Health Facilities Division
Adult Services Civil Penalty Citation

Date:	May 8, 2017
Program Name:	Vista Prairie at Keelson Harbour
Address:	2810 Aurora Ave Spirit Lake, IA 51360
Type of Action:	Recertification Visit and Investigations 64398-C, 67007-C, 66743-C
Date(s) of Action:	April 10, 2017 to April 24, 2017

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	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. Based on interviews and record review the Program failed to consistently ensure tenants received care, treatment and services that were adequate and appropriate. This potentially affected all 19 tenants in the memory care unit but specifically Tenants #3 and #13, as well as 2 of 3 of tenants interviewed who resided in the general population program (Tenants #1 and #5). Findings follow: 1. Record review on 4/25/17 revealed a document entitled Keelson Harbour Assisted Living MD Visit/Contact dated 2/3/17 stated, staff reported Tenant #2 was scratching their private area after receiving a shower and there was a foul odor. This document was faxed to the primary care provider on 2/3/17, then re-faxed on 2/6/17, 2/13/17 and 2/15/17. No reply from the primary care provider could be located. When interviewed on 4/25/17 at 3:00 p.m. the Memory Care Nurse could not remember when the issue had been resolved but admitted she had not completed follow up until 4/14/17 when staff reported seeing blood in the tenant's stool/urine. According to a Progress Note dated 4/18/17 a Urinary Analysis was obtained and an order was received for Macrodantin (antibiotic to treat and prevent urinary tract infection). Tenant #2's diagnoses included dementia, depressive disorder and a score of 6 on the Global Deterioration Scale (GDS). According to Tenant #2's Master Care Plan the tenant could not speak and needed assistance to communicate and described the tenant's speech as garbled. The plan directed staff to ask the tenant to show them what may be needed. 2. During an interview on 4/11/17 at 9:10 a.m., an interviewee expressed concern about Tenant #3 wandering in out of other tenant's apartments in the memory care unit. The interviewee described an instance when Tenant #3 wandered into Tenant #2's bathroom and had a bowel movement. Further interviews confirmed Tenant #3 also used Tenant #13's bathroom instead of the bathroom in his/her apartment or the common	**$500.00**

	area bathroom. Review of Tenant #3's Service Notes revealed the following entries: a. 1/16/17 Tenant #3 defecated in the dining room on the floor b. 2/24/17 Tenant #3 voided in Tenant #13's room c. 3/1/17 Tenant #3 used the restroom in another tenant's room d. 3/5/17 Tenant #3 urinated in Tenant #13's shower e. 3/20/17 Tenant #3 voided in Tenant #13's shower f. 3/25/17 Tenant #3 "peed" in Tenant #13's shower g. 4/13/17 Tenant #3 had bowel movement (BM) on the bedroom floor of Tenant #13 A notation in the Nurses Notes dated 4/12/17 revealed staff found Tenant #3 trying to get into bed with Tenant #13. According to an incident report dated 4/12/17 at 2:15 a.m. when staff redirected Tenant #3 the tenant became aggressive and pulled staff's hair and pushed her down. 3. Review of the Assisted Living Entrance form completed on 4/11/17 revealed Tenant #5 had experienced theft of personal belongings. When interviewed on 4/11/17 the Director of Nursing (DON) said the Program had spoken to Tenant #5 and Tenant #4 (the spouse of Tenant #5) and they described the jewelry as costume and only worth sentimental value. According to Tenant #5 and #4 they asked the Program to make sure no staff were in their apartment unless they were present. They said they did not trust the staff and were very hurt/sad that someone had taken their belongings. 4. Review of an Incident Report (IR) dated 1/28/17 revealed Program staff failed to apply Tenant #12's daily Exelon patch (cognition enhancing medication) that day. According to the IR, staff had forgotten. Tenant #12 resided in the memory care unit. 5. When interviewed on 4/12/17 Tenant #1 said the Program failed to ensure he/she had prescribed medications. Tenant #1's daughter stated the tenant was out of their Levothyroxine for at least two days starting on 3/20/17. Review of the Med Administration Summary revealed a notation under Levothyroxine that said, "This medication is kept in a caddy on the bathroom counter. [He/she] will take on [his/her] own early morning. Please check to make sure [he/she] has taken it when giving 7:30 a.m. medications." The DON noted on the Med Administration Summary on 3/20/17 and 3/21/17 that the tenant had self-administered the medication. According to Tenant #1 and her/his daughter, the tenant could not have self-administered the medication as it was not in the pill caddy for those two days. Tenant #1 told the DON on 3/20/17 that the medication had not been taken because it wasn't available but the DON did not refill the pill caddy. According to Tenant #1 and her/his daughter when the Staff Development Registered Nurse (SDRN) was notified about the issue, she got the medication for the tenant. Review of the Program's Bill of Right document revealed the following statement, "To receive care, treatment and services which are adequate and appropriate."	

	When interviewed on 4/23/17 at 3:10 p.m. the DON and SDRN confirmed the Program had failed to ensure tenants had received care, treatment and services that were adequate and appropriate.	
67.3(8)	481-67.3 Tenant rights. All tenants have the following rights: 67.3(8) To present grievances and recommend changes in program policies and services, personally or through other persons or in combination with others, to the program's staff or person in charge without fear of reprisal, restraint, interference, coercion, or discrimination. Based on interviews the Program failed to ensure tenants felt able to express concerns or recommend changes without fear of reprisal. This potentially affected 42 of 42 assisted living general population tenants and/or legal representatives. Finding follows: During a tenant meeting on 4/11/17 at 1:30 p.m. tenants and one family member expressed concerns regarding staffing. They said staff often worked double shifts and were getting worn out. Tenants also said that recently a number of staff had resigned and they had expressed concerns about both issues to administration but didn't feel the concerns were taken seriously. Tenants expressed frustration that when they did bring concerns to the Program's administration they were often labeled "troublemakers" and treated differently. Tenants also said they had been told not to talk to other tenants. On 4/12/17 a tenant expressed frustration that the Program had not invited all tenants to the community meeting held on 4/11/17by the monitor. According to the tenant the Program made an announcement regarding the meeting during lunch but did not attempt to inform tenants who had not been present. Observations revealed most apartments had a clip near the door to leave documents or notes for the tenant. During the exit interview on 4/24/17 the administrative staff acknowledged the Program had issues with tenants who felt targeted and/or unable to express concerns without fear.	

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67.9(1)	481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. Based on observations, interviews and record reviews the Program failed to ensure sufficient numbers of staff trained to meet tenant needs. This potentially affected 62 of 62 tenants who received services. Findings follow: 1. Observations on 4/11/17 and 4/12/17 revealed two staff worked on the first and second shifts in each of the two units (general population and memory care). One of the staff working in the general population area on the first shift had been placed on light duty. An interviewee expressed concern that staff were working double shifts to cover the care needs of tenants. Observations in the memory care unit on 4/10/17 revealed that although two staff were present, one administered/passed medications leaving one staff to attend to 18 of the 19 memory care tenants during preparation for the evening meal. During an interview on 4/11/17 at 10:15 a.m. the interviewee said two staff worked while the Director of Nursing (DON) administered/passed medications because the Program did not have enough staff to meet the tenant needs without assistance from the DON. Review of a document provided by the Vista Prairie Communities Care Coordinator (VPCCC) confirmed two direct care staff worked on the first and second shift while the DON administered/passed medications on 4/11/17. Further review revealed on 4/12/17 two direct care staff worked while Staff Development Registered Nurse (RN) administered/passed medications. According to information provided by the Program, staff administered medications to 20 of the 43 tenants on the general population unit, and all 19 tenants in the memory care unit. 2. During a tenant meeting held at 1:30 p.m. on 4/11/17 attended by 12 tenants and one family member, concerns were expressed about staff working back to back shifts. According to the tenants, they were worried about their well-being due to the length of time staff were having to work. The tenants/family member also expressed concern about the competency of the staff. Two tenants who used oxygen said staff did not know how to change the oxygen tanks even though the Program had agreed to provide that service. Review of information provided by the Program regarding staff resignations between the dates of 1/17/17 and 4/5/17 revealed 12 staff resignations/terminations (six occurred between the dates of 2/10/17 and 2/20/17). Of the 12 only one was terminated due to performance issues. The other 11 were all listed as personal/voluntary resignations. 3. When interviewed on 4/25/17 at 3:10 p.m. the DON and Staff	**$500.00**

	Development RN confirmed nurse reviews and evaluations had not been completed and brought up to date since they were hired at the beginning of December 2016. According to the nurses, the Program had not kept current with assessments/nurse reviews. Review of a list provided by the Program noted 21 assessments/nurse reviews were past due with one being completed on 4/26/17. The nurses said the need for them to assist with medication administration, direct care services and training new staff had prevented them from being able to complete the needed assessments/nurse reviews. During further discussion the nurses expressed their lack of training and knowledge of the assisted living (AL) rules had contributed to nurse review and/or evaluations not being completed as required by the AL rules.	
67.9(3)	481-67.9(231B,231C,231D) Staffing. 67.9(3) Training documentation. The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures. Based on interview and record review the Program failed to maintain documentation of training of nurse-delegated procedures for 5 of 5 staff reviewed (Staff A-E). Finding follows: Record review on 4/11/17 revealed no documentation of delegation training for Staff A, B, C, D or E. When interviewed on 4/11/17 at 12:50 p.m. the Director of Nursing (DON) admitted she could not find the documentation of nurse delegation trainings for the five staff.	
67.9(4)a	481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. Based on staff interview and review of documentation the Program's Registered Nurse (RN) did not complete a review to ensure staff were sufficiently trained and competent to provide services within 60 days of beginning employment. Findings follow: According to information provided by the Program, the Director of Nursing (DON) began employment on 12/1/16. When interviewed on 4/11/17 at 12:50 p.m. the DON confirmed she had not completed a review with the 5 sample staff to ensure they had been sufficiently trained and competent to provide services to tenants within the first 60	

	days of her employment.	
69.26(3)	481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. Based on interview and record review the Program failed to ensure service plans were updated within 30 days of occupancy and with significant changes. This affected 3 of 7 sample tenants reviewed (Tenants #6, Tenant #7 and Tenant #11). Findings follow: 1. Record review on 4/12/17 and 4/23/17 revealed Tenant #6 was admitted to Hospice on 3/7/17. Program staff failed to update the service plan to reflect the admission to Hospice care. When interviewed on 4/23/17 at 3:10 p.m. the Director of Nursing (DON) and Staff Development Registered Nurse (SDRN) admitted the Program failed to update the service plan with a significant change of condition when Hospice care services began for Tenant #6. 2. Record review on 4/12/17 revealed the Program admitted Tenant #10 on 2/21/17. The Program completed a service plan on 4/4/17. When interviewed on 4/23/17 at 3:10 p.m. the DON and SDRN admitted the Program failed to update/develop a service plan within 30 days of admission as required. 3. Record review on 4/12/17 and 4/23/17 revealed Tenant #11 had an increase in falls as documented by Incident Reports dated 2/9/17, 3/2/17, 3/11/17, 3/13/17, 3/15/17, 3/18/17, 3/24/17, 3/27/17 at 9:00 a.m. and 9:30 p.m. Review of Resident Notes revealed an entry on 3/13/17 which stated, Tenant #10's son reported a fracture to Tenant #10's right hand and a brace would be used for treatment. The Program completed a Nurse Review (Assessment Summary) on 3/21/17 but failed to update Tenant #11's service plan with a significant change in condition. When interviewed on 4/23/17 at 3:10 p.m. the DON and SDRN admitted the Program failed to update Tenant #11's service plan with a significant change in condition.	**$500.00**