IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 47729-C

April 18, 2014

Ms. Kaylan Hamerlinck, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

RE: Final Complaint/Incident Investigation Report – Legacy Gardens, Iowa City, IA

Dear Ms. Hamerlinck:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of March 31 & April 1, 2, 10, 14, 2014, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program: **Complaint/Incident Intake #:** 47729-C

Kaylan Hamerlinck, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

Date of Complaint/Incident Investigation:

March 31 and April 1, 2, 10, 14, 2014

Monitor(s):

Stephanie Cummins, MA

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	25
Total Population of Program at time of on-site	27
TOTAL census of Assisted Living Program	27

Program History – The program received regulatory insufficiencies during the Recertification and Complaint/Incident (40184-I, 40159-C, 40187-C) on-site of August and Sept, 2012, in the areas of: Service Plan, Medications, Nurse Review, Staffing, Policy and Procedure, Tenant Rights and Tenant Documents. During the April 2013 Incident Investigation (43251-I), the program received regulatory insufficiencies in the areas of: Life Safety, Program Reporting to the Department, Criteria for Admission and Discharge and Tenant Documents. During the May 7 and 9, 2013 Complaint Investigation (43438-C), the program received a regulatory insufficiency in the area of Service Plan. During the August 26, 2013, Incident Investigation (44982-I), the program received regulatory insufficiencies in the areas of: Staffing and Policies and Procedures. During the Complaint (45664-C) on-site of October 14, 2013, the program did not receive any regulatory insufficiencies.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged there was a concern regarding an incident between tenants.

- Monitoring Observation: Five tenant files were reviewed (Tenants #1, #2, #3, #4 and #5).

  Tenant #1, an 86 year old, was admitted on 8-19-13 and diagnoses included: Hyperlipidemia and Dementia. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline.

  Tenant #2, a 74 year old, was admitted on 7-23-13 and diagnoses included: Dementia and Hypertension. Tenant #2 was staged at a six on the GDS, which indicated severe cognitive decline.

  An incident report dated 12-10-13 indicated staff called for assistance via the walkie talkie and the responding staff found staff standing between Tenant #1 and Tenant #2,

keeping them apart. Tenant #2 was wearing only a protective undergarment and had a small amount of blood coming from the left forearm. Staff sat Tenant #1 on the bed to help calm Tenant #1 down. Tenant #2 was assisted out of Tenant #1's apartment and into Tenant #2's apartment. Tenant #2 had three small scratches on the left forearm, two small red spots in the middle of Tenant #2's back and a small scratch on the back of Tenant #2's head. Tenant #1 had a broken fingernail and a small nick on the right hand. The doctors and families of Tenant #1 and Tenant #2 were notified.

According to Staff #1's written staff statement regarding the incident, at about 9:10 p.m. Staff #1 was passing medications when Staff #1 heard yelling and starting running down the hall towards the sound. When Staff #1 approached the apartment Staff #1 heard Tenant #1 screaming to get out of Tenant #1's room and Tenant #2 screaming help, Tenant #1 was trying to "kill" Tenant #2. When Staff #1 opened up the door Tenant #2 was lying (wearing a protective undergarment only) with Tenant #2's back on the floor and the knees curled up. Tenant #1 was standing over Tenant #2 holding Tenant #2's arms crossed above the head with one hand and swinging at Tenant #2 with the other hand. Staff #1 called for help and then tried to separate the two. Tenant #1 then began dragging Tenant #2. Staff #1 intervened and removed Tenant #1's hands from Tenant #2. Staff #1 got Tenant #2 off the floor and on the couch.

According to a nurse review in Tenant #1's Clinical Notes dated 12-11-13, after the incident staff had Tenant #1 sit on the side of Tenant #1's bed, take some deep breaths and drink a glass of water. Tenant #1 broke a fingernail and had a small nick to the right hand. Tenant #1 had no complaints of pain and Tenant #1 stated Tenant #1 was fine. The doctor and family were notified. Cognitive, health and functional evaluations were completed on 12-11-13. The service plan was updated and reflected Tenant #1 had a history of aggressive behavior toward tenants and staff. Staff was to intervene immediately, separating Tenant #1 from the event. If that was unsuccessful staff was to notify the nurse. The service plan was updated on 3-3-14 and indicated Tenant #1 had a history of aggressive behavior towards tenants and staff. Staff was to intervene immediately separating Tenant #1 was from the event. Staff stayed with Tenant #1 until Tenant #1 calmed down. If Tenant #1 did not want staff in Tenant #1's apartment staff would give Tenant #1 time to cool down. Staff would continue to ensure the safety of Tenant #1, staff and other tenants by providing safety checks per protocol. If that was unsuccessful staff was to notify the nurse.

According to a nurse review in Tenant #2's Clinical Notes dated 12-11-13, after the incident Tenant #2 was assisted out of Tenant #1's apartment and into Tenant #2's apartment. Tenant #2 had three small scratches on the left forearm, two small red spots in the middle of the back and a small scratch on the back of the head. The scratches were cleansed with warm, soapy water, dried and band-aides were applied. Tenant #2 did not complain of pain. A conference was held with Tenant #2's family regarding moving Tenant #2 to the other side of the building to ensure safety. Tenant's #2's family agreed to the move. Cognitive, health and functional evaluations were completed on 12-11-13. The service plan was updated and reflected Tenant #2 had a history of wandering and anxiety. Staff was to redirect Tenant #2 to Tenant #2's apartment/activity if noted to be wandering in other tenant apartments. Staff was to administer as needed anti-anxiety medications when Tenant #2 experienced agitation/wandering/anxiety and were not able to redirect. Tenant #2

enjoyed walking the halls of the Program; staff was to walk the halls with Tenant #2 if Tenant #2 showed increased signs of anxiety to assist in preventing Tenant #2 from entering other tenant apartments. It also ensured Tenant #2's safety, according to the service plan.

Staff #2 said Tenant #2 wandered into other tenant apartments and Tenant #2 had wandered into Tenant #1's apartment. Tenant #2 was moved to the other side of the building and there had not been any subsequent issues between them. Staff #3 said there had been no issues prior to the incident or since the incident between Tenant #1 and Tenant #2. Staff #3 said Tenant #2 was moved to the other side of the building. Staff #3 said Tenant #2 wandered into other tenant apartments.

Review of tenant files, incident reports and staff interviews indicated there was not a major injury or pattern of behavior causing physical injury between Tenant #1 and Tenant #2. After the incident Tenant #2 was moved to the other side of the building. Evaluations were completed, service plans were updated as needed and reflected interventions related to the behavior. An incident report was completed related to the incident, the doctors and families of Tenant #1 and Tenant #2 were notified.

Tenant #3, an 88 year old, was admitted on 2-24-12 and diagnoses included: Dementia, L1 Fracture and Cellulitis. Tenant #3 was staged at five on the GDS, which indicated moderate cognitive decline.

Tenant #4, a 75 year old, was admitted on 3-8-14 and had a diagnosis of: Parkinson's Disease. Tenant #4 was staged at five on the GDS, which indicated moderate cognitive decline.

An incident report dated 3-25-14 at 4:15 a.m. indicated the pager went off at 4:15 a.m. and as staff approached Tenant #4 was yelling for help as there was someone over Tenant #4's bed. Staff ran to the apartment and found Tenant #3 had pulled down Tenant #4's blanket and was pulling at Tenant #4's pants. Staff immediately removed Tenant #3 and called another staff for assistance. Tenant #4 got a drink, went to the bathroom and staff talked to Tenant #4 until Tenant #4 calmed down. Staff locked Tenant #4's door, but it popped when the handle was pushed from the outside. Staff sat outside the apartment until 6:00 a.m. as the door would not lock. A nurse was called and told staff to call the former Director of Nursing (DON) and a voice message was left. It was noted Tenant #3 was very confused and there were no visible changes or injuries. No first aid treatment was needed and vital signs could not be obtained. Tenant #3's doctor and family were notified. At 4:00 p.m. Tenant #3's family arrived to discuss the situation with the Former Program DON and no complaints or concerns were voiced during the meeting. It was noted Tenant #4 was very shaken up and was frightened and scared. No first aid treatment was needed and Tenant #4 refused vital signs to be taken. Tenant #4's doctor and family were notified. The family member said Tenant #4 had called the family member and informed the family member of the situation. On 3-26-14 the Campus DON, the Executive Director (ED) and the former DON, met with Tenant #4's family. Questions were answered and family was comfortable with Tenant #3 moving to other side of the building.

According to a Witness Statement completed by Staff #4, the pager went off at 4:15 a.m. and as Staff #4 approached Tenant #4 was yelling for help as there was someone over Tenant #4's bed. Staff #4 ran to the room to find that Tenant #3 had pulled down Tenant #4's blanket and was pulling at Tenant #4's pants. Staff #4 indicated Tenant #3 was wearing a protective undergarment, which was pulled all the way up. Staff #4 immediately removed Tenant #3 and called Staff #5 to assist. As Staff #4 attempted to calm Tenant #4 down, Tenant #3 re-entered the apartment and tried to sit in Tenant #4's chair. Staff #4 immediately removed Tenant #3 from the apartment. Tenant #4 was shaky and Tenant #4's eyes were wide open. Tenant #4 got a drink and went into the bathroom. Staff talked to Tenant #4 until Tenant #4 calmed down. Staff #4 remained at Tenant #4's door until 6:30 a.m.

Staff #4 was also interviewed. Staff #4 said he got a page from Tenant #4, then heard Tenant #4 yelling that there was someone over the bed. Tenant #4 did have hallucinations. As Staff #4 approached he saw a dark shadow next to Tenant #4's bed. Tenant #3 was wearing a t-shirt and a protective undergarment and was tugging at Tenant #4's right pant leg. Tenant #4 was wearing pants and a long sleeved shirt. Tenant #4's pants were up and Tenant #4 was fully clothed. Everything was in place when Staff #4 came into the apartment. There was no other contact between them and there were no injuries to either tenant. Staff #4 got Tenant #3's hands off of Tenant #4 and escorted Tenant #3 to Tenant #3's apartment. Tenant #3 had garbled speech. Staff #4 ran back to Tenant #4's apartment and Tenant #4 was shaky and Tenant #4's eyes were big. Staff #4 called via walkie talkie for other staff to assist and they responded. Tenant #4 was asked if Tenant #4 was okay and Tenant #4 responded yes, but was upset and scared. Tenant #3 proceeded to come back in to sit in the chair in the corner of Tenant #4's apartment and redirected back to Tenant #3's apartment. Tenant #3 had a blanket that was not one from the bed. Tenant #3 stayed in Tenant #3's apartment after that. The other staff took vitals, calmed Tenant #4 down and contacted the nurse. The nurse said staff needed to contact the former DON. A voicemail was left regarding the incident. An incident report was completed and Tenant #3 was moved to the other side of the building. Staff #4 said he had never seen Tenant #3 or Tenant #4 interact previously and Tenant #3 wasn't one to go into other tenant apartments. There were no prior or subsequent issues between Tenant #3 and Tenant #4. There were no prior or subsequent issues with Tenant #3 and any other tenants. Staff #4 said there was nothing abnormal with Tenant #3 prior to and afterwards Tenant #3 was confused and did not remember. Staff #4 sat in the hallway and monitored Tenant #4's door until 6:00 a.m. Staff #4 could see both Tenant #3's and Tenant #4's doors. Staff #4 said the push button lock on Tenant #4's door did not work.

On 3-27-14 the Campus DON spoke with Staff #4 regarding the incident that occurred on 3-25-14 at approximately 4:15 a.m. Staff #4 said Tenant #3 was not acting abnormal prior to the incident and was acting normal, paging for someone to make the bed and constantly changing clothes. Staff #4 stated Tenant #4 was fully clothed and Tenant #3 was tugging at Tenant #4's pants but hadn't gotten them down. Staff #4 stated Tenant #3 was wearing a protective undergarment and the undergarment was up. Staff #4 said Tenant #3 did not have an interest in clothing, went to bed with only the protective undergarment on which was normal for Tenant #3. Staff #4 said he and Staff #5 identified a blanket of Tenant #4's in Tenant #3's apartment. Staff retrieved the blanket and placed it in Tenant #4's apartment.

According to a written statement completed by Staff #5, Staff #4 had called via walkie talkie and told her to come to Tenant #4's apartment as soon as possible. Staff #5 rushed over to the apartment and Staff #4 had Tenant #4 in the bathroom and Tenant #3 was walking back to Tenant #3's apartment. Staff #4 asked Staff #5 to help Tenant #4 with toileting and getting back to bed while Staff #4 helped Tenant #3 back to bed. Staff #4 told Staff #5 that Tenant #3 was in Tenant #4's apartment and pulled Tenant #4's blanket back and was pulling at the bottom of Tenant #4's pants. Tenant #4 was very shaken up, asked Staff #5 to call the police. Tenant #4 was told that everything would be taken care of, the door would be shut and locked and that they would not that happen. Tenant #4 did calm down some and Staff #4 said he would check on Tenant #4 more often.

Staff #2 said she worked the next morning and heard about the incident from Staff #4. Tenant #4 was shaken up and was upset and Tenant #3 had no idea what happened. Tenant #4 said Tenant #4 felt dirty and was cleaned up and given a sponge bath. There were no injuries or physical changes to Tenant #4. Tenant #4 came out to breakfast and did not seem so upset. Tenant #3 moved to the other side of the building and was checked every 15 minutes. Staff #2 said there was not a prior history of that behavior with Tenant #3 and Tenant #4 and there had not been any subsequent issues. Staff #2 said Tenant #3 was not like that at all and there had not been any other similar incidents. Staff #2 said Tenant #3 had a hard time sleeping and usually did not leave the apartment. Staff #2 said there had not been a change in behavior with Tenant #3 prior to the incident.

Staff #3 said the incident was communicated to oncoming staff and Tenant #3 moved to the other side of the building. Tenant #4 was doing okay since then and Tenant #3 had adjusted after the move. There were no issues with Tenant #3 and Tenant #4 prior to or since the incident. There were no issues with Tenant #3 prior to or since the incident with any other tenants. Staff #3 said she thought Tenant #3 woke up confused. There were no changes observed with Tenant #3 prior to the incident. There were no injuries observed to either Tenant #3 or Tenant #4.

The former DON said she received an incident report regarding the situation. There were no injuries to Tenant #3 or Tenant #4. The former DON notified Tenant #3 and Tenant #4's families. Maintenance was notified to fix the door lock on Tenant #4's door. There were meetings with Tenant #3 and Tenant #4's families. Tenant #3 was moved to the other side of the building and Tenant #3's family was in agreement with the move. She said there was never any contact and there was no assault. Tenant #3 had never displayed that behavior before with Tenant #4 or with anyone. Tenant #3's spouse had recently passed away. Tenant #3 was placed on 15 minute checks. She said Tenant #4 knew something happened. Tenant #4 told her that someone came in the apartment and Tenant #4 thought it was maybe a hallucination. The former DON indicated there was no contact and that Tenant #3 had attempted to pull Tenant #4's pants down. A head to toe assessment was completed on Tenant #4 and did not reveal any concerns. Tenant #4's skin was intact; there was no bruising and no complaints of pain. A head to toe assessment was completed on Tenant #3 and did not reveal any concerns. The doctors for Tenant #3 and Tenant #4 were notified.

The Campus DON said the former DON reported the incident to her. According to the report, Tenant #3 was tugging on Tenant #4's pants but they were not pulled down. The Campus DON instructed the former DON to complete head to toe assessments on Tenant #3 and Tenant #4 and to notify the families. Corporate staff was contacted. There were meetings with the families and it was decided to move Tenant #3 to other side of the building and 15 minute checks were initiated for Tenant #3. There was no history or pattern with Tenant #3's behavior. The Campus DON asked the nurse who was there before (a corporate nurse) who also confirmed there was no history of that behavior with Tenant #3. There had been no subsequent issues. The Campus DON interviewed Staff #4 and there was no other contact besides tugging on the pants. An assessment of Tenant #4 was completed and nothing was noted. There was staff training regarding Tenant #3's move and keeping Tenant #4 safe and the monitoring continued. Weekly nurse reviews were completed. The 15 minute checks were discontinued as there were no incidents and then hourly and 30 minute checks resumed. The Campus DON said after the incident Tenant #4's door was modified as the door would not lock. She said if Tenant #4 opted to lock the door staff had a key and could enter the apartment. Tenant #4 could leave the apartment by pulling the lever. After the incident staff contacted a nurse and was told to call the former DON. A message was left; however, a return phone call was not made. The former DON arrived on campus approximately 10:10 a.m. After the incident staff sat outside Tenant #4's door. The Campus DON was very pleased with how staff handled the situation.

The ED said the former DON informed her of the incident. The ED said at approximately 4:00 a.m. staff heard Tenant #4 calling and responded. Tenant #3 was found at Tenant #4's bedside. Neither Tenant #3 nor Tenant #4 was unclothed. Tenant #3 was pulling on Tenant #4's pants. Tenant #3 was redirected to Tenant #3's apartment without difficulty and staff stayed with Tenant #4. The ED was informed of the incident by the Former Program DON. The families of Tenant #3 and Tenant #4 were notified. A lock was put on Tenant #4's door that prevented someone from entering unless they had a key; however, Tenant #4 could leave at any time. It was an extra precaution for Tenant #4. Tenant #4's apartment was picked up, the sheets were washed and Tenant #4 was given a bath. Tenant #3 was moved to the other side of the building, emotional support was provided to Tenant #4 and staff was informed so they were aware. There were no injuries to either Tenant #3 or Tenant #4. There was no contact between besides the contact to the pants. There was no prior or subsequent with Tenant #3 and Tenant #4. There had been no prior issues with Tenant #3 and other tenants. The ED said staff handled the situation appropriately. Staff notified the nurse supervisor who had told staff they had handled the situation appropriately and to ensure there was no additional contact. A decision was made to call the Former Program DON and when called there was no ringing.

Tenant #4 reported feeling safe. Tenant #4 said one night Tenant #4 felt someone in the bedroom and the person kept saying push and Tenant #4 said there might have been more than one person. Tenant #4 said when it was all over it didn't have to be reported because it was a hallucination. Tenant #4 said Tenant #4 did not want to get anyone in trouble and did not know what happened. Tenant #4 said Tenant #4 wasn't hurt and went back to sleep. Tenant #4 said it had never happened before and not since. Tenant #4 said Tenant #4 was sleeping without locking the door. Tenant #4 said they were taking care of things but Tenant #4 wouldn't forget it.

Cognitive, health and functional evaluations were completed and the service plan was updated on 3-25-14 for Tenant #3. Clinical Notes dated 3-31-14 indicated Tenant #3's adjustment to the new environment was slow. On 3-31-14 cognitive, health and functional evaluations were completed and the service plan was updated. The service plan reflected staff would redirect Tenant #3 to Tenant #3's apartment if found wandering, disoriented or appeared lost. Staff was to ensure Tenant #3 did not wander into other tenant apartments. If Tenant #3 did so staff was to notify the nurse immediately. The service plan reflected Tenant #3 had oxygen at night. Staff would ensure Tenant #3 was wearing the oxygen at night and notify the nurse if Tenant #3 refused. The Campus DON said Tenant #3 had oxygen at night but could remove it.

According to a nurse review in Tenant #4's Clinical Notes dated 3-25-14, Tenant #4's skin remained intact head to toe, no bruising or skin tears was noted. Tenant #4's mood was appropriate, no tearful episodes were noted and Tenant #4 appeared calm and relaxed. Tenant #4 did not voice any concerns at that time. According to Clinical Notes dated 3-28-14, an assessment was completed to determine if Tenant #4 had bruising to the body. The notes indicated Tenant #4 did not have any bruising to the body. Cognitive, health and functional evaluations and the service plan was updated on 3-30-14. The service plan reflected Tenant #4 woke frequently throughout the night. Tenant #4 had hallucinations and nightmares that caused Tenant #4 to wake and have difficulty falling asleep.

At the time of the incident Tenant #3 and Tenant #4 had 30 minute checks from 9:00 p.m. to 6:00 a.m. Documentation of the 30 minute rounds from 9:00 p.m. to 6:00 a.m. indicated Tenant #3 was asleep from 12:00 a.m. to 4:00 a.m. at each 30 minute check. At 4:15 a.m. it was documented on the rounds documentation sheet that Tenant #3 was found in Tenant #4's apartment and to see incident. The check at 4:30 a.m. indicated Tenant #3 was awake in the apartment and was awake at 5:00 a.m., 5:30 a.m. and 6:00 a.m. Documentation of the 30 minute rounds from 9:00 p.m. to 6:00 a.m. indicated Tenant #4 was asleep from 9:00 p.m. until 12:45 a.m. when a pager request was received to use the bathroom. Tenant #4 was asleep at 1:00 a.m. and 1:30 a.m. At 2:00 a.m. and 2:30 a.m. a pager request was received to use the bathroom. At 3:00 a.m., 3:30 a.m. and 4:00 a.m. Tenant #4 was asleep. At 4:15 a.m. it was documented on the rounds documentation sheet that there was an incident with Tenant #3. At 4:30 a.m. a pager request was received to use the bathroom. Tenant #4 was asleep from 5:00 a.m. to 6:00 a.m. Documentation of rounds was consistently completed for Tenant #3 and Tenant #4.

According to Tenant #3's Clinical Notes dated 3-26-14, checks were increased to every 15 minutes for Tenant #3. According to the check documentation, the checks every 15 minutes were consistently completed. Clinical Notes dated 3-31-14 indicated 15 minute checks were discontinued as Tenant #3 had not exhibited abnormal behavior and resumed hourly checks from 6:00 a.m. to 9:00 p.m. and 30 minute checks from 9:00 p.m. to 6:00 a.m.

The pendant history for Tenant #4 on 3-25-14 was obtained. The history indicated Tenant #4's pendant was alarmed at 4:30:17 a.m. and reset at 4:31:44 a.m. and was alarmed at 4:56:29 a.m. and reset at 4:57:49 a.m.

Review of tenant files, incident reports and staff interviews indicated there was not a major injury or pattern of behavior causing physical injury between Tenant #3 and Tenant #4. After the incident Tenant #3 was moved to the other side of the building. Evaluations were completed, service plans were updated as needed and reflected interventions related to the behavior. An incident report was completed related to the incident, the doctors and families of Tenant #3 and Tenant #4 were notified. Checks were consistently completed prior to and after the incident.

- Regulatory Insufficiency: None noted.

B. Structural Requirements

Complaint/Incident Allegation: It was alleged there was a concern regarding a door lock.

- Monitoring Observation: The Maintenance Director said there were two different types of door locks on tenant apartment doors. One door lock could be locked when outside the apartment or when leaving the apartment and could not be locked from the inside. The lock could be popped open with anything including a screwdriver or broken key. The lock did not prevent anyone from leaving the apartment from the inside; however, prevented someone from entering the apartment without popping the lock. The other type of lock required a master key. There were four apartments with a master key lock. All staff had a key. He said he received an email from the Campus DON regarding installing a door lock on Tenant #4's door. He said prior to Tenant #4 taking occupancy the master key lock was removed per family request and then after an incident the door lock was put back on the door. He said the locks did not prevent anyone from leaving and the tenants could always get out.

  Observation of a non-master key lock door revealed the door lever on the inside of the door had a push button lock and the lever on the outside of the door had a slot. From the inside of the apartment to lock the door the button had to be pushed in while pressing down on the lever on the outside of the door. This locked the apartment from the outside but one was still able to press the lever down on the inside of the apartment and unlock/open the door. This style lock had to be locked from the outside or as leaving as the lever on the outside the door had to be pressed down as the button on the inside of the door was pushed.

  Observation of a master key lock door revealed the door lever on the inside had a push button lock and the lever on the outside of the door had a place for a key. From inside the apartment the door could be locked with the push button lock and could be locked from the outside with a key. It could be opened from the inside with the lever and from the outside with the key.

  The program had four apartment doors with the master key style lock and the rest of the apartments had a non-key style lock.

  According to an incident report dated 3-25-14, there was an incident between Tenant #3 and Tenant #4. According to interviews, staff attempted to lock Tenant #4's door after the incident and the door lock did not work. Staff sat outside Tenant #4's door until approximately 6:00 a.m. The Maintenance Director received an email regarding installing a door lock on Tenant #4's door. The master key door lock was installed on

Tenant #4's door. Clinical Notes dated 3-28-14 indicated Tenant #4 was asked if Tenant #4 wanted the apartment door open or closed/locked. Tenant #4 asked if the person was going to come in and was reassured the person had moved, would not harm Tenant #4 and staff would provide safety and security. Tenant #4 then said to do whatever was best. The door was closed for privacy but not locked and Tenant #4 was in agreement.

- Regulatory Insufficiency: None noted