AL Survey Trends Report

July, August, and September 2019

A LeadingAge Iowa Publication to help Assisted Living Programs track insufficiency data from the Iowa Department of Inspections and Appeals and utilize the information for performance improvement.

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JULY, AUGUST, AND SEPTEMBER AL SURVEYS RESULT IN MULTIPLE INSUFFICIENCIES AND SUBSEQUENT FINES RELATED TO TENANT RIGHTS …

by Liz Davidson, Director of Clinical Services

In each of the insufficiencies resulting in fines related to tenant rights, a significant incident occurred. Specifically, the largest fine was imposed after a resident asphyxiated and died in an improperly placed bed rail. The second largest fine was imposed after a resident suffered a head injury resulting in death, and the third fine was imposed after a tenant eloped. The commonality in each of these scenarios was a breakdown in the Programs' safety systems. Of note, in the second example which included a fall with head injury, the Program also received a citation related to staffing after staff interviews revealed that "more often than not", they did not have adequate staff available to provide care and could not keep up with safety checks as directed by the Tenants' service plans. In Chapter 67, the regulation for Tenant Rights (67.3) outlines several rights that Programs must support. In each of these insufficiencies, the specific right that was not met was that the tenants have the right to receive care, treatment, and services which are adequate and appropriate.

For questions related to these or other insufficiencies, contact Liz Davidson, LAI's Director of Clinical Services.

Insufficiencies

Criminal, Dependent Adult Abuse, and Child Abuse Record Checks (481-67.19)
($500 fine) Failed to request an evaluation with DHS to determine whether an employee's crime warrants prohibition of the person's employment for Staff B and Staff C. Staff C's background check identified they had a record of operating while intoxicated, first offense. There was no record the Program requested an evaluation with DHS to determine whether the crime warrants prohibition of the person's employment. Staff B's background check identified there was a record of Theft in the 5th degree. There again was not record the Program requested an evaluation with DHS to determine the crime warranted prohibition of the person's employment.

($500 fine) Failed to complete child and dependent adult abuse record checks for 2 of 2 staff reviewed. Review of Staff A's file revealed a hire date of 6-18-18. No record of child and dependent adult abuse record checks could be located. Review of Staff B's file revealed a hire date of 6-4-18. No record of child and dependent adult abuse record checks could be located.

Failed to request background checks prior to employment for 2 of 8 staff and failed to ensure background checks were valid for 1 of 8 staff reviewed as the staff's background checks were completed more than 30 days prior to hire.

Failed to complete a criminal, child abuse and dependent adult abuse background check prior to employment for 1 of 5 staff reviewed. Background check was completed after employment start date.

Failed to complete criminal, child abuse, and dependent adult abuse background checks prior to employment for 1 of 6 staff reviewed.

Failed to obtain a completed criminal background check and abuse registry background check prior to staff employment.

Failed to obtain the approval from DHS to determine if employment was prohibited prior to employment for 1 of 6 staff reviewed.

Policies and Procedures (481-67.2)

($500 fine) Failed to report an allegation of suspected dependent adult abuse to the Department within 24 hours or the next business day as required. Staff failed to report to the Charge Nurse an incident dated 4/11/2019 in which Staff A witnessed Staff C stand in front of Tenant #1's walker, trying to redirect her when Tenant #1 swung at Staff C. Staff C then put her hands up and yelled, "Don't you dare smack me, because I will smack you back." Tenant #1 immediately started crying and put her face in her hands.

Failed to follow policies and procedures for medication administration and documentation of narcotics for two Tenants. Review of Tenant #1's March through July 2019 MAR revealed staff failed to consistently count and document the number of tablets remaining after administration as well as at shift change on the Medication Count Sheet. Tenant #2's MAR revealed they received hydrocodone every six hours as needed; during medication pass on 7/8/19 Staff A handed Tenant #2 a PRN hydrocodone but failed to observe the Tenant swallow the medication. Tenant #2 proceeded to put the hydrocodone on their side table and did not take the medication. Staff A called for another staff member to count the remaining hydrocodone and noted the count to be off by one. That staff instructed Staff A to notify the nurse on the count. Continued review of the July hydrocodone count sheet revealed medication was administered as ordered but staff failed to consistently document on the July MAR each time hydrocodone was administered.

Failed to follow its policy regarding the administration and documentation of medications. Tenant #1's July and August 2019 MARs revealed the following: Accu-check, test 3 times daily, if blood glucose was greater than 300 then give 8 units. It reflected times of 8 am and 5 pm. The order reflected a frequency of twice daily, before breakfast and supper. The frequency indicated in the directions on the MAR, of three times daily, did not match the order. Additionally, Tenant #1 received scheduled Levemir Insulin, inject 20 units SQ daily at

bedtime at 8pm. In July 2019 there were four times at 8am and 15 times at 5pm that Tenant #1's blood glucose levels were greater than 300; however, staff initialed for the administration of the Novolog insulin 23 times at 8am from 7-9-19 to 7-31-19. In August 2019 there were two times at 8am and 19 times at 5pm and 26 times at 8pm from 8-1-19 to 8-27-19 that Tenant #1's blood glucose levels were greater than 300, however staff initialed for the administration of Novolog insulin. Tenant #2's July and August 2019 MARs reflected the following: The order dated 7-2-19 for Humalog sliding scale insulin with meals was not transcribed to the MAR and there were no orders found to discontinue the sliding scale from 7-2-19 to 7-11-19. Nitroglycerin was prescribed to Tenant #2 and listed on the medication list from the PCP; however, it was not listed on the MAR and no communication to the PCP regarding the Program not storing or administering the medication could be located. Blood glucose checks three times daily at 8am, 12pm, 5pm was indicated. On 7-7-19 and 7-9-19 at 12pm the blood glucose check was not documented as completed. On five different dates in July at 12pm and four different dates in August staff recorded their initials; however, did not document the blood glucose reading. On 8-12-19 at 12pm the blood glucose check was not documented as completed.

Failed to follow their policy regarding the identification, investigation and reporting of dependent adult abuse after a report of allegations by Tenant #1. In June 2019 Tenant #1 had reported Staff A had brushed their arm against their breasts up and down while they were in the Tenants shower replacing a shower head as the Tenant was asked to come into the shower to show them where they would like the shower head placed. Tenant #1 did not want Staff A to know they made these allegations and did not want anything to be done about the matter. The Director of Maintenance was instructed to not allow Staff A to do work in Tenant #1's apartment anymore. Staff A retired on 7/31/19 and no one ever mentioned the allegations to Staff A.

Failed to follow the policy regarding bedside positioning bars for 6 of 6 tenants who utilized positioning bars. Tenant 1 was found deceased in her apartment with her feet entangled in the sheets and her neck resting on the U bar attached to her bed with the nurse on-call button activated. Autopsy revealed that the death was due to positional asphyxia from the weight and pressure on her neck in relation to the bed rail. The policy regarding bed rails had not been followed as there were no signed releases, physician orders, and assessments prior to installation of the U bars in 6 of 6 tenant rooms.

Failed to immediately record incidents for 1 of 1 tenant. Reports dated 7/1/19 documented eight incidents for Tenant #1 that occurred between 3/22/19 - 5/9/19. An interview with the director on 9/11/19 revealed that she learned staff members documented unusual occurrences for Tenant #1 in the progress notes and not on Incident Reports.

Failed to complete an incident report for Tenant #1. Review of incident report completed by the ADON on 6/25/19 indicated a 5 mg methadone tablet was mistakenly given to Tenant #1 which resulted in a double dose on the night of 6/24/19 instead of the ordered 2.5 mg order for methadone. The incident report was incomplete and did not reveal the full picture of the discussion held between hospice and the ADON on 6/24/19. Tenant #1 was given five

double dosages not just on 6/24/19. The doctor was notified on 6/24/19 and Tenant #1 showed minor signs of sleepiness due to the medication error. Tenant #1's MAR revealed on 7/11/19, 7/12/19, 7/13/19 and 7/14/19 Tenant #1's order for 2.5 mg of methadone at bedtime had dropped off the documentation record. Nurse's notes completed on 7/17/19 by the DON revealed a notation Tenant #1 had not received their methadone dosage on 7/12/19 and 7/13/19 due to the medication being absent from the MAR. On 9/18/19 after review of Tenant #1's MAR the DON stated the methadone order for Tenant #1 was absent from the MAR on 7/11/19, 7/12/19, 7/13/19 and 7/14/19 resulting in four days without the medication. No side effects were noted. No incident was completed on this medication error.

Tenant Rights (481-67.3)

($10,000 fine) Failed to provide care, treatment and services that were adequate and appropriate for 1 of 1 tenant identified. Tenant was found deceased in her apartment with her feet entangled in sheets and her neck resting on the U bar attached to the bed. The autopsy report revealed the tenant died from positional asphyxia. The position the decedent was found in placed significant weight and pressure on her neck in relation to the bed rail. Investigation revealed that the U bar was not properly leveled and had no strap.

($2500 fine) Failed to ensure adequate and appropriate care was provided to 2 of 6 tenants reviewed. Review of documentation for Tenant #1 revealed the tenant was to be checked by staff sixteen times per 8-hour shift (once every 30 minutes). There were several large gaps (1-6-hour intervals) where there was no documentation of checks being done during the month of May 2019. On 5/26/19 the documentation revealed Tenant #1 was checked at 5:00 AM but not again until 6:55 AM at which time the Tenant was heard yelling and found on the floor by her sink with an abrasion to her right elbow. Tenant #4 has a diagnosis of Lewy Body Dementia and a note from Tenant #4’s physician noted Tenant #4 was having more difficulty walking and was shaky. A service plan dated 3/21/19 noted Tenant #4 was at risk for falls due to his history and was to receive safety checks for falls 16 times per 8-hour shift (every 30 minutes). Progress notes reflected Tenant #4 fell twice on 4/3/19 with no apparent injury, once on 4/5/19 with no apparent injury, and once on 4/6/19 resulting in pain in his hip with a subsequent transfer to the hospital where he was diagnosed with a hematoma and confusion, returning to the Program later in the day. On 4/7/19, the tenant fell and had an open area on the top of his head. He was again transferred to the hospital and diagnosed with a brain bleed and was admitted to the hospital. As a result, the tenant was unresponsive with a poor prognosis. Tenant #4 returned to the Program on hospice on 4/8/19 and passed away on 4/15/19. A review of documentation for April 2019 identified Tenant #4 received no documented safety checks until 4/8/19 at 4:30 PM.

($1000 fine) Failed to provide appropriate care to 1 of 1 tenant identified as a result of a program self-reported incident. Tenant #1 was admitted to the program on 5/7/19 with moderately severe cognitive decline. An unusual occurrence report dated 5/23/19 revealed Tenant #1 eloped from the building at 4:50 p.m. from the courtyard attached to the memory care unit. The back-up RN received a call from an employee at a nearby school informing her she had seen Tenant #1 walking down the road. The school employee also notified Tenant #1's spouse she had seen Tenant #1. Tenant #1's spouse found Tenant #1 and returned

Tenant to the program. Tenant was found 1.1 miles away and had crossed a highway before being found. There were no injuries resulting from the elopement. When interviewed on 7/18/19 at 3:50 p.m. the Director stated a page did go off notifying staff of the egress, but no one responded to check the gate as the alarm had been going off all day.

Failed to ensure a tenant's treatment and services during the medication pass were adequate and appropriate. Observation during noon medication pass revealed Staff C accidentally dropped two 650mg caplets of Acetaminophen on Tenant #1's bathroom floor. Staff C picked up both pills from the floor, put them back in the medication cup and proceeded to give the pills to Tenant #1. Staff C was stopped by the monitor. Staff C threw the pills away in Tenant #1's bathroom trashcan and went to find the RN for direction. The nurse directed Staff C to use Tenant #1's spares. Staff C did so without washing her hands after removing the pills from up off the floor and/or prior to handling Tenant #1's cassette to remove the spare medication. Review of the medication policy revealed the policy did not include direction on handwashing and/or procedures for the wasting of a resident's medication after dropping on the floor.

Failed to provide appropriate treatment and services for Tenant #2. Review of the May MAR from 5/13/19 revealed staff failed to have the Lidocaine patch applied for 8 days. Staff documented no patches were available. The June MAR reflected they did not use a patch from 7/2/19 to 7/5/19 as no patches were available according to staff documentation.

Failed to provide services that were adequate and appropriate for 2 of 5 tenants reviewed. Tenant had an order for Lorazepam twice daily for anxiety and aggressive behaviors and a second order for Lorazepam at bedtime. It was documented multiple times that medication was not given. Medications were not given multiple times due to unlicensed staff documenting as not needed.

Failed to ensure healthcare documents regarding tenant's care and services were signed by the tenant and/or a designated legal representative for healthcare for 1 of 2 discharged tenants reviewed.

Failed to provide adequate and appropriate services to meet tenants' needs, specifically services identified in tenants' service plans. Tenant #1, who lived in the dementia unit, was found outside unattended in a gated courtyard on multiple occasions, and on one occasion the tenant opened the gate and walked into the driveway. Tenant #1's service plan indicated that they required assistance for redirection of time and place, and all tenants required supervision in the gated courtyard.

Failed to provide care, treatment, and services that were adequate and appropriate for 4 of 4 current and one former tenant reviewed who resided in the dementia unit based upon improper medication administration techniques related to handwashing, donning gloves, crushed medications, and eye drops. Lack of supervision that crushed medication in applesauce was completely taken during mealtimes and to ensure the correct tenant took the

correct medication in the food cup on the table. Additionally, the exhaust fan in a tenant's apartment was not working and had not been addressed in months.

Medications (481-67.5)

Failed to consistently administer medications as prescribed for 1 of 4 tenants reviewed. According to progress notes of Tenant #1, tenant did not receive Levetiracetam solution 6/3/19 - 6/5/19 and was noted as "med not available". Staff A said staff generally would notify the nurse/pharmacy a week before medication would run out, but it was difficult to tell with Tenant #1's liquid medication when this should have occurred.

Failed to consistently administer medications and physician ordered treatments as prescribed for four Tenants. For example, Tenant #1's MAR indicated insulin and blood glucose assistance was not documented as completed per order, as staff did not consistently document the units of insulin administered; Tenant #5's July 2019 MARs reflected multiple missed doses of Prednisolone AC 1% eye drop as well as missed doses of several other medications throughout the month.

Failed to ensure all medications administered were documented on the MAR. A review of Tenant #1's MARs revealed several gaps in the documentation with no explanation of why the medication was not documented or administered.

Failed to ensure the medications for Tenant #1 were administered as ordered by the physician. Review of incident report completed by the ADON on 6/25/19 indicated a 5 mg methadone tablet was mistakenly given to Tenant #1 which resulted in a double dose on the night of 6/24/19 instead of the ordered 2.5 mg order for methadone. The incident report was incomplete and did not reveal the full picture of the discussion held between hospice and the ADON on 6/24/19. Tenant #1 was given five double dosages not just on 6/24/19. The doctor was notified on 6/24/19 and Tenant #1 showed minor signs of sleepiness due to the medication error. Tenant #1's MAR revealed on 7/11/19, 7/12/19, 7/13/19 and 7/14/19 Tenant #1's order for 2.5 mg of methadone at bedtime had dropped off the documentation record. Nurse's notes completed on 7/17/19 by the DON revealed a notation Tenant #1 had not received their methadone dosage on 7/12/19 and 7/13/19 due to the medication being absent from the MAR. On 9/18/19 after review of Tenant #1's MAR the DON stated the methadone order for Tenant #1 was absent from the MAR on 7/11/19, 7/12/19, 7/13/19 and 7/14/19 resulting in four days without the medication. No side effects were noted. Tenant #1's medications were not administered as prescribed in both incidents.

Nurse Delegation (481-67.9)

Failed to provide a sufficient number of staff to fully meet identified needs for 2 of 4 tenants reviewed who resided in the dementia unit. Staff shared that due to insufficient number of staff in the dementia unit, they were directed in a memo to wake at least three residents prior to 6 a.m. (using the overnight staff) to have ample time to get everyone ready.

Failed to provide adequate staffing on the locked memory care unit, potentially affecting all 16 tenants. (See accompanying citation under Tenant Rights resulting in a $2500 fine)

Failed to ensure staff were competent to meet the needs of the tenant. A staff member failed to take vitals and report an illness (vomiting) to the nurse. The lack of reporting and taking vitals resulted in a tenant not going to hospital and ultimately dying from a bowel obstruction.

Failed to ensure documented staff training regarding the administration of nasal medications for 4 of 4 staff. Through record review, it was revealed a Quality Assurance form dated 8-20-19 (also the date of survey) identified nasal spray delegations as an area of concern and the delegating nurse was responsible for completing the delegations on 8-20-19. Record review further identified tenants who required nasal medications.

Failed to document a review to ensure staff were sufficiently trained and competent within 60 days of the newly hired nurse. Record revealed Staff B was hired on 2-7-19. Training and tasks including ADLs, vitals, mobility assistance and transfer assistance was documented by the Nurse on 7-3-19 which was greater than 60 days from the Nurse's hire date. Record revealed Staff E was hired on 9-25-19. Training on ADLs and vitals was dated 7-2-19. Training completed on 7-2-19 did not include all tasks such as: mobility, transfers, gait belts, anti-embolism hose and catheter care.

Failed to provide training on tasks within 30 days of employment. Record review on 8-14-19 revealed Staff C was hired on 7-2-19. Training including ADL, mobility, transfers, gait belt and vitals were dated 7-31-19. Training completed did not include catheter care and anti-embolism hose. Staff C had a Medication Pass Competency Checklist dated 7-5-19 however did not have any delegations for medication delegated tasks including oral medications, eye drops, nasal sprays, nebulizers, inhalers, blood sugars and insulin.

Failed to ensure documented staff training regarding the injection of insulin for six staff members.

Engaged in prohibited services by serving as representative payees of social security for 3 of 3 tenants reviewed whose funds were managed by the program.

Failed to ensure staff received Dependent Adult Abuse Training within 6 months for 2 of 4 staff reviewed.

Evaluation of Tenant (481-69.22)

Failed to fully evaluate tenants needs. Tenant #1 diagnosed with dementia with behavioral disturbance when admitted 5/7/19. Tenant had tried to leave the family home five times in one night. Sundowning behaviors had become a major issue beginning around 3:00 p.m. Physician Admission Orders completed on that date identified Tenant #1 as ambulatory and prone to wandering. Tenant #1 had service assessments dated 5/7/19 and 5/17/19. Neither service assessment addressed Tenant #1's wandering.

Failed to complete evaluations within 30 days of occupancy and as needed with significant change. Tenant #2's file revealed admission date of 12-1-18 evaluations completed 30 days

of taking occupancy could not be located. Tenant #4's file revealed an admission date of 1-25-19 evaluations completed within 30 days of taking occupancy could not be located. Record review revealed evaluations were most recently completed on 6-12-19 and were not completed as needed with a significant change in condition for Tenant #4 including for a diagnosis of gout with dietary recommendation and new orders and treatments, treatment for lesions on their face, refusals of cares, excoriated areas on the buttocks with new orders and treatment and OT services.

Failed to evaluate tenant's functional, cognitive and health status as needed with significant change for 2 of 4 tenants reviewed. Change of condition included a return from the hospital with a catheter and a tenant changing from self-administration of medications to staff administration.

Retention Criteria (481-69.23)

Failed to follow the criteria for admission and retention of tenants by retaining a tenant who had unmanageable incontinence for 1 of 6 tenants reviewed. Despite five to six bathroom assists during a shift, tenant was still often incontinent through clothing, was unable to communicate when needed restroom, and required two people to assist.

Tenant Documents (481-69.25)

Failed to complete incident reports as needed for 4 of 7 tenants reviewed ranging from episodes of inappropriate and unwanted touching, hitting staff, making sexual passes at another tenant.

Service Plans (481-69.26)

Failed to update service plans as needed and failed to have service plans reflect the specific service needs of the tenants. For example, two tenants' service plans were not updated after hospital visits; a tenant's service plan did not reflect that they required a divided plate; two tenants' service plans did not reflect the correct level of assistance for transfers.

Failed to update service plans within 30 days occupancy and failed to have the service plan signed by all parties.

Failed to develop service plans to reflect the identified needs of the tenants. Specifically, service plans failed to include key information, such as, the use of unit dose medications from a pharmacy and twice daily medication reminders provided by staff, a tenants independence with nasal medication administration, a tenant’s back pain and interventions to include opioid use, a tenant’s use of oxygen and a CPAP machine, and adaptive equipment including a side rail and toilet frame.

Failed to develop service plans that reflected the identified needs of tenants. Tenant had functional issues and need to use a continuous positive airway pressure (CPAP) machine. The service plan did not reflect the use of the CPAP machine.

Failed to update service plans as needed and failed to ensure service plans reflected the identified needs of tenants. Tenant #1's service plan was not updated to reflect to hold morning insulin if Tenant #1 did not eat breakfast. Tenant #2's service plan was not updated as needed and did not reflect the change from leg wraps to compression hose. Tenant #3's service plan dated 6-18-19 was not updated as needed and did not reflect the medication refusal, right eye issues with treatment, and treatment for facial lesions. Tenant #4's service plan more recently updated on 6-17-19 was not updated as needed with a significant change in condition and did not reflect the following: a diagnosis of gout with dietary recommendation and new orders and treatments, treatment for lesions on their face, refusals of cares, excoriated areas on the buttocks with new orders and treatment and OT services. Tenant #4 had two open areas, on near coccyx. The evaluation indicated it was "ongoing" and "not new". The service plan dated 6-24-19 and 8-10-19 did not reflect these open areas.

Failed to ensure service plans addressed all need areas and was updated at least annually for 5 of 6 current tenants. Service plans did not address behaviors toward staff during cares, urination/defecation in places outside of apartment, need for 2-person assist for toileting, refusals of prescribed mouthwash, disrobing in common areas, chronic pain interventions, inability to dress properly independently, and episodes of inappropriate/unwanted touching towards other tenants.

Failed to update the service plans within 30 days of taking occupancy for two Tenants. Tenant #2's file revealed an admission date of 12-1-18; an assessment and negotiated service plan summary with review range of 12-28-18 to 12-31-18 indicated it was a 30-day service plan. The document was not signed. A service plan was not updated within 30 days of taking occupancy that was signed and dated by all parties. Tenant #4's file revealed an admission date of 1-25-19. Additional record review failed to produce a service plan updated within 30 days of taking occupancy.

Failed to develop an individualized service plan according to tenants' identified needs, affecting 1 of 1 tenant reviewed. Staff failed to update Tenant #1's service plan after an elopement to reflect exit seeking behavior and interventions to minimize them.

Failed to develop service plans that reflected the identified needs of the tenants. Tenant #1's service plan signed on 7-3-19 did not reflect Tenant #1's identified needs including: history of falls and specific fall interventions, the use of assistive equipment including a wheelchair and toilet riser, services provided by Hospice including bathing, the administration of an anti-coagulant medication, swelling in the lower extremities and weights twice per week and a private caregiver. The service plan also did not reflect the discontinuation of PT and OT services. Tenant #2's service plan did not reflect Tenant #2's identified needs including: the history of cellulitis, the use of a two wheel walker, walking to the dining room one to two times per day, nebulizer treatments, an open area on the buttock with Mepilex treatment and storage and administration of Nitroglycerin.

Failed to reflect person-centered planned and spontaneous activities on the service plans for 5 of 6 tenants reviewed. The service plan referenced the monthly calendar and said that staff

would provide activities based on interest sheet in file but did not reflect specific planned and spontaneous activities.

Failed to update a service plan with a significant change for 1 of 1 tenant. A review of incident report revealed 14 incidents of aggressiveness from 4/17/19 - 6/25/19; however, Tenant #1's service plan was not updated until 6/25/19. The service plan was not updated in a timely manner after a significant change in tenant behavior.

Failed to develop a service plan that reflected the identified needs of 1 of 1 tenant related to assistance with meals and pocketing food, assistance provided with ambulation or checks at night regarding toileting assistance, and discontinuation of hospice services.

Failed to develop service plans that reflected identified needs for 2 of 5 tenants. Plan did not address what type of supervision was needed or provided during smoking or the change of ointment type for wound care.

Nurse Review (481-69.27)
Failed to ensure orders were current. For example, one tenant received new diet orders, but they were not implemented; MARs did not reflect Ativan medication time adjustment for one tenant; one tenant's new wound orders were not transcribed on June or July MARs and were not documented as completed.

Failed to complete nurse reviews every 90 days for four tenants.

Dietary (481-69.28)
Failed to provide an orientation on sanitation and safe food handling prior to handling food for four staff reviewed that served or prepared food. The Executive Director revealed staff signed vomiting and diarrhea procedures and a Conditional Employee and Food Employee Interview. They confirmed Staff A, B, D and E served food and did not have additional training on food safety and sanitation.

Failed to ensure four staff received an orientation on safe food handling prior to preparing or serving food. Each of the four received training, but it occurred 1 to 3 months after hire.

Failed to have 2 of 6 staff reviewed complete an orientation on sanitation and safe food handling prior to handling food.

Dementia Specific Education for Program Personnel (481-69.30)
Failed to ensure 1 of 1 new staff hired since May 2018 had 8 hours of dementia-specific education within 30 days of employment.

Failed to ensure dementia-specific training included hands-on training within 30 days of hire for 5 of 6 staff reviewed.

Life and Structural Safety; Emergency Policies and Procedures (481-69.32)
($500 fine) Failed to ensure door alarms were installed on all exit doors of the ALP/D program.

Failed to have an operating alarm system connected to each exit door in a dementia-specific program as required.

Activities (481-69.34)
Failed to provide activities appropriate for each tenant, potentially affecting all tenants in the dementia unit. Staff admitted that activities could be improved in dementia unit, and staff were unsure whether activities were appropriate for the tenants. Nine of the 10 tenants had a GDS score of four or greater.

Structural Requirements (481-69.35)
Failed to have single-action lockable entrance doors on tenant apartments (26 of 26 doors).

Failed to maintain a well-maintained, clean and sanitary building. Observation on 8-14-19 revealed the hallways of the Program contained small debris on the floors throughout the common areas including the stairway and hallways on both first and second floors. There was also an area on drywall in need of repair outside of one of the apartments on second floor.

Failed to maintain a building that was safe regarding the placement and installation of assistive bed positioning bars for 1 of 1 tenant. Tenant was found deceased in her apartment with her feet entangled in sheets and her neck resting on the U bar attached to the bed. The autopsy report revealed the tenant died from positional asphyxia. The position the decedent was found in placed significant weight and pressure on her neck in relation to the bed rail. Investigation revealed that the U bar was not properly leveled and had no strap.

For comments or questions related to the AL Survey Trends Report, please contact Liz Davidson, LAI's Director of Clinical Services.

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Additional Resources:

Chapter 67

Chapter 69