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
	S0090	A. BUILDING: _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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. Number of tenants without cognitive disorder: 4 Number of tenants with cognitive disorder: 10 Total census: 14 An onsite infection control survey was completed and no regulatory insufficicies were identified. 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 Complaints #92954-C, #93099-C and #94907-C:	A 000	This shall serve as a credible allegation of compliance. All regulatory insufficiencies will be corrected by the completion date.	11/19/2021
A 125	481-67.2(1)d Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Review of a Fall Scene Investigation Report dated 8-21-20 at 3:30 p.m. indicated Tenant C2 ran outside and staff tried to catch her. When staff called her name, she turned around quickly	A 125	Promise House will continue to include statements from individuals who are witnesses to an incident. The QA committee will assume compliance by reviewing all incident reports to assure documentation is appropriate.	11/19/2021

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A 125	Continued From page 1 and fell. She hit her head on the chair after she was on the ground. Interventions to prevent future falls included the tenant was to have the assistance of one staff as well as a gait belt for the rest of the night. The report indicated Tenant C2's temperature was 98 degrees, pulse was 100, respiration rate was 30, oxygen saturation was 96% and blood pressure was refused. There was a bruise on the right elbow and skin tear on the right elbow. The report was signed by Staff G. The report indicated Staff H was present when Tenant C2 fell. An Incident Report dated 8-21-20 at 4:45 p.m. indicated staff (unnamed) came to Staff G and reported Tenant C2 hit her across the face. The same staff came to her again and reported Tenant C2 kicked her. Tenant C2 had gotten up from the table and started walking independently, stating she needed to use the bathroom. Staff (unnamed) tried to redirect her to wait for assistance. Tenant C2 dug her nails into staff (unnamed) and yelled at them saying she needed to go to the bathroom. Two staff walked the tenant down the hallway using a gait belt. Tenant C2 hit, kicked and dug her nails into staff. When walking down the hallway she bumped staff into the wall. Tenant C2 was put into a wheelchair and staff (unnamed) took her to her apartment to use the bathroom. Tenant C2 yelled at staff (unnamed) to get out and said she could do it. Tenant C2 stood up with the bar in the bathroom independently. Tenant C2 yelled at, hit and kicked staff and could not be redirected. The witness statement section completed by Staff J indicated Tenant C2 was upset and did not understand why the gait belt was on. She screamed "uncontrollably" and was hitting. A wheelchair was called for and she started to calm down. Tenant C2 stood up on her own and went to the	A 125		

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A 125	Continued From page 2 bathroom independently. When interviewed Staff H said Tenant C2 started to run, went outside, got scared, turned around and fell on the ground. The former ADON (Assistant Director of Nursing) and two other staff came outside. They got the tenant up forcefully. They grabbed her leg and aggressively straightened it out. She was taken inside. A gait belt being utilized was pulled on aggressively. The former ADON and someone else took the tenant back to her apartment and they had her up against the wall. They tried to get her into a wheelchair. They were screaming at the tenant who was screaming at them. Staff L told her staff were rude and forced the tenant to get on the toilet and aggressively removed her clothes. Staff H said she could hear Tenant C2 screaming in the dining room. An ambulance was called and Tenant C2 was sent out but not for her injuries. Staff H said Tenant C2 had hit her head and the former Unit Director grabbed ice and slapped the ice on the back of her head in an aggressive manner. Staff H wondered why Tenant C2 was forced to go to the bathroom. She said she wrote statements including for the police. When interviewed Staff L said she remembered Tenant C2 fell on the cement. Staff had said her name and she turned and had fell. She was brought inside by the former Unit Director and former ADON. There were no proper vitals taken and she was not checked. They yelled at the tenant and told her she was being dramatic. Staff J was also present. The former ADON and Staff J used a gait belt to take her to the bathroom in her apartment. The strap of the gait belt was above the tenant's head. Tenant C2 grabbed onto the railing but was told she had to walk. Tenant C2 kept crying a lot and saying it hurt. Staff L was	A 125		

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A 125	Continued From page 3 following behind them with a wheelchair. The tenant was taken into the bathroom and told she had to sit down. They "kind of forced her to sit." Tenant C2 kept screaming. After the tenant was done in the bathroom Staff J got a wheelchair and put her in it. Tenant C2 kept screaming asking for help. Tenant C2 was sent to the hospital. No additional staff statements were provided related to the 8-21-20 incident with Tenant C2 despite staff witnessing the fall and an alleged incident between Tenant C2 and other staff after the fall.	A 125		
A 130	481-67.2(1)e Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure incident reports were completed for all unusual occurrences for 1 of 3 former tenants reviewed (Tenant C3). Findings include: Review of Tenant C3's record on 9-13-21 revealed a diagnoses of Alzheimer's dementia and a GDS score of 6, which indicated severe cognitive decline.	A 130	Promise House will continue to assure that all accidents/ unusual occurances are reported and investigated. The QA committee will assure compliance by periodically reviewing incidents to assure regulatory compliance.	11/19/2021

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A 130	Continued From page 4 A Staff Communication Report dated 8-11-21 indicated Tenant C3 refused dressing and displayed aggression. He tried to hit staff with a lamp. A Staff Communications Report dated 8-16-21 at 7:00 a.m. indicated Tenant C3 hit staff with a towel rack. It was broken off the wall and he fought with staff. Nurse's Notes indicated on 8-12-21 staff called the Unit Director regarding Tenant C3's aggression. When the Unit Director arrived the tenant was calm. Staff reported she was standing in the doorway of the middle of the building. Tenant C3 walked up and grabbed the newspaper and hit staff across the face with it. No incident reports could be located regarding these events. Review of the Incident Report Policy dated (updated on 1-25-21) indicated an incident was any unusual occurrence, including an altercation between staff and tenants and unusual behavior by a tenant. On 9-23/21 at 9:00 a.m. the Unit Director confirmed there were no incident reports.	A 130		
A 160	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.	A 160	Promise House will continue to provide care, treatments and services that are adequate and appropriate. The QA committee will assure compliance by reviewing all incidents to assure compliance is being maintained.	11/19/2021

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A 160	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate for 2 of 3 former tenants reviewed (C1 and C2). Findings follow: 1. Record review on 9-13-21 revealed an Incident Report dated 11-22-20 at 8:00 a.m. indicating Tenant C1's shower "required an assist of 3 for tenant and staff's safety. Tenant was hitting, kicking, punching, and spitting at staff. She was being completely resistive to cares." Tenant C1 hit staff throughout the shower. She elbowed one staff in the jaw and hit two others in chest. "Tenant was screaming the whole time." Tenant C1's diagnoses included late stage Alzheimer's without behavioral disturbances. She was staged at a six to seven on the GDS (Global Deterioration Scale), which indicated severe to very severe cognitive decline. The signed service plan dated 10-5-20 reflected Tenant C1 was resistant to cares and at times might refuse bathing. Staff were to re-approach or switch off to another person. If she continued to refuse, Trazadone could be administered if needed. She was to receive assistance with bathing twice per week and as needed. Further record review revealed the November 2020 medication administration records (MARs) reflected orders for Trazodone 50 milligram (mg) tablet, 1/2 tablet (25 mg) orally every four PRN (as needed) for agitation and Haldol with pentravan cream topically up to three times daily PRN for aggressive behaviors. There were no documented doses of either of these PRN	A 160		

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A 160	Continued From page 6 medications being administered on 11-22-20. Continued record review revealed fax communication documents to the primary care provider (PCP) documenting the following: - On 10-16-20 Tenant C1 refused staff assistance with ambulation to the bathroom. Staff was by her side but were unable to assist her due to Tenant C1 being resistant and striking out. She required additional staff to complete her morning cares. - On 10-26-20 Tenant C1 hit staff, slammed her walker into the wall and grabbed staff's arms and twisted them. Tenant C1 was not easily redirected and required one to one attention much of the time. - On 11-22-20 it was noted Tenant C1 continued to refuse cares and it took three staff in the shower for everyone's safety. She hit a staff member in the jaw and spit at staff. She refused her oral cares and refused to let staff change her and complete perineal cares. This fax was sent by the former Assistant Director of Nursing (ADON) - On 12-1-20 it was noted the program was "kind of at the end of our ropes" with Tenant C1. She was constantly combative including hitting, kicking, biting and resisting cares. She required two staff for cares and refused meals. This fax was sent by the former ADON. - On 12-3-20 it was noted Tenant C1 required a two staff assist for safety and refused to walk at times. Tenant C1 hit and kicked at staff. She was being evaluated if to determine if she needed a higher level of care. This fax was sent by the former ADON. When interviewed Staff A said Tenant C1 was really combative and it took three staff to assist with the shower (regarding the incident report	A 160		

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A 160	Continued From page 7	A 160		

11-22-20). Tenant C1 hit, kicked and tried to bite staff. They tried to get it done fast; one staff washed her, one staff making sure did not fall out of the chair and one staff dried her. Typically two people assisted with her showers. Staff approached the former ADON after the fact. Tenant C1 refused a lot of cares and was a two to three assist. Staff A did not believe the tenant was appropriate for the Program. She remembered several instances of observed bruising on Tenant C1 but could not recall specifics. She said Tenant C1 bumped into things and struck out at staff or objects.

When interviewed Staff I said Tenant C1 was usually a two assist for bathing and required staff to do the entire task. Tenant C1 did not like bathing. She said three people were used on 11-22-20. She had hit, kicked and pulled staffs' hair. One person assisted with washing her, one person tried to calm her down and one person dried her off. The Former ADON was informed multiple times that Tenant C1 was combative during bathing but nothing was done. Tenant C1 was not appropriate for the Program and staff did not have the proper training to take care of her. Staff did the best they could. Tenant C1 took away time from other tenants as it took two people to assist with her cares. Staff I said in October/November 2020 timeframe she reported a bruise on either the top of the tenant's hand or wrist to the medication passer.

When interviewed Staff J said Tenant C1 normally took three staff to shower due to her combativeness. The former ADON was made aware of the issues regarding the tenant and her resistance to bathing. Staff J said she felt bad for Tenant C1. Staff were not aggressive with Tenant C1 in the shower but did sometimes have to hold

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A 160	Continued From page 8 her hands or feet down in order to block the tenant form hitting and kicking them. She felt staff did everything they could for the tenant and said it was better when hospice became involved. When interviewed Staff K said it took at least two staff to bathe the tenant, and a third staff would be called if needed. She said one staff would wash her, one staff held her hands and one staff held her feet so she couldn't hit or kick. It was not done aggressively and there were no injuries to her. The former ADON and former Unit Director were told it was not fair to Tenant C1 or to staff. Soon after, hospice started her bathing tasks. When interviewed the former ADON said everyday was different with Tenant C1 and she was not aware of how many staff it took to bathe her. She had no knowledge of any bruising on the tenant, and none was reported to her. She could not recall if staff had apprised her of Tenant C1 being combative during bathing. She was not aware and did not remember if any staff held Tenant C1's feet or arms during bathing. In summary, Tenant C1 had a diagnosis of late stage Alzheimer's without behavioral disturbances and had severe to very severe cognitive decline. Tenant C1 required more than one staff for cares including bathing, and could be combative during cares. Her service plan indicated she was resistive to cares and might refuse bathing. Staff was to re-approach or try another person. An as needed medication was also available to administer. Staff indicated it took more than one staff to bathe Tenant C1 and at times it took three staff. Staff held or blocked her feet and hands to prevent her from kicking or hitting staff. On 11-22-20, three staff bathed Tenant C1, who as	A 160		

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A 160	Continued From page 9	A 160		

the incident report indicated, was completely resistive, hit staff throughout the shower and screamed the entire time. Staff said they did the best they could, Tenant C1 was not appropriate for the level of care and it was not fair to her or they felt bad for her. The interventions listed on the service plan were not followed. Staff went to the nursing staff regarding Tenant C1's resistance to cares, including bathing, but no further interventions were provided to staff to be able to safely provide appropriate bathing services for Tenant C1. Tenant C1 did not received services that were adequate and appropriate.

2. Review of Resident C2's record on 9-13-21 revealed diagnoses including dementia of Alzheimer's type, anxiety disorder and depression. Tenant C2 was staged at a five to six on the GDS, which indicated moderately severe to severe cognitive decline. The service plan updated on 7-20-20 reflected Tenant C2 was independent with ambulation.

Nurse's Notes dated 8-21-20 indicated Tenant C2 had increased agitation and ran outside. She turned quickly and fell onto the patio. Tenant C2 was able to move all extremities and had no complaints of pain. Range of motion (ROM) was normal, there was no shortening or outward turn of the foot or hip. Tenant C2 hit her head on the chair but there was no bump. She refused to have her blood pressure taken. There was no increased confusion or blurred vision. Tenant C2's provider and family were notified. On 8-24-20 (late entry for 8-21-20) it was noted staff called the former ADON and said Tenant C2 had bit, yelled and kicked staff. She was upset with the gait belt and did not want it on. Tenant C2 continued to be abusive to staff and hit staff

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A 160	Continued From page 10 across the face and kicked staff. Tenant C2 stood up from the table and walked toward her apartment. Staff tried to get her to wait for staff assistance and she dug her nails into staff's arm. Tenant C2 wanted to go to the restroom and two staff attempted to walk to the apartment with her and she continued to dig her nails into staff and pushed staff against the walls while hitting and kicking them. Staff got a wheelchair. Tenant C2 stood up independently without assistance to the toilet. Tenant C2 yelled, hit and kicked staff. Tenant C2 was sent out to the hospital. Review of a Fall Scene Investigation Report dated 8-21-20 at 3:30 p.m. indicated Tenant C2 ran outside and staff tried to catch her. When staff yelled her name, she turned around quickly and fell. She hit her head on the chair after she was on the ground. Interventions to prevent future falls included assistance of one staff as to ambulate as well as a gait belt for the rest of the night. The report indicated Tenant C2's temperature was 98 degrees, pulse was 100, respiration rate was 30, oxygen saturation was 96% and blood pressure was refused. There was a bruise on the right elbow and skin tear on the right elbow. The report was signed by Staff G. The report indicated Staff H was present when Tenant C2 fell. An Incident Report dated 8-21-20 at 4:45 p.m. indicated staff (unnamed) came to Staff G and reported Tenant C2 hit her across the face. The same staff came to her again and reported Tenant C2 kicked her. Tenant C2 had gotten up from the table and started walking independently, stating she needed to use the bathroom. Staff (unnamed) tried to redirect her to wait for assistance. Tenant C2 dug her nails into staff (unnamed) and yelled at them saying she needed	A 160		

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A 160	Continued From page 11 to go to the bathroom. Two staff walked the tenant down the hallway using a gait belt. Tenant C2 hit, kicked and dug her nails into staff. When walking down the hallway she bumped staff into the wall. Tenant C2 was put into a wheelchair and staff (unnamed) took her to her apartment to use the bathroom. Tenant C2 yelled at staff (unnamed) to get out and said she could do it. Tenant C2 stood up with the bar in the bathroom independently. Tenant C2 yelled, hit, kicked staff and could not be redirected. The witness statement section completed by Staff J indicated Tenant C2 was upset and did not understand why the gait belt was on. She screamed "uncontrollably" and was hitting. A wheelchair was called for and she started to calm down. Tenant C2 stood up on her own and went to the bathroom independently. When interviewed Staff H said Tenant C2 started to run, went outside, got scared, turned around and fell on the ground. The former ADON (Assistant Director of Nursing) and two other staff came outside. They got the tenant up forcefully. They grabbed her leg and aggressively straightened it out. She was taken inside. A gait belt being utilized was pulled on aggressively. The former ADON and someone else took the tenant back to her apartment and they had her up against the wall. They tried to get her into a wheelchair. They were screaming at the tenant who was screaming at them. Staff L had reported to her staff were rude and forced the tenant to get on the toilet and aggressively removed her clothes. Staff H said she could hear Tenant C2 screaming in the dining room and tenants without cognitive impairment heard her screaming across the building. An ambulance was called and Tenant C2 was sent out but not for her injuries. Staff H said Tenant C2 had hit her head and the	A 160		

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A 160	Continued From page 12 former Unit Director grabbed ice and slapped the ice on the back of her head in an aggressive manner. Staff H wondered why Tenant C2 was forced to go to the bathroom. She said she wrote statements including for the police. A Police Department Voluntary Statement (undated) completed by Staff H indicated Tenant C2 went out the door to the patio. Staff H responded, said her name, she turned out and fell. Tenant C2 landed on her hips and hit her head. The bosses ran out and called her stupid. An assessment was not completed. They aggressively brought her back inside and forced her to sit down. Tenant C2 was crying out in pain. They said the tenant was aggressive and refused her vitals, even though they did not ask if they could take them. It was obvious she was in pain. Staff G and the "supervisor" gave her a prn (as needed) medication. Staff H told them the tenant had hit her head and the former Unit Director smacked an ice pack on her head and said, "Now it's red." Tenant C2 said she had to go to the bathroom and Staff H began to get her up. The former Unit Director and the former ADON aggressively tightened her gait belt and she screamed "I can't breathe" and "Stop. You're killing me." They pulled it tighter and yanked her up. They told Staff H to back off. They then yanked the tenant down the hallway. During this time the tenant fell back against Staff J who then claimed the tenant was being aggressive. Staff H said the tenant was not aggressive but was resistive and having trouble walking. The staff called for a wheelchair and pinned the tenant against the wall until one was brought. They slammed the tenant into the wheelchair. Tenant C2 screamed for help. They took her to the bathroom and Staff H did not witness the rest. When Tenant C2 came back out she was	A 160		

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A 160	Continued From page 13 screaming and sobbing. When interviewed Staff L said she remembered Tenant C2 fell on the cement. Staff had said her name and she turned and had fell. She was brought inside by the former Unit Director and former ADON. There were no proper vitals taken and she was not checked. They yelled at the tenant and told her she was being dramatic. Staff J was also present. The former ADON and Staff J used a gait belt to take her to the bathroom in her apartment. The strap of the gait belt was above the tenant's head. Tenant C2 grabbed onto the railing but was told she had to walk. Tenant C2 cried a lot and said it hurt. Staff L was following behind them with a wheelchair. The tenant was taken into the bathroom and told she had to sit down. They "kind of forced her to sit." Tenant C2 kept screaming. After the tenant was done in the bathroom Staff J got a wheelchair and put her in it. Tenant C2 kept screaming asking for help. Tenant C2 was sent to the hospital. A Police Department Voluntary Statement dated 8-22-20 written by Staff L indicated on 8-21-20 at approximately 3:00 p.m. a tenant tried to leave the building out of the back door, fell and hurt her hip. The bosses were treating her horribly and said she was being dramatic. Staff L was not present at the beginning of the incident but was there when they put the gait belt on the tenant. The gait belt was incredibly tight. The tenant begged for the belt to be removed but Staff J just tightened more. Staff then brought the tenant up to common area in a wheelchair and she screamed for help. The ambulance and police came and took her in. When interviewed Staff G said she remembered Tenant C2 falling outside on the patio. Staff G	A 160		

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A 160	Continued From page 14 was not outside at that time. The former Unit Director and former ADON assessed her. There was someone else, possibly one to two aides, who walked the tenant back into the building. Tenant C2 was seated in the dining room. Staff G attempted to take her blood pressure but she refused. She had a bump on the back of her head and someone gave her ice for it. They tried to have the tenant go to the bathroom. The tenant got up and she (Staff G) and Staff J tried to walk her back but she did not want staff to touch her so they let her use the railing. The gait belt was put on when she was outside on the patio. Staff G could not recall the placement of the gait belt on the tenant. During this time period Tenant C2 screamed and yelled at Staff G and Staff J. She did not want to staff to touch her so staff got a wheelchair when she decided she was not going to walk anymore. Staff tried to help her in the bathroom. Staff J was with the tenant who proceeded to hit and kick Staff J. The former ADON called the hospital and sent Tenant C2 out. Staff G said staff did not push, pull or drag Tenant C2 with the gait belt and were not aggressive with the gait belt. Some staff went to the police department and said she (Staff G) and Staff J were mean to Tenant C2. She said there were no concerns with Tenant C2's treatment and staff did the best they could. Staff G gave Tenant C2 ½ of a Lorazepam and signed it out. The former ADON said to give her one after the fall. When interviewed Staff J said she heard over the radio that Tenant C2 had fallen on the patio. Range of motion (ROM) was completed by the former ADON and Staff G got a gait belt. The tenant was assisted up and walked inside. The gait belt was on her from the fall outside. When she got to the first apartment in the hall staff could not hold onto her anymore and Staff J got a	A 160		

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A 160	Continued From page 15	A 160		

wheelchair. Tenant C2 started flipping out. It was Staff G and her (Staff J) who assisted the tenant into the wheelchair. The former ADON and some other staff were present as well. After Tenant C2 sat in the wheelchair she said "you hurt me" and tried to get out of the wheelchair. Staff J said Tenant C2 had high anxiety and everything was very dramatic with her. Staff J said she did not observe any staff pushing, pulling, or dragging Tenant C2 with the gait belt.

When interviewed the former ADON said she remembered it was second shift when Tenant C2 ran out and fell on the patio. She went outside and saw the tenant sitting on the patio. She could not recall who else was present. Tenant C2 was able to move all extremities. She was helped up and brought back inside. She said she did not remember what happened next but remembered Tenant C2 kicking the staff. She believed the tenant had a gait belt on when on the patio, but did know who put the gait belt on. She did not observe staff take her to the apartment. She did not remember if she provided assistance in Tenant C2's apartment. She did not remember if any staff came to her with concerns regarding the incident. She did not observe any staff being aggressive to the tenant. When she called the hospital to check on her, they would not give her any information about the tenant.

When interviewed the former Unit Director said she could not remember anything as it was too long ago. She did remember Tenant C2 had a fall on the patio but could not remember the specifics. She said she responded to the fall, but could not remember if Tenant C2 had injuries. She did not recall any details after the fall. She did not remember if Tenant C2 had any behaviors that day; however, said Tenant C2 had a

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A 160	Continued From page 16 tendency to display behaviors. When asked if she observed any staff pulling or dragging the tenant with the gait belt she said she couldn't remember but found it hard to believe as staff treated the tenants well. Review of fire department records revealed they were dispatched to the program on 8-21-20 for an out of control patient. Police were present. The patient was identified as Tenant C2. The narrative indicated Tenant C2 was sitting outside with a female when they arrived. Tenant C2 complained that her left "him" (hip) hurt from a fall and staff had been picking on her, holding her down, and not allowing her to move. Staff reported Tenant C2 was supposed to be moved with staff assistance and a gait belt and had been observed multiple times trying to move without help. Staff reported a fall occurred when Tenant C2 was trying to leave the building and turned and fell. Staff reported she was evaluated after the fall and she kicked one of the staff with her left leg. Hospital records indicated Tenant C2 presented with pain after a fall on 8-21-20 and was admitted for a left femoral neck fracture. She fell backwards onto her hip while attempting to hit staff or escape from them. She fell on the ground and was helped back up. She had increased behaviors and was transported to the hospital for a psych evaluation. Tenant C2 complained of leg hip and leg pain. The hip fracture was not surgically repaired and Tenant C2 transferred to inpatient hospice. The documentation indicated Tenant C2 was normally ambulatory. She fell and had difficulty ambulating "secondary to hip pain." Diagnoses also included acute cystitis with hematuria. A Preliminary Medical Examiners Report	A 160		

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A 160	Continued From page 17 indicated Tenant C2 died on 8-25-20. The manner of death was an accident. The probable cause of death was physical deconditioning due to a fall with a left hip fracture. A contributing factor was dementia. The Narrative Summary indicated on 8-26-20 the former Unit Director reported Tenant C2 had tried to leave three times prior and ran out of the door and fell. She landed on her buttocks and hit her head on the chair. The former Unit Director assessed her and she was in her "normal mental state" and ROM was normal. Tenant C2 refused blood pressure and a gait belt. Tenant C2 had no complaints of pain and walked to a chair in the dining room. She got up from the chair and went to the other side of table. She needed to use the restroom and staff attempted to assist her with a gait belt which she refused. A wheelchair was used to get her to her apartment. Tenant C2 transferred independently to the toilet and back to the wheelchair. Tenant C2 hit and kicked staff while they assisted her and was sent out for her behaviors. Review of Termination Notices revealed Staff H and Staff L were terminated on 8-25-20 for insubordination, violation of rules and dishonesty. In summary, Tenant C2 had diagnoses that included Alzheimer's type, anxiety disorder and depression and she had moderately severe to severe cognitive decline. Her service plan indicated to allow Tenant C2 to de-escalate in her apartment and to check on her every 10 to 15 minutes. Tenant C2, who was independent with ambulation without an assistive device, fell outside on 8-21-20. Program documentation indicated after the fall, Tenant C2 got up from a table and started to walk as she needed to use the restroom. Staff tried to walk her down the hallway but she did not want the gait belt on.	A 160		

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A 160	Continued From page 18 Tenant C2 dug her nails into staff and hit and kicked staff. It was noted in Program documentation that Tenant C2 pushed staff against the wall and hit staff across the face. Staff got a wheelchair for the tenant and took her to the bathroom. The incident report indicated Tenant C2 screamed uncontrollably. Staff said Tenant C2's screaming could be heard in the dining room and tenants from the other side of the building heard the screaming. Staff said Tenant C2 was grabbing onto the railing and was told she had to walk and was crying a lot and said it hurt. A Fire Department report indicated when they arrived Tenant C2 complained that staff had been "picking on her, holding her down, and not allowing her to move." Tenant C2 displayed combativeness, verbalized pain and resisted the care provided. Tenant C2 did not receive services that were adequate and appropriate.	A 160		
A 290	481-67.5(2)g Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: g. Narcotics protocol, including destruction and reconciliation, shall be determined by the program's registered nurse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure the medication policy and procedure was followed regarding medication administration and narcotics destruction for 1 of 3 former tenants reviewed (Tenant C2). Findings follow:	A 290	Promise House will continue to comply with the medication policy. Compliance shall be maintained by the QA committee periodically reviewing the narcotic protocol to assure correct policies are being followed.	11/19/2021

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A 290	Continued From page 19 On 9-13-21 review of Tenant C2's file revealed Physician's Orders indicating the following - Lorazepam 0.5 milligram (mg) tablet, 1/2 tablet orally, four times per day (with 0.5 mg to equal 0.75 mg). - Lorazepam 1 mg tablet, 1/2 tablet orally, four times per day (with 0.25 mg dose to equal 0.75 mg) - Lorazepam 0.5 mg tablet, 1 tablet orally, twice daily as needed (PRN) A Fall Scene Investigation Report dated 8-21-20 indicated Tenant C2 ran out the door at 3:30 p.m. Staff yelled her name, she turned around and lost her balance. She hit her head on a chair when on the ground. The cause of the fall was indicated as running and turning too fast and increased anxiety and agitation. When interviewed Staff G reported she was told to give Tenant C2 a PRN after the fall on 8-21-20. She gave her Lorazepam, which she signed out. Review of the MAR for August 2020 and the Control Utilization Record did not reveal documentation of the dose of the PRN Lorazepam given to Tenant C2 post fall as reported by Staff G. The last recorded dose of the PRN Lorazepam on 8-21-20 was at 9:30 a.m. In addition, the Control Utilization Record reflected on 8-21-20 at 9:40 a.m. 0.25 mg (1/2 of a 0.5 mg tablet) was wasted by the former Unit Director (one staff only). Review of the Program's policy and procedure regarding medications reflected narcotics were to be destroyed by two staff, including at least one nurse. The medication policy indicated staff would note on the MAR when medication was taken or	A 290		

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A 290	Continued From page 20 refused. When interviewed on 9-23-21 at 9:00 a.m. the Unit Director confirmed narcotic medications should be destroyed by two staff.	A 290		
A 355	481-67.9(4)d 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: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide nurse delegated training regarding service plan tasks, including catheter care, to 3 of 6 staff reviewed (Staff A, D and E). Findings follow: On 9-9-21 review of Tenant #2's file revealed service plans dated 8-6-21 and 9-9-21 reflected staff was to provide catheter and perineal care on each shift. The catheter bag was to be emptied once per shift and as needed. Staff documented intake and output and the drainage bag was to be kept below the level of the bladder. On 9-8-21 review of training documents revealed the following:	A 355	Promise House will continue to assure that nurse delegation procedures are being followed. The QA committee will review all nurse delegation tasks to assure compliance is being maintained.	11/19/2021

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A 355	Continued From page 21 - Staff A was re-hired on 7-19-21. Nurse delegated training was not completed with her current employment. Previous nurse delegated training dated 2-14-21 was provided. The nurse delegated training did not include catheter care. - Staff D was hired on 5-17-21 and nurse delegated training was documented on 6-7-21. The nurse delegated training did not include catheter care. - Staff E was hired on 2-2-21 and nurse delegated training was documented in February 2021. The nurse delegated training did not include catheter care. When interviewed on 9-23-21 at 9:00 a.m. Unit Director stated Staff A, D, and E assisted with catheter care and confirmed the above finding.	A 355		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall 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, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as	A 145	Promise House will continue to evaluate Tenants annually or with a significant change. Compliance shall be maintained by the QA committee reviewing Tenant records to assure compliance.	11/19/2021

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A 145	Continued From page 22 needed with significant change for 1 of 3 current (Tenant #1) and one of three former (Tenant C1) tenants reviewed. Findings include: 1. Review on 9-8-21 of Tenant #1's file revealed diagnoses including lewy body dementia. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Nurse's Notes indicated the following: - On 8-25-21 it was noted Tenant #1 was throwing things, had ripped the towel bar off of the wall and was hitting things with it. Tenant #1 held the towel bar up at staff and told them to get off of his property. Staff left and called the Unit Director. As the Unit Director was on her way to the building, staff called back and said Tenant #1 had come out of his apartment, ripped a decorative bat and decorative sign off the wall and walked down the hall and hit things. A shattering noise was heard and staff was told to call 911. An order was received to send Tenant #1 to the hospital. When the Unit Director arrived Tenant #1 was on the gurney. He had hit the thermostat and thermostat cover with the bat and broke it off the wall. He had also hit the exit sign and broke it off the wall. It was noted prior to the incident he was in the living room and said made a sexual comment to one of the staff and touched her leg. Staff directed Tenant #1 to his apartment. He was in the apartment for about 30 minutes before the disturbance began. - On 8-30-21 it was noted Tenant #1 returned to the Program from the hospital. - On 9-8-21 it was noted Tenant #1 was not eating and had two emesis that weekend. His spouse reported he started not eating when he went to the hospital. On 9-4-21 staff was getting Tenant #1 ready for bed and he made a sexual	A 145		

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comment towards staff and grabbed her breast. Staff redirected him by continuing to help him change his clothes.
- On 9-8-21 it was noted Tenant #1 drank his supplement and took a few bites of tomato soup. Tenant #1 had a 12 pound weight loss from the previous week.

A weight document provided by the Program indicated Tenant #1 had a 37 pound weight loss from his pre-admission screen (August 2021 at 295 pounds) to the most current weight (on 9-14-21 at 258 pounds).

No evaluations completed with significant weight loss, sexual comments towards staff or aggressive behavior could be located.

2. Review of Tenant C1's file on 9-13-21 revealed diagnoses including late stage Alzheimer's without behavioral disturbances. Tenant C1 was staged at a six to seven on the GDS, which indicated severe to very severe cognitive decline.

A review of fax communication documents to the primary care provider indicated the following:
- On 10-15-20 an order was received for a front wheeled walker.
- On 10-16-20 Tenant C1 refused staff assistance with ambulation to the bathroom. Staff was by her side but were unable to assist her due to Tenant C1 being resistant and striking out. She required additional staff to complete her morning cares.
- On 10-26-20 Tenant C1 hit staff, slammed her walker into the wall and grabbed staff's arms and twisted them. Tenant C1 was not easily redirected and required one to one supervision much of the time.
- On 10-26-20 Tenant C1 had a couple of

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A 145	Continued From page 24 incidents that caused concern and fear from the other tenants and staff. She threw her walker at staff, attempted to hit staff with her walker and kicked staff. The walker was taken away from her. - On 11-4-20 it was noted staff had not been ambulating Tenant C1 recently but used the wheelchair for mobility. - On 11-22-20 it was noted Tenant C1 continued to refuse cares and it took three staff in the shower for staff and her safety. She hit a staff member in the jaw and spit at them. She refused her oral cares and refused to let staff change her and complete perineal cares. - On 12-1-20 it was noted "We are kind of at the end of our ropes" with Tenant C1. She was constantly combative including hitting, kicking, biting and resisting cares. She required two staff for cares and refused meals. - On 12-3-20 it was noted Tenant C1 required a two staff assist for safety and refused to walk at times. Tenant C1 was hitting and kicking at staff. It was being evaluated if she needed a higher level of care. - On 12-7-20 it was noted Tenant C1 lost the ability to feed herself and had a difficult time drinking. Evaluations were completed on 10-5-20 and 12-9-20. However evaluations could not be located as needed with significant change including with increased care needs, increased behaviors, loss of ability to feed herself or changes in mobility. 3. When interviewed on 9-23-21 at 9:00 a.m. the Unit Director confirmed these findings.	A 145		

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A 350	Continued From page 25	A 350		
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 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 interview and record review the Program failed to update service plans as needed for 2 of 3 current (Tenants #1 and #3) and 3 of 3 former (C1, C2 and C3) tenants reviewed. Findings follow: 1. Review of Tenant #1's file on 9-8-21 revealed a diagnoses of lewy body dementia. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Nurse's Notes indicated the following: - On 8-25-21 Tenant #1 was throwing things, had ripped the towel bar off of the wall and was hitting things with it. Tenant #1 held the towel bar up at staff and told them to get off of his property. Staff left and called the Unit Director. As the Unit Director was on her way to the building, staff called back and said Tenant #1 had come out of his apartment, ripped a decorative bat and decorative sign off the wall and walked down the hall and hit things. A shattering noise was heard and staff was told to call 911. An order was received to send Tenant #1 to the hospital. When the Unit Director arrived Tenant #1 was on the gurney. He had hit the thermostat and thermostat	A 350	Promise House will continue to develop service plans that meet the Tenant needs. Compliance shall be maintained by the QA committee reviewing the service plans to assure the service plans are being done correctly.	11/19/2021

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A 350	Continued From page 26 cover with the bat and broke it off the wall. He had also hit the exit sign and broke it off the wall. It was noted prior to the incident he was in the living room and said made a sexual comment to one of the staff and touched her leg. Staff directed Tenant #1 to his apartment. He was in the apartment for about 30 minutes before the disturbance began. - On 8-30-21 Tenant #1 returned to the Program from the hospital. - On 9-8-21 Tenant #1 was not eating and had two emesis that weekend. His spouse reported he started not eating when he went to the hospital. On 9-4-21 staff was getting Tenant #1 ready for bed and he made a sexual comment towards staff and grabbed her breast. Staff redirected him by continuing to help him change his clothes. - On 9-8-21 Tenant #1 drank his supplement and took a few bites of tomato soup. Tenant #1 had a 12 pound weight loss from the previous week. The tenant's service plan dated 8-18-21 was not updated to reflect Tenant #1's sexual comments towards staff, aggressive behavior or weight loss. 2. Review of Tenant #3's file on 9-9-21 revealed a fax to the primary care provider (PCP) dated 7-7-21 indicating there was a red area on the top of his foot that was hard. Orders were received to apply a padded Opsite, to the reddened area on the left foot and change every other day and as needed. An order was also received for a corn cushion to the area on the lateral 5th digit of the left foot to be changed every other day and as needed. The orders were dated 7-7-21. Continued record review revealed the service plan did not reflect the affected areas on Tenant	A 350		

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A 350	Continued From page 27 #3's foot or the treatment. 3. Review of Tenant C1's file on 9-13-21 revealed a diagnosis of late stage Alzheimer's without behavioral disturbances. Tenant C1 was staged at a six to seven on the GDS, which indicated severe to very severe cognitive decline. A review of fax communication documents to the primary care provider indicated the following: - On 10-15-20 an order was received for a front wheeled walker. - On 10-16-20 Tenant C1 refused staff assistance with ambulation to the bathroom. Staff was by her side but were unable to assist her due to Tenant C1 being resistant and striking out. She required additional staff to complete her morning cares. - On 10-26-20 Tenant C1 hit staff, slammed her walker into the wall and grabbed staff's arms and twisted them. Tenant C1 was not easily redirected and required one to one supervision much of the time. - On 10-26-20 Tenant C1 had a couple of incidents that caused concern and fear from the other tenants and staff. She threw her walker at staff, attempted to hit staff with her walker and kicked staff. The walker was taken away from her. - On 11-4-20 it was noted staff had not been ambulating Tenant C1 recently but used the wheelchair for mobility. - On 11-22-20 it was noted Tenant C1 continued to refuse cares and it took three staff in the shower for staff and her safety. She hit a staff member in the jaw and spit at them. She refused her oral cares and refused to let staff change her and complete perineal cares. - On 12-1-20 it was noted "We are kind of at the end of our ropes" with Tenant C1. She was	A 350		

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A 350	Continued From page 28	A 350		

constantly combative including hitting, kicking, biting and resisting cares. She required two staff for cares and refused meals.
- On 12-3-20 it was noted Tenant C1 required a two staff assist for safety and refused to walk at times. Tenant C1 was hitting and kicking at staff. It was being evaluated if she needed a higher level of care.
- On 12-7-20 it was noted Tenant C1 lost the ability to feed herself and had a difficult time drinking.

Further record review revealed signed service plans were dated 10-5-20 and 12-9-20. Neither service plan was updated to reflect increased care needs, increased behaviors with cares, loss of ability to feed herself or changes in mobility.

4. Review of Tenant C2's record on 9-13-21 revealed diagnoses including dementia of Alzheimer's type, anxiety disorder and depression. Tenant C2 was staged at a five to six on the GDS, which indicated moderately severe to severe cognitive decline.

A 90 day nurse review dated 6-18-20 indicated, "She will hit and kick staff with attempts to redirect at times, other times redirects quickly."

Review of Incident Reports revealed the following:
- On 6-27-20 Tenant C2 was upset about her pants being too tight and staff asked her if she wanted to walk to her apartment. Staff walked with Tenant C2 back to her apartment and she began to squeeze staff's hand tightly and hit staff's arm. Staff explained her pajamas would be more comfortable and had to remove her keys from the door. Tenant C2 became "hysterical" and shoved staff. She tried to pull staff while walking

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A 350	Continued From page 29 away. Staff called for assistance. - On 8-21-20 staff said Tenant C2 hit her across the face and kicked her. Staff got her up from the table and she walked by herself. Staff tried to redirect her to wait for assistance and she dug her nails into staff and yelled at staff. Staff walked her down the hallway with a gait belt. Tenant C2 was hit, kicked and dug her nails into staff. She bumped staff into the wall. Tenant C2 was put into a wheelchair and taken to the bathroom. Continued record review revealed the service plan did not reflect Tenant C2's physical behaviors and interventions related to the behaviors. 5. Record review on 9-13-21 revealed Tenant C3 had a diagnoses of Alzheimer's dementia and was staged at a six on the GDS, which indicated severe cognitive decline. Review of Incident Reports revealed the following: - On 8-14-21 Tenant C3 punched staff in the stomach with his fist. Staff was in pain all night. - On 8-15-21 Tenant C3 had gone into another tenant's apartment, urinated on the floor and sat in the recliner. Staff tried to get Tenant C3 to leave the other tenant's apartment and noted his arm was bleeding from a previous spot. Staff attempted to put a wash cloth on his arm and he tried to hit staff again. - On 8-16-21 Tenant C3 became agitated and grabbed staff's arm and struck out. He grabbed staff's shirt and hit staff in the neck with a fist. He was redirected to the bed. Tenant C3 attempted to kick while the staff was trying to get released from him. A Staff Communications Report dated 8-11-21	A 350		

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A 350	Continued From page 30 indicated Tenant C3 attempted to hit staff with a lamp. A Staff Communications Report dated 8-16-21 at 7:00 a.m. indicated Tenant C3 was hitting staff with towel rack that was broken off the wall. Tenant C3's Nurse's Notes indicated the following: - On 8-12-21 staff called the Unit Director regarding Tenant C3 being aggressive. When the Unit Director arrived he was calm. Staff reported she was standing in the doorway of the middle of the building. Tenant C3 walked up and grabbed the newspaper and hit staff across the face with it. - On 8-14-21 staff called the Unit Director regarding Tenant C3. Staff had tried to direct him to his bed and he got angry and tried to hit her. She left the room and when she returned he was on the floor and his chair was laying on the side. - On 8-16-21 Tenant C3's PCP was called and updated on behaviors. An order was received to send him to the hospital. Continued record review revealed the service plan did not reflect Tenant C3's physical behaviors or interventions. 6. When interviewed on 9-23-21 at 9:00 a.m. Unit Director confirmed these findings.	A 350		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other	A 355	Promise House will continue to develop service plans that meet the Tenant needs. Compliance shall be maintained by the QA committee reviewing the service plans to assure the service plans are being done correctly.	11/19/2021

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A 355	Continued From page 31 individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure preliminary service plans were signed by the tenant or tenant's legal representative prior to signing the occupancy agreement for 2 of 3 tenants reviewed (Tenants #1 and #2). Findings follow: Review on 9-8-21 of Tenant #1's file revealed an admission date of 8-23-21. The service plan was developed and signed by the Unit Director on 8-18-21. The occupancy agreement was signed on 8-23-21. The service plan was not signed by Tenant #1 or a legal representative. Review on 9-9-21 of Tenant #2's file revealed an admission date of 8-9-21. The service plan was developed and signed by the Unit Director on 8-6-21. The occupancy agreement was signed on 8-9-21. The service plan was not signed by Tenant #2 or a legal representative prior to signing the occupancy agreement. When interviewed on 9-23-21 at 9:00 a.m. the Unit Director confirmed the above finding.	A 355		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or	A 465	Promise House will continue to employ staff who are trained adequately to handle food safety. Compliance shall be maintained by the QA committee periodically reviewing employee files to assure adequate training is being done.	11/19/2021

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A 465	Continued From page 32 both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure orientation on sanitization and safe food handling was completed by 2 of 6 staff reviewed prior to handling food (Staff A and Staff C). Findings follow: Review of Staff A's training documents on 9-8-21 revealed a hire date of 7-19-21. Staff A had a food safety training dated 11-4-20 with a previous employment; however, did not have an orientation on food safety prior to handling food with her current employment. Review of Staff C's training documents on 9-8-21 revealed a hire date of 2-17-21. Staff C had a food safety training dated 7-13-19 with a a previous employment; however, did not have an orientation on food safety prior to handling food with her current employment. When interviewed on 9-23-21 at 9:00 a.m. the Unit Director stated Staff A and Staff C prepared and served food and confirmed the above finding.	A 465		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either	A 545	Promise House will continue to employ individuals who have received the required dementia training. Compliance shall be maintained by the QA committee by reviewing employee files.	11/19/2021

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A 545	Continued From page 33 employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure eight hours of dementia-specific training was completed within 30 days of hire for 3 of 6 staff reviewed (Staff A, C and D) Findings follow: Review of Staff A's training documents on 9-8-21 revealed a hire date of 7-19-21. Staff A did not have eight hours of dementia specific education completed within 30 days of employment. Review of Staff C's training documents on 9-8-21 revealed a hire date of 2-17-21. Staff C did not have eight hours of dementia-specific education completed within 30 days of employment. Review of Staff D's training documents on 9-8-21 revealed a hire date of 5-17-21. Staff D did not have eight hours of dementia-specific education within 30 days of employment. When interviewed on 9-23-21 at 9:00 a.m. the Unit Director confirmed the above finding.	A 545		
A 565	481-69.30(5) Dementia Specific Education for Personnel 69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program	A 565		

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A 565	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure the dementia education staff received within 30 days of hire included hands on dementia training. This pertained to 2 of 3 staff reviewed who had eight hours of dementia education completed within 30 days of hire (Staff B and Staff F). Findings follow: Review of Staff B's training documents on 9-8-21 revealed a hire date of 6-22-21. Staff B had eight hours of dementia specific education completed within 30 days of employment; however, none of the training documented included hands on dementia training. Review of Staff F's training documents on 9-8-21 revealed a hire date of 7-13-21. Staff F had eight hours of dementia specific education completed within 30 days of employment; however, none of the training documented included hands on dementia training. When interviewed on 9-23-21 at 9:00 a.m. the Unit Director confirmed the above finding.	A 565		