IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 35306-C
Incident Intake #: 35174-I

October 17, 2011

Mr. James Hunter, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

RE: Final Incident & Complaint Investigation Report, Legacy Gardens, Iowa City, Iowa

Dear Mr. Hunter:

Enclosed is the **Final Incident & Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Incident & Complaint Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation & Complaint Investigation Report

Assisted Living Program:

James Hunter, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

Complaint Intake #: 35306-C
Incident Intake #: 35174-I

Dates of Investigation:

August 23, 24 & 25, 2011

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations. IAC r. 481-67.10(5). The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 481 IAC chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit and complaint investigation on-site visit was conducted at Legacy Gardens on August 23, 24 & 25, 2011. In preparing this report, the following information was considered:

Current Program Census:

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	37
Total Census of ALP:	37

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Program History – The program has not received any regulatory insufficiencies during this certification period.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Criteria for Exclusion of Tenants

Complaint Allegation #35306-C: It was alleged there were many tenants that could not do anything for themselves and required the assistance of more than one person for all cares.

- Monitoring Observation: Review of 11 current tenant files indicated none of the tenants exceeded the appropriate level of care. The Director of Nursing (DON) and the Executive Director (ED) stated none of the current tenants exceeded the appropriate level of care. Staff #2, #6, #7 did not identify any tenants that exceeded the appropriate level of care.

- Regulatory Insufficiency: None noted.

B. Service Plan

During the course of the investigation, the following information was obtained.

- Monitoring Observation: Tenant #2 (the Tenant), a 61 year old, was admitted on 5-25-11 and had a diagnosis of: Alzheimer's Dementia. The Tenant was staged a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. A service plan was not developed within 30 days of taking occupancy.

  Tenant #3 (the Tenant), a 79 year old, was admitted on 4-28-03 and diagnoses include: Werneke's Syndrome (Alcoholism), Acid Reflux, Anxiety and Vitamin Deficiency. The Tenant was staged at a five on the GDS, which indicated moderately severe cognitive decline. According to Clinical Notes dated 8-12-11, Hospice

services were discontinued on 8-15-11. A nurse review was completed related to the discontinuation of Hospice services; however, the service plan was not updated to reflect the change. The service plan was not updated as needed.

Tenant #4 (the Tenant), a 77 year old, was admitted on 6-6-11 and diagnoses include: Confusion/Paranoia. The Tenant was staged at a four on the GDS, which indicated moderate cognitive decline. A service plan was not developed within 30 days of taking occupancy.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3))

C. Medications

Complaint Allegation #35306-C: It was alleged narcotic counts were not completed and missing medications were covered up. It was alleged narcotic records and medications were destroyed.

- Monitoring Observation: Narcotic count sheets for the past three months were reviewed and were consistently documented. During a medication pass on 8-24-11 narcotic medications for two tenants were reviewed and the medications were all accounted for and the count was accurate. Staff #6 and Staff #7 stated narcotic counts were completed each shift. The ED stated medications were counted on each shift and there had been no issues. The DON stated medications were counted on each shift and there had been no issues. Narcotic records were available to the monitors for review and the narcotic medications observed were accounted for and accurate.

- Regulatory Insufficiency: None noted.

Complaint Allegation #35306-C: It was alleged medications were borrowed from tenants and given to other tenants. It was alleged names of the medication packs did not match the Medication Administration Records (MARs).

- Monitoring Observation: Staff #6 and Staff #7 reported medications were not borrowed from tenants and administered to other tenants. The DON and ED stated medications were not borrowed from tenants and administered to other tenants. A medication pass was observed and medications were not borrowed and administered to other tenants. The tenant names on the medication packs matched the tenant names on the MARs.

  Three family interviews were held. They reported the tenants received the cares and medications they requested.

- Regulatory Insufficiency: None noted.

During the course of the investigation, the following information was obtained.

- Monitoring Observation: A medication pass was observed by a monitor on 8-24-11 at 8:10 a.m. It was observed medications and treatments were not consistently

administered in the prescribed timeframe. For example, a supplement was ordered at 10:00 a.m. and was still not given at 12:55 p.m. A medication ordered at 7:00 a.m. before breakfast and was given at 8:50 a.m. after breakfast. At 10:15 a.m. Staff #7 was not done with the morning medication pass. Staff #7 stated she was not able to get medications administered within the two hour timeframe.

On 8-25-11, Staff #11 stated at 9:15 a.m. all morning medications were completed. She stated the DON and Assistant Director of Nursing (ADON) assisted her that morning.

On 8-24-11, Tenant #11 (the Tenant) refused medications and the medications were placed in a medication cup in the top drawer of the medication cart and were not identified at that time. There was another medication cup with four pills in the top drawer with no identification. At 3:00 p.m. a monitor observed the Tenant's refused medications were labeled and were in the drawer. The Tenant's refused medications and the unidentified medications were pointed out to the ADON, who took the medications and reported he would destroy the medications. On 8-25-11, the Tenant's refused medications were in a medication cup without identification and syringe of Senna was also unmarked.

On 8-24-11 it was observed Tenant #12 was administered Donepezil 5 mg during the morning medication pass. The label indicated the medication was to be administered at bedtime. The label was changed to morning.

According to the Program's Medication Policy medications must be administered within one hour before or after their prescribed time. Before and after meals orders must be administered as ordered.

- Regulatory Insufficiency: When medications are administered traditionally by the program: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

D. Nurse Review

During the course of the investigation, the following information was obtained.

- Monitoring Observation: Tenant #5 (the Tenant), an 83 year old, was admitted on 5-3-10 and diagnoses include: Alzheimer's Disease, Prostate Cancer, Hypertension (HTN) and Hyperlipidemia. The Tenant was staged at a six on the GDS, which indicated severe cognitive decline. A nurse review was not completed every 90 days.

  Tenant #6 (the Tenant), an 87 year old, was admitted on 3-27-09 and diagnoses include: Dementia, Hypothyroidism, Hyperlipidemia, Coronary Artery Disease, HTN and Gastro Esophageal Reflux Disease. The Tenant was staged at a six on the GDS, which indicated severe cognitive decline. According to an Incident Report dated 8-18-11, the Tenant was found on the floor during hourly checks. The Tenant had a bruise and big bump on the right eye and knee. There was no documentation in the Clinical Notes of the fall or injury. Nurse review was not completed as needed.

- Regulatory Insufficiency: If a tenant does not receive personal or health related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

E. Staffing

Complaint Allegation #35306-C: It was alleged nursing staff was not available in emergency situations and tenants were left for long periods of time until a nurse was reached. It was alleged a tenant was in distress and it took over 30 minutes to reach a nurse.

- Monitoring Observation: The Nurse on Call policy indicated a registered nurse or licensed practical nurse was on call for each campus 24 hours a day, seven days a week. The schedules for the past three months were reviewed and provided a schedule of rotating on call nursing coverage. Staff #6 stated the nurses were available when they were on call and there were no issues reaching a nurse. Staff #7 stated the nurses were available when they were on call. She had to wait about 20 minutes one time; however, normally they answered immediately. Three family interviews were held. They stated nursing services were available. Review of three months of incident reports indicated a nurse was consistently notified and contacted regarding incidents.

  A file was reviewed for Tenant #4 (the tenant). According to an Incident Report dated 8-3-11, the Tenant was found lying on the bathroom floor in his/her apartment. The report indicated the Tenant had been shaky for the past couple of weeks. The report also indicated the Tenant had been leaning to the left for a couple of days and asked staff to call his/her doctor. The Tenant complained of mild back pain. The report documented the DON was notified and she instructed staff to give the Tenant as needed Tylenol. The Tenant's family was also notified. According to Clinical Notes, a note was made regarding the Tenant's fall and complaint of chronic back pain.

  According to Clinical Notes dated 7-21-11, the Tenant came to the DON and was concerned about an increase in feeling anxious and the DON faxed a request for a medication change. An order was received to increase the Tenant's Ativan. On 7-28-11 the Tenant was seen by the Tenant's doctor, was sent to the emergency room and returned with medication changes. On 8-2-11 the Tenant reported he/she was still not feeling well and a fax was sent to the Tenant's doctor. Notes dated 8-3-11 indicated the doctor ordered Seroquel 50 mg in the AM and 25 mg in the PM and a Psych consult would be added.

- Regulatory Insufficiency: None noted.

Complaint Allegation #35306-C: It was alleged a staff member on third shift slept while on duty.

- Monitoring Observation: According to a statement, on 8-12-11 the DON was notified that Staff #9 was sleeping on the overnight shift. The ED was notified. They planned to come in on her next scheduled shift and terminate her immediately. Staff #9 did not show up for the next scheduled shift and therefore it was a no call no show and she was terminated. No tenants were harmed because there was an additional staff member on duty, according to the statement. The hourly checks were reviewed and were consistently documented as completed, including on third shift. The Program had a zero tolerance policy regarding sleeping while on the clock and it resulted in immediate discharge. Staff #9 had signed the zero tolerance policy. Staff #6 stated staff did not sleep on duty. Staff #7 said she heard Staff #9 slept on duty but did not witness it herself.

  Two staff members were scheduled on third shift. The Program was attended by at least one staff person awake and on duty in the approximate area.

  Three family interviews were held. They reported the tenants received the cares requested and there was sufficient staff to meet the needs of the tenants.

- Regulatory Insufficiency: None noted.

Complaint Allegation #35306-C: It was alleged staff was not trained appropriately, there was a high number of falls and no privacy was given.

- Monitoring Observation: Staff #2, #5, #6 and #7 had nurse delegation on personal and health related tasks. Staff #5 did not administer medications and did not have medication administration training. Staff was also trained on communication and tenant rights, incident reports, basic first aid, transfer and lifting techniques. Staff #6 and Staff #7 stated privacy was given to tenants. The monitors did not observe any issues with tenant privacy.

  Incident reports for the past three months were reviewed and falls were documented. Review of 11 current tenant files indicated if a tenant had a history of falls interventions were listed on the service plan.

- Regulatory Insufficiency: None noted.

Complaint Allegation #35306-C: It was alleged there had been an increase in Urinary Tract Infections (UTIs) due to lack of appropriate cares.

- Monitoring Observation: According to the DON three tenants had UTIs and peri-cares were completed appropriately. The ED stated there had been three to four tenants with UTIs and peri-cares were completed appropriately. Staff #6 stated peri-cares were completed appropriately. Staff #7 stated two tenants had UTIs and sometimes peri-cares were completed appropriately.

  Three family interviews were held. They reported the tenants received the cares they requested.

- Regulatory Insufficiency: None noted.

Complaint Allegation #35306-C: It was alleged hand washing was not a big concern.

- Monitoring Observation: Appropriate sanitation was observed during a medication pass. Staff #2, #5, #6 and #7 had nurse delegated training on hand washing. Staff #6 and Staff #7 stated hand washing was completed at appropriate intervals. The ED and the DON stated hand washing was completed at appropriate intervals.

- Regulatory Insufficiency: None noted.

Complaint Allegation #35306-C: It was alleged a staff member left half of the building unattended.

- Monitoring Observation: The schedule for the past three months and staff time records indicated the building was staffed with two staff on night shift. The night shift was from 11:00 p.m. to 7:00 a.m. and the staffing pattern on third shift was two staff. Staff #10's time records were reviewed. She was employed from 7-6-11 to 8-10-11. Time card records indicated she worked six night shifts from 7-17-11 to 7-30-11. Records indicated on she punched out between 6:00 a.m. and 6:08 a.m. on these shifts. Staff #5 and the DON provided coverage on these shifts, according to a record. For example, on 7-18-11 Staff #10 punched in at 10:50 p.m. and punched out at 6:08 a.m. Staff #5's time records showed on 7-19-11 she punched in at 5:40 a.m. Staff #6 and Staff #7 stated the building was not left with one person on duty. The DON and the ED stated the building was not left with one person on duty.

  Three family interviews were held. They reported the tenants received the cares they requested.

- Regulatory Insufficiency: None noted.

Complaint Allegation #35306-C: It was alleged tenants had fallen and been down all night.

- Monitoring Observation: Incident reports for the past three months were reviewed.

  A file was reviewed for Tenant #6 (the Tenant). An Incident Report dated 7-24-11, indicated staff completed hourly checks and found the Tenant sitting on the floor in front of his/her chair. No alarms were found on the Tenant and the Tenant was wet and had a bowel movement (BM). There were no visible injuries. The report indicated the Tenant seemed content being there as if he/she had been there a long time. A nurse was notified. Hourly checks were reviewed indicated the Tenant was checked hourly.

  Tenant #8 (the Tenant), an 81 year old, was admitted on 5-11-30 and had a diagnosis of: Dementia. The Tenant was staged at a six on the GDS, which indicated severe cognitive impairment. An Incident Report dated 7-24-11, the Tenant was found on the floor in his/her closet. The Tenant was incontinent of urine and had various scratches and bruises on his/her back. The Tenant was very sleepy, as if he/she had been there all night, according to the incident report. Hourly checks were reviewed

and indicated the Tenant was checked hourly. Bed and chair alarms were ordered on 7-26-11 due to increased falls, according to Clinical Notes.

Documentation indicated the hourly checks were consistently completed during this time period.

- Regulatory Insufficiency: None noted.

Complaint Allegation #35306-C: It was alleged tenants were ignored on third shift. It was alleged a tenant waited over an hour for assistance.

- Monitoring Observation: A file was reviewed for Tenant #6 (the Tenant). An Incident Report dated 7-24-11, indicated staff completed hourly checks and found the Tenant sitting on the floor in front of his/her chair. No alarms were found on the Tenant and the Tenant was wet and had a BM. The service plan indicated the Tenant was to have bed and chair alarms on all times. According to the report, no alarms were found on the Tenant, as required in the service plan, when hourly checks were completed.

  Tenant #10 (the Tenant), an 83 year old, was admitted on 11-23-10 and diagnoses include: Dementia, Benign Prostate Hypertrophy, Diabetes, HTN, Arthritis and Depression. The Tenant was staged at four on the GDS, which indicated moderate cognitive impairment. The Tenant reported he/she waited over an hour one to two times when he/she called for assistance. The Tenant reported more help was needed at night and the Tenant asked if the Program knew the monitors were coming because there seemed to be more help that week. The computer call system was reviewed for the tenant. The system showed some entries that exceeded 50 minutes for the Tenant in July 2011. Staff #2 stated everyone responded to the Tenant's pendant. Staff cancelled the neck pendant and not the wall pendant which showed no one responded. Staff #11 stated a week or two ago the Tenant's pendant went off and he/she did not need anything; however, the bathroom pendant was not turned off.

  Tenant #9 (the Tenant), a 97 year old, was admitted on 3-30-11 and diagnoses include: Dementia, HTN, Right Breast Cancer, Skin Cancer and Osteoarthritis. The Tenant was staged at a six on the GDS, which indicated severe cognitive decline. Clinical Notes dated 8-5-11 indicated a task sheet was initiated. The task sheets were reviewed and were incomplete. There were no records of the task sheet provided after 8-17-11 to the time of the investigation.

  Three family interviews and two other tenant interviews indicated there was enough staff to meet the needs of the tenants.

Incident Allegation #35174-I: The Program reported a tenant eloped and was returned to the Program by local police.

- Monitoring Observation: Tenant #1 (the Tenant), an 81 year old, was admitted on 11-20-10 and diagnoses include: Advanced Alzheimer's Disease, Chronic Diarrhea, Hyperlipidemia and HTN. The Tenant was staged at a five on the GDS, which indicated moderately severe cognitive decline. The Tenant was discharged on 7-28-11. Clinical Notes indicated on 3-5-11 the Tenant tried to climb out a window to

leave. On 3-8-11 the Tenant got up in the middle of the night and tried to leave. Staff redirected the Tenant back to bed. Evaluations were completed and the service plan was updated. The service plan dated 3-9-11 indicated the Tenant had an episode of exit seeking behavior. The service plan provided interventions regarding the exit seeking behavior.

According to an Incident Investigation Report, Staff #4 looked for the Tenant to take the Tenant to an activity at approximately 9:30 a.m. to 9:45 a.m. She was unable to locate the Tenant and notified Staff #1. Staff #1 came to the DON at approximately 10:00 a.m. and notified her that the Tenant was missing. One staff on each side started a room search and two staff went outside and started looking. The Tenant's family was called and asked if they had taken the Tenant out of the building. Family had not taken the Tenant out of the building. Executive staff searched for the Tenant, staff walked around the campus and drove their personal vehicles to look for the Tenant. It was reported the local police had the Tenant and they returned the Tenant to the Program at approximately 10:10 a.m. The Tenant was wearing appropriate clothes and was unharmed. The police had located the Tenant approximately four to five blocks from the Program.

According to an Incident Investigation Report, Staff #1 said the west lounge window alarm went off and when she checked the window it was open about a half inch. She closed the window at that time. The screen was found off during the search for the Tenant; however, Staff #1 did not see the screen was off when she checked the window alarm. Staff #5 said when the window alarm had gone off she was not sure which window it was and asked Staff #1 to check it. Staff #3 reported the window alarm went off and she communicated with Staff #1 and Staff #5. Staff #3 stated Staff #1 had checked the window and it was open about half an inch. Staff #2 reported the west lounge alarm had gone off.

Staff #1 stated a window alarm went off in the west side sitting area. The window was open approximately one to two inches and she closed the window. The screen was missing; however, she did not observe the screen was gone at that time. Staff #4 began looking for the Tenant. Staff searched the inside the building and then outside the building. The police found the Tenant and there was no harm or injury to the Tenant.

The DON stated at approximately 9:45 a.m. Staff #1 asked her if she had seen the Tenant. She asked her to do a building search. She had two staff search the grounds outside. Staff #4 notified the ED. A phone call was received and indicated the police had the Tenant. She said it was approximately 15 minutes from the time the Tenant left until he/she returned. She met the Tenant at the door and gave him/her water and checked the Tenant's vitals. She said it was very hot that day; however, there were no ill effects to the Tenant from the elopement. Immediately 15 minute checks were initiated, staff was re-trained on door alarms and the missing tenant policy. The window alarms were changed so the alarms did not clear but required staff to clear the alarms.

Documented check records for 7-19-11 indicated 9:00 a.m. and 10:00 a.m. checks were not documented as completed for the west side of the building. Tenant #1

resided on the west side of the building. Checks were not completed during the approximate timeframe of the elopement.

The Door and Window Alarms policy indicated all door and window alarms were responded to in three minutes. When a door or window alarm sounded a message was sent to all employee pagers with the location of the alarm. Staff responsible for the area in which the alarm sounded reported to the location immediately. If staff was unable to respond immediately staff would contact another staff member and request assistance. Staff would check the immediate area of the alarm, if the tenant was outside the secure area staff would redirect the tenant back into the secure area and reset the alarm. If the alarm was an external door or window alarm staff would complete a head count to ensure all tenants were accounted for. If a tenant was not located in the area surrounding the alarm staff would perform a complete head count to ensure all tenants were accounted for and reset the alarm.

Staff did not complete a head count of tenants to ensure all tenants were accounted for when the window alarmed sounded.

According to the Incident Investigation Report, staff was retrained on the alarm breach policies. Safety checks every 15 minutes were implemented for the Tenant. The Tenant's family had given a 30 day notice on 7-1-11.

On 7-19-11 at 9:00 a.m. the temperature was 86 degrees and the heat index was 98 degrees. At 10:00 a.m. the temperature was 89 degrees and the heat index was 103 degrees. There was no rainfall that day.

Review of checks for the Tenant indicated checks were consistently completed every 15 minutes. The Tenant was discharged on 7-28-11. Evaluations were completed and the service plan was updated and reflected the 15 minute checks.

The incident was reported to the Department and an incident report and investigation was completed.

Staff #1, #2, #3 and #5 received Performance Deficiency Notifications related to failing to perform duties or job assignment satisfactorily and efficiently regarding the window alarm in the west lounge went off and was not responded to in an appropriate time and the Tenant got outside through the window.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

F. Life safety

Complaint Allegation #35306-C: It was alleged the fire alarms were often not functional and in error status.

- Monitoring Observation: According to Fire Control System Reports, on 1-19-11 and 7-20-11 inspections were completed. Staff #8, the Maintenance Director, reported there had been no issues with the fire alarm panel. He said one time a tenant pulled

an alarm and staff did not have a key to reset the alarm. The ED said he was notified by phone that a tenant had pulled the fire alarm and he arrived in 40 minutes. The employees silenced the alarm and the fire department came out and checked. He went to the maintenance office, got the key and put the lever back up on the pull station. The alarm functioned during the time it took the ED to arrive. Keys for the pull station were located in the fire manual at the time of investigation, according to the ED. Staff #6 and Staff #7 reported the fire alarms functioned appropriately. The DON and ED indicated the fire alarms functioned appropriately.

- Regulatory Insufficiency: None noted.

G. Other

Complaint Allegation #35306-C: It was alleged gloves were not available to staff who administer medications. It was alleged equipment was not available.

- Monitoring Observation: A medication pass was observed and appropriate sanitation was observed. Staff #6 and Staff #7 reported supplies including gloves were available. Staff #6 and #7 reported equipment was available. The DON and ED stated gloves and equipment was available. Three family interviews were held. They reported supplies were available.

- Regulatory Insufficiency: None noted.

Complaint Allegation #35306-C: It was alleged tenants did not follow the non-smoking policy. It was alleged tenant smoking affected the staff.

- Monitoring Observation: Iowa Administrative Code Chapters 67 and 69 did not have rules that pertained to staff health concerns regarding tenant smoking. The staff smoking policy was reviewed and staff smoking was allowed in designated areas only. Staff was to use their rest periods for smoking. The Company's intent was to provide a safe and healthful work environment.

  The Tenant Smoking policy was reviewed. The purpose was to allow for tenant autonomy and to follow tenant's rights and wishes. Staff was to allow the tenant to go outside to smoke in the designated area when the tenant wished. Staff was to keep the tenant's lighter for safety. Staff was to provide the tenant with the lighter when they wished to go out to designated areas to smoke. Staff was to request the tenant to return the lighter to staff when they were done smoking and staff was to ensure they received the lighter. If staff had concerns regarding the safety of the tenant when he/she was smoking outside in designated areas staff was to notify the nurse immediately.

  A file was reviewed for Tenant #3 (the Tenant). The service plan identified the Tenant enjoyed going outside to smoke in the courtyard. Staff was to assist the Tenant with applying a smoke apron prior to going out to smoke in the courtyard. Staff was to give the Tenant three cigarettes per the Tenant's request and the lighter. Staff was to remind the Tenant to return the lighter as needed. Staff was to notify the

nurse if the Tenant had any difficulty lighting the cigarette, burning self or clothing, not giving the lighter back to staff or any other issues. The Tenant was observed smoking outside. He/she stated he kept his/her lighter and sometimes they took his/her lighter. Two packs of the Tenant's cigarettes were observed in the medication cart.

Tenant #7 (the Tenant), a 75 year old, was admitted on 5-11-09 and diagnoses include: HTN, Arthritis, Seizure Disorder, Dementia, Status/Post Cerebral Vascular Accident, History of Alcohol Abuse and Aphasia. The Tenant was staged at a five on the GDS, which indicated moderately severe cognitive decline. The service plan identified the Tenant smoked and staff was to assist the Tenant outside when he/she wanted to have a cigarette. The Tenant was not to have lighters in his/her apartment. One pack of the Tenant's cigarettes was found in the medication cart. Staff #6 and a monitor went to the Tenant's apartment. The Tenant lifted up the cushion to a side chair and pulled out a lighter when asked where the lighter was kept. The Tenant had two packs of cigarettes on his/her side table. The ED reported the Tenant was going to be given a notice for discharge.

Staff #7 stated tenants smoked in designated areas. Staff #7 stated Tenant #3's cigarettes and lighter was kept in the medication cart and Tenant #7 kept his/her own. Staff #6 stated tenants smoked in designated areas. Staff #6 stated Tenant #3's cigarettes and lighter was kept in the medication cart and Tenant #7 kept some in his/her apartment. Staff #6 stated Tenant #7's normal routine was to go to the courtyard door, light his/her cigarette and then exit the building.

The Program did not follow the Tenant Smoking policy.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by the program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2))

Dated this 17th day of October, 2011.