IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

April 10, 2008

Complaint Intake: #14760
#14987
#13455R
#12444R2

Mr. Mark Thomsen, Administrator
Meadowview Memory Care Village
3005 F Avenue NW
Cedar Rapids, IA 52405-2944

RE: I. Final Complaint Investigation & Revisit Report – #14760, #14987, #13455R and #12444R2
II. Immediate Sanction – Conditional Operation
III. Civil Penalty
IV. Hearings and Appeals
V. Conclusion

Dear Ms. Traum:

I. Final Complaint Investigation & Revisit Report – MeadowView Memory Care Village, Cedar Rapids, IA

Enclosed is the **Final Complaint Investigation & Revisit Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2007) and Iowa Administrative Code, chapters 321—25, pertaining to assisted living programs and 321—26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. The Final Report notes the **Regulatory Insufficiencies,** as defined in the areas of: Evaluation of Tenant, Criteria for Exclusion of Tenant, Service Plan, Medications, Nurse Review and Other.

DIA is accepting the Plan of Correction (POC) following the program's submission of additional information. The Request for Reconsideration under Evaluation of Tenant is accepted. The Request for Reconsideration under Criteria for Exclusion is being denied as the data reflects that the tenant exceeded criteria at the time of our visit.

II. Immediate Sanction - Conditional Operation

As reflected in this Report, the program failed to comprehensively follow the regulations in 321 IAC Chapter 25. Due to the program's noncompliance, current Regulatory Insufficiencies and the findings from the on-site monitoring visit of January 8-10, 2008, MeadowView Memory Care Villages Conditional Certificate, effective November 5, 2007, is being extended. In addition, the program will not be allowed to admit new tenants until such time as the restrictions and/or conditional certificate is lifted by the department. The program will also be required to complete monthly nurse reviews and submit documentation to DIA showing the Administrator and Registered Nurse attended Assisted Living Program Management Training. The conditional certificate is issued as an alternative to denial, suspension or revocation pursuant to Iowa Code section 231C.10(2).

While effective immediately, the program may appeal these sanctions by filing an appeal within 30 days of issuance of this letter.

III. Civil Penalty

If no appeal is requested within 30 days of receipt of this Final Complaint Investigation Report the civil penalty obligation, in the amount of ten thousand ($10,000.00) dollars, is required.

IV. Hearings/Appeals

The Program may appeal the DIA decision in accordance to 321 IAC 26.4, within 30 days of notice, by submitting a request for appeal to the DIA. Hearings will be held pursuant to 481 IAC Chapter 10. If the program appeals, the civil penalty will be suspended, pending appeal. If the program does not appeal, the fine is due within 30 days of notice.

V. Conclusion

The Plan of Correction that was submitted is accepted. The Conditional Certificate and above sanctions remain. DIA shall revisit the program to confirm compliance in fulfilling the POC's corrective measures. If the program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

If you have any questions in regard to these matters, please contact me at (515) 281-5077.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

cc Stacy Hejda

Iowa Department of Inspections and Appeals
Assisted Living Program
AMENDED Final Recertification, Complaint & Complaint Revisit Investigation Report

Assisted Living Program:

Mr. Mark Thomsen, Administrator
Meadowview Memory Care Village
3005 F Avenue NW
Cedar Rapids, IA 52405-2944

Complaint Intake # 12444R2
13455R
14760
14987

Date of Investigation:

January 8 - 10, 2008

Monitor(s):

Hal L. Chase, RN BSN MPH
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, a first and second complaint revisit investigation and a recertification on-site visit were conducted at Meadowview Memory Care Village on January 8 – 10, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable

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:	40
Current number of tenants without cognitive disorder:	1
Total Population:	41

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

Tenant/Family Satisfaction Results – A community meeting was not held due to the cognitive status of the tenants. The building was neat and it appeared tenant's needs were being met. An interview with the Activities Director was conducted. She stated tenants have multiple options of activities and she follows a four domain approach, consisting of cognitive, social, emotional and religious practices.

Accreditation Status – Not Applicable.

Complaint History – There were substantiated complaints this certification period in the areas of Evaluation of Tenants, Criteria for Exclusion of Tenants, Service Plans, Medications, Nurse Review and Staffing.

The complaint history during this certification period includes the complaint investigations of November 20, 2006, July 19, 2007 and October 9, 10 & 11, 2007. The November 20, 2006 complaint investigation resulted in no fine or additional sanctions. The July 19, 2007 complaint investigation resulted in a fine of $1,500.00. The October 9, 10 & 11, 2007 complaint investigation and revisit resulted in a fine of $8,000.00 and sanctions that include no new admissions and management training for the Program Administrator and Nurse.

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

A. 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)]

Complaint Allegation #14760: It is alleged Tenant #8 "has had multiple choking spells" and was not transferred to a hospital for evaluation.

Monitoring Observation: Tenant #8, a 72 year old, was admitted on 4-14-06, with diagnoses of: Depression, Hypertension (HTN) and Progressive Supranuclear Palsy. Staff # 1 through #6 indicated they remind the tenant to take small bites and sit with the tenant at meal times. The service plan of 9-4-07 includes: staff cutting foods into small pieces, verbal cueing and sitting with the tenant at meals. A Videopharyngogram Report from 9-20-07 indicated the tenant had difficulty with swallowing and recommendations were made. Nurse's notes from 12-12-07 to 1-7-08 indicated the tenant had three coughing or chocking spells with either food consumption or with taking medications. Nurse's notes of 12-23-07 indicated the tenant had a 10 to 20 second period of unresponsiveness, without Dyspnea and stated "I'm okay." The tenant was given a 30-day written notice to leave the program.

During the course of complaint investigation #13455 on 10-9-07 & 10-10-07, the program received a regulatory insufficiency related to not completing functional, cognitive and health evaluations when a change in condition existed for Tenant #15.

Tenant #15, an 88 year old, was admitted on 6-21-07 and has diagnoses of: Osteoporosis, Hypothyroidism, Alzheimer's Disease, Pernicious Anemia and Delusions. A cognitive evaluation was completed on 12-13-07, staging the tenant at a four on the Global Deterioration Scale (GDS), indicating moderate cognitive decline. Functional and health evaluations were completed on 10-30-07 and a cognitive evaluation was completed on 10-29-07 with a change in condition.

During the course of the first revisit to complaint investigation #12444 and #13455 on 10-9-10-07, the program received a regulatory insufficiency related to not completing functional, cognitive and health evaluations when a change in condition existed for Tenant #2, #5, #7, #12 and #19.

Monitoring Observation: Tenant #2, #7, #12 and #19 were discharged from the program.

Tenant #5, an 83 year old, was admitted on 3-24-06 and has diagnoses of: Seizure Disorder, Osteoporosis, Diverticulitis, Urinary Frequency, History of Cholecystectomy, History of two Hip Fractures and Transient Ischemic Attacks (TIA). A cognitive evaluation was completed on 12-12-07, staging the tenant at a four on the GDS, indicating moderate cognitive decline. The service plan was updated on 11-9-07 to include staff to: Debrox ears as ordered and as needed, to apply ice to left knee for 10 minutes, as needed, when the tenant complained of pain and to apply hydrocortisone cream to the rectum, three times daily and, as needed, when the tenant complained of itching. Functional, cognitive and health evaluations were not completed with a change in condition related to treatments.

During the course of the recertification, the following information was obtained:

Tenant #10, an 85 year old, was admitted on 2-17-06 and has diagnoses of: Schizophrenia, Alzheimer's Disease and Dementia. A cognitive evaluation was completed on 11-28-07, staging the tenant at a seven on the GDS, indicating very severe cognitive decline. Service plan updates were made on 10-14-07 to reflect "mental status/behaviors" interventions, on 11-15-07 to reflect services from an outside provider, 11-29-07 related to physical therapy and admitted to Hospice on 12-21-07. Functional, cognitive and health evaluations were completed on 10-29-07, functional and health evaluations on 11-29-07 and a cognitive evaluation on 11-28-07. Functional, cognitive and health evaluations were not completed with a change in condition related to changes in the service plan on 10-14-07, 11-15-07 and 12-21-07.

Tenant #16, a 62 year old, was admitted on 5-18-07 and has diagnoses of: Dementia-Frontal Lobe, Hyperglycemia and Anxiety. A cognitive evaluation was completed on 12-19-07, staging the tenant at a six on the GDS, indicating severe cognitive decline. A service plan was updated on 10-24-07 to reflect new interventions related to aggressive behaviors, but the program did not complete functional, cognitive and health evaluations with a change in condition.

Tenant #17, an 85 year old, was admitted on 9-4-07 and has diagnoses of: Dementia, Diabetes Mellitus II, HTN, Chronic Urinary Incontinence, Bilateral Cataract removals, Cholecystectomy, Bilateral Rotator Cuff Repair, Atrial Fibrillation, Arthritis, Cystocele/Rectocele repair with Bladder Suspension and Chronic Bronchitis. A cognitive evaluation was completed on 12-12-07 staging the tenant at a five on the GDS, indicating moderately severe cognitive decline. Nurse's notes of 11-16-07 indicated the tenant complained of increased pain in the groin area and a physician ordered Nystatin cream. The program did not complete functional, cognitive and health evaluations with a change in condition.

Tenant #26, an 83 year old, was admitted on 3-18-06, with diagnoses of: Parkinson's Disease, Depression and Dementia. A cognitive evaluation was completed on 12-13-07, staging the tenant at a four on the GDS, indicating moderate cognitive decline. Nurse's notes of 1-3-08 indicated the tenant had fallen and sustained a skin tear to the left forearm measuring 12 centimeters by 3 centimeters. The Tenant denied dizziness prior to the fall. The program updated the service plan on 1-3-08 to include stand by assistance with ambulation and wound care but did not complete functional, cognitive and health evaluations with a change in condition.

Tenant #27, a 79 year old, was admitted on 4-30-07, with diagnoses of: Dementia and Diabetes, Type Two. A cognitive evaluation was completed on 12-12-07, staging the tenant at a four on the GDS, indicating moderate cognitive decline. Nurse's notes of 10-23-07 through 1-7-08 indicated the tenant was sexually aggressive toward staff nine times and made four suicidal threats. The program but did not complete functional, cognitive and health evaluations with a change in condition related to sexual aggression and suicidal ideation.

Tenant #28, a 67 year old, was admitted on 7-13-07, with diagnoses of: Dementia, HTN and Diverticulosis. A cognitive evaluation was completed on 11-12-07, staging the tenant at a four on the GDS, indicating moderate cognitive decline. Nurse's notes of 1-2-08 indicated the tenant had increased agitation beginning 11-29-07 through 1-2-08 with

increased shouting, yelling and refusal of cares and activities. Nurse's notes of 1-1-08 indicated the tenant hit another tenant twice and an outside agency would be providing one on one care. Nurse's notes of 1-2-08 indicated the tenant was to have a psychological evaluation on 1-29-08. The physician was notified on 1-2-08 regarding a medication adjustment. The program did not complete functional, cognitive and health evaluations with a change in condition.

- Regulatory Insufficiency: The program did not complete a functional, cognitive and health evaluation within 30-days and, as needed, to determine the tenant's continued eligibility for the program and to determine any modifications to needed services. (25.23(2))

B. 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]

Complaint Allegation #14760: It is alleged there are several tenants who no longer qualify for the level of care the program is able to provide

Monitoring Observation: Tenant #14, a 68 year old, was admitted on 8-13-07 and has a diagnosis of Dementia. A cognitive evaluation was completed on 9-4-07, staging the tenant at a five on the GDS, indicating moderately severe cognitive decline. Tenant #14 was discharged from the program.

Tenant #27's nurse's notes of 10-23-07 through 1-7-08 indicated the tenant had three incidents of suicidal ideation and the tenant stated he/she felt like a caged animal and would kill himself/herself. Nurse's notes of 10-23-07 indicated the tenant stated he/she was going to shoot himself/herself. Nurse's notes of 11-11-07 indicated the tenant eloped from the program, with staff finding the tenant several blocks from the program. When found by staff the tenant stated "I just want to go to the bridge and jump." Nurse's notes of 10-23-07 through 1-7-08 indicated seven incidents of sexual aggression toward staff. Nurse's notes of 10-23-07 indicate the tenant was grabbing the breasts of a female staff. On 11-19-07 the tenant slid his/her hand from a staff person's inner thigh to their groin. On 11-27-07 the tenant stated, "come here let me see those" referring to a staff person's breasts. On 1-4-08 the tenant stated to staff, he/she "would give her some." The staff re-directed the tenant by stating she was married and the comment was "inappropriate." The program did not exclude a tenant who chronically displayed behaviors of sexual aggressiveness toward staff.

During the course of the first complaint investigation revisit of complaint #12444, on 10-9-10-07, the program received a regulatory insufficiency related to not excluding Tenant #7, #10, #12 and #14 who exceeded occupancy and retention criteria.

Monitoring Observation: Tenant #7 was discharged from the program. The program received a waiver for Tenant #8 on 1-14-08. Tenant #10 was identified on 7-19-07 as exceeding occupancy and retention criteria. The program was given a waiver on 12-31-07. Tenant #12 was discharged from the program.

- Regulatory Insufficiency: The program did not exclude tenants who exceeded occupancy and retention criteria. (25.23(3)c(2))

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

Complaint Allegation #14987: It is alleged that Tenant #24's family member did not receive a copy of the tenant's service plan.

Monitoring Observation: Tenant #24 was transferred to MeadowView Memory Care Village from an adjacent, affiliated, assisted living program on 2-9-07. Service plans of 12-22-06 and 3-16-07 were signed by the tenant. The service plan of 1-12-07 was signed by the tenant's Durable Power of Attorney (DPOA). Despite a cognitive deficit, the tenant has a history of signing his/her service plans. The program determined the tenant understood the services being offered and the tenant's DPOA would not be asked to sign the tenant's service plan when the tenant is able to determine what services he/she wants and needs.

The program completed a service plan on 3-16-07; however, this service plan was not updated within 30-days of admission to the program. This service plan was signed by the tenant. The program completed a functional evaluation on 3-16-07 in support of the 3-16-07 service plan but did not complete a cognitive and health evaluation in support of the service plan.

During the course of the first revisit complaint investigation of #12444 on 10-9-10-07, the program received a regulatory insufficiency related to not developing service plans that were individualized to meet the identified tenant's needs for Tenant #1, #2, #7, #11, #12, #13, #14 and #18. The program received a regulatory insufficiency related to not developing a service plan based on the evaluations conducted for tenant #12. The program received a regulatory insufficiency related to not developing a service plan with a change in condition for tenants #15 and #19.

- Monitoring Observation: Tenant #1, #2, #7, #11, #12, #13, #14, #18, and #19 were discharged from the program.

Tenant #15's service plan was updated on 10-30-07 with a change in condition.

During the course of the complaint investigation #13455 on 10-9-10-07, the program received a regulatory insufficiency related to not having the tenant or tenant's legal representative sign the service plan for Tenant's #9, #10, #12 and #17.

Monitoring Observation: Tenant #9, and #12 was discharged from the program.

Tenant #10's service plan was updated on 10-4-07, 11-21-07, 11-28-07, 12-26-07 and 12-28-07. Service plans were not signed by the tenant or the tenant's legal representative with a change in condition.

Tenant #17's service plan was updated on 12-11-07 and was signed by the tenant's legal representative. Nurse's notes of 11-16-07 indicated the tenant complained of increased pain in groin area. There is a physician's order for Nystatin cream to be applied, three times daily for three days, then twice daily until healed and then, as needed. The service plan of 12-11-07 did not include this treatment.

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

Monitoring Observation: Tenant #5's service plan was updated 11-9-07 but was not supported by functional, cognitive and health evaluations. The service plan of 12-11-07 was updated, but was not supported by a cognitive evaluation as this was completed on 12-12-07. The service plan of 11-9-07 was not signed by the tenant or the tenant's legal representative and by the RN. The service plan of 12-11-07 was not signed by the tenant or the tenant's legal representative.

Tenant #15's service plan was updated on 10-30-07 with a change in condition, but was not signed by the tenant or tenant's legal representative.

Tenant #16's service plan was updated on 10-24-07 to reflect interventions related to aggressive behaviors towards staff but was not supported by functional, cognitive and health evaluations. Nurse's notes of 12-9-07 through 1-8-08 indicated the tenant was difficult to redirect, verbally inappropriate, abusive toward staff, often refused cares and swore at staff. The program notified the tenant's physician on 12-20-07 of several episodes during November and December 2007 related to aggressive behaviors with cares that included yelling at staff, throwing items at staff and refusing personal cares. Nurse's notes of 1-8-08 indicated the tenant was yelling, refusing cares, pushing and "throwing hands" at staff. The service plan was updated on 12-20-07, but was not updated in regard to establishing interventions related to the continued aggressive behavior and identified needs of the tenant. The service plan of 10-24-07 was signed by the tenant's legal representative on 10-25-07 but not signed by the RN and two additional staff.

Tenant #21, an 86 year old, was admitted on 5-14-07, with diagnoses of: Glaucoma and Alzheimer's Disease. A cognitive evaluation was completed on 11-8-07, staging the tenant at a four on the GDS, indicating moderate cognitive decline. Social progress notes of 11-13-07 indicated the RN and Social Worker met with the tenant to complete a quarterly assessment and asked the tenant questions regarding a personal relationship with another tenant. The program did not establish guidelines/interventions for staff regarding the relationship between tenants, therefore, allowing staff to interfere in the tenant's relationship with another tenant. The program eventually updated the service plan on 1-4-08 establishing the appropriate interventions.

Tenant #22, an 83 year old, was admitted on 4-20-06, with a diagnosis of Dementia. A cognitive evaluation was completed on 11-8-07, staging the tenant at a five on the GDS, indicating moderately severe cognitive decline. Social progress notes of 11-13-07 indicated the RN and Social Worker met with the tenant to complete a quarterly assessment and asked the tenant questions regarding a personal relationship with another tenant. The program did not establish guidelines/interventions for staff regarding the relationship between tenants, therefore, allowing staff to interfere in the tenant's relationship with another tenant. The program eventually updated the service plan on 1-4-08 establishing the appropriate interventions.

Tenant #23, a 77 year old, was admitted on 10-25-07 and has a diagnosis of Dementia. A cognitive evaluation was completed on 11-27-07, staging the tenant at a five on the GDS, indicating moderately severe cognitive decline. An updated service plan was completed

on 11-23-07 and supported by a functional and health evaluation, but was not supported by a cognitive evaluation, as the cognitive evaluation was completed on 11-27-07. The service plan of 11-23-07 was not signed by the tenant or the tenant's legal representative.

Tenant #25, an 87 year old, was admitted on 9-14-07 with a diagnosis of Dementia. The tenant was staged at a five on the Global Deterioration Scale on 11-21-07, indicating moderately severe cognitive decline. The tenant's service plan was updated on 11-27-07 to reflect the tenants need for physical therapy, occupational therapy and increased assistance with Activities of Daily Living. The program did not consistently insure service plans were signed by the RN, two staff, the tenant or the tenant's legal representative.

Tenant #26, an 83 year old, was admitted on 3-18-06, with diagnoses of: Parkinson's, Depression and Dementia. The tenant was staged at a four on the GDS, indicating moderate cognitive decline. Nurse's notes of 1-3-08 indicated the tenant had fallen, sustained a skin tear to the left forearm measuring 12x3 centimeters. Tenant denied dizziness prior to the fall. The program did not update functional, cognitive and health evaluations when the service plan was updated on 1-3-08.

Tenant #27's nurse's notes of 10-23-07 through 1-7-08 indicated the tenant was sexually aggressive and abusive toward staff nine times and made four suicidal threats. The service plan was updated on 12-13-07, 12-20-07 and 1-3-08, but did not include interventions related to sexual aggression until 1-3-08. The program did not establish interventions on any of the service plans related to suicidal ideation. The program did not complete functional, cognitive and health evaluations to support the service plan update of 1-3-08.

Tenant #28's service plan was updated 1-2-08 to reflect interventions related to the aggressive behavior and the use of an outside provider for personal cares. The service plan was previously updated on 12-20-07 to reflect actions staff were to follow related to the tenant's bathing, hygiene and dressing but did not address aggressive behaviors. The program did not complete functional, cognitive and health evaluations to support the updated service plan of 1-2-08 and the service plan was not signed by the tenant or the tenant's legal representative.

- Regulatory Insufficiency: The program developed a service plan that was not based on the evaluations conducted in accordance with 25.23(1) and 25.23(2). (25.28(1))

- Regulatory Insufficiency: The program did not develop services plan 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. (25.28(2))

- Regulatory Insufficiency: The program did not individualize and indicate, at a minimum, the tenant's identified needs and the tenant's requests for assistance and expected outcomes. (25.28 (4))

D. 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]

During the course of the recertification, the following information was obtained:

Monitoring Observation: Medication and treatment documentation indicated medications and treatments were not charted as given. The RN stated staff were to document tenant refusals on the back side of the Medication Administration Record and treatment record or in the nurse's notes. A review of the MAR, treatment record and nurse's notes indicated staff did not document why medications or treatments were not given.

Treatment Record:

Treatment Record	Tenant #29	Ted Hose on in a.m off in p.m's	1-5-08 not removed, 1-6-08 not applied in a.m
Treatment Record	Tenant #30	Wash right foot with soap and water, apply iodine ointment and cover with band-aid daily - 2-10 shift.	1-3-08 through 1-6-08 treatment was refused but the reason was not documented.
Treatment Record	Tenant #31	Thigh-High compression hose both legs, on in a.m off p.m	1-5-08 treatment was refused but not documented.
Treatment Record	Tenant #31	Clotrimazole 1% ointment apply to feet twice a day.	1-4, 1-6 and 1-7-08 treatment refused but the reason was not documented.
Treatment Record	Tenant #32	Right foot soak in Epson Salt once a day then apply povidone Iodine ointment and band-aid	1-3-08 treatment was refused but not documented.
Treatment Record	Tenant #27	Apply moisturizing Lotion twice a day 6-2 and 2-10	1-3-08 & 1-4-08 a.m not completed and 1-6-08 p.m not completed.
Treatment Record	Tenant #27	Apply TAO on red areas twice a day until healed	1-6-08 evening treatment not completed
Treatment Record	Tenant #27	Apply Eucerin to dry areas twice a day until healed	1-6-08 treatment not completed.
Medication Record	Tenant #27	Atenolol 100mg daily, hold if B/P is < 100/40	12-8-07 & 12-9-07 not given and no Blood Pressure was documented

Medication Record:

Medication Record	Tenant #27	Enalapril Maleate 20 mg once daily hold if B/P is < 100/40	12-8-07 & 12-9-07 not given and no BP documented
Medication Record	Tenant #16	Mirtazapine 15mg at bedtime	1-5-08 not given or refused
Medication Record	Tenant #34	Prilosec 20mg once daily	1-2-08 not given or refused
Medication Record	Tenant #34	Cipro 250mg twice a day for seven days	1-6-08 was not documented as given.
Medication Record	Tenant #35	Atrovent 0.03% spray twice a day	1-5-08 & 1-6-08 not documented as given.

Regulatory Insufficiency: The program did not consistently follow an acceptable medication protocol. (IAC 655-Chapter 6)

E. 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]

Monitoring Observation: A review of Tenants #10, #16, #23, #24, #28 files indicated physician's orders and treatments were not consistently signed, dated and timed.

- Regulatory Insufficiency: The program did not consistently have written documentation showing signature, date and time of physician orders. (25.30(4))

F. 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]

Complaint Allegation #14760: It is alleged Staff #7's start date was "fudged to avoid having to file a W2 at the end of year this last December."

Monitoring Observation: Iowa Administrative Code Chapter 25 does not have regulations pertaining to this issue.

Complaint Allegation #14760: It is alleged staff tried to contact the Administrator and RN when Tenant #23 eloped from the program and were unable to get either of them to respond. It is alleged the program's policy states the Administrator and RN are to "respond to the facility immediately."

Monitoring Observation: A review of program policy and procedures indicated the program had an "emergency management plan" when a tenant wanders away from the program. This policy indicated in the event a tenant was determined to be missing the charge nurse is notified, who in turn notifies the Executive Director and/or Director of Nursing. Staff #1, #2, #3, #4, #5 and #6 stated the Administrator and RN have been available in case of an emergency.

Complaint Allegation #14760: It is alleged there was not enough staff, as a staff person was "out of state and several call offs that night," to meet the needs of tenants.

Monitoring Observation: Staff #1, #2, #3, #4, #5 and #6 stated there was enough staff to meet the identified needs of tenants. The RN stated there was enough staff to meet the needs of tenants.

Complaint Allegation #14760: It is alleged Certified Nursing Assistants (CNAs) are placed in charge of a shift and perform the duties of a nurse.

Monitoring Observation: Staff #1, #2, #3, #4, #5 and #6 stated there was sufficient staff to meet the identified needs of tenants. Staff #1 stated she felt confident when placed in charge of a shift. Staff #2 stated she was not aware of any CNAs or Certified Medical Assistance (CMAs) who were placed in charge of a shift. Staff #4 stated an OMT was placed in charge on two occasions but an LPN or RN is normally in charge of a shift. Staff #5 stated she has never been placed in charge, an OMT was placed in charge one or two times in the past but LPNs are usually in charge. Staff #6 stated he has never been asked to be in charge and did not feel comfortable being in charge. Staff #1, #2, #3, #4, #5 and #6 stated they were trained by the RN and demonstrated their competency to the RN in providing personal and medical cares to tenants.

Complaint Allegation #14987: It is alleged staff are not making routine rounds on tenants with impaired memory and Tenant #24 was found "on the floor with a large hematoma," and no one knew how long the tenant laid on the floor. It is alleged the tenant suffered from a severe Urinary Tract Infection and staff did not offer water to the tenant, as requested by family.

Monitoring Observation: Tenant #24's service plan of 3-16-07 indicated the tenant was to maintain independence by using a walker. The service plan indicated the tenant was escorted to and from meals, to activities and is reminded to use the toilet every four hours. Staff #1, #2, #3, #4, #5 and #6 stated every tenant is checked on every one to two hours. Nurse's notes of 7-17-07 indicated the tenant was found on the floor and was sent to a local hospital. Nurse's notes of 2-9-07 through 7-17-07 did not indicate a history of falls. The service plan of 3-16-07 indicated staff were to provide cranberry juice with each meal and offer two glasses of water between meals.

During the course of the complaint investigation #13455 on 10-9-10-08, the program received a regulatory insufficiency related to not having sufficiently trained staff available at all times to fully meet Tenant #19's identified needs.

Monitoring Observation: Tenant #19 was discharged from the program.

- Regulatory Insufficiency: None noted.

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

Complaint Allegation #14760: It is alleged Tenant #23 eloped from the program "due to the staff's inability to operate the Home Free Security System."

Monitoring Observation: Tenant #23's nurse's notes of 10-25-07 through 12-27-07 indicated the tenant eloped on 10-25-07, the day of admission, with no other incidents of

elopement recorded. The Administrator stated the tenant was given a Global Positioning System (GPS) watch, which gave the program immediate location of the tenant on the day of admission. However, the tenant's GPS watch was not programmed into the computer and did not alarm when the tenant eloped. Staff #1, #2, #3, #4, #5 and #6 stated they were knowledgeable in the use of the system and knew what to do if a tenant left the program. A review of program in-services indicated staff were given an in-service on 10-29-07. The Administrator stated they have taken additional steps to ensure the Home Free System works properly. Daily alarm checks of the system are completed and a "special needs – elopement risk" form is implemented for tenants with the potential or history of trying to elope from the program.

- Regulatory Insufficiency: None noted.

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

Complaint Allegation #14760: It is alleged the program "hired and started several employees without running their criminal background check." It is alleged the previous Director of Nursing worked for two months before the program completed criminal background checks.

Monitoring Observation: A review of criminal background checks on the previous Director of Nursing and thirteen staff hired from 10-1-07 through 12-14-07 indicated the program completed criminal background checks prior to employment.

- Regulatory Insufficiency: None noted.

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

During the course of the complaint investigation #13455 on 10-9-10-08, the program received a regulatory insufficiency related to not establishing standards that allow flexibility in design which promotes a social model of service delivery by focusing on independence, individual needs and desires, and consumer driven quality of service for tenant's #21 and #22.

Monitoring Observation: Tenant #21's service plan was updated on 1-4-08 to include interventions related to the tenant's involvement with tenant #22 and staff's actions regarding this relationship.

Tenant #22's service plan was updated on 1-4-08 to include interventions related to the tenant's involvement with tenant #21 and staff's actions regarding this relationship.

- Regulatory Insufficiency: None noted.

During the course of the complaint investigation #13455 on 10-9-10-08, the program received a regulatory insufficiency related to not implementing the Plan of Correction submitted.

Monitoring Observation: The program did not consistently follow their plan of correction related to evaluation of tenant with a change in condition, service plan updates with a change in condition and obtaining signatures of the tenant or tenant's legal representative.

- Regulatory Insufficiency: The program did not implement the Plan of Correction submitted. (26.2(6) (a))

Dated this 4th day of April, 2008.