IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED

March 5, 2010

Complaint: #23567-C
25926-C
Incident: # 26120-I

Vicki Truby, Administrator
Rose of East Des Moines Assisted Living
1331 Idaho Street
Des Moines, IA 50316-2463

RE: I. Final Complaint and Incident Investigation Report, Rose of East Des Moines, Des Moines, IA
II. Appeals/Hearings
III. Civil Penalty
IV. Conclusion

Dear Ms. Truby:

I. Final Complaint and Incident Investigation Report, Rose of East Des Moines, Des Moines, IA

Enclosed is the **Final Complaint and Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C, 321 Iowa Administrative Code chapter 25 (pertaining to assisted living programs), and 321 Iowa Administrative Code chapter 26 (pertaining to monitoring, civil penalties, and complaints). The report notes Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Service Plan, Nurse Review, and Structural Requirements. The Rose of East Des Moines ("Program") is being assessed a $5,000.00 civil penalty.

DIA has reviewed the Plan of Correction (POC) and the Request for Reconsideration in response to the complaint investigation Report dated November 4, 12, 19 & 23, 2009. Based on the information provided, DIA accepts the Request for Reconsideration for Managed Risk; however, denies the Request for Reconsideration as it relates to: Evaluation of Tenant, Service Plan, Nurse Review and Structural Requirements

Evaluation of Tenant: Evaluations were not completed prior to, within 30 days of admission or with a change of condition and the cognitive evaluation utilized was not based as an objective tool.

Service Plan: The service plans were not based on updated cognitive, health and functional evaluations.

Nurse Review: The nurse reviews were not complete.

Structural Requirements: Six fire drills are to be completed bimonthly, with two of them conducted during the night when tenants can reasonably be expected to be sleeping.

The Plan of Correction that was submitted is accepted.

II. Appeals/Hearings

The Program may appeal the DIA decision in accordance with 321 Iowa Administrative Code rule 26.4, within 30 days of notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to 321 Iowa Administrative Code chapter 10. If the Program appeals, the civil penalty will be suspended, pending appeal process.

III. Civil Penalty

If, within thirty (30) days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 231C.14. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send written notice to the Certification Coordinator and remit the penalty assessed by check or money order in the amount of three thousand two hundred fifty dollars ($3,250.00) within 30 business days after the receipt of this demand letter.

IV. Conclusion

The Program is being assessed a $5,000.00 civil penalty. DIA may 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 regarding this letter and report, please contact your Certification Coordinator, Connie Schaffer, at 515-281-5003.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint & Incident Investigation Report

Assisted Living Program:

Complaint Intake: #23567-C
25926-C
Incident Intake: #26120-I

Vicki Truby, Administrator
Rose of East Des Moines Assisted Living
1331 Idaho Street
Des Moines, IA 50316-2463

Date of Investigation:

November 4, 12, 19 & 23, 2009

Monitor(s):

Hal L. Chase, RN BSN MPH

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 and incident investigation visit was conducted at the Rose of East Des Moines Assisted Living on November 4, 12, 19 & 23, 2009. 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:	66
Current number of tenants with cognitive disorder:	0
Total Population:	66

Dementia Specific Program (DSP)* – Not applicable.

***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 – The program has had substantiated Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Service Plan and Record Checks.

The Initial certification was completed on December 24, 2008 with Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Service Plan and Record Checks, which resulted in a $500.00 fine.

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]

During the course of the investigation, tenants stated there is no social worker available during the day as indicated in their basic service plan.

- Monitoring Observation: The program's Executive Director stated the "in house service plan summary" indicated a licensed social worker was available at Rose of Des Moines and not at the Rose of East Des Moines. Some of the tenants accidently received the wrong "in house service plan summary." The program has scheduled a tenant meeting for the week of 12-1-09 to explain the error to tenants and the services offered.

- Regulatory Insufficiency: None noted.

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)]

Incident Allegation: The program reported a tenant stopped a nurse in the hallway and stated he/she had not seen Tenant #1 for a couple of days and asked the nurse to check on the tenant. The registered nurse (RN) found the apartment door unlocked and found the tenant on the bed in feces. The RN called 911 and family. The actual date and time of death was undetermined. An evaluation completed prior to occupancy indicated Tenant #1 reported he/she had spent three months in the hospital for internal bleeding and a foot injury.

- Monitoring Observation: Tenant #1, a 69 year old, had an undetermined date of admission to the program. The tenant signed his/her occupancy agreement on 8-21-09, but the program reported the tenant possibly moved in the weekend of 8-30-09 as the Administrator and Staff #6, RN saw the tenant in the building on 9-2-09. Admitting diagnoses included: History of Internal Bleeding, History of an Open Wound to the Right Foot and History of a Right Faciaotomy.

  The program completed functional, cognitive and health evaluations prior to occupancy on 8-21-09. Staff #6, RN, stated the tenant's interview (evaluation) was conducted at the program on 8-21-09 and the tenant drove himself/herself to the program for the interview. The tenant indicated he/she was only at the skilled nursing facility because of a broken foot and needed to receive wound care. Staff #6, RN, stated the tenant did not mention any other health conditions and indicated he/she would be at the skilled nursing facility for at least another three weeks and did not plan on leaving the facility until the foot wound had healed. The Staff #6, RN, stated he did not feel any other medical information was needed.

  Hospital records indicated the tenant was hospitalized 7-14-09 through 7-20-09 with admitting diagnoses of Right Foot Pain Secondary to Multiple Fractures, Compartment Syndrome of the Right Foot, Alcohol Abuse – Continuous,

Hypokalemia and Gastro Esophageal Reflux Disease. The tenant's past medical history included previous diagnoses of Alcoholism – Continuous, Hypothyroidism, Cirrhosis, Ascites, Esophageal Varices, Gastro Esophageal Reflux Disease (GERD), Type II Diabetes Mellitus, Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD), Hiatal Hernia and Restrictive Lung Disease.

Care call notes of 9-2-09 indicated the tenant pressed his/her Personal Emergency Response System (PERS) pendent. Staff #6 RN found the tenant sitting in a recliner, diaphoretic and hypotensive and complaining of being extremely short of breath. Staff called 911 and the tenant was transported to a local hospital.

Care call notes of 9-13-09 indicated another tenant asked staff to check Tenant #1's blood pressure as the tenant was light headed and having difficulty breathing and had been for three to four days. Staff #7, licensed practical nurse (LPN), stated the only thing they could do was send him/her to the hospital. The tenant refused.

Care call notes of 10-15-09 at 6:05 p.m. indicated the tenant was on the first floor hallway and asked to speak to staff. The tenant was in a moderate amount of distress, appeared to be short of breath and diaphoretic. The tenant's temperature was 96.9, pulse was 140, respiration was 28 and blood pressure was 133/98. Care call notes indicated the tenant had a history of Alcohol (ETOH) abuse and gastrointestinal (GI) bleed. The tenant complained of nausea, vomiting and diarrhea. Positive black stools were observed on the bathroom floor. Staff #7, LPN, advised the tenant he/she should be evaluated to rule out GI bleed but the tenant refused. Staff asked the tenant about alcohol consumption but the tenant stated he/she had not consumed any alcohol in the last 48 hours. Staff advised the tenant he/she may be in withdrawl. At 8:20 p.m. Staff #7, LPN re-evaluated the tenant and tenant stated he/she was feeling better.

Care call notes of 10-17-09 indicated the tenant pressed his/her personal emergency response system (PERS) pendent at 7:00 a.m. because of having a sweat and feeling like he/she may have the flu. Care call notes of 10-17-09 indicated the tenant pressed his/her PERS pendent at 8:35 a.m., calling for assistance. The tenant's apartment had a foul odor of blood and stool and positive dark black liquid stool were on the tenant's legs and floor. Staff #7, LPN assisted the tenant to the bathroom where the tenant had explosive black diarrhea. The tenant's temperature was 97.8, pulse was 164, respirations were 48 and blood pressure was 100/60. The tenant complained of nausea with positive dark emesis. It was noted the tenant was extremely pale and diaphoretic. Emergency personnel were called and the tenant was transported to a local hospital by ambulance. Summary progress notes of 10-26-09 indicated the tenant was seen outside smoking and Staff #6, RN, asked the tenant when he/she had been discharged. The tenant indicated he/she was discharged from the hospital on 10-22-09.

Care call note, written as a late entry of 11-4-09, without a date that identified the date and time the incident occurred, indicated the tenant had pressed his/her PERS pendent and staff responded. Staff indicated the tenant was sitting in a chair by the front door and complained of having problems breathing. Staff asked if the tenant wanted an ambulance, but the tenant refused. Staff gave the tenant some orange juice and asked if he/she wanted to see a nurse. A nurse was called but no other information was available.

Progress notes of 11-2-09 indicated staff was asked by another tenant to check on Tenant #1, as the tenant had not been seen for a few days. Staff #6, RN, went to the tenant's apartment, knocked on the tenant's door without a response from the tenant, went into the tenant's apartment and found the tenant lying in bed unresponsive. Staff #6, RN, checked the tenant for a pulse and none was found. Local fire department emergency personnel were called. The tenant had passed away.

Tenant #2 stated he/she told Staff #5, RN and Staff #6, RN, Tenant #1 was depressed and had suicidal thoughts. Both staff reportedly stated it wasn't their responsibility. Tenant #2 stated he/she didn't approach staff about Tenant #1 not being around prior to his/her death. Tenant #2 stated Tenant #1 came back from the hospital on 10-22-09 and told him/her no one knew he/she was back and Tenant #1 reportedly stated "what good would it do."

Tenant #3 did not remember when he/she told staff he/she had seen Tenant #1, remembered telling someone but doesn't remember when. Tenant #3 stated Tenant #1 was a quiet person and didn't talk much and would be gone for 5-6-7-8-9 days. Tenant #3 stated there was an odor from Tenant #1's apartment, especially after he/she knew the tenant had passed away. Tenant #3 didn't remember when the odor was present but stated it had been a week or more. He/she stated Tenant #1 had been coughing a lot for a couple of days and it had kept him/her awake for a couple of days but he/she did not check on the tenant and didn't complain to staff.

Tenant #4 stated on 11-2-09 at 5:30 p.m. he/she told Staff #6, RN he/she hadn't seen Tenant #1 for days. The tenant stated he/she told Staff #1 on Thursday 10-29-09, Friday 10-30-09 and Saturday 10-31-09 that Tenant #1 hadn't been seen and would she check on the tenant. The tenant stated Staff #1 just stood there and looked at him/her. The tenant stated he/she knocked on Tenant #1's door on Thursday 10-29-09 around 8:00 p.m., Friday 10-30-09 around 8:00 p.m. and again on Saturday 10-31-09 around 8:00 p.m. On Sunday 11-1-09 around 10:00 p.m. The tenant knocked and opened the door and saw a cane on the floor in the doorway, smelled an odor and thought it smelled like garbage.

Tenant #5 stated he/she talked with Tenant #2 and Tenant #3 as they expressed their concern regarding Tenant #1. Tenant #5 stated he/she didn't notice anything out of the ordinary. Tenant #5 stated Tenant #4 reported smelling "a really bad body odor" on Sunday, 11-1-09 around 10:30 p.m.

Tenant #6 stated he/she lived directly below Tenant #1's apartment. Tenant #6 stated he/she heard Tenant #1 moving about his/her apartment on 10-30 and 31-09 and again on 11-1-09.

The program did not complete functional, cognitive and health evaluations, within 30-days of admission, and with changes in health status when the tenant returned after being hospitalized from an incident of 9-2-09, and after an incident that occurred on 9-13-09, after the tenant returned following hospitalization. Functional and health status evaluations were completed on 10-26-09, but a cognitive evaluation was not completed.

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

Nineteen files were reviewed. Tenants' #5, #13, #14, #19, #20, #21, and #22s' functional, cognitive and health evaluations were not completed within 30-days of admission.

Tenant #10, a 78 year old, was admitted to the program on 10-30-08. Diagnoses included: Congestive Heart Failure (CHF), Arthropathy, Myalgia, Myositis, Asthma and HTN. Functional and Health status evaluations were completed on 10-12-09 and indicated the tenant was recently released from a skilled care facility to regain his/her strength following a hospital stay for infected diverticulitis. The tenant was scheduled to receive skilled nursing visits weekly to help monitor fluid balance and pain control. The program did not complete a cognitive evaluation with a change in health status.

Tenant #11, a 54 year old was admitted on 5-1-09. Diagnoses included: a History of Stroke, HTN, High Cholesterol, CHF, COPD and Arthritis. Functional, cognitive and health evaluations were completed on 3-9-09 and again on 5-6-09. The program did not complete functional, cognitive and health status evaluations within 30-days of admission to the program. Functional and health evaluations were completed on 7-29-09 following a hospitalization for CHF and a new diagnosis of COPD in addition to medication changes, but a cognitive evaluation was not completed. Functional and health status evaluations were completed on 8-21-09 following a hospitalization for exacerbation of CHF in addition to medication changes, but a cognitive evaluation was not completed. A managed risk agreement was initiated on 9-23-09 which included daily nursing visits for medication management for a period of three to four weeks due to possible poor medication management. Functional and health evaluations were completed on 9-23-09 following a hospitalization for exacerbation of CHF and Pulmonary Effusion in addition to medication changes, but a cognitive evaluation was not completed. The tenant's home health plan of care of 11-8-09 indicated the program was setting up medications in a weekly planner and medications were delivered daily to the tenant. Hospitalization date of admit and discharge were unknown as they were not documented by the program.

Tenant #12, a 73 year old, was admitted on 1-29-09. Diagnosis included History of Bilateral Total Knee Replacement. Functional and health evaluations were completed on 9-22-09 due to a change of payer source and a change in health status. Functional/Health notes of 9-22-09 indicated the tenant needed assistance with activities of daily living (ADLs) following a fall in which the tenant had broken his/her shoulder. The date the tenant broke his/her shoulder is unknown. The tenant received occupational therapy and a home health aide was to provide services three times weekly and homemaker services two hours weekly. The program did not complete a cognitive evaluation with a change in health status.

Tenant #15, an 83 year old was admitted on 10-22-09. Diagnoses included Diabetes Mellitus II, Asthma, Sleep Apnea, Mental Disorder, Angina Pectoris and Urinary Incontinence. A nursing visit of 10-3-09 indicated the tenant had complained of chest pain and pain in the left shoulder and was transported by ambulance to a local emergency room. Program records indicated the tenant was hospitalized 10-3-09

through 10-5-09. Functional and health evaluations were completed on 10-6-09 but a cognitive evaluation was not completed with a change in health status.

Tenant #17, a 45 year old, was admitted on 3-13-09. Diagnoses included: Diabetes Mellitus, HTN, Asthma and Degenerative Disc Disease. Program records indicated the tenant was hospitalized 11-1-09 through 11-6-09 and was readmitted to the hospital 11-9-09 through 11-13-09, with admitting diagnoses of Difficulty Breathing. Progress notes of 11-13-09 indicated the tenant was given intravenous steroids which made the tenant's blood sugars elevate. The tenant continued to be short of breath when walking less than 10 feet and used oxygen intermittently and a Continuous Positive Air Pressure (CPAP) device nightly. Progress notes of the same entry indicated the tenant's feet and lower legs had 2+ edema bilaterally. Progress notes of the same entry indicated there was no change in the tenant's functional assessment and the tenant scored 11 out of 11 on the mini mental evaluation. The tenant's file did not include functional, cognitive and health evaluations. The program did not complete a functional, cognitive and health evaluations with a change in health status as the tenant continued to have difficulty breathing when ambulating and had elevated blood sugars.

- Regulatory Insufficiency: The program did not evaluate each proposed tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy in order to determine the tenant's eligibility for the program, including whether services needed can be provided. (25.23)(1))

- Regulatory Insufficiency: The program did not 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 services needed. (25.23)(2))

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

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

Monitoring Observation: Nineteen files were reviewed. Tenants #5, #13 #14, #19, #20, #21 and #22s' initial service plan was completed on 8-26-09, but the program did not complete a service plan within 30-days of admission.

Tenant #1's service plan was not updated within 30-days of admission. The service plan was updated on 10-26-09, four days after the tenant reported retuning from the hospital. The service plan was not supported by a cognitive evaluation.

Care call notes of 9-2-09 indicated the tenant pressed his/her PERS pendent. Staff #6, RN, found the tenant sitting in a recliner, diaphoretic and hypotensive and complaining of being extremely short of breath. Staff called 911 and the tenant was transported to a local hospital.

Care call notes of 9-13-09 indicated another tenant asked staff to check Tenant #1's blood pressure as the tenant was light headed and having difficulty breathing and had

been for three to four days. Staff stated the only thing they could do was send her to the hospital. The tenant refused.

Care call notes of 10-15-09 at 6:05 p.m. indicated the tenant was on the first floor hallway and asked to speak to staff. The tenant was in moderate amount of distress, appeared to be short of breath and diaphoretic. The tenant's temperature was 96.9, pulse was 140, respiration was 28 and blood pressure was 133/98. Care call notes indicated the tenant had a history of Alcohol (ETOH) abuse and GI (gastrointestinal) bleed. The tenant complained of nausea, vomiting and diarrhea. Positive black stools observed on the bathroom floor. Staff #7, LPN, advised the tenant he/she should be evaluated to rule out GI bleed the tenant refused. Staff asked the tenant about alcohol consumption, but the tenant stated he/she had not consumed any alcohol in the last 48 hours. Staff #7, LPN advised the tenant he/she may be in withdrawl. The tenant stated it did not feel like withdraws. At 8:20 p.m. staff re-evaluated the tenant and tenant stated he/she was feeling better.

Care call notes of 10-17-09 indicated the tenant pressed his/her PERS pendent at 7:00 a.m. because of having a sweat and feeling like he/she may have the flu. Care call notes of 10-17-09 indicated the tenant pressed his/her PERS pendent at 8:35 a.m., calling for assistance. The tenant's apartment had a foul odor of blood and stool and positive dark black liquid stool were on the tenant's legs and floor. Staff #7, LPN, assisted the tenant to the bathroom where the tenant had explosive black diarrhea. The tenant's temperature was 97.8, pulse was 164, respirations were 48 and blood pressure was 100/60. The tenant complained of nausea with positive dark emesis. It was noted the tenant was extremely pale and diaphoretic. Emergency personnel were called and the tenant was transported to a local hospital by ambulance.

Care call note, written as a late entry dated 11-4-09, without a date and time the incident occurred indicated the tenant had pressed his/her PERS pendent and staff responded. Staff indicated the tenant was sitting in a chair by the front door and complained of having problems breathing. Staff asked if the tenant wanted an ambulance, but the tenant refused. Staff gave the tenant some orange juice and asked if he/she wanted to see a nurse. A nurse was called but no other information was available.

The service plan of 8-21-09 indicated the tenant was independent with ADLS and Individual Activities of Daily Living (IADLS), but did not include specific service needs of the tenant, including nursing interventions related to previous and present health status. The tenant's service plan of 10-26-09 was developed without a cognitive evaluation and did not include the specific needs of the tenant as evidenced by the health status changes documented in care call notes and hospitalizations beginning 9-2-09 through 10-26-09.

Tenant #10's functional and health evaluation notes of 10-12-09 indicated the tenant was recently released from a skilled care facility to regain his/her strength following a hospital stay for infected diverticulitis. The tenant was scheduled to receive skilled nursing visits weekly to help monitor fluid balance and pain control. The tenant's service plan of 11-25-08 was not updated to reflect a change in health status related to weekly nursing visits and interventions related to monitoring of fluid balance and pain control.

Tenant #11's service plan of 5-26-09 indicated the tenant was independent with medications, received skilled nursing assessment weekly and was independent with ADLs. The tenant was hospitalized on three separate occasions between 7-29-09 and 9-23-09 for CHF and a new diagnosis of COPD and two separate events of exacerbation CHF and Pulmonary Effusion. With all three hospitalizations medication changes were made. Dates of hospitalization admission and discharge are unknown as they were not documented by the program. The program initiated three home health plans of care. Home health plan of care of 9-9-09 through 11-7-09 indicated the tenant was independent with medications, assistance with personal care and hygiene, home health aide twice daily and skilled nursing once weekly. A managed risk agreement was initiated on 9-23-09 which included daily nursing visits for medication management for a period of three to four weeks due to possible poor medication management. During an interview, it was noted the tenant had a weekly planner of medications on the dining room table and the tenant had not taken all of the previous two days of medications and, according to the tenant, had taken today's morning and noon medication at the same time. The RN stated the tenant went back to weekly medication planners the beginning of November, 2009. On 10-20-09 the plan of care was changed and included a change in skilled nursing visits to twice weekly. Home health plan of care of and 11-8-09 through 1-6-2010 indicated weekly medication set up with daily medication planners given to the tenant, assistance with whirlpool bath twice weekly, daily weights and blood pressure and homemaker services one time per week. The program did not update the service plan of 5-26-09 with a change in health status evidenced by three hospitalizations between 7-29-09 and 9-23-09, changes in the home health plans of care and for the implementation of a managed risk agreement for possible non compliance of medications.

Tenant #12's Functional/Health notes of 9-22-09 indicated the tenant needed assistance with ADLs following a fall, with a broken shoulder. The tenant receiving occupational therapy to assist with becoming more independent; however, the tenant needs assistance with bathing and dressing. Tenant records indicated on 9-22-09 home health aide was to provide services three times weekly and homemaker services two hours weekly. Service plan of 2-26-09 was not updated to reflect services added.

Tenant #15's file noted a nursing visit of 10-3-09, which indicated the tenant had complained of chest pain and pain in the left shoulder. The tenant was transported by ambulance to a local emergency room. Program records indicated the tenant was hospitalized from 10-3-09 through 10-5-09. Service plan of 3-4-09 was not updated to reflect nursing interventions related to the hospitalization for chest pain.

Tenant #17 was hospitalized 11-1-09 through 11-6-09 and readmitted 11-9-09 through 11-13-09. Admitting diagnoses were Difficulty Breathing. Progress notes of 11-13-09 indicated the tenant was given intravenous steroids, which made the tenant's blood sugars elevate. Progress notes of the same entry indicated the tenant's feet and lower legs had 2+ edema bilaterally. The tenant continued to be short of breath when walking less than 10 feet used oxygen intermittently and a CPAP device nightly. The service plan of 4-17-09 was not updated to include interventions related to bilateral 2+ pitting edema to legs, the intermittent use of oxygen and a CPAP device.

- Regulatory Insufficiency: The program did not develop a service plan for each tenant based on the evaluations conducted in accordance with 25.23(1) and 25-23(2), and designed to meet the specific service needs of the individual tenant. (25.28)(1)

- Regulatory Insufficiency: The program did not update the service plan within 30 days of occupancy and as needed, but not less than annually, by a multidisciplinary team that consists of no fewer that 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)(3))

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 investigation, a tenant stated he/she was not receiving assistance with application of pain patches.

- Monitoring Observation: Nineteen files were reviewed. Tenant #11's home health plan of care of 11-8-09 indicated the program was setting up medications in a weekly planner and each days medications were delivered to the tenant. The tenant was prescribed Lidoderm 5% 700mg/patch twice daily – on for 12 hours and off for 12 hours. The tenant stated he/she needed assistance with the Lidoderm pain patch but had not asked staff for assistance.

- Regulatory Insufficiency: None noted.

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]

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

- Monitoring Observation: Nineteen files were reviewed.

  Tenant #1's Care call notes of 9-2-09 indicated the tenant pressed his/her PERS pendent. An RN found the tenant sitting in a recliner, Diaphoretic and Hypotensive and complaining of being extremely short of breath. Staff called 911 and the tenant was transported to a local hospital.

  Care call notes of 9-13-09 indicated another tenant asked staff to check Tenant #1's blood pressure as the tenant was light headed and having difficulty breathing. Staff stated the only thing they could do was send her to the hospital. The tenant refused.

  Care call notes of 10-15-09 at 6:05 p.m. indicated the tenant was on the first floor hallway and asked to speak to staff. The tenant was in moderate amount of distress, appeared to be short of breath and diaphoretic. The tenant's temperature was 96.9, pulse was 140, respiration was 28 and blood pressure was 133/98. Care call notes

indicated the tenant had a history of ETOH abuse and GI bleed. The tenant complained of nausea, vomiting and diarrhea. Positive black stools observed on the bathroom floor. Staff #7, LPN, advised the tenant he/she should be evaluated to rule out GI bleed; the tenant refused. Staff #7, LPN asked the tenant about Alcohol consumption, but the tenant stated he/she had not consumed any Alcohol in the last 48 hours. Staff #7, LPN advised the tenant he/she may be in withdrawl. The tenant stated it did not feel like withdrawls. At 8:20 p.m. staff re-evaluated the tenant and tenant stated he/she was feeling better.

Care call notes of 10-17-09 indicated the tenant pressed his/her PERS pendent at 7:00 a.m. because of having a sweat and feeling like he/she may have the flu. Care call notes of 10-17-09 indicated the tenant pressed his/her PERS pendent at 8:35 a.m., calling for assistance. The tenant's apartment had a foul odor of blood and stool and positive dark black liquid stool were on the tenant's legs and floor. Staff #7, LPN, assisted the tenant to the bathroom where the tenant had explosive black diarrhea. The tenant's temperature was 97.8, pulse was 164, respirations were 48 and blood pressure was 100/60. The tenant complained of nausea with positive dark emesis. It was noted the tenant was extremely pale and diaphoretic. Emergency personnel were called and the tenant was transported to a local hospital by ambulance.

Care call note, written as a late entry dated 11-4-09, without a date and time the incident occurred indicated the tenant had pressed his/her PERS pendent and staff responded. Staff indicated the tenant was sitting in a chair by the front door and complained of having problems breathing. Staff asked if the tenant wanted an ambulance, but the tenant refused. Staff gave the tenant some orange juice and asked if he/she wanted to see a nurse. A nurse was called but no other information was available.

The program did not complete a nurse review with changes in health status on 9-2-09 when the tenant returned to the program from a hospitalization and did not complete a nurse review when the tenant refused to go to the hospital after being light headed and having trouble breathing on 9-13-09.

Tenant #17's file indicated the tenant was hospitalized 11-1-09 through 11-6-09 and readmitted to the hospital 11-9-09 through 11-13-09 with admitting diagnoses of Difficulty Breathing. Progress notes of 11-13-09 indicated the tenant was given intravenous steroids, which made the tenant's blood sugars elevate. The tenant continued to be short of breath when walking less than 10 feet and uses oxygen intermittently and a CPAP device nightly. Progress notes of the same entry indicated the tenant's feet and lower legs had 2+ edema bilaterally. Progress notes of the same entry indicated there was no change in the tenant's functional assessment and scoring 11 out of 11 on the mini mental evaluation. The tenant's file did not include functional, cognitive and health evaluations. The program did not complete a nurse review with a change in health status.

- Regulatory Insufficiency: The program did not 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)

F. 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]

Complaint Allegation #25926-C: It is alleged Tenant #10 gave written notice on 9-1-09 he/she no longer wanted lunch. However, the tenant was billed for 19 noon meals. It is alleged there is no tracking system to keep track of tenants cancelling their meals. The program requires 48 hour written notice if a tenant is not going to eat a meal. If the tenant doesn't show up to the meal, the meal is boxed and put in the refrigerator. If not claimed, it is thrown away and the tenant is billed.

- Monitoring Observation: Tenant #10's service plan of 11-25-08 indicated the tenant was to receive two meals daily, seven days a week. Program records indicated they received correspondence from an outside agency, that provided funding for the tenant's meals, that had cancelled the tenant's noon meals. On 9-3-09 the tenant's name was removed from the list of tenants who received a noon meal. The program did not remove the tenant's name from the list of tenant's who receive meals for the month of October 2009 and the tenant did not participate in the noon meal. Program documentation indicated the agency that funded the noon meals was not charged for either month.

  The program's occupancy agreement indicated missed meals will be credited against a subsequent month's food service contract. In order to receive a credit, notice of missing a meal must be given to the cook 48 hours before the meal; otherwise, no credit will be given. The tenant had signed the occupancy agreement prior to admission to the program.

- Regulatory Insufficiency: None noted.

G. 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 #23567-C: It is alleged staff are not completing homemaking tasks and are not staying the two hours as contracted.

- Monitoring Observation: Tenant #2 stated homemakers go beyond what is required. Staff are courteous and polite. Tenant #3 stated homemaker services did an excellent job of cleaning and dusting his/her apartment and staff were very courteous. Tenant #4 stated he/she just signed up for homemaker services and could not comment further. Tenant #5 stated he/she did not receive homemaker services. Tenant #6 stated he/she is "okay with them" and they do a good job as far as he/she knew. Tenant #7 stated he/she received 15 hours of homemaker services monthly. Two hours a week is spent on unpacking, which is unnecessary but the caseworker wants staff to help unpack boxes. Staff bring boxes out of the closet and wait until the tenant goes through them. Sometimes they leave and return later to help him/her put things away. Tenant #8 stated homemaker services had not yet started and he/she was having his/her case manager look into the issue. Staff #12 stated staff have always done a good job and are punctual and thorough.

- Regulatory Insufficiency: None noted.

Complaint Allegation #23567-C: It is alleged dietary staff are disrespectful and publicly humiliate tenants. It is alleged dietary staff talk about how bad the food is in front of tenants. It is alleged staff are eating food prepared for tenants and there is not enough food for tenants who want second servings.

- Monitoring Observation: Tenant #2 stated dietary staff have not been disrespectful or humiliated tenants during meals. There has been no cursing and staff go out of their way to offer additional food to tenants who say they are still hungry. Tenant #3 stated he/she did not eat meals at the program and can't exactly state concerns, but had heard from others dietary staff have been rude. Tenant #4 stated dietary staff have been very pleasant to work with and talk to. Staff was not disrespectful and have not publicly humiliated tenants. The tenant stated he/she has never asked for second helpings, but stated if tenants are hungry they can ask for second helpings. Tenant #5 stated dietary staff are courteous to tenants and has not heard of concerns from other tenants. Usually there is food left over and tenants are asked if anyone wants second helpings. Tenant #6 stated dietary staff seem to be polite. The Dietary Manager spouts off, but she means well. If someone wants a second helping, staff will usually give it to them. Tenant #7 stated dietary staff are polite and courteous but the Dietary Manager has been rude and interrupts tenant's conversations during meals. Tenant #8 stated dietary staff are very nice and not disrespectful. Tenant #12 stated dietary staff are very polite and courteous. Second helpings are not always available but when a tenant wants a second helping and it is available, staff give it to them.

- Regulatory Insufficiency: None noted.

Complaint Allegation #23567-C: It is alleged staff are parking in the handicapped parking spots in front of the building intended for tenants and visitors.

- Monitoring Observation: Tenant #2 stated he/she has never seen staff park in the handicapped areas. Tenant #3 stated staff haven't parked their care in the handicapped stalls. Family and friends of tenants have parked there when dropping off a tenant. Tenant #4 stated he/she hasn't seen staff park in the handicapped stalls. Tenant #5 stated he/she stated staff have not parked in the handicapped stalls. Staff usually park on the street. Tenant #6 stated staff haven't parked in the handicapped areas. Staff usually park in back of the building or on the street in front of the building. Tenant #7 stated staff have never parked in the handicapped areas. Sometimes family members park in handicapped areas when dropping off tenants or items for tenants. Tenant #8 stated there are people who park in the handicapped stalls without a handicapped sticker but did not know who they were. Tenant #12 had not seen anyone park there that shouldn't be there.

- Regulatory Insufficiency: None noted.

During the course of the investigation, tenants stated staff have no experience and no training in the cares given to tenants.

- Monitoring Observation: A review of five direct care staff training files indicated staff were trained by an RN and demonstrated their competency in providing cares to tenants. Tenant #2 stated staff were trained to care for him/her and knew what needed to be done. Tenant #3 stated staff know what he/she need and are trained well. Tenant #4 stated staff knew what was needed and have assisted to his/her satisfaction. Tenant #5 stated staff were trained and, knowledgeable about the cares needed. Tenant #6 stated staff provided excellent care and knew what was needed. Tenant #7 stated staff provided good care and had no complaints. Tenant #12 stated staff were knowledgeable with the cares needed and provided good care.

- Regulatory Insufficiency: None noted.

During the course of the investigation, tenants stated staff are not responding to care calls, provide very minimal to no service, do not respond and do not provide help when called.

- Monitoring Observation: PERS response times were reviewed between 10-1-09 through 11-4-09 and indicated staff consistently responded within 15 minutes of being called. Tenant's #2, #3, #4, #6, #7 #8 and #12 stated staff respond to calls within 15 minutes of being called. Tenant #5 has not had to use her pendent to call for assistance. Tenant's #9 was not available to be interviewed.

- Regulatory Insufficiency: None noted.

During the course of the investigation tenants stated Tenant #12 had fallen in he/she apartment and was not found for several hours.

- Monitoring Observation: Tenant #12's PERS record for 10-1-09 through 11-4-09 indicated the tenant pressed his/her pendent six times with staff responding within 10 minutes of being called. The tenant stated he/she had fallen sometime in October, 2009, but didn't remember the specific date, but did remember staff responded quickly when called. The tenant stated he/she was not injured but needed assistance up from the floor. A review of the tenant's record did not indicate the tenant had a history of falls.

- Regulatory Insufficiency: None noted.

H. Structural requirements – The structure of the program shall be designed and operated to meet the needs of the tenants. The buildings and grounds shall be well-maintained, clean, safe and sanitary.

During the course of the investigation, tenants stated a fire alarm went off and staff did not come to assist tenants with physical limitations out of the building.

- Monitoring Observation: Program records indicated the program's fire drill policy and procedure includes six fire drills per year and at least two drills to be conducted during the night when tenants are expected to be sleeping. All staff and tenants in the building will participate. All staff and tenants must evacuate to a point of refuge: east wing of all floors, west wing of all floors, dining room and community room. Staff are assigned to monitor and to time the movement of tenants to their respective point

of refuge. All tenants will be instructed to their points of refuge regarding evacuation procedures that would ensue in the event the exercise was not a drill. Examples given were building exits, transportation contingencies and emergency housing contingencies.

Tenants #2, #3, #4, #5, #6, #7, #8 stated they participate in fire drills and staff are helpful, knowledgeable and know what to do and help tenants get to safe place. Staff #2, #4, #5 and #7 stated staff helps those tenants who need assistance during fire drills.

Program records indicated fire drills were completed on 10-23-08 at 3:50 p.m., 12-29-08 at 1:30 p.m.,2-26-09 at 3:00 p.m., 4-28-09 at 4:00 p.m. 6-26-09 at 4:00 p.m., 8-27-09 at 3:00 p.m. and an unannounced fire drill on 10-27-09 at 3:30 p.m. On 11-7-09 a fire alarm went off at 2:30 p.m. A smoke detector in the program's kitchen alarmed as the kitchen's ventilation system "wasn't good enough for what they were cooking." Records indicated staff and all but three tenants participated in the fire alarm. The three tenants who did not participate were notified of their responsibility, as part of their occupancy agreement, to participate in fire drills and fire alarms. Records indicated the program did not complete at least two fire drills during the night.

- 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 during the night when tenants are sleeping. (25.40(1)(e) (231C(4)

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 investigation, tenants stated emergency personnel bringing tenants in and out of the program are going through the garage and are not allowed to come through the front of the building. Tenants stated emergency personnel are stopped at the front door and not allowed to come in.

- Monitoring Observation: Program records indicated tenants taken by ambulance are transported through the garage for the privacy of the tenant as there is less chance the tenant would be seen by others as opposed to going past the dining room and other common areas to exit. During poor weather conditions an ambulance can back directly into the garage and not expose tenants to the elements. The front entryway was designed to allow room for emergency personnel and equipment but it would be quicker to enter through the garage. The Executive Director indicated if a tenant prefers not to go through the garage, they have the option to be taken through the front entryway.

During the course of the investigation, tenants stated a tenant asked staff to let another tenant know he/she was going to the hospital and staff stated they were not able to give this information to tenants.

- Monitoring Observation: Program records indicated tenants had asked the program to notify tenants when tenants were hospitalized. The program indicated they advised

tenants they cannot share this information with other tenants due to confidentiality. Tenants requested they have a bulletin board in the hobby room so they can communicate this information with others. Tenants were polled and not all tenants were in agreement, therefore a communication board was not placed in the hobby room.

During the course of the investigation, a tenant stated he/she was charged $30.00 for a tenant meeting, $50.00 for candy and $40.00 for donuts and cookies.

- Monitoring Observation: Program records indicated in April, 2009 tenants voiced concerns regarding the cost of the basic service plan tenants are required to pay monthly. A revenue and expense document was presented which gave a description of costs incurred in providing services under the basic service plan.

- Regulatory Insufficiency: None noted.

Dated this 8th day of March, 2010.