IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 45769-I
45771-C

December 16, 2013

Mr. Nick Lensch, Program Manager
Courtyard Estates at Cedar Pointe
6132 NE 12th Avenue
Pleasant Hill, IA 50327

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – AMENDED FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - COURTYARD ESTATES AT CEDAR POINTE
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Mr. Lensch:

I. Amended Final Complaint/Incident Investigation Report – Courtyard Estates at Cedar Pointe, Pleasant Hill, IA

Enclosed is the **Amended Final Complaint/Incident Investigation Report ("Report")** issued 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, following an investigation by DIA on **November 4 & 5, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Structural Requirements and Criteria for Admission and Retention.

Courtyard Estates at Cedar Pointe ("Program") is being assessed a **$2,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.12(3)(a)(1), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The determination of a **$2,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, the Program failed to keep a tenant with dementia from exiting the program. The tenant was at risk for injury while gone from the building.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of **one thousand three hundred dollars ($1,300)** within 30 days after the notice or service of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of the notice or service of this demand letter.

IV. Conclusion

The Program is being assessed a **$2,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1). The Plan of Correction (POC) submitted on December 11, 2013, has been reviewed and will constitute the final POC related to the on-site visit of November 4 & 5, 2013. The Request for Reconsideration in the area of Program Reporting to Department has been accepted and the Amended Final Report is enclosed. The program has agreed not to appeal the fine and has paid the civil penalty in the amount of **$1,300**.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of notice or service of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Nick Lensch, Program Manager
Courtyard Estates at Cedar Pointe
6132 NE 12th Ave.
Pleasant Hill, Iowa 50327

Complaint/Incident Intake #:

45769-I
45771-C

Date of Complaint/Incident Investigation:

November 4 and 5, 2013

***Monitor(s)*:**

Maribeth Freland RN

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:	3
Number of tenants with cognitive disorder:	23
Total Population of Program at time of on-site	26
TOTAL census of Assisted Living Program	26

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

A. Structural Requirements

Complaint/Incident Allegation: The program reported a tenant eloped without staff knowledge.

- Monitoring Observation: The program reported only one tenant currently residing at the program, Tenant #1, exhibited wandering behaviors and exit seeking behaviors.

  During interview, Staff #1, #2, #3, #4 and #7, all direct care workers, identified Tenant #1 as the only tenant who exhibited wandering behaviors and exit seeking behaviors. All five staff members reported Tenant #1 exhibited exit seeking behaviors multiple times per shift on a routine basis. Tenant #1 would go to the exit doors in the program, push down on the door handle which would activate an audible alarm, then back off from the door at the alarm sounding and go to the next door to attempt the same process.

  All exit doors in the building are alarmed. The front main entrance, southwest front entrance and the two rear exit doors were alarmed with an audible alarm system. The audible alarm system included a keypad that allowed a code to be put in to bypass the audible alarm and the 15 second egress function when opening the door. The alarm would not sound if the code is correctly inputted; however, a message is sent to pagers carried by staff members reporting the door had been opened. If the code was not put in and the door handles were turned to open the door, an audible alarm sounded. If the handle was released, the audible alarm would cease sounding. If the handle was pushed continually, the door lock would release in 15 seconds, allowing egress from the building. The audible alarm would continue to sound and a message would be sent to staff members' pagers notifying them of the door being opened. Each door had a keyed box located at the top of the door that activated and

deactivated the audible alarm feature to the door. Staff members carried a key to the door system. The key was required to shut off the audible alarm should the 15 second egress feature be activated, as the alarm continued to sound audibly until reset. The key could also be used to completely shut off the audible alarm system to each door.

All universal workers carry a pager and a portable two way radio while working so if the universal workers are unable to respond timely to a pager message, they can call to the others for assistance.

The program's policy, titled Elopement Policy, directed staff members to check alarms promptly should a side door alarm sound. Staff members were to check thoroughly inside and outside should an alarm be triggered. If a potential elopement was identified, all tenants were to be accounted for, a search inside and outside for the missing tenant should be initiated and law enforcement should be contacted if the tenant is not found following the search.

Tenant #1, an 81 year old, was admitted to the program on 8-24-13. Tenant #1 had diagnoses of: Alzheimer's Type Dementia, Peripheral Neuropathy, Hypertension, Dermatitis, Alopecia and Irritable Bowel Syndrome. Tenant #1 scored 5 on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #1's service plan documented Tenant #1 was independent with transfers and ambulation. The same service plan documented the Tenant wandered frequently and exhibited exit seeking behavior; therefore, staff members were to attempt redirection by engaging in conversation, offer to assist Tenant #1 into the secured outdoor courtyard or redirect him/her with an activity. Tenant #1 had no history of elopement from the building but often went to the doors attempting to open and frequently told staff members, "I want to go home." During interview with Staff #1, #2, #3, #4 and #7, Tenant #1 went to the program's exit doors multiple times almost daily to try to open the doors but backed away from the door at the first sound of the audible alarm.

On 9-25-13 at approximately 12:55 p.m., staff member pagers received notification that the southwest front exit door had been opened. During interview, Staff #1, CNA, reported she had not heard an audible alarm sound. Staff #1 responded to the door, noting a cognitively intact tenant had gone out the door. The cognitively intact tenant knew the code to input to temporarily deactivate the audible alarm, therefore, Staff #1 had no concern with the audible alarm had not sounded as she assumed the cognitively intact tenant deactivated it with the code. Staff #1 visually checked the immediate exterior perimeters, noting no other tenants outside. Staff #1 was then asked to assist another tenant in the bathroom. Just as Staff #1 began assisting the other tenant with an incontinent bowel movement, another notification came across the pager. Staff #1 reported she again did not hear the audible alarm. Staff #1 reported she called out to Staff #2 and Staff #8 on a portable two way radio indicating her delay and asked them to check the door. Staff #1 reported she heard no return response from either Staff #2 or Staff #8. Staff #1 finished caring for the tenant and assisted the tenant she was working with to a safe place then hurried to the southwest front exit, arriving at approximately 1:00 p.m. During this time, the pager received yet again another notification that the southwest door was opened. Staff #1 got to the door approximately five minutes after the second pager notification. Staff #1 visually checked the outside immediate perimeters, noting only the cognitively intact tenant

who was petting a cat. Staff #1 returned to the building, turned and watched the cognitively intact tenant open the door without putting a code into the pad to deactivate the audible alarm. The alarm did not sound but notification came to her pager. At this time, Staff #1 checked the door, noting the audible alarm had been shut off with a key at the top of the door which disengaged the audible alarm system to the southwest front exit door.

Staff #1 immediately told the registered nurse (RN) the door alarm was turned off and both started checking the program for presence of all tenants, eventually noting Tenant #1 was not in the building. All staff members were notified of Tenant #1's absence from the building and all began looking both inside and outside the program. A visiting home health physical therapy assistant had been in the building. The therapy assistant's teenaged daughter was waiting in the parking lot in her mother's car when she saw an elderly person leave the building, walk up the driveway and turn to the south, walking down the road. The teenager reported this to staff members who were searching the perimeters. Several staff members then began searching the community in cars in search for Tenant #1.

According to the State Climatologist, it was 75 degrees at 1:00 PM on 9-25-13 and partly cloudy with winds from the east at 7 miles per hour (mph).

At 1:25 p.m. the program staff members had not been able to locate Tenant #1. A call was placed to the police department reporting the missing tenant at approximately 1:25 p.m. The program was told the police had already located Tenant #1 and would bring him/her back to the program. Tenant #1 was returned to the program at approximately 1:35 p.m.

The Program RN completed an immediate assessment of Tenant #1, noting no apparent injury. Tenant #1 was wearing a sweater, long pants, socks and shoes during the elopement.

During telephone call, the Pleasant Hill Police office reported receiving a call at 1:21 p.m. related to Tenant #1 on 9-25-13, reporting an elderly person was seen wandering around the off ramp exiting from Highway 65 on University (Highway 163) in Pleasant Hill. The reported indicated the person appeared to be confused. The police office reported the computer report indicated officers located Tenant #1 by the Git N Go gas station on University. The program later notified the Pleasant Hill police office of the missing tenant and the officers returned Tenant #1 to the building. The Pleasant Hill police office signed off on the return of Tenant #1 to the program at 1:38 p.m.

During interview, the Officer who responded to the citing of a confused person wandering around the off ramp exiting from Highway 65 on University (Highway 163) reported finding Tenant #1 by the Git N Go gas station further west of the off ramp, which was 0.8 miles from the program. The police secured the tenant then received a call indicating he/she was from the assisted living program. The officer returned Tenant #1 to the program, indicating staff members were very relieved to have the tenant returned.

Tenant #1 appeared to have traveled from the program on NE 12th Ave. to University (Highway 163); however, the exact route taken by Tenant #1 could not be determined. NE 12th Ave. is a two lane paved road with no sidewalk areas. The speed limit on this street is 35 mph. NE 12th Ave. runs parallel with Highway (Hwy) 163, which is a four lane highway with a posted speed limit of 55 mph. Tenant #1 had walked west on University (Highway 163) where there are no sidewalks. The surface changes from highway pavement to a gravel shoulder. Tenant #1 walked through three busy intersections with stoplights. One of the intersections included two off ramps and to entrance ramps coming and going from Highway 65, a four lane with 65 mph posted speed limits.

The Program Manager initiated an immediate internal investigation into Tenant #1's elopement. Upon initiation of the program's investigation, the Manager noted the audible alarm system attached to the southwest front exit was believed to have been shut off at approximately 7:35 p.m. on 9-24-13 using a key carried only by staff members. Staff #4 and #6, both universal workers, had been carrying out trash and had shut the alarm off as the trash became stuck in the door and the alarm was sounding continually. The Program Manager believed the staff members either forgot to reengage the lock or did not get the lock reengaged appropriately with the key following the trash removal.

During observation of the southwest front exit door, the monitor found the light bulb located at the top of the door that usually indicated solid red if the alarm was engaged and green if the alarm was disengaged or deactivated with the code was missing. A hole remained in the box where the bulb usually was in place. Without the light bulb staff members could not visually determine reengagement of the alarm system.

During interview, Staff #2 reported she did not have a pager to carry on 9-25-13 as the program only had three pagers and the third one was not working when she came on shift on 9-25-13. Staff #2 reported she was in the laundry room folding clothes, which was located down the same hallway as the southwest front entrance but did not hear any audible alarms sound during the time of Tenant #1's elopement. Staff #2 reported she was carrying a portable two way radio but had accidentally bumped the button on the radio to shut it off and was unaware that the radio was shut off until after Tenant #1's elopement.

The monitor attempted to reach Staff #8 but was unable to make contact with her. Staff #8's witness statement, collected by the Program Manager and interview with the Program Manager indicated Staff #8 did have a working pager on 9-25-13 but did not have a working two way radio. Staff #8 had reported noting a pager notification that the door was opened but had not heard an alarm so she did not check the door. Staff #8's employment was terminated following completion of the program's internal investigation as she had not responded to the pager alarm as required by policy.

The monitor walked the distance from the program to the site where police found Tenant #1, taking 20 minutes to arrive at the gas station. The monitor walked at a brisk, even pace.

After the elopement, the program initiated visual checks of Tenant #1 every 15 minutes which continued at the time of the on-site visit. The program had already installed a motion sensor alarm on the door of Tenant #1's apartment in an attempt to know where Tenant #1 was at all times. When Tenant #1 walked through the door of his/her apartment, a message was sent to each pager carried by staff members.

Tenant #1's service plan addressed his/her wandering and exit seeking behaviors. The plan identified ways to redirect Tenant #1. The service plan was updated appropriately following Tenant #1's elopement. Staff members were to each carry a working pager and portable two way radio. On the day of the elopement, two of three staff members did not have either a working pager and/or a working two way radio; therefore, were unable to identify the potential elopement in progress. The audible alarm system had been disengaged with a key by staff members, which bypassed the audible alarm warning that is both meant to deter an exit seeking tenant from continuing to attempt exit from the door and to notify staff members that an unauthorized exit from the door was being attempted. The light on the southwest front exit door audible alarm system was missing, therefore, staff members could not visually check the door to assure the system was activated. The program's system failed to keep Tenant #1 from exiting the building without staff member knowledge or supervision. Tenant #1 was at risk for injury while gone from the building.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481-69.35(1)(b))

B. Staffing

Complaint/Incident Allegation: It was alleged a tenant was not adequately supervised, resulting in the tenant's fall with major injury.

- Monitoring Observation: The program administration reported staffing the program with two to three direct care workers caring for tenants during the day and evening shifts and two direct care workers caring for program tenants during the overnight hours. The Manager, RN and Life Enrichment Coordinator were present routinely Monday through Friday from 8:00 a.m. to 5:00 p.m. Dietary and housekeeping staff members were also routinely present during the day and evening shifts.

  During interview, Staff #1 and #2, both direct care workers, reported three staff members routinely worked on the day and evening shift and two staff members were routinely working on the overnight shift. Both staff members reported a belief that this was enough staff to adequately care for the tenants.

  The monitor reviewed the program's incident reports for a three month period, noting Tenants #1, #3 and #4 had experienced major injuries as a result of an unusual occurrence. The monitor reviewed the clinical records of all three tenants, noting the following:

  Tenant #1, a cognitively impaired, independently ambulatory tenant, experienced a wrist fracture of unknown etiology. Tenant #1 frequently wandered throughout the program and could not be visually observed by staff members at all times. Staff

members noted swelling to Tenant #1's wrist and beginning bruising. Due to dementia, Tenant #1 was unable to indicate whether a fall had occurred or how the injury occurred. Staff members immediately reported the wrist injury to the RN and the nurse immediately obtained medical evaluation for Tenant #1.

Tenant #4, a cognitively impaired hospice tenant, experienced a fall resulting in a major head injury. Tenant #4 had been experiencing weakness and, due to his/her dementia, could not remember to wait for staff member assistance to stand and ambulate. Staff members monitored Tenant #4 visually every 30 minutes in an attempt to prevent Tenant #4 from transferring and ambulating without staff member assistance. Tenant #4 stood and fell in his/her apartment, resulting in a major head injury. Staff members immediately called 911, immediately contacted the RN and Tenant #4 was transferred to the emergency room for medical evaluation.

Tenant #3, an 88 year old, was admitted to the program on 5-4-13. Tenant #3 had diagnoses of Dementia, Depression, Arthritis, Anxiety, Chronic headaches and a history of falls. Tenant #3 scored a 4 on the GDS completed on 8-23-13 and 9-29-13, indicating moderate cognitive impairment. According to the Service Plan, dated 8-23-13, Tenant #3 required staff member assistance with bathing, dressing and medication administration. Tenant #3 was independent with grooming, toileting, transfers and ambulation. The Service Plan lacked specifics indicating Tenant #3 had any concerns with ambulation on all types of surfaces. Tenant #3 was able to use the program's emergency pendant notification system to request assistance with needs and staff members performed visual checks once every hour to assure all needs were met.

Incident reports identified Tenant #3 fell on 8-23-13 during exercise activity, losing balance while rotating his/her leg, causing the fall which resulted in a "goose egg" to the right temporal area of the head. A staff member was leading the exercise activity when Tenant #3's fall occurred. Staff members immediately applied ice to the injury and notified the RN.

Incident reports identified a second fall which occurred during an outing to the local zoo on 9-26-13. Tenant #3 "lost his/her footing" and fell backwards hitting Tenant #3's head on the sidewalk. Staff members immediately applied pressure to the wound, called 911 and Tenant #3 was transferred to an emergency room for medical evaluation and treatment.

During interview, the RN reported two staff members, Staff #7, certified nursing assistant (CNA), and the Life Enrichment Coordinator, accompanied five tenants to the zoo for an outing on 9-26-13.

During interview, the Staff #7 and the Life Enrichment Coordinator both reported taking five tenants to the zoo for an outing. Both staff members reported two tenants were ambulatory and the others were in wheelchairs. At the end of the outing, the group sat at the monkey cage to watch the animals and rest for approximately 15 minutes. When preparing to leave the zoo, the group turned to follow an inclined sidewalk to the zoo exit. Tenant #3 caught his/her shoe end on a raised area at the corner of joining sidewalks causing Tenant #3's foot to turn to the side. Tenant #3 lost his/her balance, falling backwards. Staff #7 was walking next to Tenant #3

pushing one of the other tenants in a wheelchair. Staff #7 attempted to grab Tenant #3's hand but was unsuccessful in stopping the fall. Tenant #3 hit the back of his/her head on the sidewalk during the fall. Staff members immediately applied pressure to the Tenant #3's head injury, called 911 and Tenant #3 was transferred by ambulance to a local emergency room for medical evaluation and treatment. Both staff members reported Tenant #3's gait was steady and usual during the outing prior to the fall.

Tenant #3 was hospitalized from 9-26-13 to 9-29-13 with the diagnosis of Bilateral Frontal Contusions. Tenant #3 returned to the program with staples securing the head laceration. Tenant #3 appeared tired upon return to the program but was able to talk with staff members indicating he/she was "okay". Nurse notes indicated Tenant #3 was able to ambulate independently with a steady gait following return to the program.

Nurse Notes, dated 9-29-13, indicated Tenant #3 returned to the program with independent ambulatory ability, steady gait and a poor appetite. Tenant #3 had an approximate 3 centimeter laceration to the back of the head that had been closed with 24 staples. Tenant #3 had begun experiencing poor appetite while hospitalized.

The Service Plan, dated 9-29-13, indicated Tenant #3 returned to the program with continued need for staff member assistance with bathing, dressing and medication administration. Tenant #3 continued to be independent with grooming, toileting, transfers and ambulation. The program initiated visual checks by staff members every 30 minutes to identify Tenant #3's needs and Tenant #3 had "24/7" one on one supervision. Tenant #3 continued to be able to use the program's emergency pendent system.

During interview, the RN reported Tenant #3's family members did not want Tenant #3 to go to a skilled facility following the hospitalization for rehabilitation due to increased tiredness/weakness. Tenant #3's family made the decision to stay in Tenant #3's apartment 24 hours per day seven days per week to more closely supervise Tenant #3.

Following Tenant #3's hospitalization, he/she ate and drank poorly. Tenant #3 became more lethargic, sleeping more frequently. Tenant #3 began experiencing symptoms of dehydration. On 10-2-13, the RN talked with Tenant #3's family indicating a need for Tenant #3 to go to the emergency room to receive intravenous fluids. The family agreed and Tenant #3 was transported via ambulance to the emergency room for medical evaluation and treatment.

Tenant #3 was admitted to the hospital on 10-2-13 through 10-11-13 due to dehydration with associated critical blood potassium levels. While hospitalized, Tenant #3 was admitted to hospice services with the diagnosis of malnutrition as a result of adult failure to thrive. Tenant #3's family and a private care giver continued to provide 24 hour supervision seven days per week. Tenant #3 returned needing the assistance of one person for ambulation but had been progressively improving since the second hospitalization.

During the on-site visit, the monitor observed Tenant #3 ambulation without any devices with only stand by assistance throughout the building. Tenant #3 was in good

spirits. Tenant #3's gait appeared steady. Tenant #3's family continued to stay with Tenant #3 16 hours per day seven days per week. The family member present during the monitor's observation reported Tenant #3 had lost approximately 18 pounds but appeared to be doing much better. The family member reported continued one-on-one supervision "just to make sure nothing else happens."

Regulations do not prescribe tenant/staff ratios. The program direct care workers believed the tenant/staff ratios were adequate to meet the needs of the tenants. Staff members addressed injuries and changes in health condition in a timely manner when Tenants #1, #3 and #4 were injured.

- Regulatory Insufficiency: None noted.

During the course of the investigation the monitor identified the following:

C. Criteria for Admission and Retention

Monitoring Observation: Tenant #1 scored 5 on the GDS, which indicated moderately severe cognitive decline. Tenant #1's service plan documented Tenant #1 was independent with transfers and ambulation. The same service plan documented the Tenant wandered frequently and exhibited exit seeking behavior; therefore, directed staff members to attempt redirection by engaging in conversation, offer to assist Tenant #1 into the secured outdoor courtyard or redirect him/her with an activity. Tenant #1 had no history of elopement from the building but often went to the doors attempting to open and frequently told staff members "I want to go home." During interview with Staff #1, #2, #3, #4 and #7, Tenant #1 went to the program's exit doors multiple times almost daily to try to open the doors but backed away from the door at the first sound of the audible alarm.

Tenant #1's clinical record included the following:

On 8-24-13 Tenant #1 was admitted to the program.
On 8-26-13 Tenant #1 was exit seeking multiple times throughout the day, stating "I want to go home" and was combative with staff members when attempting to redirect. Tenant #1 was biting, kicking, scratching and hitting staff members. Tenant #1 went into the enclosed courtyard in the middle of the night, grabbed a bird feeder and began hitting the windows of other tenants yelling "help me" and waking the other tenants.
On 8-27-13 Tenant #1 exhibited exit seeking but was easily redirected and was telling others "I want to go home."
On 8-30-13 Tenant #1 became combative with staff members, told them "I'm going to kill you then kill myself".
On 9-1-13 Tenant #1's physician changed Tenant #1's Clonazepam (an anticonvulsant often used to treat acute mania) from as needed to routine three times daily and initiated the use of Trazadone (an antidepressant) at bedtime. A motion sensor was added to Tenant #1's apartment door due to Tenant #1's continued exit seeking.
On 9-3-13 Tenant #1 became upset following family visit, was telling others "I want to go home" with much redirection required for several hours.

On 9-6-13 Tenant #1 was exhibiting "severe exit seeking" and kept telling others "I want to go home."
On 9-7-13 Tenant #1 attempted to elope out a back door exit. Staff members responded timely to prevent the elopement and Tenant #1 was easily redirected back into the building.
On 9-9-13 Tenant #1 exhibited increased anxiety during the night, was exit seeking multiple times in the evening shift and was awake multiple times throughout the night.
On 9-10-13 Tenant #1 exhibited continued exit seeking and experienced an incontinent episode. (A urinalysis was completed on 9-11-13 with no urinary tract infection noted.)
On 9-11-13 Tenant #1 continued to exhibit increased anxiety and exit seeking behaviors. Tenant #1's physician increased the dosage of the bedtime Trazadone from 50 milligrams (mg) to 100 mg.
On 9-13-13 Tenant #1 exhibited minimal exit seeking.
On 9-17-13 Tenant #1 exhibited exit seeking behaviors.
On 9-20-13 Tenant #1 began requiring more assistance with bathing and grooming and was exhibiting continued exit seeking.
On 9-21-13 Tenant #1 exhibited exit seeking behaviors but was easily redirected. Later in the day Tenant #1 was unable to be redirected. Was screaming and kicking at the doors when unable to exit for several hours on the evening shift.
On 9-22-13 Tenant #1 exhibited continued exit seeking. He/she became upset when staff members attempted to redirect from exiting attempts, grabbed a staff member's wrist and scratched the staff member. Tenant #1 was screaming at staff. Later, Tenant #1 grabbed another staff member's chest and twisted his/her fingers pulling the staff member's skin.
On 9-23-13 Tenant #1's physician discontinued the Clonazepam, initiated the use of Lorazapam (an antianxiety medication) on an as needed basis, and added a morning dose of Trazadone 25 mg to Tenant #1's medication regime.
On 9-24-13 Tenant #1 exhibited continued exit seeking behavior but was easily redirected.
On 9-25-13 at approximately 12:55 p.m., Tenant #1 eloped from the building without staff member knowledge or staff member supervision. Tenant #1 was missing from the program for approximately 40 minutes and was found by police officers approximately 0.8 miles from the program wandering around areas of highway off ramps and busy intersections.
On 9-26-13 Tenant #1 had periods of increased anxiety.
On 9-28-13 Tenant #1 followed a group of visitors out the front main entrance. Staff members were able to return Tenant #1 back into the building without incident. Staff members found Tenant #1's right wrist to be swollen and beginning to bruise. When staff members touched the wrist, Tenant #1 reported pain. Tenant #1 was diagnosed having a fracture of the ulna and radius. The wrist was splinted at the emergency room.
On 9-30-13 Tenant #1 exhibited exit seeking behaviors and was telling others "I want to go home." Tenant #1's physician changed the Lorazepam order from as needed to three times routinely on a daily basis and once as needed daily and increased the morning Trazadone from 25 mg to 50 mg every morning. (Tenant #1 continually removed the splint from the fractured wrist throughout 10-1-13 to 10-17-13 at which time the wrist was casted.)

On 10-10-13 Tenant #1 placed clothing in the microwave in his/her apartment and turned the microwave on. Staff members found the clothing due to a foul odor that was emitting while the clothing was heated in the microwave. The microwave was removed from Tenant #1's apartment. Later in the day staff members found Tenant #1 messing with the television wires, attempting to remove wires from the television. The television was removed from Tenant #1's apartment.
On 10-11-13 Tenant #1's physician increased the morning Trazadone from 50 mg to 75 mg every morning.
On 10-16-13 staff members documented Tenant #1 had begun to refuse showers.
On 10-17-13 Tenant #1 pulled apart the thermostat in his/her apartment leaving exposed wires dangling from the box.
On 10-18-13 Tenant #1 exhibited exit seeking, looking for a way out to go home.
On 10-19-13 Tenant #1 exhibited exit seeking, looking for a way out to go home. Tenant #1 pulled down his/her pants and urinated on the living room floor in his/her apartment. Tenant #1 was awake multiple times throughout the night.
On 10-21-13 Tenant #1 exhibited exit seeking behaviors.
On 10-22-13 Tenant #1's physician discontinued Lorazepam and initiated the use of Xanax (an antianxiety medication) to be administered three times routinely daily and once on an as needed basis daily and increased the morning Trazadone from 75 mg to 100 mg. Tenant #1 was exit seeking but was easily redirected.
On 10-24-13 staff members documented noting less anxiety and exit seeking noted.
On 10-26-13 Tenant #1 was actively exit seeking with easy redirection.
On 10-29-13 Tenant #1 exhibited exit seeking behaviors and told others "I want to go home."
On 10-30-13 Tenant #1 was awake most of the night attempting to exit seek and exhibited increased anxiety and agitation throughout the night.
On 10-30-13 Tenant #1's physician initiated the use of Zoloft (an antidepressant).
On 11-1-13 Tenant #1 exhibited exit seeking behaviors. Tenant #1 attempted to exit the front main exit but was stopped by staff members. Tenant #1 punched a staff member in the stomach when attempting to redirect.

During the on-site visit, the monitor observed Tenant #1 continually exit seeking from the front main exit and the southwest front exit for a continuous one hour period. Tenant #1 would push down on the door handle, the audible alarm would sound, then Tenant #1 was back away and walk to the next door to try to open in the same manner.

Tenant #1 exhibited exit seeking behaviors on an almost daily basis from 8-26-13 to 9-25-13 at which time Tenant #1 successfully eloped from the building. During the elopement, Tenant #1 was at serious risk for injury as he/she was found 0.8 miles from the program and had walked in areas of high speed traffic and highway off ramps and entrance ramps. Following the elopement, Tenant #1 had gotten the doors open and made it outside two other times with staff members getting to the tenant before he/she could leave the immediate perimeter. Tenant #1 struck staff on 8-26-13, 9-22-13 on two separate occasions and on 11-1-13. Tenant #1 became aggressive, attempting to break tenant apartment windows with a bird feeder on 8-26-13 and kicking the program's exit doors continually for several hours on 9-21-13. Tenant #1 placed clothing in a microwave and turned the microwave on, took apart wires on a television and a thermostat and urinated on the floor in his/her apartment. Due to Tenant #1's continual exit seeking behaviors, multiple exit attempts, one elopement

and multiple behaviors that place either Tenant #1 or others at risk, Tenant #1 exceeded the level of care allowable for an assisted living program.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk. (IAC r. 481-69.23(1)c(1)(2))