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
	S0163	A. BUILDING: _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDENS	15 SILVERCREST PLACE IOWA CITY, IA 52240

(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: 19 TOTAL Census of Assisted Living Program for People with Dementia: 23 The investigation of Incident #86500-I resulted in regulatory insufficiencies.	A 000	See attached POC 2/7/2020	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. 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 a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow policy and procedure regarding the completion of incident reports. This pertained to 2 of 2 tenants reviewed (Tenants #1 and #2). Findings follow:	A 003		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 003	Continued From page 1 1. Record review on 12-3-19 of Tenant #1's file revealed a diagnosis included: Alzheimer's dementia. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Charting Notes indicated on 7-9-19 it was noted Tenant #1 walked around in a state of undress with only a shirt on. Tenant #1 said "The guy left me in a room waiting and now I'm looking for him so we can get done." Staff assisted Tenant #1 back to her apartment to get dressed. She then came out of the apartment and started walking with Tenant #2. Staff tried to separate them several times and it was not successful until an outside agency staff arrived to assist Tenant #1 with a shower. Tenant #2 was upset when staff told him that she was not his spouse and Tenant #1 needed to get a shower done. Tenant #2 followed Tenant #1 and the outside agency staff to her apartment and then was redirected to the other side of the building. Continued record review revealed an incident report was not completed related to the incident noted above between Tenant #1 and Tenant #2. 2. Record review on 12-4-19 of Tenant #2's file revealed a diagnosis included: Lewy Body Dementia. Tenant #2 was staged at a four on the GDS, which indicated moderate cognitive decline. Charting Notes revealed the following: a. On 6-29-19 it was noted Tenant #2 was extremely combative and was found pulling on another tenant while she was in bed sleeping. When staff attempted to redirect him he became combative. Tenant #2 unplugged the other tenant's oxygen tank. At the beginning of the shift staff found Tenant #2 in another tenant's	A 003		

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A 003	Continued From page 2 apartment in a physical altercation. b. On 7-3-19 it was noted Tenant #2 and another tenant got into an altercation. c. On 7-17-19 it was noted made sexually inappropriate comments to staff. He also attempted to urinate on his reclining chair. d. On 7-30-19 it was noted Tenant #2 grabbed staff's arm really tight, when staff told him to let go he pushed staff in the door corner and let go a little while after. e. On 7-31-19 it was noted Tenant #2 told staff that he loved them and staff needed to end her relationship immediately to love him. Tenant #2 then got up and approached staff and staff put a chair between them. Tenant #2 shoved the chair out of the way to get staff and staff ran around the other side of the table. f. On 8-7-19 it was noted Tenant #2 was more agitated than normal. He grabbed staff, hit them and yelled at them. He also wandered more and argued with other tenants. g. On 8-31-19 it was noted Tenant #2 attempted to leave the building and staff tried to redirect him. Tenant #2 grabbed both of staff's hands tightly. Later, approximately 30 minutes, Tenant #2 attempted to leave the building and staff redirected him to his apartment. Tenant #2 grabbed staff's arms and tried to get staff out. Staff got her hands free. When staff left the apartment he grabbed staff's hands again and staff could not get out of it. Tenant #2 pushed staff against the door, which shoved staff into the door. Other staff responded and assisted. Staff's arms hurt for approximately five minutes.	A 003		

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A 003	Continued From page 3 h. On 9-23-19 it was noted staff observed Tenant #2 was going towards the lobby doors and Tenant #2 began shoving staff. Tenant #2 started jumping around, swung his arms and made strange sounds before acting like he was going to hit staff. i. On 9-30-19 it was noted Tenant #2 burst into tears and became agitated. Per staff Tenant #2 talked about killing himself and how he wanted to kill others. j. On 10-2-19 it was noted Tenant #2 was very agitated and yelled. Night staff informed day staff that Tenant #2 had not slept, had been agitated, non-compliant with medications and aggressive throughout the night. Day shift staff contacted the on-call nurse and Tenant #2 was sent to the emergency room. Tenant #2 returned with family and no other issues were noted. When family left Tenant #2 started wandering and threatened staff. He said "I'm going to kill all of you and it will be no one's fault but your own." He pulled down his pants in a female tenant's apartment and attempted to climb into bed with a female tenant as staff assisted her. k. On 10-14-19 it was noted Tenant #2 spoke about hanging himself. Later that morning Tenant #2 had no recollection of the conversation and denied wanting to hurt himself or anyone else. Further record review revealed incident reports could not be located for the incidents noted above for Tenant #2. 3. Further record review revealed the Program's Incident Report Policy and Procedure indicated an incident report would be completed for an	A 003		

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A 003	Continued From page 4 accident or incident that affected a tenant. All accidents and incidents including a fall, abrasion, observed on the floor, bruising, elopement, injuries and tenant conflict would be reported as incidents to the DON and the responsible party (as applicable). The staff who was in charge, or witnessed or was first informed of the incident would completed an incident report. 4. When interviewed on 12-5-19 at 1:56 p.m. the DON confirmed all incident reports requested for the tenants listed above were provided.	A 003		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate services to meet the identified needs of tenants. This pertained to 1 of 1 tenant reviewed that eloped (Tenant #1) and potentially affected all tenants (census of 23). Findings follow: 1. Record review of a Tenant/Resident Incident Report reflected on 9-13-19 at 6:30 p.m. Tenant #1 eloped. There were no injuries noted. The Assistant Director of Nursing (ADON) was notified and family was notified.	A 013		

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A 013	Continued From page 5 Charting Notes dated 9-16-19 (completed by the ADON) reflected the ADON received a telephone call on 9-13-19 at 9:00 p.m. from staff regarding Tenant #1 leaving the building unattended at approximately 6:30 p.m. The front entrance was checked, the outside of the building was checked and a head count was started. When the head count was being completed a staff from the independent living (IL) building brought Tenant #1 back to the building at approximately 7:00 p.m. The Executive Director (ED) and Regional Director of Nursing were notified. The ADON came to the building and completed an assessment. Tenant #1 was calm, showed no signs of distress and had no recollection of going for a walk outside of the building. There was no visible injuries noted, Tenant #1 denied pain and was able to bear full weight. An Incident Investigation Report dated 9-16-19 reflected on 9-13-19 the front lobby door went off. Staff did not respond immediately because they were helping another tenant and could not leave them unattended. Staff responded to the alarm when finished and looked outside for any unattended tenants and did not see anyone. A head count was initiated and during the process a staff from independent living (IL) brought Tenant #1 back to the building. An IL resident had seen her outside of her window. The investigative conclusion indicated staff did not respond to the door alarms per policy and Tenant #1 left the locked unit and was brought back unharmed. Tenant #1 eloped from the building. Corrective action was noted as required and indicated all staff would be re-educated on the policy and procedure for door alarms and elopements. An untitled and undated Program document	A 013		

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A 013	Continued From page 6 indicated on 9-13-19 the ADON was notified Tenant #1 eloped. At 6:37 p.m. the front lobby entrance door alarm went off. There were four staff working at the time of the incident, one Program staff and three agency staff. When the pager alarmed Staff A was assisting another tenant and was unable to leave the other tenant unattended. When Staff A finished assisting the other tenant she went to the lobby door at approximately 6:58 p.m. She went outside and looked for any unattended tenants and did not see anyone. She then came back inside and started a head count. During the time of the head count an IL staff brought Tenant #1 back to the building and said another tenant had seen her outside. Tenant #1 was dressed appropriately for the weather. Tenant #1 had previously lived in the IL with her spouse who still resided there. Tenant #1 had lived at the Program since March 2019. When assessed on 9-13-19 there were no issues or concerns noted. Family, the physician and the nurse on-call were notified. Staff was re-educated on the tenant missing persons/elopement policy and the door alarm policy. Staff was aware door alarms must be responded to immediately. The Director of Nursing (DON) and ADON inquired as to why walkie-talkies were not carried and staff was re-educated on usage. Elopement drills were to be done randomly for continuous education and preparedness for staff. Staff A's (Program staff) statement indicated after the evening meal at approximately 7:00 p.m. she finished up a task with another tenant when when she received a page for the front door alarm. When she was done assisting the other tenant she went to check the door alarm. She checked outside and did not see anyone. She returned back inside and started a head count. When she	A 013		

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A 013	Continued From page 7 was completing the head count someone from the IL brought Tenant #1 back. The statement indicated she was gone for 30 minutes at most. Regarding the weather, it was light outside and approximately 70 degrees. Tenant #1 was wearing an orange shirt with a yellow sweater, gray sweatpants and brown shoes. There were no injuries noted. Once Tenant #1 was brought back she still tried to leave. There were a couple of people watching her until she was in bed. Staff B's (IL staff) statement indicated it was about 6:30 p.m. to 7:00 p.m. she got telephone call from a IL resident who said a woman walked outside the sliding glass door and she was unsure where she lived. Staff B responded to the IL apartment and a woman (Tenant #1) repeated an address and said she was unsure where she lived. The IL resident thought Tenant #1 looked familiar and they learned who her spouse was and Tenant #1's last name. Staff B walked Tenant #1 back to the Program. When they got back Staff B talked to one of the staff about what happened and she was physically upset and went around talking about what happened. When she got back to the IL she let the IL resident know that Tenant #1 made it back safely. She also told Tenant #1's spouse what had happened. Staff C's (agency staff) statement indicated at approximately 6:45 p.m. an alarm sounded at the front door. Staff A said she had checked the doors and did a head count. An agency staff on the other side of the hallway said she also checked the door that alarmed. Within 10 to 15 minutes Tenant #1 was returned from the IL building to the Program by staff. There were no injuries noted and Tenant #1 denied pain/discomfort.	A 013		

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A 013	Continued From page 8 2. When interviewed on 12-3-19 at 3:03 p.m. Staff A revealed she was working on second shift and was working with agency staff. She was giving another tenant a bath in the bathing room. She thought it was about 7:00 p.m. and her pager went off and she could not look at it right away. Once she could look at it she saw it was the front door going off. She went to check on the front door and went outside to look. Her pager was still going off when she responded to the door. Agency staff told her IL staff had brought Tenant #1 back from the IL building. She checked everyone to make sure all tenants were accounted for and all tenants were present. She checked on Tenant #1 and she was irritated but did not have any injuries. Tenant #1 had on sweatpants, shoes, a shirt and sweater. Tenant #1 ambulated independently. Regarding the weather, it was warm, it was still light out and there was no precipitation. Tenant #1 was last seen by Staff A in the living room watching television at approximately 6:30 p.m. When Tenant #1 returned to the building she kept trying to leave and wanted to see her spouse. Someone had watched until bed approximately 9:30 p.m. Tenant #1 filled out an incident report and said she had not completed an incident report before. Staff did not use walkie-talkies and they were available for use. That night the ADON came in and did an elopement drill. When interviewed on 12-4-19 at 9:07 a.m. the ADON revealed she received a telephone call at approximately 9:00 p.m. from Staff A. She was told the door alarms had gone off and Staff A was assisting another tenant with cares. She responded to the door alarm and looked outside and did not see anyone. A head count was started and IL staff had brought Tenant #1 back to the building. Tenant #1 had appropriate clothing,	A 013		

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A 013	Continued From page 9 no complaints of pain and no visible injury. The ADON said the ED and Regional Director of Nursing were notified. The ADON revealed Staff A did not understand she needed to call as there were no injuries to Tenant #1. The more Staff A thought about it she then called the ADON. The ADON came into the building at approximately 10:00 p.m./10:30 p.m. (close to shift change) and completed an assessment of Tenant #1, which did not reveal any injuries or complaints of pain. Tenant #1 was lying in bed and was surprised to see the ADON. Tenant #1 was not in distress and did not have any recollection of the incident. After the assessment she discussed the situation with staff and went over the proper steps. The physician was notified on 9-16-19, a voicemail was left for family and staff was asked to write statements. The ADON said Tenant #1 was last seen at the evening meal, which was at 5:00 p.m. It was determined Staff A said the front door alarmed (it went off at 6:37 p.m. and was reset at 6:58 p.m.). When the ADON arrived staff had pagers and she thought Staff A said she did not have a walkie-talkie (although available to her). When the door alarms went off staff was expected to respond and expected to radio. Regarding the incomplete safety checks the ADON said she believed staff completed the checks; however, did not document them. There were four or five staff working including, one Program staff and the rest agency staff. They liked staff to respond as quickly as possible to the door alarms. Regarding training for agency staff on the door alarms, walkie-talkies and policies there was no documented training. Agency staff were walked around the building, shown how to reset the alarm and shown the pagers and walkie-talkies. The door alarm would alarm for a time period and the pager would continue to go	A 013		

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A 013	Continued From page 10	A 013		

off. There was re-education for staff on the communication with the walkie-talkies and to notify the nurse on-call as soon as anything happened.

When interviewed on 12-4-19 at 10:05 a.m. the DON revealed on the Monday following the incident an investigation was started. Staff statements were collected. It was determined an alarm went off at 6:37 p.m. for the front entrance door. Staff A could not leave as she was assisting another tenant with a bath and could not leave that tenant. There was one Program staff and the remaining staff were agency staff. When Staff A responded to the door it was still green (unlocked). The pager would keep beeping until it was cleared. Staff A started a head count and an IL staff brought Tenant #1 back to the building. Tenant #1 had appropriate clothing on and was not in distress. Tenant #1 had been last seen after the evening meal and it was served between 5:00 p.m./5:30 p.m. Staff A was a new employee and had unaware of the process and did not realize she needed to the call the on-call nurse. The ADON assessed Tenant #1 and she had no recollection of the incident and no injuries. He was not sure if Staff A or agency staff knew of the expectation to carry walkie talkies. All staff had a pager. The DON revealed he felt staff completed the safety checks; however, they were not documented. Agency staff were trained verbally however, there was not a hard copy of the training for agency staff. Program staff had access to all policies and during the orientation process staff had training. There was a delay in responding to the door alarms, staff did not have walkie-talkies and there was an expectation to notify the nurse on-call.

When interviewed on 12-4-19 at 10:53 a.m. the

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A 013	Continued From page 11 ED reveled she was notified that evening right after the ADON received a telephone call. She was told Tenant #1 had gone to the IL, where her spouse lived and where she used to reside. The Regional Director of Nursing was also notified. An investigation and attempts to report to the Department started on the following Monday. For corrective action the Program needed to increase the frequency of elopement drills, a focus on training/hiring staff to limit the use of agency staff and all staff had signed off on the policy and procedure (regarding door alarms and elopement). 3. Continued record review of Tenant #1's file revealed a diagnosis that included: Alzheimer's dementia. Tenant #1 was staged at a Global Deterioration Scale (GDS) of four, which indicated moderate cognitive decline. The service plan dated 4-8-19 (service plan in place at the time of the incident) reflected Tenant #1 had a history of exit seeking in her apartment in the IL. Staff was to try to redirect Tenant #1 by offering to spend time on a 1:1 activity, offering a snack or beverage or walking or exercising with Tenant #1. If it was not effective to notify the nurse. It also indicated Tenant #1 had shown impaired judgement to her spouse by trying to leave the apartment at inappropriate times or when she believed something was going on that was not actually happening. Tenant #1's service plan dated 4-8-19 reflected safety checks every hour during the day and every 30 minutes at night. The September medication administration records (MARs) reflected Seroquel 25 milligram tablet, take one tablet every day as needed for agitation. On 9-13-19 at 9:00 p.m. it was charted as administered as needed and the result was indicated as not effective.	A 013		

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A 013	Continued From page 12 Tenant #1's service plan dated 4-8-19 and 9-18-19 reflected safety checks every hour during the day and every 30 minutes at night. An ADL Worksheet from safety checks for the entire side of the building that Tenant #1 resided reflected the last safety check on 9-13-19 that was documented as completed was at 6:00 a.m. There were no additional safety checks documented from 6:30 a.m. to 11:30 p.m., including prior to and after Tenant #1's elopement. Further record review of door alarm records indicated the lobby entrance door alarmed on 9-13-19 at 6:37 p.m. and it was reset 21 minutes and 5 seconds later at 6:58:14 p.m. Prior to the 9-13-19 6:58:14 p.m. alarm clear on 9-13-19 at 6:56:26 p.m. the front door bell went off and was cleared at 6:58 p.m. A schedule document indicated on 9-13-19 on second shift five staff were scheduled, Staff A and four staff from two different staffing agencies. Training records prior to the incident with Tenant #1, for agency staff for the door alarms, walkie talkies and missing tenant policy were requested and were not available. The State Climatologist revealed the following weather conditions on 9-13-19 at 6:00 p.m.: temperature was 67 degrees, relative humidity was 68% and winds were from the southwest at five miles per hour (mph). There was no cloud cover, no precipitation and no heat index. On 9-13-19 at 7:00 p.m. weather conditions were: temperature was 64 degrees, relative humidity was 73% and winds were calm. There were clear conditions.	A 013		

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A 013	Continued From page 13 Tenant #1's elopement was not witnessed and the exact path Tenant #1 traveled could not be determined; however, when observed on 12-3-19 at approximately 4:25 p.m., possible terrain traveled included: parking lots, sidewalks and grassy area. When the monitor traveled by foot from the Program's entrance to the independent living building it took approximately 2 minutes and 30 seconds. 4. Continued record review revealed the Program's Tenant/Resident Missing Persons and Elopement Policy and Procedure indicated it was the policy of the Program to investigate all reports of missing tenants. It a staff determined a tenant was missing from the Program staff would notify additional staff immediately to perform a thorough search of the building and grounds and if not located would notify the Executive Director and the nurse. Upon locating the tenant the nurse would examine the tenant for injuries and contact the physician. The Executive Director or nurse would notify the responsible party. An incident report and investigation report would be completed. The Program's Alarmed Door Policy and Procedure for Locked Memory Unit indicated it was the policy of the Program to ensure each tenant was safe. As part of the security system in the unit all doors that led to the exterior were alarmed/coded doors. If a door alarm went off staff was to "immediately perform a physical check" of the area outside the door that alarmed to ensure that no tenant was outside of the building. Staff was then to perform a physical check of each tenant in the Program to ensure tenant safety and to ensure no tenants had exited the through the alarmed door. If additional assistance to perform a physical check of all	A 013		

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A 013	Continued From page 14	A 013		

tenants, staff would radio for additional staff and request assistance in accounting for all tenants.

The Program's policy regarding walkie-talkies indicated it was to ensure staff had effective and efficient system for communication with other employees throughout the Program. All staff was to carry a walkie-talkie "on their person at all times while working." All staff was to carry a walkie-talkie with them at all times and were to respond to calls in a timely fashion. If staff heard another staff call for help and staff was unable to provide assistance they were to respond over the walkie-talkie and notify them that they were unable to assist so staff could call another staff for assistance.

The Program's Staffing Policy and Procedure indicated it was the policy of the Program to maintain competent staff at all times who were able to implement the accident, fire safety and emergency procedures. Staff would have access to pagers in order to respond to the 24 hour personal emergency response device assigned to each tenant. In a dementia-specific program staff would be awake and on duty 24 hours a day in the proximate area and would check on tenants as indicated in the tenants' service plans.

In summary, Tenant #1 had a history of exit seeking behavior, impaired judgement and had safety checks as indicated on the service plan. On 9-13-19 Tenant #1 left the building presumed through the front door based on alarm records. There were five staff working, including one Program staff and four agency staff. The page went off for the front door alarm and was not reset for 21 minutes. One staff was providing a shower to another tenant and could not respond; however, staff did not communicate via

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A 013	Continued From page 15 walkie-talkies, per policy, to determine who was responding to the door alarm. Staff did not respond immediately to the door alarms, per policy, as it was not cleared for 21 minutes. Safety checks for Tenant #1 as indicated in the service plan, hourly during the day and every 30 minutes at night, were not completed per the staffing policy. This occurred both prior to and after Tenant #1's elopement. Tenant #1 was returned to the Program by IL staff and staff failed to notify the nurse on-call until approximately two hours after Tenant #1's return to the building. Staff failed to follow the policies and procedures for door alarms, walkie-talkies and staffing and per the missing persons/elopement policy failed to notify the nurse timely for an assessment of Tenant #1 once she was located.	A 013		
A 083	481-69.26(1) Service Plans 481-69.26(231C) 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 develop service plans that were updated as needed and reflected the needs of the	A 083		

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tenants. This pertained to 2 of 2 tenants reviewed (Tenants #1 and #2). Findings follow:

1. Record review on 12-3-19 of Tenant #1's file revealed a diagnosis included: Alzheimer's dementia. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Charting Notes indicated the following:

a. On 7-2-19 it was noted Tenant #1's legal representative felt Tenant #1's appetite had diminished and wanted an Ensure daily. An order was faxed to the primary care provider for an Ensure drink one time daily.

b. On 7-5-19 it was noted an order was received for Ensure one supplement drink daily. Tenant #1 had a four pound weight loss in approximately one month.

c. On 7-5-19 it was noted staff voiced concerns they found Tenant #1 laying in bed with another tenant on 7-4-19 at approximately 7:30 p.m. Tenant #1 stated, "We aren't doing anything wrong just a little kiss that's all." The tenants were separated at that time. The tenants spent much of the evening walking around holding hands.

d. On 7-9-19 it was noted Tenant #1 walked around in a state of undress with only a shirt on. Tenant #1 said "The guy left me in a room waiting and now I'm looking for him so we can get done." Staff assisted Tenant #1 back to her apartment to get dressed. She then came out of the apartment and started walking with Tenant #2. Staff tried to separate them several times and it was not successful until an outside agency staff arrived to assist Tenant #1 with a shower. Tenant #2 was

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upset when staff told him that she was not his spouse and Tenant #1 needed to get a shower done. Tenant #2 followed Tenant #1 and the outside agency staff to her apartment and then was redirected to the other side of the building.

e. On 7-9-19 it was noted a nurse was made aware of intimate interactions with Tenant #1 and Tenant #2 both on 7-9-19 and the prior Friday. The interactions would be discussed with Tenant #1's spouse. A significant change was to be done to note the behavior.

f. On 9-18-19 it was noted a change of condition was completed at that time to reflect Tenant #1's inappropriate sexual behavior.

2. Continued record review revealed Tenant #1 had service plans dated 4-8-19 (30 day service plan) and 9-18-19 (change of condition). The current service plan dated 9-18-19 did not reflect the nutritional supplement and or weight loss was noted. The 9-18-19 service plan reflected intimate behaviors with another tenant; however, the documented incidents between Tenant #1 and Tenant #2 occurred on 7-4-19 and 7-9-19 and the service plan was not updated until 9-18-19.

3. Record review on 12-4-19 of Tenant #2's file revealed a diagnosis included: Lewy Body Dementia. Tenant #2 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #2 was admitted on 6-20-19. Charting Notes revealed the following:

a. On 6-29-19 it was noted Tenant #2 was extremely combative and was found pulling on another tenant while she was in bed sleeping. When staff attempted to redirect him he became combative. Tenant #2 unplugged the other

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A 083	Continued From page 18 tenant's oxygen tank. At the beginning of the shift staff found Tenant #2 in another tenant's apartment in a physical altercation. b. On 7-3-19 it was noted Tenant #2 and another tenant got into an altercation. c. On 7-10-19 it was noted on 7-9-19 Tenant #2 was involved with a conflict with another tenant. Tenant #2 entered the other tenant's apartment. The other tenant grabbed Tenant #2's right arm and twisted the skin. Tenant #2 complained of tenderness to the right arm and slight redness. d. On 7-17-19 it was noted made sexually inappropriate comments to staff. He also attempted to urinate on his reclining chair. e. On 7-26-19 it was noted Tenant #2 attempted to strike staff and attempted to push through staff to go into other tenants' apartments. f. On 7-30-19 it was noted Tenant #2 tried to staff keys and was aggressive with staff and very irritable. g. On 7-30-19 it was noted Tenant #2 grabbed staff's arm really tight, when staff told him to let go he pushed staff in the door corner and let go a little while after. h. On 7-31-19 it was noted Tenant #2 told staff that he loved them and staff needed to end her relationship immediately to love him. Tenant #2 then got up and approached staff and staff put a chair between them. Tenant #2 shoved the chair out of the way to get staff and staff ran around the other side of the table. i. On 8-7-19 it was noted Tenant #2 was more	A 083		

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A 083	Continued From page 19 agitated than normal. He grabbed staff, hit them and yelled at them. He also wandered more and argued with other tenants. j. On 8-19-19 it was noted Tenant #2 exhibited behaviors of increased aggression towards staff, including he pinned a staff up against the wall and made inappropriate gestures and comments towards staff. k. On 8-31-19 it was noted Tenant #2 had attempted to leave the building and staff tried to redirect him. Tenant #2 grabbed both of staff's hands tightly. Later, approximately 30 minutes, Tenant #2 attempted to leave the building and staff redirected him to his apartment. Tenant #2 grabbed staff's arms and tried to get staff out. Staff got her hands free. When staff left the apartment he grabbed staff's hands again and staff could not get out of it. Tenant #2 pushed staff against the door, which shoved staff into the door. Other staff responded and assisted. Staff's arms hurt for approximately five minutes. l. On 9-23-19 it was noted staff observed Tenant #2 was going towards the lobby doors and Tenant #2 began shoving staff. Tenant #2 started jumping around, swung his arms and made strange sounds before acting like he was going to hit staff. m. On 9-30-19 it was noted Tenant #2 burst into tears and became agitated. Per staff Tenant #2 talked about killing himself and how he wanted to kill others. n. On 10-2-19 it was noted Tenant #2 was very agitated and yelled. Night staff informed day staff that Tenant #2 had not slept, had been agitated, non-compliant with medications and aggressive	A 083		

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A 083	Continued From page 20 throughout the night. Day shift staff contacted the on-call nurse and Tenant #2 was sent to the emergency room. Tenant #2 returned with family and no other issues were noted. When family left Tenant #2 started wandering and threatened staff. He said "I'm going to kill all of you and it will be no one's fault but your own." He pulled down his pants in a female tenant's apartment and attempted to climb into bed with a female tenant as staff assisted her. o. On 10-7-19 it was noted Tenant #2 threatened to hit staff in the face but staff blocked the hit with arms. p. On 10-14-19 it was noted Tenant #2 spoke about hanging himself. Later that morning Tenant #2 had no recollection of the conversation and denied wanting to hurt himself or anyone else. q. On 10-17-19 it was noted Tenant #2 was combative towards staff and was not receptive to redirection. 4. Continued record review revealed Tenant #1's service plan dated 10-9-19 reflected aggression and combativeness towards staff. It also reflected Tenant #2 had a history of making statements of self-harm or harm to others. The service plan prior to the 10-9-19 was dated 7-27-19 and did not reflect those behaviors or interventions for Tenant #2's safety and the safety of others. The service plan did not reflect Tenant #2's sexual comments towards staff and interventions. 5. When interviewed on 12-5-19 at 1:56 p.m. the Director of Nursing confirmed the service plans requested were provided for the tenants listed above.	A 083		

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✓ 2/3/20 OK 1130b000

HEALTH FACILITIES

JAN 27 2020

In Response to
Incident Investigation #86500-1
Dated January 23rd, 2020

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared is prepared and/or executed solely because it is required by the provisions of state law.

Evaluation

Regulatory Insufficiency: Tenant rights. All tenants have the following rights: To receive care, treatment and services which are adequate and appropriate (IAC r. 481-67.3(2)).

1. Elements detailing how the program will correct each regulatory insufficiency.
    a. Retraining will be completed with staff on use of equipment and procedure for clearing of alarms.
    b. Elopement drills to be conducted to ensure that staff responding appropriately to alarm system
    c. Retraining will be completed with staff on completion and documentation of safety checks as documented on service plan.
2. What measures will be taken to ensure the problem does not recur.
    a. Staff meeting to be conducted on 1/30/20. Will review with employee's equipment needing to be worn at all times, how to use equipment, and expectation to document safety checks.
    b. Elopement Drills to be completed to ensure staff responding appropriately to alarms, and that process are being followed appropriately.
3. How the Program plans to monitor performance to ensure compliance.
    a. Staff will continue to be trained and educated on alarm response policies and missing person's policy. Training will be documented in employee files.
    b. Elopement drills will be reviewed by DON and ADON to ensure staff understands process and will review any in time training needed during drills.
    c. All documentation will be reviewed by DON and ADON. Any inconsistencies noted or training needed will be addressed by DON and reported back to the Executive Director, Regional RN to ensure follow through and adherence to established policies.
4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will begin to be implemented and or corrected by February 7th, 2020

Evaluation

Regulatory Insufficiency: Policy and Procedures. Program policies and procedures, including those for incident reports. 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 a 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 (231B, 231C, 231D))

1. Elements detailing how the program will correct each regulatory insufficiency.
    a. Retraining to be completed with staff to review the incident report policy and procedure
    b. Staff to be educated on when incident reports need to be completed
    c. Caregiver chart notes to be reviewed by DON/ADON to ensure incident reports filled out as applicable. Random chart audits to be conducted by Regional DON to ensure incident reports completed.
2. What measures will be taken to ensure the problem does not recur
    a. Staff meeting to be conducted on 1/30/20. Will review with employees incident report policy and procedure as well as when to fill out incident reports.
    b. Reviewed with staff understanding of policies and procedures, where they are located, and who to contact with any questions.
    c. Random chart audits to be conducted by Regional DON to ensure incident reports are being filled out appropriately.
3. How the Program plans to monitor performance to ensure compliance.
    a. Staff will continue to be trained and educated on incident reports and when they need to be completed. DON/ADON will contact staff if noted incident report not completed for an incident in which it should have been.
    b. Incident reports will be filed in IR binder at time of incident after reviewed by DON/ADON.
    c. Regional DON will complete random chart audits to ensure incident reports being filled out for all accidents or incidents that affect a resident.
4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will begin to be implemented and or corrected by February 7th, 2020

Evaluation

Regulatory Insufficiency: Service Plans. 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 needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed (481-69.26(231C))

1. Elements detailing how the program will correct each regulatory insufficiency.
    a. Education provided to DON/ADON regarding change of conditions and discretionary notes and when they are to be done
    b. DON/ADON to review random resident chart notes and service plans to ensure accurate information documented on service plan
    c. Regional DON to perform random chart audits to ensure completion and accuracy
2. What measures will be taken to ensure the problem does not recur
    a. DON/ADON to update resident service plans when any change to routine of daily living is determined.
    b. DON/ADON will ensure accuracy of all information on service plans upon admission to facility and at time of change of conditions and/or annual assessments.
3. How the Program plans to monitor performance to ensure compliance.
    a. DON/ADON to review chart notes entered by caregivers to determine if change of condition needs to be completed.
    b. Regional DON to perform random chart audits of service plans and chart notes to ensure accuracy and completion.
4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will begin to be implemented and or corrected by February 7th, 2020