Iowa Department of Inspections and Appeals
Assisted Living Program
Fimal Complaint-Revisit Investigation Report

Assisted Living Program: **Complaint Intake #: 15910**

Jackie Vaske, Housing Director
Summit Pointe Senior Living
3505 English Glen Avenue
Marion, IA 52302-4711

Date of Investigation:

February 18, 19, 20 & 21, 2008

Monitor(s):

Stephanie Cummins, SW MA
Lincoln Newsom, RN

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation-revisit on-site visit was conducted at Summit Pointe Senior Living on February 18, 19, 20 & 21, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	92
Current number of tenants with cognitive disorder:	0
Total Population:	**92**

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	7
Current number of tenants without cognitive disorder:	2
Total Population:	**9**

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There were Regulatory Insufficiencies this certification period in the areas of occupancy agreement, evaluation of tenant, tenant documents, service plan, nurse review, food service, staffing, dementia-specific education for program personnel, transportation, record checks and other.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Occupancy Agreement – The program shall enter into an occupancy agreement with the tenant or tenant's legal representative, if applicable, prior to the tenant's taking occupancy that clearly describes the rights and responsibilities of the tenant and of the program, and shall sign a managed risk policy disclosure statement. [321 IAC 25.22]

The program received a regulatory insufficiency during the October, 2007 visit related to not consistently reviewing and updating the occupancy agreement, as necessary, to reflect a change in the services and financial arrangement.

Monitoring Observation: Tenant #1, a 62 year old, was admitted on 7-20-07 and diagnoses include: Dementia and HTN. The tenant was staged at a four on the GDS, which indicated moderate cognitive decline. The tenant currently resides in the dementia unit. According to a tenant file review, Tenant #1 moved from the general population to the dementia unit and an addendum to the occupancy agreement was updated appropriately.

- Regulatory Insufficiency: None noted.

During the course of the complaint investigation and revisit, the following information was obtained.

Monitoring Observation: Tenant #12, a 90 year old, was admitted on 2-14-08 and diagnoses include: Hypertension (HTN), Anxiety, Depression and Paranoia. The tenant was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The tenant resided in the dementia unit. The tenant's occupancy agreement was signed by the tenant's legal representative on 2-15-08, one day after taking occupancy.

- Regulatory Insufficiency: The program did not consistently enter into an occupancy agreement prior to the tenant's taking occupancy, by the tenant or tenant's legal representative, if applicable, that clearly describes the rights and responsibilities of the tenant and the program, and shall sign a managed risk policy disclosure statement. (25.22(1))

B. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

The program had received a regulatory insufficiency during the October, 2007 visit for Tenants #1, #2, #3, #4 and #5, related to not consistently evaluating tenants' functional and cognitive abilities and health status prior to taking occupancy, within 30 days of taking occupancy and as needed.

Monitoring Observation: Tenant #1 moved from the general population to the dementia unit on 2-2-08 and health and functional evaluations were not completed, as needed.

Tenant #5, an 85 year old, was admitted on 9-13-07 and diagnoses include: Cerebrovascular Accident (CVA) with Aphasia and HTN. Service notes of 1-12-08 indicated the tenant was taken to the emergency room and admitted with an unknown

diagnosis. Service notes of 1-15-08 indicated the tenant retuned to the program, it does not indicate the tenant was moved into the dementia unit at this time. Health and cognitive evaluations were completed on 1-15-08 upon the tenant's return to the program; however, the program did not complete a functional evaluation. Service notes from 1-19-08 to 2-9-08 indicated the tenant had fallen and had been agitated on at least five occasions. The program did not complete functional, cognitive and health evaluations to determine any modifications to services needed.

Tenant #10, an 83 year old, was admitted on 8-3-07 and diagnoses include: Benign Essential HTN, Osteoporosis, Memory Lapse or Loss and Dementia. The tenant was staged at a seven on the GDS, which indicated very severe cognitive decline. The tenant resided in the dementia unit and died on 2-21-08. Services notes from 12-7-07 through 1-13-08 indicated increased confusion, episodes of unresponsiveness and walking into walls and furniture. Evaluations were not completed as needed. The tenant was hospitalized on 1-13-08 with a grand mal seizure. According to Staff #10, who is a Registered Nurse (RN), the tenant had a change on 2-18-08. Evaluations were dated 2-18-08; however, Staff #10 stated the evaluations were completed on 2-19-08.

The files for Tenant #2 & #8 did not have cognitive, functional and health status evaluations completed following the Tenants return from the hospital. The file for Tenant #3 did not have cognitive, functional and health status evaluation completed with the addition of Physical Therapy. The file for Tenant #7 did not have cognitive, functional or health status evaluations with a change in condition.

- Regulatory Insufficiency: The program did not consistently evaluate each tenant's functional, cognitive and health status within 30 days of occupancy and as needed, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any modifications to needed services. The evaluation shall be conducted by a health care professional or a human service professional. (25.23(2))

C. Criteria for exclusion of tenants - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

During the course of the complaint investigation and the revisit, the following information was obtained.

Monitoring Observation: Tenant #4, an 84 year old, was admitted on 3-15-07, and has a diagnosis of Alzheimer's Disease. The tenant was staged at a five on the GDS, which indicated moderately severe cognitive decline. The tenant currently resides in the dementia unit. The program documented that the tenant was a two person transfer from 10-20-07 through 2-10-08. Service notes from 10-13-07 through 2-17-08 indicated the tenant was incontinent of urine and bowel. Service notes of 1-7-08 indicated the program spoke to the family regarding the tenant exceeding level of care and the need to transfer. The Administrator indicated this had been the tenant's 30 day notice. The tenant continued to reside in the program and the program did not request a waiver from the Department of Inspection and Appeals in regard to the occupancy and retention criteria. A copy of a 30 day notice was requested and the Housing Director provided a letter dated 2-21-08 in which she indicated the tenant was exceeding level of care and the family

needed to look at other options. The program gave the tenant's Power of Attorney a 30 day written notice on 2-21-08. Staff #1, #3, #5 and #6 identified Tenant #4 as a routine two person transfer and as unmanageably incontinent.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who requires routine two–person assistance with standing, transfer or evacuation and on a routine basis, has unmanageable incontinence. (25.23(3)b,g)

D. Tenant Documents – Program maintains a complete file for each tenant containing all appropriate documentation. [321 IAC 25.27]

The program received a regulatory insufficiency during the October, 2007 visit, for Tenant #4, related to not consistently maintaining a complete file for each tenant, including a copy of the tenant's legal representative paperwork.

Monitoring Observation: Tenant #4 had a copy of their legal representative's paperwork in the file. Two new admissions were reviewed and indicated a complete file was maintained.

- Regulatory Insufficiency: None noted.

E. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

The program received regulatory insufficiencies during the October, 2007 visit for Tenants #3 and #4 related to not consistently updating the service plan, as needed, and not consistently developing service plans that reflected the current and identified needs of the tenants.

Monitoring Observation: Tenant #1 moved from the general population to the dementia unit on 2-2-08. A service plan was not developed as needed. On 1-7-08 health and functional evaluations were completed and the service plan was updated; however, the cognitive evaluation was completed on 1-8-08, one day after the service plan was developed. The service plan dated 1-7-08 has N/A (not applicable), under Activities/Socialization. The service plan did not address planned and spontaneous activities for those unable to plan their own.

Tenant #4's service plan is dated 10-11-07. According to the transfer and assist sheets and service notes the tenant has been a two person assist with transfer and mobility since 10-20-07. Service notes from 10-13-07 through 2-17-08 indicated the tenant was incontinent of urine and bowel. The service plan was not individualized and updated with modifications to services and to address activities for tenant's who cannot plan their own.

Tenant #5's service plan of 1-16-08 indicated the tenant is to socialize with other tenants and is encouraged to participate in activities. Service notes of 1-12-08 indicated the tenant was taken to the emergency room. Service notes of 1-15-08 indicated the tenant retuned to the program, it does not indicate the tenant was moved into the dementia unit at this time. The service plan was not individualized and updated with modifications to services and to address activities for tenant's who cannot plan their own.

Tenant #10 had increased confusion, episodes of unresponsiveness and walking into walls and furniture, according to services notes from 12-7-07 through 1-13-08. The service plan was not updated as needed. The tenant was hospitalized on 1-13-08. According to Staff #10, the tenant had a significant change on 2-18-08. The service plan was dated 2-18-08; however, Staff #10, stated the service plan was completed on 2-19-08. The service plan did not address planned and spontaneous activities for those unable to plan their own.

Tenant #11, an 83 year old, was admitted on 1-16-08 and diagnoses include: Arthritis, Left Total Hip Arthroplasty, HTN, Osteoarthritis, Hyperlipidemia and Atrial Fibrillation. The 30 day service plan was updated and signed on 2-18-08, two days late.

Tenant #12 had an initial service plan signed on 2-15-08; one day after taking occupancy. The service plan stated (under Socialization/Activities) the tenant will be encouraged to participate. The service plan did not address planned and spontaneous activities for those unable to plan their own.

Tenant files #2, #3 #7 and #8 were also reviewed and the tenants' service plans were not updated as needed. The service plans did not reflect the needs of the tenants and did not address planned and spontaneous activities for those unable to plan their own.

- Regulatory Insufficiency: The program did not consistently update the tenants' service plans prior to the tenant's signing the occupancy agreement and taking occupancy. A preliminary service plan shall be developed prior to the tenant taking occupancy, by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. The service plan shall subsequently be updated at least annually and whenever changes are needed. When a tenant needs personal care or health–related care, the service plan shall be updated within 30 days of occupancy and as needed, but not less than annually, by a multidisciplinary team that consists of no fewer than three individuals, including a health care professional and other staff appropriate to meet the needs of the tenant, in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. (25.28(2)(3))

- Regulatory Insufficiency: The program did not consistently develop a service plan that is individualized and shall indicate, at a minimum, the tenant's identified needs and the tenant's requests for assistance and expected outcomes. (25.28(4)a)

- Regulatory Insufficiency: The program did not consistently develop service plans based on the evaluations conducted in accordance with 25.23(1) and 25.23(2) and shall be designed to meet the specific service needs of the individual tenant. (25.28(1))

- Regulatory Insufficiency: The program did not consistently develop service plans that identified tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. (25.28(4)d)

F. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

Complaint Allegation: It was alleged Staff # 9, who is a RN, mismanages medications including the following examples. Direct care staff were told to write the medications that come from the pharmacy on the Medication Administration Record (MAR) for new admission, Tenant # 11. There was no physician order to check and verify that the medications are what were ordered. The direct care staff was told to administer the medication to the tenant. It was also alleged Tenant #10, in the memory care unit, was supposed to receive Dilantin at 8:00 a.m. and the family was present and the Dilantin was not given. At 11:00 a.m. the family questioned direct care staff about the medication and was told that Staff #9 was in a meeting and was too busy to give the medication.

Monitoring Observation: Staff #9, stated there were no issues with Tenant #11's medications and MARs. Staff #5 stated when the tenant came in, he/she did not have some of his/her medications and family complained. Upon review of the January 2008 MAR, medications were given according to physician orders.

Staff #3 stated medications arrived for Tenant #12 and Staff #9, told the staff to administer the medications despite not being on the MAR. Staff #3 did not administer the medications.

Staff #9, stated for Tenant #13, Hospice ordered the medication and family picked it up at the pharmacy. Staff read the label over the phone to Staff #9 and the medication was given without a MAR or physicians order.

Staff #9, stated Tenant #10 received all doses of Dilantin post hospitalization on 1-13-08. She stated MARs were available for the tenant to receive Dilantin and she did not recall asking staff to administer Dilantin without the January MAR reflecting the medication. Staff #10, stated the following was hearsay but that she heard staff continuously called Staff #9, to put Dilantin on the January MAR for Tenant #10. Staff would not give the Dilantin without it being on the MAR. Staff #9, had a meeting and did put the medication on the January MAR; however, the medication was administered late. Staff #6 stated Tenant #10 came back from the hospital on 1-16-08 and had medication changes. The tenant's bubblepacks had arrived; however, the January MARs were not updated. Staff #6 stated third shift staff told her to administer the medications and Staff #9, would add it to the MAR when she came in. Staff #6 stated a seizure medication was one of the new medications and was supposed to be administered between 7:00-8:00 a.m.; however, it was not administered until 11:00 a.m. The medications were not given because they were not on the MAR. Staff #6 stated she called Staff #9, when she noticed the medications were not on the MAR and Staff #9, stated she would be there at 9:00 a.m. and would administer the medications. Staff #6 stated Staff #9, arrived at 9:00 a.m.; however, went to a meeting. Staff #6 stated the tenant's son got upset and asked for the nurse to be found to administer the medications. Staff #9, punched the medications out of the bubble packs and put them in a medication cup and Staff #6 and the tenant's son took the tenant's pills to him/her and administered them. Staff #6 stated this occurred at approximately 11:00 a.m. to 11:15 a.m. Staff #6 stated, at noon, the seizure medication

was not on the MAR and Staff #9, again came and punched the medications out of the bubble packs at approximately 1:00 p.m. Staff #9, put the tenant's medications on the MAR at 2:00 to 2:15 p.m. According to the Service Plan, Tenant #10 was hospitalized on January, 2008 for a grand mal seizure and placed on Dilantin at that time.

During the course of the investigation, the following information was obtained.

Monitoring Observation: According to the hospital medication reconciliation report, Tenant #2 was admitted to the hospital on 12-8-07 for Congestive Heart Failure (CHF). Service notes indicated the tenant returned to the program on 12-18-07. According to the patient transfer form, the tenant was to receive Accuchecks four times daily. According to Staff #9 and Staff#10, the tenant did not receive the Accuchecks four times daily. The Accuchecks were discontinued 2-20-08. The tenant had not received a B12 injection since September 2007, according to Staff #9. The tenant had previously gone to his/her physician's office to get the injection; however, Tenant #2 did not show up for scheduled appointments and the B12 injection had not been given by the program. The tenant's service notes included detailed entries of fatigue and feeling worn out, bruising and cuts and complaints of dizziness. Tenant #2 had a diagnosis that included Pernicious Anemia.

The back of the MAR for Tenant #2, dated 2-7-08, stated no medications were given as they were not found in the box. The back of the MAR for Tenant #2, dated 2-16-08, stated, Potassium and Mirtazapine were not initially available in the box; however, were found later. The Potassium was ordered three times daily. The February 2008 MAR indicated one dose of the Potassium was not given on 2/7/08 and 2/16/08. It also indicated one dose of Mirtazapine was not given on 2/16/08.

Tenant #9 had been using a pharmacy of his/her choice. Service notes of 2-5-08 indicated the tenant wished to have the program take over his/her medications. A copy of the tenants Amoxicillin, 500 mg bottle, was obtained indicating the Amoxicillin was ordered by the dentist. The tenant had a dentist appointment and the Amoxicillin was not given to the tenant prior to the appointment. One of the program's RN's indicated they did not have an order for this medication and were unaware of the tenants' appointment. In an interview with the tenants' son, he stated he had forgotten the dentist appointment and the tenant received the medication at the dentist office.

A review of Medication Administration Records (Mar's) for tenant's #1, #2 #3, #5,#7, #8, and #10 indicated the tenants either missed their medications or the medications were not signed off on the MAR, to indicate they were given.

The back of the MAR for Tenant #10 stated Amoxicillin, 875/125 mg, was not in the box.

The back of the MAR for Tenant #11 indicated, on 2-4-08, Azopt, 15 ML was not in the box. On 2-5-08, Azopt, 15 ML, was not in the box and the nurse administered this after receiving it from the pharmacy at 1200. Tylenol, 500 MG, was documented on the back of the MAR as still being in the cup from the previous day on 2-5-08, 2-12-08, 2-15-08, 2-17-08 and 2-20-08.

- Regulatory Insufficiency: When medications are administered or stored by the program, the following requirement shall apply, the administration of medications shall be

provided by an Iowa–licensed registered nurse or advanced registered nurse practitioner registered in Iowa or the authorized agent in accordance with 655—subrule 6.2(5) and 655—subrule 6.3(1) and Iowa Code chapter 155A, the registered nurse shall recognize and understand the legal implications of accountability and the licensed practical nurse shall recognize and understand the legal implications within the scope of nursing practice. The licensed practical nurse shall perform services in the provision of supportive or restorative care under the supervision of a registered nurse or physician as defined in the Iowa Code. (IAC655-6) (25.29(2)a)

G. Nurse Review - Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. [321 IAC 25.30]

The program had received a regulatory insufficiency during the October, 2007 visit for Tenant #3 and Tenant #4 related to not consistently assessing and documenting the tenants' health related activities, with a change in health status.

Monitoring Observation: Tenant files were reviewed and indicated nurse review was not completed every 90 days or as needed for Tenants #1, #2, #7, #8, #9 and #10.

- Regulatory Insufficiency: The program did not consistently assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress on previous recommendations at least every 90 days or if there are changes in health status. (25.30(3))

During the course of the complaint investigation and the revisit, the following information was obtained.

Monitoring Observation: Tenants #1, #2, #3, #4, #5, #7 #8 and #10 did not have medication reviews documented every 90 days or as needed.

- Regulatory Insufficiency: The program did not consistently monitor, at least every 90 days or after a change in condition, each tenant receiving program-administered prescription medications for adverse reactions to program-administered medications and make appropriate interventions or referrals and ensure that the prescription medications are administered consistent with such orders. (25.30(1))

H. Food Service – Program shall provide or coordinate with other community providers to provide hot or other appropriate meal(s) at least once a day or make arrangements for the availability of meals. Menus shall be appropriately planned. If applicable, therapeutic diets shall meet all requirements. Food preparation personnel shall meet all requirements. [321 IAC 25.32]

The program received a regulatory insufficiency during the October, 2007 visit for Staff #1 and Staff #2 related to not consistently providing staff that is responsible for preparing or serving food or both, an orientation on sanitation and safe food handling, prior to, handling food and an annual in-service training on food protection.

Monitoring Observation: Staff files were reviewed and indicated Staff #1 and Staff #2 did not have documented food safety training. Staff #5 had training on 1-18-07 and was

past due for annual food safety training and Staff #6 had training on 1-5-07 and was past due for annual food safety training.

- Regulatory Insufficiency: The program did not consistently provide staff that is responsible for preparing or serving food or both, an orientation on sanitation and safe food handling prior to handling food and an annual in-service training on food protection. At a minimum, one person directly responsible for food preparation shall have successfully completed a state–approved food protection program. (25.32(5))

I. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

The program received a regulatory insufficiency during the October, 2007 visit related to not consistently providing sufficient, trained staff, at all times, to fully meet the tenants' identified needs.

Monitoring Observation: According to interviews, Staff #1, #3, #5, #6 and #7 indicated there was not appropriate nurse delegated training. Staff #7 stated she had no previous medication experience and other direct care staff trained her. She did not have training from nurses at the program. A tenant indicated he/she stopped a staff from administering the wrong medication, Fosamax, a newly ordered medication, to him/her about three weeks ago.

Complaint Allegation: It was alleged the Director of Nursing told Staff #5, a direct care staff, that she did not have to stay in the memory care unit when she was the only direct care staff on duty, leaving the tenants alone in the unit.

Monitoring Observation: Staff #9, stated she had never instructed a staff to leave the dementia unit and stated there had to be 24 hour staffing in the unit. Staff #5 stated one time she was asked by Staff #9, to leave the dementia unit; however, the Activity Director stayed in the unit. Staff #5 indicated she was gone from the unit, approximately 20 minutes, to administer medications. Staff #6 stated she had to leave the dementia unit unattended for about ten minutes to get items for meals. Another staff had to leave the unit to assist her with a tenant who had fallen and was gone for approximately a half hour. Staff #1 stated someone will stay in the dementia unit and said the Activity Director may stay in the unit. Staff #1 indicated on rare occasions staff may have had to leave the unit at night due to a fall in the assisted living/independent living area.

During the course of the complaint investigation and revisit, the following information was obtained.

Monitoring Observation: The staffing on third shift is one direct care staff in the assisted living/independent living area and one in the dementia unit. Staff #9, indicated there was one situation were one staff was not able to stay the whole night in the assisted living/independent living area. Staff #9, asked the staff in the dementia unit if she would be okay if she was in the building by herself. Staff #9 indicated she decided that was not a good thing and called back to the program. The staff who was leaving said she would stay and the area was not left unattended.

During the course of the complaint investigation and revisit, the following information was obtained.

Monitoring Observation: Staff #1, #3, #5 and #6 stated Tenant #10 was bed bound at the time of the on-site and died on 2-21-08. Staff #10, stated the tenant had a significant change on 2-18-08, in the a.m,. with increased seizures. Staff #6 reported she had not worked with the tenant for approximately one month and was not given any instructions for his/her care. She was not told to reposition the tenant or to swab his/her mouth; however, she provided the care. Staff #6 also stated she was not sure what tasks Hospice did and what tasks the program did regarding cares. Staff #6 stated when she came into work on second shift the tenant was on the mattress and box springs and not in the hospital bed. The tenant was wet when the staff arrived and she did not feel the tenant's needs were met and did not feel she could meet the other tenants' needs if she was to meet Tenant #10's needs. Staff #5 stated there was a change in the tenant and she was repositioning the tenant; however, no one told her to do so. She knew this from previous experience. Staff #5 stated she was using swabs for the tenant; however, she was not instructed to do so. She did not know how other staff would know what to do for the tenant's care. Staff #5 stated she had no instruction from the nurses on the tenant's care and there were no task sheets. She thought the tenant was getting good care; however, she could not meet the needs of the other tenants while providing this care. Staff #3 stated the tenant had been unresponsive for the past three to four days and the tenant was repositioned every two hours and staff sponged his/her mouth. Staff #3 stated there was no nurse direction regarding the tenant's condition and she had no instruction to reposition or hydrate the tenant. Staff #3 stated there were no task sheets; however, there was good communication between direct care staff. Staff #7 stated Staff #10, verbally directed care for the tenant; however, the service sheets did not reflect the tasks. Staff #7 stated the tenant was repositioned every two hours, was getting morphine every hour, Lorazapam every four hours and oral care. Staff #7 stated the tenant was getting good care. The Hospice nurse was interviewed and expressed no concerns with the tenant's care. She stated the program nurses, Staff # 9 and #10, were instructing direct care staff on repositioning and liquids for the tenant. Staff #10 verbally instructed the staff and she stated the tenant was getting good care. Staff #9, stated she had not done training with staff regarding the tenant's care. The service sheets from 2-18-08, 2-19-08 and 2-20-08, on all three shifts, do not reflect the care described by staff or the care stated on the tenant's service plan. The service notes dated 1-16-08 indicate the tenant was found on the floor next to the tenant's bed. The tenant's personal alarm was still attached and had not gone off.

During the course of the complaint investigation and revisit, the following information was obtained.

Monitoring Observation: Staff #3, #6 and #7 indicated there were issues with hearing the call lights notification. Staff #10, indicated there would be potential problems hearing the alarms if staff were not near the front desk or by the panel in the dementia unit. Staff #10, stated the receptionist and dementia unit staff were responsible for calling staff in the assisted living/independent living area when call lights go off.

The monitors tested the call light system in the dementia unit and assisted living/independent living area. In the dementia unit, a monitor went into an empty tenant apartment at the end of hall and another monitor remained by the nurse's office where the

panel was located. The monitor pulled the call cord and the monitor by the panel heard the alarm. The monitor in the empty tenant apartment did not hear the alarm. The panel located at the front desk/reception area was tested. One monitor remained by the panel and the other monitor went into a public restroom on the first floor. The monitor pulled the cord in the bathroom. The monitor by the panel heard the alarm and the monitor in the bathroom did not hear the alarm.

During the course of the complaint investigation and revisit, the following information was obtained.

Monitoring Observation: Staff #3, Staff #5, Staff #6 and Staff #7 indicated the staffing was not sufficient with Staff #6 and Staff #7 stating that staffing was not sufficient in the memory care unit. Staff #3, Staff #5, Staff #6 and Staff #7 indicated that tenants or family had complained regarding the lack of help. Staff #7 indicated family helped out in the memory care unit. Staff #10, stated until recently, staffing was sufficient in the dementia unit but there had been two recent admissions. She also indicated that with new admissions and the increased level of care with Tenant #10 there had been no increases in staffing. Staff #10, stated she had asked for additional staff and was told they would have to talk about it. A tenant reported waiting 45 minutes for assistance one time last week.

- Regulatory Insufficiency: The program did not consistently provide sufficient trained staff at all times to fully meet the tenants' identified needs. (25.33(1))

Complaint Allegation: It was alleged Tenant #6 had a doctor's appointment and the nurse did not have anything ready.

Monitoring Observation: Staff #1 stated she was working the dementia unit. Tenant #6's son had called Staff #9, regarding the tenant's appointment. Staff #9, told Staff #1 to bring the medication book up and Staff #1 said she could not do that; however, she would bring it up at an unspecified time. Tenant #6's son had to wait on the medication sheets and for the tenant to get ready due to Staff #9, not telling Staff #1 of the tenant's appointment. Staff #1 was only told to bring the medication book up and not about the appointment. Staff #1 reported the tenant ended up getting the medication sheets. Staff #9, indicated there were no issues with paperwork or missed appointments for Tenant #6. The tenant's file was reviewed and service notes did not discuss the issue noted above.

- Regulatory Insufficiency: None noted.

During the course of the complaint investigation and the revisit, the following information was obtained.

Monitoring Observation: Staff #9, stated she went to Minnesota for corporate management training; however, she did not receive training on state regulations. Staff #10, stated she had very little training and stated the former Program Director helped her. Staff #10, stated she trained Staff #9, and stated she learned by asking questions.

- Regulatory Insufficiency: The owner or management corporation of the program did not ensure that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. (25.33(5))

During the course of the complaint investigation and the revisit, the following information was obtained.

Monitoring Observation: According to the Dietary Manager, on 2-17-08, the oven exhaust fans in the kitchen were going off and turning back on. On 2-17-08, smoke from the grill reached out into the hallway causing the alarms to go off. Maintenance fixed the issue.

Staff #3 stated she was working on 2-17-08 in the dementia unit. She and Staff #7 did not know where to take the tenants. Staff #3 stated she did not have any training on fire drills and she did not know what to do. Staff #3 reported none of the tenants were evacuated from the assisted living/independent living area. She did not know the doors in the dementia unit released in the event of a fire or drill. Staff #3 stated Tenant #10 was bed bound at the time of the incident.

Staff #7 stated she was working on 2-17-08 in the assisted living/independent living area when the fire alarm went off. Staff #7 indicated Staff #3 did not know what to do for a fire. Staff #7 stated she went to the dementia unit to look at the panel and was not aware of any other panels. The monitors observed a panel at the front area reception desk and a panel in the dementia unit office. Staff #7 stated the maintenance staff shut off alarms and staff did not know how to turn off alarms. Staff #7 stated she went over fire safety in the employee handbook; however, she had never walked through a drill. Staff #7 stated none of the tenants were evacuated at the time of the incident.

- Regulatory Insufficiency: The program did not ensure all personnel of a program knew how to implement the program's accident, fire safety and emergency procedures. (25.33(8))

J. Dementia-specific education for program personnel – A dementia-specific program shall employ or contract with personnel who have received appropriate dementia-specific education and training. [321 IAC 25.34]

The program had received a regulatory insufficiency during the October, 2007 visit in regard to Staff #3 not having the required six hours of dementia training documented within 90 days of hire.

Monitoring Observation: Staff files were reviewed and indicated Staff #3 had six hours of dementia training. Staff #8 had two hours of dementia training; however, did not have six hours of dementia education prior to or within 90 days of employment.

- Regulatory Insufficiency: The program did not consistently provide a minimum of six hours of dementia-specific education and training prior to or within 90 days of employment. (25.34(1))

K. Life safety – The program shall follow written emergency policies and procedures and structural safety requirements. [321 IAC 25.37]

During the course of the complaint investigation and the revisit, the following information was obtained.

Monitoring Observation: Review of fire training documents indicated the program had fire drills on 1-26-07, 3-23-07, 9-19-07 and 12-16-07. The program did not have six fire drills annually. The drill on 12-16-07 occurred at 9:55 p.m., and was the only drill that occurred during hours of sleep.

- Regulatory Insufficiency: The program did not conduct emergency egress and relocation drills not less than six times per year on a bimonthly basis, with not less than two drills conducted when the tenants are sleeping. The state fire marshal shall adopt rules, in coordination with the department of elder affairs and the department of inspections and appeals, relating to the certification and monitoring of the fire and safety standards of certified assisted living programs. (IAC 231C.4) (25.40(1)e)

During the course of the complaint investigation and the revisit, the following information was obtained.

Monitoring Observation: According to the Dietary Manager on 2-17-08, the oven exhaust fans in the kitchen were going off and turning back on. On 2-17-08, smoke from the grill reached out into the hallway causing the alarms to go off. Maintenance fixed the issue.

Staff #3 stated she was working on 2-17-08 in the dementia unit. She and Staff #7 did not know where to take the tenants. Staff #3 stated she did not have any training on fire drills and she did not know what to do. Staff #3 reported none of the tenants were evacuated from the assisted living/independent living area. She did not know the doors in the dementia unit released in the event of a fire or drill. Staff #3 stated Tenant #10 was bed bound at the time of the incident.

Staff #7 stated she was working on 2-17-08 in the assisted living/independent living area when the fire alarm went off. Staff #7 indicated Staff #3 did not know what to do for a fire. Staff #7 stated she went to the dementia unit to look at the panel and was not aware of any other panels. The monitors observed a panel at the front area reception desk and a panel in the dementia unit office. Staff #7 stated the maintenance staff shut off alarms and staff did not know how to turn off alarms. Staff #7 stated she went over fire safety in the employee handbook; however, she had never walked through a drill. Staff #7 stated none of the tenants were evacuated at the time of the incident.

- Regulatory Insufficiency: The program did not ensure all personnel of a program knew how to implement the program's accident, fire safety and emergency procedures and the program did not follow written emergency policies and procedures which include fire safety procedures. (25.33(8)) (25.37(i))

L. Transportation – When the program provides transportation services directly or under contract with the program, the services shall be provided as required. [321 IAC 25.38]

The program had received a regulatory insufficiency during the October, 2007 visit related to not consistently providing a driver with a valid and appropriate Iowa driver's license or commercial driver's license, as required by law, for the vehicle being utilized for transportation.

Monitoring Observation: The drivers of the vehicle being utilized for transportation had appropriate driver's licenses.

- Regulatory Insufficiency: None noted.

M. Activities – The program provides appropriate programming for tenants based on individual interests. Programming shall support the service plans, be consistent with the program statement and occupancy policies, and available in writing as required. [321 IAC 25.39]

During the course of the complaint investigation and the revisit, the following information was obtained.

Monitoring Observation: Interviews with Staff #1 #3, #5 and #6 indicated activities were not sufficient for those with dementing illness. Staff #1 stated activities were not sufficient due to the increased number of tenants. Staff #3 stated there were not appropriate activities offered. Staff #5 stated direct care staff were to conduct activities in the memory care unit and staff were too busy to complete this task.

- Regulatory Insufficiency: The program did not consistently provide appropriate programming for each tenant. Programming did not reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement. (25.39(1))

N. Record Checks – The program conducts applicable employee record checks. [Iowa Code section 135C.33(5)]

The program received a regulatory insufficiency during the October, 2007 visit related to not consistently completing a Department of Public Safety, criminal history check and Department of Human Services, dependent adult abuse check of the potential employee, prior to hire.

Monitoring Observation: Three new employee files were reviewed and background checks were completed appropriately.

- Regulatory Insufficiency: None noted.

O. Other – The provisions of this section address the program's noncompliance with other applicable statutory and administrative rule requirements.

The program received a regulatory insufficiency during the October, 2007 visit for Tenants #3, #4 and #5 related to not consistently promoting a social model of service delivery by focusing on independence, individual needs and desires and consumer-driven quality of care.

Monitoring Observation: Tenant file reviews indicated An Assessment for Need for Medication Reminders, Assistance, Administration or Central Storage document was not found in Tenants #3, #4 and #5's files. Two new admissions were reviewed and the document was not found in the files.

- Regulatory Insufficiency: None noted.

During the course of the complaint investigation and the revisit, the following information was obtained.

Monitoring Observation: The program did not consistently follow the written Plan of Correction (POC) that was submitted on11-29-07 regarding the initial certification visit conducted on October 22, 2007.

- Regulatory Insufficiency: The program did not fully implement the POC submitted in response to the initial certification visit. (25.5(5))

Dated this 2nd day of May, 2008.

Summit Pointe
Senior Living Community

3505 English Glen Avenue
Marion, IA 52302-4711

April 23, 2008

Iowa Department of Inspections and Appeals
Lucas State Office Building
321 East 12th Street, Des Moines, Iowa 50319-0083

Ms. Ann Martin,

I am writing at this time in response to the **Preliminary Complaint Investigation and Revisit Report - #15910** dated April 11, 2008 and received by Summit Pointe Senior Living Community on April 18, 2008.

Summit Point Senior Living Community is submitting the Plan of Correction as directed by DIA and per the time requirement stated within the report. Management and staff are working diligently to meet all compliance requirements with May 23, 2008 set as our deadline to be in full compliance. As required under **Section II – Immediate Sanction –** we will be submitting evidence of the Administrator/Housing Director and program nurses participation in management training.

In addition, and as indicated under **Section II – Immediate Sanction**, Summit Pointe shall submit the required documentation of staff training in regard to future completed fire drills and monthly nurse reviews, on an ongoing basis and until such time it is determined by DIA that this requirement is no longer necessary.

If you have any questions regarding this report, please contact me at 319-373-4242

Sincerely,

Jackie Vaske,
Housing Director

Enclosures

c.c Beth Deneau, V.P. Compliance, Walker Senior Services
Denny O'Donnell, V.P. Walker Elder Care Services

Summit Pointe Plan of Correction 4/23/2008

Citation	Correction Made	Date Completed
A. Occupancy – Survey Identified Tenant **#12** was admitted on 2-14-08. The tenant's occupancy agreement was signed by the tenant's legal representative on 2-15-08, one day after taking occupancy.	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** Marketing Director and Housing Director reviewed Occupancy Agreement policy and procedure in conjunction with the Corporate Director of Home Services and Compliance	2/28/08
Regulatory Insufficiency: The program did not consistently enter into an occupancy agreement prior to the tenant's taking occupancy, by the tenant or tenant's legal representative, if applicable, that clearly describes the rights and responsibilities of the tenant and the program, and shall sign a managed risk policy disclosure statement. (25.22(1))	**What actions the program will take to protect tenants in similar situations.** **1.** Tenants' records were audited by the Housing and the Marketing Directors to ensure all occupancy agreements were signed and dated prior to occupancy. **2.** For those Tenants where a change was identified, however, a new occupancy agreement or Tenant Agreement Financial Addendum was not completed; a Tenant Agreement Financial Addendum was initiated.	1. - 3/21/08 2. - 3/25/08
	What measures will be taken to ensure the problem does not recur. **1.** Prior to tenants occupying an apartment, the Marketing Director will ensure that an Occupancy Agreement has been completed, signed and dated. **2.** The Tenant Agreement Financial Addendum will be utilized when a tenant has a change or the addition of other services.	1. – On going 2. – On going
	How the program plans to monitor performance to ensure compliance. **1.** Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to address the tentative POC, and provide re-education to facility staff.	1. – 2/26/08 1. – 4/02/08

	2. Corporate Quality Improvement and/or facility staff will conduct audits quarterly of tenant records where service or financial arrangement changes have occurred. The audit sample will be 10 tenant files or 25% of those tenants with a service or financial arrangement change – whichever is less. **3.** If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	2. – Quarterly 3. - Quarterly

Summit Pointe Plan of Correction 4/23/2008

Citation	Correction Made	Date Completed
B. Evaluation – Survey Identified **1. Tenant #1**, health and functional evaluations were not completed, as needed. **2. Tenant #5** the program did not complete functional, cognitive and health evaluations to determine any modifications to services needed. **3. Tenant #10** evaluations were not completed as needed. According to staff the tenant had a change on 2-18-08. Evaluations were dated 2-18-08; however, the evaluations were completed on 2-19-08. **4.** The files for **Tenant #2 & #8** did not have cognitive, functional and health status evaluations completed following the Tenants return from the hospital. **5.** The file for **Tenant #3** did not have cognitive, functional and health status evaluation completed with the addition of Physical Therapy. **6.** The file for **Tenant #7** did not have cognitive, functional or health status evaluations with a change in condition. *Regulatory Insufficiency: The program did not consistently evaluate each tenant's functional, cognitive and health status within 30 days of occupancy and as needed, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any modifications to needed services. The evaluation shall be conducted by a health care professional or a human service professional. (25.23(2))*	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** **1. Tenant #1** nurse evaluations were reviewed updated as necessary to ensure they are current and accurate. **2. Tenant #5** nurse evaluations were reviewed and updated as necessary to ensure they are current and accurate. **3. Tenant #10** expired 2/21/08. Staff were re-educated on standards of practice related to signing and dating of documents. **4. Tenants #2 and #8** nurse evaluations were reviewed updated as necessary to ensure they are current and accurate. **5. Tenant #3** nurse evaluation was reviewed and updated as necessary to ensure they are current and accurate. **6. Tenant #7** nurse evaluation was reviewed and updated as necessary to ensure they are current and accurate.	1. – 5/04/08 2. – 5/04/08 3. – 2/28/08 4. – 5/04/08 5. – 5/04/08 6. – 5/04/08
	What actions the program will take to protect tenants in similar situations. The Health Service Director will review and correct other tenant records as indicated to ensure continued eligibility and modify services as needed.	5/04/08
	What measures will be taken to ensure the problem does not recur. **1.** The Corporate Director of Home Service reviewed Summit Pointe's policies and procedures (which are based on Iowa regulations), including evaluation of tenants, as	1. – 2/28/08

	part of re-education with the Health Service Director. **2.** The Health Services Director will complete a monthly nurse review for all tenants receiving services.	 2. – On going
	How the program plans to monitor performance to ensure compliance. **1.** Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to address the tentative POC, and to provide re-education for facility staff. **2.** Corporate Quality Improvement and/or facility staff will conduct audits quarterly of tenant records. The audit sample will be 10 tenant files or 25% of those tenants with a service – whichever is less. **3.** If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	 1. – 2/26/08 1. – 4/02/08 2. – Quarterly 3. - Quarterly

Summit Pointe Plan of Correction 4/23/2008

Citation	Correction Made	Date Completed
C. Criteria for exclusion of tenants – Survey Identified **Tenant #4** was documented as a two person transfer from 10-20-07 through 2-10-08. Service notes from 10-13-07 through 2-17-08 indicated the tenant was incontinent of urine and bowel. The tenant continued to reside in the program and the program did not request a waiver from the Department of Inspection and Appeals in regard to the occupancy and retention criteria. *Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who requires routine two–person assistance with standing, transfer or evacuation and on a routine basis, has unmanageable incontinence. (25.23(3)b,g)*	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** **Tenant #4's** responsible party received a written 30 day notice for discharge on 2/21/08 and moved out on 3/14/08. On 4/3/08 the Corporate V.P. of Quality, during an on-site audit interviewed 4 health service staff regarding level of care. Facility staff reported that there were no tenants on the memory care unit that exceeded the level of care requirements.	 2/21/08 4/03/08
	What actions the program will take to protect tenants in similar situations. The Housing and Health Services Directors have reviewed tenants' services for appropriate level of care.	 3/25/08
	What measures will be taken to ensure the problem does not recur. **1.** The Corporate Director of Home Services reviewed Summit Pointe's policies and procedures (which are based on Iowa regulations), including discharge and transfer criteria as part of re-education with the Health Service Director and the Housing Director. **2.** The Health Service Director will review all instances where tenant services exceed level of care standards with the Housing Director	 1. – 2/28/08 2. – On going
	How the program plans to monitor performance to ensure compliance. **1.** Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to	 1. – 2/26/08 1. – 4/2/08

	address the tentative POC, and to provide re-education to facility staff. **2.** Corporate Quality Improvement and/or facility staff will conduct audits quarterly of tenant records. The audit sample will be 10 tenant files or 25% of those tenants with services – whichever is less. **3.** If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	2. – Quarterly 3. - Quarterly

Summit Pointe Plan of Correction 4/23/2008

Citation	Correction Made	Date Completed
D. – Tenant Documents – No Regulatory Insufficiencies **E. - Service Plan – Survey Identified**	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.**	
1. Tenant #1 a service plan was not developed as needed. Cognitive evaluation was completed on 1-8-08, one day after the service plan was developed. The service plan did not address planned and spontaneous activities for those unable to plan their own.	**1. Tenant #1** Service Plan will be reviewed and as necessary corrected to ensure it is accurate, updated and signed accordingly, individualized, and meets the requested as well as specific needs of the tenant.	1. – 5/04/08
2. Tenant #4's The service plan was not individualized and updated with modifications to services and to address activities for tenant's who cannot plan their own.	**2.** Since survey, **tenant #4** was discharged for exceeding the level of care requirement.	2. – 5/04/08
3. Tenant #5's service plan was not individualized and updated with modifications to services and to address activities for tenant's who cannot plan their own.	**3. Tenant #5** Service Plan will be reviewed and as necessary corrected to ensure it is accurate, updated and signed accordingly, individualized, and meets the requested as well as specific needs of the tenant.	3. – 5/04/08
4. Tenant #10's service plan was not updated as needed. According to staff the tenant had a significant change on 2-18-08. The service plan was dated 2-18-08; however, the service plan was completed on 2-19-08. The service plan did not address planned and spontaneous activities for those unable to plan their own.	**4. Tenant #10** expired on 2/21/08. On 2/28/08 the RN was educated on the Standards of Practice related to dating of documents.	4. – 5/04/08
5. Tenant #11, the 30 day service plan was updated and signed on 2-18-08, two days late.	**5. Tenant #11** Service Plan will be reviewed and as necessary corrected to ensure it is accurate, updated and signed accordingly, individualized, and meets the requested as well as specific needs of the tenant.	5. – 5/04/08
6. Tenant #12 had an initial service plan signed on 2-15-08; one day after taking occupancy. The service plan did not address planned and spontaneous activities for those unable to plan their own.	**6. Tenant #12** Service Plan will be reviewed and as necessary corrected to ensure it is accurate, updated and signed accordingly, individualized, and meets the requested as well as specific needs of the tenant.	6. – 5/04/08
7. Tenant files #2, #3 #7 and #8 were also reviewed and the tenants' service plans were not updated as needed. The service plans did not reflect the needs of the tenants and did not address planned and spontaneous activities for those unable to plan their own. *Regulatory Insufficiency: The program did not consistently update the tenants' service plans prior to the tenant's signing the occupancy agreement and taking occupancy. A preliminary service plan shall be developed prior to the tenant taking occupancy, by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. The service plan shall subsequently be updated at least annually and whenever changes are needed. When a tenant needs personal care or health–related care, the service plan shall be updated within 30 days of occupancy and as needed, but not less than annually, by a multidisciplinary team that consists of no fewer than three individuals, including a health care professional and other staff appropriate to meet the needs of the tenant, in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. (25.28(2)(3))*	**7. Tenants #2, #3, #7, #8** Service Plans will be reviewed and as necessary corrected to ensure they are accurate, updated and signed accordingly, individualized, and meet the requested as well as specific needs of the tenants.	7. – 5/04/08

Regulatory Insufficiency: The program did not consistently develop a service plan that is individualized and shall indicate, at a minimum, the tenant's identified needs and the tenant's requests for assistance and expected outcomes. (25.28(4)a) *Regulatory Insufficiency: The program did not consistently develop service plans based on the evaluations conducted in accordance with 25.23(1) and 25.23(2) and shall be designed to meet the specific service needs of the individual tenant. (25.28(1))* *Regulatory Insufficiency: The program did not consistently develop service plans that identified tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. (25.28(4)d)*	**8.** Summit Pointe's Service Plan document has been updated to address planned and spontaneous activities.	8. – 5/04/08
	What actions the program will take to protect tenants in similar situations. The Health Service and Activities Directors will review and revise as needed the records of all tenants currently receiving services.	5/04/08
	What measures will be taken to ensure the problem does not recur. **1.** The Corporate Director of Home Services reviewed Summit Pointe's policies and procedures (which are based on Iowa regulations), including service plans as part of re-education with the Health Service Director. **2.** The Health Services Director will complete monthly nurse reviews in order to determine changes in condition and follow through with appropriate service plans.	1. – 2/28/08 2. – On going
	How the program plans to monitor performance to ensure compliance. **1.** Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to address the tentative POC, and to provide re-education to facility staff. **2.** Corporate Quality Improvement and/or facility staff will conduct audits quarterly of tenant records. The audit sample will be 10 tenant files or 25% of those tenants with services – whichever is less. 3. If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	1. – 2/26/08 1. – 4/02/08 2. – Quarterly 3. - Quarterly

Summit Pointe Plan of Correction 4/23/2008

Citation	Correction Made	Date Completed
F. - Medication Systems – Survey Identified **1.** Non-licensed health service staff indicated that **Staff #9** directed them to give medications that were not on the MAR for **Tenants #10 and #11**. **2. Tenant #2** did not receive the Accuchecks four times daily or B12 injections as had been ordered. The back of the MAR for **Tenant #2**, indicated medications were not given as they were not found in the box. It also indicated other medications were not given. **3. Tenant #9** Amoxicillin was not given to the tenant prior to a dental appointment. **4.** A review of Medication Administration Records (Mar's) for **tenant's #1, #2 #3, #5,#7, #8, and #10** indicated the tenants either missed their medications or the medications were not signed off on the MAR, to indicate they were given. **5.** The back of the MAR **for Tenant #10** stated Amoxicillin, 875/125 mg, was not in the box. **6.** The back of the MAR **for Tenant #11** indicated, a medication was not in the box. Tylenol, 500 MG, was documented on the back of the MAR as still being in the cup from the previous day on 2-5-08, 2-12-08, 2-15-08, 2-17-08 and 2-20-08. *Regulatory Insufficiency: When medications are administered or stored by the program, the following requirement shall apply, the administration of medications shall be provided by an Iowa–licensed registered nurse or advanced registered nurse practitioner registered in Iowa or the authorized agent in accordance with 655—subrule 6.2(5) and 655—subrule 6.3(1) and Iowa Code chapter 155A, the registered nurse shall recognize and understand the legal implications of accountability and the licensed practical nurse shall recognize and understand the legal implications within the scope of nursing practice. The licensed practical nurse shall perform services in the provision of supportive or restorative care under the supervision of a registered nurse or physician as defined in the Iowa Code. (IAC655-6) (25.29(2)a)*	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** **1. Staff #9** is no longer an employee at Summit Pointe. The new Health Service Director has followed up to ensure that all medications have a physician order and are listed on the MARs. **2. Tenant #2's** B-12 is ordered and being administered. There is an agreement with the pharmacy to deliver medications daily. **3.** Medication error completed **4.** Health service personnel have been educated on the Standards of Practice of medication administration including the documentation and reporting of medication incidents'. **5.** There is an agreement with the pharmacy to deliver medications daily. **6.** Health service personnel have been educated on the Standards of Practice of medication administration including the documentation and reporting of medication incidents'. 7. Non-licensed health service staff will be re-educated to notify the nurse when medications are delivered from the pharmacy. **What actions the program will take to protect tenants in similar situations.** MARs were reviewed for additional medication and transcription errors **What measures will be taken to ensure the problem does not recur.** 1. Staff #9 is no longer employed at Summit	1. – 2/25/08 2. – 4/02/08 3. – 2/29/08 4. – 3/06/08 5. – 4/24/08 6. – 4/08/08 7. - 4/21/08 2/29/08 1. – 2/27/08

	Pointe and a new Health Services Director has been hired.	
	2. The Corporate Director of Home Services reviewed Summit Pointe's policies and procedures (which are based on Iowa regulations), including Medication Administration; as part of re-education with the Health Service Director.	2. – 2/28/08
	3. Health Service Director reviewed medication administration and documentation with all RA's.	3. – 3/06/08
	4. MARs will be reviewed weekly by the Health Service Director or designee. When it is found that medication has not been signed off the auditor shall contact the individual responsible for the medication administration to investigate the reason and implement corrective actions.	4. – On going
	How the program plans to monitor performance to ensure compliance.	
	1. Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to address the tentative POC, and to provide re-education to facility staff.	1. – 2/26/08 1. – 4/02/08
	2. Corporate Quality Improvement and/or facility staff will conduct audits quarterly of MARs. The audit sample will be 10 MARs or 25% of those tenants receiving medication administration services – whichever is less.	2. – Quarterly
	3. If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	

Summit Pointe Plan of Correction 4/23/2008

Citation	Correction Made	Date Completed
G - Nurse Review – Survey Identified **1.** Tenant files were reviewed and indicated nurse review was not completed every 90 days or as needed for **Tenants #1, #2, #7, #8, #9 and #10.** **2. Tenants #1, #2, #3, #4, #5, #7 #8 and #10** did not have medication reviews documented every 90 days or as needed. *Regulatory Insufficiency: The program did not consistently assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress on previous recommendations at least every 90 days or if there are changes in health status. (25.30(3))* *Regulatory Insufficiency: The program did not consistently monitor, at least every 90 days or after a change in condition, each tenant receiving program-administered prescription medications for adverse reactions to program-administered medications and make appropriate interventions or referrals and ensure that the prescription medications are administered consistent with such orders. (25.30(1))*	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** 1. A monthly nurse review will be completed on all tenants receiving services to determine changes in condition and follow through with appropriate assessments and service plans and, per request, sent to the Department of Inspections and Appeals. 2. Effects of all medications will be noted in the nurse review.	1. – 5/04/08 and on going 2. – 5/04/08 and on going
	What actions the program will take to protect tenants in similar situations. The Health Service Director or RN designee has reviewed and corrected other tenant records as indicated.	3/25/08
	What measures will be taken to ensure the problem does not recur. The Corporate Director of Home Services reviewed Summit Pointe's policies and procedures (which are based on Iowa regulations), including Nurse Review; as part of re-education with the Health Service Director	2/28/08
	How the program plans to monitor performance to ensure compliance. 1. Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to address the tentative POC, and to provide re-education to facility staff. 2. Corporate Quality Improvement and/or facility staff will conduct audits quarterly of tenant records. The audit sample will be 10 tenant files or 25% of those tenants with	1. – 2/26/08 1. – 4/02/08 2. – Quarterly

	services – whichever is less. 3. If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	3. - Quarterly

Summit Pointe Plan of Correction 4/23/2008

Citation	Correction Made	Date Completed
H - Food Service – Survey Identified Staff files were reviewed and indicated **Staff #1** and **Staff #2** did not have documented food safety training. **Staff #5** had training on 1-18-07 and was 10 past due for annual food safety training and **Staff #6** had training on 1-5-07 and was past due for annual food safety training. *Regulatory Insufficiency: The program did not consistently provide staff that is responsible for preparing or serving food or both, an orientation on sanitation and safe food handling prior to handling food and an annual in-service training on food protection. At a minimum, one person directly responsible for food preparation shall have successfully completed a state–approved food protection program. (25.32(5))*	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** **1. Staff #1** received Safe Food handling training from the Food Service Director. **Staff #2** is no longer an employee at Summit Pointe. **2. Staff #5 and #6** will complete annual training which includes food safety training	 1. – 2/22/08 2. – 4/25/08
	What actions the program will take to protect tenants in similar situations. **1.** The Housing Director has expanded food safety training to all staff. The Business Office Manager has conducted an audit of all staff to determine who is still in need of annual food safety training. **2.** The Food Service Director will provide the safe food handling training for all staff identified in the audit as needing training.	 1. – 307/08 2. – 3/21/08
	What measures will be taken to ensure the problem does not recur. The Food Service Director will provide the safe food handling training at each new employee orientation. Staff in need of annual safe food handling training will be invited to attend this section of the orientation process to get their annual training component.	 1. – 3/03/08
	How the program plans to monitor performance to ensure compliance. 1. Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to address the tentative POC, and to provide re-education to facility staff.	 1. – 2/26/08 1. – 4/02/08

	2. Corporate Quality Improvement and/or facility staff will conduct audits annually of each employee record to ensure that they current with their safe food handling training.	2. – Quarterly
	3. If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	3. – Quarterly

Summit Pointe Plan of Correction 4/23/2008

Citation	Correction Made	Date Completed
I. - Staffing – Survey Identified **1.** According to interviews, Staff indicated there was not appropriate nurse delegated training. **2.** Staff indicated they were asked or needed to leave the dementia unit to provide cares/assistance elsewhere in the building. **3. Tenant #10** The service sheets from 2-18-08, 2-19-08 and 2-20-08, on all three shifts, do not reflect the care described by staff or the care stated on the tenant's service plan. **4.** Monitors were unable to hear the dementia unit emergency panel when in a tenant's room. Monitors were unable to hear the front desk emergency panel when in the public bathroom. **5. Staff #10**, stated until recently, staffing was sufficient in the dementia unit but there had been two recent admissions. She also indicated that with new admissions and the increased level of care with **Tenant #10** there had been no increases in staffing. A tenant reported waiting 45 minutes for assistance one time last week. **6. Staff #9** stated she went to Minnesota for corporate management training; however, she did not receive training on state regulations. According to the Dietary Manager, on 2-17-08, the oven exhaust fans in the kitchen were going off and turning back on. On 2-17-08, smoke from the grill reached out into the hallway causing the alarms to go off. Maintenance fixed the issue. **7. Staff #3** stated she and **Staff #7** did not know where to take the tenants during a fire alarm, did not have any training on fire drills and she did not know what to do. **Staff #3** reported none of the tenants were evacuated. Staff did not know the doors in the dementia unit released in the event of a fire or drill. *Regulatory Insufficiency: The program did not consistently provide sufficient trained staff at all times to fully meet the tenants' identified needs. (25.33(1))* *Regulatory Insufficiency: The owner or management corporation of the program did not ensure that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. (25.33(5))* *Regulatory Insufficiency: The program did not ensure all personnel of a program knew how to implement the program's accident, fire safety and emergency procedures. (25.33(8))*	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** **1.** All non-licensed health service staff have received nurse delegated training for services provided at Summit Pointe. All newly hired non-licensed staff will complete a scheduled 3 days of orientation where they will be oriented to the facility, their roles and responsibilities, Emergency Procedures Plan, and nurse delegated training. **2.** Iowa regulations and Summit Pointe policies indicate that dementia specific unit will remain staffed with appropriately trained personnel on the unit at all times. Leadership staff received training regarding this requirement. Staff will be re-educated that 911 is to be called on the night shift for any situation that warrants a 2nd person, e.g. tenant fall. **3. Tenant #10** expired on 2/21/08. Nursing staff were educated on accurate service plans and service schedules (service sheets) and delegations of services. All assisted services will be listed on the service schedule. **4.** Tenant room alarms sound at both the front desk and also the memory care desk. Health service staff carries phones with them for communication. Health services receptionists have been educated to call each other/Health Service staff when an alarm has gone off and there is a delay in response time. **5.** Tenants exceeding the level of care requirements are no longer on the memory care unit. On 4/3/08 during an on-site audit the Corporate V.P. of Quality interviewed 4 health service staff regarding the memory	1. – 3/14/08 2. – 2/27/08 3. – 2/28/08 4. – 4/04/08 5. – 4/03/08

	care unit's level of care. Facility staff reported no tenants on the dementia unit exceeded the level of care requirements.	
	6. Staff #9 was an experienced Assisted Living RN that had worked in Iowa prior to hire at Summit Pointe. **Staff #9** received orientation on December 18th and 19th, 2007 on orientation requirements as well as specific orientation to Summit Pointe's policies and procedures which are based on Iowa regulations. This orientation was reinforced when the Corporate Director of Home Services visited Summit Pointe on January 10th and 11th of 2008. Delegated tasks, orientation requirements and the Plan of Correction of the October 2007 survey visit were reviewed again at that time.	6. – 12/19/07
	7. All current staff has been trained on Emergency policies and procedures. The Maintenance Director has posted written fire alarm response directions for staff. The Emergency Procedures Plan has been posted at the Receptionist's desk and in the Memory Care unit office. During an on-site audit by the Corporate V.P. of Compliance on 4/3/08 a Memory Care Unit RA was interviewed and was able to identify where to locate information related to fire procedures.	7. – 4/25/08
	What actions the program will take to protect tenants in similar situations.	
	1. Housing Director and Health Service Director reviewed current tenants' needs and staffing.	1. – 3/14/08
	2. All non-licensed staff have received delegated nurse training.	2. – 4/17/08
	What measures will be taken to ensure the problem does not recur.	
	1. The Corporate Director of Home Services and Compliance reviewed Summit Pointes policies, procedures, and training	1. – 2/27/08

	requirements (which are based on Iowa regulations) as part of re-education with Summit Pointe leadership.	
	2. Summit Pointe will provide orientation to newly hired staff following a consistent practice to ensure all direct and non-direct care staff are sufficiently trained to meet the care and safety needs of tenants.	2. – On going
	3. All staff will receive training as needed. Fire drills will be monitored for appropriate staff response. If staff response is identified as insufficient or incorrect re-education will be provided at the time of the drill by the Director of Maintenance.	3. – On going
	How the program plans to monitor performance to ensure compliance.	
	1. Corporate Quality Improvement staff conducted on site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to address the tentative POC, and to provide re-education to facility staff.	1. – 2/26/08 1. – 4/02/08
	2. Corporate Quality Improvement and/or facility staff will conduct audits quarterly of employee records. The audit sample will 25% of employee files.	2. – Quarterly
	3. If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	3. – Quarterly

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Citation	Correction Made	Date Completed
J. - Dementia Care – Survey Identified Staff #8 had two hours of dementia training; however, did not have six hours of dementia education prior to or within 90 days of employment. *Regulatory Insufficiency: The program did not consistently provide a minimum of six hours of dementia-specific education and training prior to or within 90 days of employment. (25.34(1))*	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** Staff #8 has completed the required six hours of dementia-specific education.	2/27/08
	What actions the program will take to protect tenants in similar situations. 1. The Business Office Manager conducted an audit for staff that has completed their initial memory care training, but are now due or coming due for either the six or two hour annual dementia training. 2. Staff identified as having a need for training will be scheduled for and will attend the next available training opportunity.	1. – 3/21/08 2. – On going
	What measures will be taken to ensure the problem does not recur. 1. Six hours of dementia-specific training is required within 90 days of employment. Staff will be scheduled for training by the Housing Director or designee. 2. Annually, direct care staff will receive six hours of dementia training and non-direct care staff will receive two hours of dementia training. 3. The Business Office Manager will audit and maintain an updated listing of staff training and education needs for orientation and annual training.	1. – 5/23/08 2. – 5/23/08 3. – On going
	How the program plans to monitor performance to ensure compliance. 1. Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to address the	1. – 2/26/08 1. – 4/02/08

	tentative POC, and to provide re-education to facility staff.	
	2. Corporate Quality Improvement and/or facility staff will conduct audits quarterly of tenant records. The audit sample will be 10 tenant files or 25% of those tenants with services – whichever is less.	2. – Quarterly
	3. If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	3. - Quarterly

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Citation	Correction Made	Date Completed
K. - Life Safety – Survey Identified **1.** Review of fire training documents indicated the program had fire drills on 1-26-07, 3-23-07, 9-19-07 and 12-16-07. The program did not have six fire drills annually. The drill on 12-16-07 occurred at 9:55 p.m., and was the only drill that occurred during hours of sleep. **2.** Staff stated they did not know where to take the tenants when the fire alarm sounded on 2/17/08. They did not have any training on fire drills, did not know what to do and none of the tenants were evacuated. *Regulatory Insufficiency: The program did not conduct emergency egress and relocation drills not less than six times per year on a bimonthly basis, with not less than two drills conducted when the tenants are sleeping. The state fire marshal shall adopt rules, in coordination with the department of elder affairs and the department of inspections and appeals, relating to the certification and monitoring of the fire and safety standards of certified assisted living programs. (IAC 231C.4) (25.40(1)e)* *Regulatory Insufficiency: The program did not ensure all personnel of a program knew how to implement the program's accident, fire safety and emergency procedures and the program did not follow written emergency policies and procedures which include fire safety procedures. (25.33(8)) (25.37(i))*	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** **1.** Six fire drills will be completed annually, with two of them completed during sleeping hours, and submitted to the Department of Inspections and Appeals upon completion. **2.** The Corporate Director of Home Services and Compliance provided training to Summit Pointe leadership on orientation/annual training requirement, the emergency procedures plan and on the emergency policies and procedures. The Maintenance Director provided an in-service for all staff on 3/21/08 and will ensure updated Emergency Procedures Plan booklets are posted at the front receptionist desk and the Memory Care desk. **3.** The Emergency Procedures Plan was reviewed and updated by the Corporate Director of Home Services with input from Summit Pointe leadership.	1. – 2/27/08 and on going 2. – 3/21/08 3. – 2/28/08
	What actions the program will take to protect tenants in similar situations. All staff and residents to receive education on emergency policies and procedures upon hire and/or move-in, and annually thereafter.	3/21/08
	What measures will be taken to ensure the problem does not recur. 1. Housing Director, or designee, will submit documentation of staff training in regard to fire safety and all future completed fire drills to DIA. 2. Emergency policies and procedures will be reviewed with all staff on hire and annually and with residents upon move-in and annually	1. – On going 2. – On going

	thereafter. 3. All staff will complete all mandatory orientation or annual training requirements.	3. – On going
	How the program plans to monitor performance to ensure compliance. 1. Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to address the tentative POC, and to provide re-education to facility staff. 2. Corporate Quality Improvement and/or facility staff will conduct audits quarterly of employee records. The audit sample will be of all employees due for annual training in the preceding quarter. 3. If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	1. – 2/26/08 1. – 4/02/08 2. – Quarterly 3. – Quarterly

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Citation	Correction Made	Date Completed
L - Transportation – No Regulatory Insufficiencies Noted **M - Activities – Survey Identified** Interviews with indicated activities were not sufficient for those with dementing illness, were not sufficient due to the increased number of tenants, appropriate activities were not offered, and care staffs were to conduct activities in the memory care unit which they were too busy to complete. *Regulatory Insufficiency: The program did not consistently provide appropriate programming for each tenant. Programming did not reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement. (25.39(1))*	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** 1. The Activity Director, or designee, will complete a Therapeutic Recreation Assessment and Leisure Activity Care Plan upon admission, with a significant change, and annually. The Activity Director or designee will create the activity calendar specific to the population. *(See attachments A & B).* 2. Summit Pointe's Service Plan document has been updated to include planned and spontaneous activities.	1. – 5/23/08 2. – 3/21/08
	What actions the program will take to protect tenants in similar situations. 1. The Activity Director, or designee, will complete a Therapeutic Recreation Assessment and Leisure Activity Care Plan upon admission, with a significant change, and annually. The Activity Director or designee will create the activity calendar specific to the population. *(See attachments A & B).*	5/04/08
	What measures will be taken to ensure the problem does not recur. The Housing Director reviewed the Iowa regulations and Corporate policies and procedures as part of re-education with the Activities Director and will ensure activity calendar provides appropriate programming.	4/18/08
	How the program plans to monitor performance to ensure compliance. 1. Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in	1. – 2/26/08 1. – 4/02/08

	establishing an action plan to address the tentative POC, and to provide re-education to facility staff.	
	2. Corporate Quality Improvement and/or facility staff will conduct audits quarterly of tenant records. The audit sample will be 10 tenant files or 25% of tenants receiving services, whichever is less.	2. – Quarterly
	3. If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	3. - Quarterly

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Citation	Correction Made	Date Completed
N. – Record Checks – No Regulatory Insufficiencies Noted **O. - Other – Survey Identified** The program did not consistently follow the written Plan of Correction (POC) that was submitted on 11-29-07 regarding the initial certification visit conducted on October 22, 2007. *Regulatory Insufficiency: The program did not fully implement the POC submitted in response to the initial certification visit. (25.5(5))*	**Elements detailing how the program will correct the insufficiency as it relates to the tenant.** **1.** Corporate Quality Improvement staff provided training on the POC to leadership team at Summit Pointe regarding citations. **2.** The Housing Director, in conjunction with Department Directors will review and ensure the POC is implemented.	1. – 2/27/08 2. – 4/02/08
	What actions the program will take to protect tenants in similar situations. The Housing Director and the Corporate Quality Improvement staff reviewed old POC and implemented the new POC that will be followed.	New POC implemented 4/25/08
	What measures will be taken to ensure the problem does not recur. Housing Director to continue to monitor POC to ensure accuracy and submit required documents to the State.	On going
	How the program plans to monitor performance to ensure compliance. 1. The Housing Director in conjunction with Department Heads will monitor and audit for continued/on going compliance. 2. Corporate Quality Improvement staff conducted on-site visits to review preliminary regulatory insufficiencies, assist facility staff in establishing an action plan to address the tentative POC, and to provide re-education to facility staff. 3. Corporate Quality Improvement and/or facility staff will conduct audits quarterly to ensure compliance with POC, state regulatory requirements and tenant care needs.	1. – On going 2. – 2/26/08 2. – 4/02/08 3. – Quarterly

	4. If compliance issues are identified corrections will be made and staff re-education and/or corrective action will be implemented.	4. – Quarterly