's stomach. Tenant #2 also pinched staff several times. The report indicated there was an injury to

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A 350	Continued From page 15 the staff. -On 6-19-22 another tenant walked between Tenant #2's feet and he grabbed her arm, hit her shoulder and tried to garb her hand. Staff separated them and Tenant #2 turned to the other tenant and said "I will make sure you're no longer living anymore." -On 8-8-22 staff observed Tenant #2 use both hands on another tenant's shoulders and push him down on the couch. Continued record review revealed Communication Log documents indicated the following: -On 8-16-22 Tenant #2 removed his clothing and walked around after supper. He tried to push doors to leave outside. -On 8-19-22 Tenant #2 removed his clothing in the dining room. -On 9-4-22 Tenant #2 refused his morning medications. -On 9-5-22 Tenant #2 refused his shower four times. -On 9-8-22 Tenant #2 refused his shower and refused lunch. -On 9-10-22 Tenant #2 did not have any laundry to be completed. -On 9-15-22 Tenant #2 tried to get into other tenant apartments. -On 9-16-22 Tenant #2 had been "very irritable"	A 350		

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and staff locked everyone's apartments due to his wandering.

-On 9-19-22 Tenant #2 refused to put his pants on

-On 9-20-22 Tenant #2 did not get up all day and refused to put his pants on.

-On 9-23-22 Tenant #2 tried to hit another tenant.

-On 9-27-22 Tenant #2 was irritated. He pushed staff into the kitchen while he screamed. He attempted to go into another tenant's apartment and "got mad" when redirected.

-On 9-30-22 Tenant #2 had an odor from his person. "Can be smelled when he walks by." Staff attempted to set up a shower but was unsuccessful. He was in another tenant's bed.

Further record review revealed August and September 2022 MARs reflected refusals of medications.

The ALP/ADS/EEG Monitoring Entrance Form identified there was one tenant who consistently refused cares and services. At the Entrance meeting the Director indicated Tenant #2 as the tenant and said he refused bathing.

Continued record review revealed the service plan dated 4-19-22 reflected staff provided Tenant #2 with verbal reminders to shower one to two times per week. It indicated he was difficult to direct to shower related to his cognition. It reflected Tenant #2 was physically aggressive towards another tenant on 4-8-22 and had shook his fists at staff and others. The service plan did not reflect the extend of the behavior as noted

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above in Communication Log documents and incident reports. It also did not reflect the extend of Tenant #2's refusals related to bathing or medications.

3. Record review on 10-5-22 of Tenant #3's file revealed Tenant #3 received hospice services. A Physician's Orders document dated 9-21-22 reflected an order to crush medications as needed. A Physician's Orders document dated 10-2-22 reflected an order for thickened liquids as needed.

Continued record review revealed the service plan dated 9-21-22 was not updated as needed and the service needs for Tenant #3 including the orders for crushed medications and thickened liquids as needed.

4. Record review on 10-5-22 of Tenant #4's file revealed Communication Log documents indicated the following:

-On 8-12-22 Tenant #4 was very upset all shift, "lots of elopement behavior", he cried and used "abusive language" when redirected. An as needed medication was given.

-On 9-12-22 Tenant #3 was "very irritable."

-On 9-15-22 on third shift Tenant #4 was up from 2:30 a.m. to 5:30 a.m. screaming.

-On 9-18-22 Tenant #4 was in pain, was very agitated and took off his brace.

-On 9-19-22 Tenant #4 had behaviors today.

-On 9-20-22 Tenant #4 had "bad behaviors today", refused "everything" and urinated on the

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dining room floor.

-On 9-30-22 Tenant #4 refused his shower and was agitated.

Continued record review revealed the service plan dated 9-1-22 reflected when Tenant #4 was hospitalized in 2017 including for aggression, exit seeking and destructive behavior. Since he returned from the hospital no aggressive behavior had been noted. It noted if staff noticed increased agitation, refusals of cares, exit seeking or aggressive behavior to contact the nurse or Director. The service plan did not reflect Tenant #4's current behavior as noted above in Communication Logs.

5. Record review on 10-5-22 of Tenant #5's file revealed a Progress Note dated 8-30-22 indicated staff reported an increase in her behaviors including, verbal aggression, hitting, pinching and smearing feces on wall and on staff. Tenant #5 was difficult to redirect.

A Long Term Care Facility Acute Visit with the PCP dated 8-31-22 indicated staff reported behavioral concerns since a medication change was made from Seroquel to Haldol. Staff reported she smeared feces on staff, hit and pinched staff, threw things in her apartment and pulled things off of the wall. A new order was received to increase Haldol from 1 mg to Haldol 2 mg twice daily.

Continued record review revealed August, September and October 2022 MARs reflected medication refusals or medications spit out by Tenant #5. The MARs also reflected medications were crushed and given in her breakfast or in her oatmeal.

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A 350	Continued From page 19 Further record review revealed a fax to the PCP indicated Tenant #5 had frequent falls and an order was requested for physical therapy (PT) to evaluate and treat. The PCP provided an order for PT dated 9-27-22. Continued record review revealed the service plan dated 8-26-22 did not reflect Tenant #5's behaviors as noted above including aggressive behaviors and medication refusals. The service plan reflected Tenant #5 had falls and a new bed was ordered; however, did not reflect the order for PT. 6. Record review on 10-4-22 of Tenant C1's file revealed an Unusual Occurrence Report indicated on 12-4-21 Tenant C1 was "extremely agitated" and staff was unable to redirect her. Tenant C1 grabbed knives off the dining room tables and threatened staff and threw knives at them. Several other tenants observed her throwing knives and were upset and wanted the police called. Tenant C1 was sent to the emergency room (ER). Progress Notes indicated the following: -On 12-8-21 the nurse evaluated Tenant C1 at the hospital and discharge was planned for 12-9-21. -On 12-9-21 Tenant C1 arrived via a transport service and she was "very aggressive and combative" with the driver and staff. An ambulance was called and she was sent back to the hospital. It was noted she was also combative and aggressive with ambulance staff. Tenant C1 was taken back to the hospital. -On 1-10-22 Tenant C1 was sent to the ER twice	A 350		

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over the weekend, once on Friday evening and once on Saturday evening for behaviors. Tenant C1 was verbally aggressive and threw shoes and dishes. Tenant C1 threw water and as medications at staff. No changes were made at the hospital and she was not admitted.

-On 1-11-22 a decision was made to issue a 30 day notice for discharge to Tenant C1 related to level of care.

-On 1-31-22 it was noted on 1-30-22 Tenant C1 was combative with staff and attempted to "go after staff." She threw herself on the floor from the wheelchair and kicked another tenant's walker. She refused assistance from staff and screamed and hit the floor. She was transferred to the hospital via ambulance. "Per RNC on call and Divisional RN" Tenant C1 could not return until one to one care was in place.

-On 2-2-22 it was noted on 2-1-22 at 7:45 p.m. Tenant C1 returned from the hospital. There was a outside caregiver to provide one to one care until alternative placement was secured.

Continued record review revealed a 30 day notice for discharge was dated 1-11-22. It indicated Tenant C1 exceeded the criteria to be retained based on being dangerous to self or others and having aggressive behavior. Transfer needed to occur no later than 2-10-22.

Further record review revealed the service plan dated 12-15-21 reflected she was admitted to a hospital on 12-4-21 for behaviors. The service plan reflected staff was to provide reminders when her behavior was not appropriate and offer her a cup of coffee or popcorn if agitated. The service plan was not updated as needed and did

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A 350	Continued From page 21 not reflect Tenant C1's behaviors as noted above. 7. When interviewed on 10-13-22 at 10:04 a.m. the Director confirmed all current service plans for the tenants listed above were provided.	A 350		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure the exit doors were alarmed at all times. This potentially affected all tenants (census of 38). Findings follow: 1. When observed on 10-3-22 at approximately 11:30 a.m. the two exit doors to the courtyard in the front of the building were not alarmed. There were no audible alarms heard when the first courtyard door was opened. When the second courtyard door was opened (near the sunroom) there was an alarm that was heard; however, after review of the alerts on the computer it was not related to the courtyard door. The courtyard door off of the smaller unit in the back of the building was locked; however, when the door was unlocked and opened it did not alarm. The staff working in the unit had a pager and it was observed. A page was not received to alert staff regarding the door being opened. When the courtyard door was opened it did not	A 635		

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A 635	Continued From page 22 alarm audibly. 2. When interviewed at the time of the tour and observation of the doors the Director said the courtyard doors were alarmed in the winter season and it was set to be alarmed on 10-15-22. 3. Record review revealed the Program an Assisted Living Program Certificate for a Dedicated Dementia Specific Assisted Living Program. Continued record review revealed a policy and procedure related to Safety and Security indicated the courtyard doors would be alarmed from 7:00 p.m. to 7:00 a.m. and would be alarmed 24 hours per day from October 1st through March 31st. 4. When interviewed on 10-13-22 at 10:04 a.m. the Director confirmed the courtyard doors were not alarmed when the tour was completed. She said the policy and procedure related to the door alarms was reviewed and the courtyard doors were alarmed that afternoon.	A 635		