IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 27914-C
28353-C

July 23, 2010

Ms. Michelle Van Dolah, Manager
Rosebush Gardens
4925 West Avenue
Burlington, IA 52601-9469

RE: I. Final Complaint Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Van Dolah:

I. Final Complaint Investigation Report – Rosebush Gardens, Burlington, IA

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69. The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenants, Service Plan, Medications, Nurse Review and Staffing. **Rosebush Gardens** ("Program") is being assessed a $1,500 civil penalty.

II. Civil Penalty

If, within 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 civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Tamara Halvorson** and remit the civil penalty assessed by check or money order in the amount of nine hundred seventy five dollars ($975) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $1,500 civil penalty. The Plan of Correction (POC) submitted on July 22, 2010, has been reviewed and will constitute the final POC related to the on-site visit of April 21, 22, 27 & 28, 2010.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Certification Coordinator, Tamara Halvorson, at 515/281-5721.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Michelle Van Dolah, Manager
Rosebush Gardens
4925 West Avenue
Burlington, IA 52601-9469

Complaint Intake #: 27914-C
28353-C

Date of Investigation:

April 21, 22, 27 & 28, 2010

Monitor(s):

Hal L. Chase, RN BSN MPH
Stephanie Cummins, MA

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. IAC r. 481-67.10(5). 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 481 IAC chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Rosebush Gardens on April 21, 22, 27 & 28, 2010. In preparing this report, the following information was considered:

Current Program Census

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

Current number of tenants without cognitive disorder:	36
Current number of tenants with cognitive disorder:	0
Total Population:	36

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.**

Program History – There were substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Service Plans and Staffing.

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

A. Evaluation of Tenant

Complaint Allegation #28353-C & #27914-C: It was alleged assessments were falsified.

Monitoring Observation: The registered nurse (RN) was interviewed and stated records were not falsified and she had not been instructed to falsify them. She stated the service plans were based on evaluations and reflected the true needs of the tenants and their requests for assistance. The RN stated there was a staff meeting on 4-5-10 and staff were asked by the RN if tenants needed more care than the service plans indicated and if so, to tell them and the service plan would be updated.

Staff #8, the license practical nurse (LPN), was interviewed. She stated she was not aware of any records in the building that were falsified. She stated she had not asked to falsify any records and she would not do it if she were asked. She stated the service plans were based on the evaluations and reflected the needs of the tenants.

The Manager was interviewed. She stated records were not falsified and she stated she had not instructed staff to falsify records. She stated the service plans reflected the needs of the tenants.

- Regulatory Insufficiency: None noted.

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

Monitoring Observation: Twelve tenant files and one discharged tenant's file were reviewed.

Tenant #1, 89 years old, was admitted on 9-29-09 and diagnoses include: Atrial Fibrillation, Fall Risk, Parkinson's Disease and Prostate Enlargement. The tenant scored a nine on the Mental Status Questionnaire (MSQ) completed on 1-15-10, indicating no or mild cognitive impairment. The tenant scored a five on the MSQ on 4-26-10, which indicated moderately advanced impairment. Staff #8, LPN, stated the tenant had good days and bad days regarding confusion. She stated the tenant had been incontinent of bowels in his/her apartment in locations other than the bathroom. She stated since that occurred staff provided toileting reminders every two hours. Staff #1 stated one time per month the tenant came out without appropriate clothing on from the waist down. Staff #2 stated the tenant urinated in another tenant's garbage can that was left out in the hall. Twenty-four hour report sheets indicated episodes of confusion, the need for incontinence and toileting assistance and wandering into another tenant's apartment. Evaluations were not updated as needed.

Tenant #2, 93 years old, was admitted on 1-19-04 and diagnoses include: Hypertension (HTN) History of Gastric Ulcers, History of Anemia and Restless Leg Syndrome (RLS). According to Nurse's Notes dated 2-18-10 through 3-19-10, the tenant had recurrent vomiting and nausea, refused medications, refused meals and had difficulty swallowing. The tenant was prescribed Zofran and then Phenergan, as needed. Evaluations were not completed as needed.

Tenant #8, 94 years old was admitted on 1-5-09 and diagnoses include: HTN, Coronary Artery Disease (CAD), Parkinson's Disease, Heart Murmur and Urinary Retention. The tenant was discharged on 3-8-10. Nurse's Notes dated 2-21-10 through 2-27-10 indicated the tenant had been to the Emergency Room (ER) and returned with a foley catheter. The tenant also had rolled out of bed, was ambulating very slowly and had difficulty rising. Evaluations were not completed as needed.

Tenant #13, 89 years old was admitted on 5-28-07 and diagnoses include: Post Herpetic Neuralgia, Hyperkalemia, Bi-Polar Disorder, Benign HTN and Constipation. Nurse's Notes dated 2-23-10 indicated the tenant had a choking episode in the dining room and was sent to the ER. The tenant returned on 2-24-10. The tenant's service plan was updated on 2-25-10 and indicated the tenant was on an antibiotic for food aspiration and choking. The Nurse took the tenant's temperature, oxygen stats and listened to lung sounds daily until the antibiotic was finished. All staff monitored the tenant in the dining room when eating and encouraged the tenant to eat slowly and take small bites. Evaluations were not completed as needed.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC 481-r.69.22 (3))

B. Criteria for Exclusion of Tenants

Complaint Allegation #27914-C: It was alleged a tenant had increased confusion, was exit seeking and did not wear appropriate clothing. It was alleged a tenant had hallucinations. It was alleged a tenant had recurrent vomiting. It was alleged tenants required two to three people for transfers and did not provide many cares for themselves.

Complaint Allegation #28353-C: It was alleged a tenant pulled feces out of his/her pants and placed it around the program. It was alleged a tenant enters other tenants' apartments and other tenants were scared. It was alleged a tenant had unmanageable incontinence. It was alleged a tenant required maximal assistance with activities of daily living (ADLs) and had frequent falls. It was alleged a tenant had numerous falls and no effective intervention related to the falls.

Monitoring Observation: Twelve tenant files and one file for a discharged tenant were reviewed, none of the tenants exceeded the appropriate level of care.

Staff #1, #2, #3, #4 & #9 did not identify any tenants that exceeded the appropriate level of care. Staff identified tenants who required more care than listed on their service plans; however, the tenants did not exceed the level of care allowed.

The Manager and Staff #8, LPN, indicated none of the current tenants exceeded the appropriate level of care.

Observation of tenant cares did not indicate any of the tenants exceeded the appropriate level of care.

Although none of the tenants exceeded the appropriate level of care, the tenants' service plans did not reflect increased care needs as identified under the evaluation and service plan sections of this report.

- Regulatory Insufficiency: None noted.

C. Service Plan

Complaint Allegation#28353-C & #227914-C: It was alleged service plans were falsified.

Monitoring Observation: The RN was interviewed. She stated records were not falsified. She stated she had not been instructed to falsify any records. She stated the service plans reflected the true needs of the tenants and requests for assistance. The RN stated there was a staff meeting on 4-5-10 and staff were asked by the RN if the tenants needed more care than the service plan indicated to tell them and the service plan would be updated.

Staff #8, LPN, was interviewed. She stated she was not aware of any records in the building that were falsified. She stated she had not asked to falsify any records and she would not do it if she were asked. She stated the service plans reflected the needs of the tenant.

The Manager was interviewed. She stated records were not falsified and she had not instructed staff to falsify records. She stated the service plans reflected the needs of the tenants.

- Regulatory Insufficiency: None noted.

Complaint Allegation #28353-C: It was alleged a tenant had fallen numerous times and there were no interventions on the tenant's service plan.

Monitoring Observation: Tenant #10, 84 years old, was admitted on 11-15-08 with a diagnosis of a History of Rib Fractures. Nurse's notes indicated the tenant had recurrent falls and dizziness. A managed risk agreement dated 1-5-10 was implemented in regard to the falls. The service plan was updated on 1-5-10 reflecting the managed risk agreement; however, only the nurse signed the plan. The tenant's service plan was updated on 1-11-10 to reflect physical therapy (PT); however, only the nurse signed the plan. The service plan was not signed appropriately.

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

Monitoring Observation: Twelve tenant files and one file for a discharged tenant were reviewed.

Tenant #1's file was reviewed. Staff #8, an LPN, stated the tenant had good days and bad days regarding confusion. She stated the tenant had been incontinent of bowels in his/her apartment, in locations other than the bathroom, and since then staff have provided toileting reminders every two hours. Staff #1 stated one time per month the tenant came out without appropriate clothing on. Staff #2 stated the tenant urinated in another tenant's garbage can that was left out in the hall. Twenty-four hour report sheets indicated the tenant had episodes of confusion, incontinence, needed toileting assistance and wandered into another tenant's apartment. The tenant's service plan did not address the tenant's confusion, behaviors and increased toileting assistance. The tenant's service plan was not updated, as needed, and did not reflect the identified needs of the tenant.

Tenant #2's file was reviewed. According to Nurse's Notes dated 2-18-10 through 3-19-10, the tenant had recurrent vomiting and nausea, refused medications, refused meals and had difficulty swallowing. The tenant was prescribed Zofran and then Phenergan, as needed. The tenant's service plan stated (under Meals) staff and facility provided three meals a day and snacks upon request. The tenant was on a low salt diet. The tenant's service plan did not address the recurrent vomiting, nausea, refusals of medications and refusals of meals. The service plan was not updated as needed and did not reflect the identified needs of the tenant. The tenant's service plan was updated on 3-8-10 and reflected staff were to continue and assist the tenant, as needed, to and from the dining room and continue to use the wheelchair as needed. The service plan update was only signed by the nurse. The service plan was not signed appropriately.

Tenant #8's file was reviewed. Nurse's Notes dated 2-21-10 through 2-27-10 indicated the tenant went to the ER and returned with a foley catheter, had rolled out of bed, was ambulating very slowly at times and had difficulty rising. An outside service provider assisted with the tenant's catheter and this was reflected on the service plan; however, the tenant did not sign the updated plan. The remaining changes as stated above, were not reflected on the service plan. The tenant's service plan was not updated as needed and did not reflect the tenant's identified needs.

Tenant #9, an 80 year old, was admitted on 9-28-08 and diagnoses include: Dementia, Vitamin B12 Deficiency, History of Left Pubic Ramus Fracture, CAD, Peripheral Vascular Disease (PVD), HTN, Gastroesophageal Reflux Disease (GERD) and Arteriosclerotic Heart Disease (ASHD). Staff #4 and #9 stated they reminded the tenant every two hours for toileting. Staff #9 stated the tenant was incontinent approximately one time per day. The service plan did not reflect the two hour toileting reminders and urinary incontinence.

Tenant #13's file was reviewed. Nurse's Notes dated 2-23-10 indicated the tenant had a choking episode in the dining room and was sent to the ER. The tenant returned on 2-24-10. The tenant's service plan was updated on 2-25-10 and indicated the tenant was on an antibiotic for food aspiration and choking. The Nurse would take the tenant's temperature, oxygen levels and listen to lung sounds, daily, until the antibiotic was finished. All staff would monitor the tenant in the dining room when eating and encourage the tenant to eat slowly and take small bites. The service plan was signed by the nurse and not the tenant.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as

needed with a significant change, but not less than annually. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. (IAC 481-r.69.26(3)(a))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum the tenant's identified needs and preferences for assistance. (IAC 481-r.69.26(4)(a))

D. Medications

Complaint Allegation #27914-C: It was alleged medications were not administered on time.

Monitoring Observation: A medication pass was observed on 4-22-10 and medications were administered appropriately.

Staff #1 and #2 stated medications were administered on time. Staff #2 stated medications were administered appropriately on her shift; however, she had heard there were some issues on first shift. Staff #3 stated for the most part medications were administered on time; however, sometimes they got behind. She stated sometimes medications were administered at 9:30 a.m. Staff #4 stated medications were administered in an appropriate timeframe but new staff might be outside of the timeframe and administer some at approximately 9:15 a.m. She stated things were different at the time of the investigation because one staff was the medication aide and one staff did the cares.

The RN was interviewed and stated the tenants had not complained about the tardiness of medication administered. She stated medications were administered on time, one hour before and one hour after. She stated as of 4-12-10, there was one staff dedicated on each shift to administer medications. She stated medications were not administered late.

Staff #8, LPN, indicated on 4-12-10 a new program for administering medications was initiated. Beginning on 4-12-10 one PCA (Personal Care Attendant)/Certified Nursing Assistant (CNA) administered medications while the other PCA/CNA concentrated on Activities of Daily Living (ADL) and when ADLs were complete the PCA/CNA would then assist with the completion of medication administration, if needed, to complete the medication pass in the appropriate time frame. She indicated in the trial period there had been times when the medication pass went beyond the two hour window for administering medications; however, it was only by a few minutes.

Tenants and family members were interviewed and did not identify any issues with the timeliness of the administration of medications.

- Regulatory Insufficiency: None noted.

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

Monitoring Observation: The table below represents medications either not documented or not administered.

TENANTS	MEDICATION/TREATMENT	DATE/TIME
Tenant #1	Lisinopril, 2.5 mg tablet, take 1	B/P not documented for

	by mouth daily and hold if Blood Pressure (B/P) is less than 110.	the month of April.
Tenant #1	Lisinopril, 2.5 mg tablet, take 1 by mouth daily and hold if Blood Pressure (B/P) is less than 110.	This was not documented as administered on 4-18-10.
Tenant #1	Aspirin, 325 mg EC, take 1 tablet by mouth daily.	This was not documented as administered on 4-18-10.
Tenant #1	Digoxin, 125 mcg tablet, take 1 tablet by mouth daily. Hold and notify the nurse to call the physician if tenant's pulse is below 60.	The tenant's pulse was not documented on 4-17-10 & 4-18-10.
Tenant #1	Selegiline HCL, 5 mg capsule, take 1 capsule by mouth daily.	This was not documented as administered on 4-18-10.
Tenant #1	Flomax., 0.4mg capsule SA, take 1 capsule by mouth twice daily.	This was not documented as administered on 4-18-10.
Tenant #1	Metoprolol Tartrate, 50 mg, take 1 & ½ tablets by mouth twice daily.	This was not documented as administered on 4-18-10.
Tenant #1	Levothyroxin, 75 mcg daily.	This was not documented as administered on 4-8-10 and 4-18-10.
Tenant #1	Tolnadex opth. Ointment, apply 1/4" to eye lid every 12 hours.	This was not documented as administered on 4-9-10 and 4-18-10.
Tenant #2	Amlodipine Besylate, 10 mg, take 1 tablet by mouth daily.	This medication was to be discontinued on 4-8-10 and was documented as administered on 4-9-10.
Tenant #2	Vitamin D, 50,000 units SO, take 1 capsule by mouth every two weeks.	This medication was documented with initials and circled; however, no explanation was provided on the back for the dates of: 4-1-10, 4-3-10 through 4-9-10 and 4-11-10 through 4-12-10.
Tenant #3	Blood sugars four times daily.	A blood sugar reading was not documented at 8:00 p.m. on 4-18-10.

Tenant #4	Oxygen saturation is to be monitored three times daily for one week.	Oxygen saturations were not checked or not documented on the following dates: 4-15-10 at 2:00 p.m., 4-17-10 at 2:00 p.m., 4-18-10 at 9:00 a.m. and 2:00 p.m., 4-19-10 at 2:00 p.m. & 4-20-10 at 2:00 p.m.
Tenant #4	Calcium Carbonate, 600 mg, take 1 tablet by mouth three times daily, with food.	Not administered or not documented on: 4-4-10 at 12:00 p.m., 4-10-10 at 12:00 p.m. & 4-14-10 at 12:00 p.m.
Tenant #4	Nasal spray, 0.65%, instill 2 sprays into each nostril three times daily.	Not administered or not documented on: 4-4-10 and 4-10-10 at 12:00 p.m.
Tenant #4	MAPAP, 500 mg caplet, take 1 tablet by mouth four times daily.	Not administered or not documented on: 4-4-10 and 4-10-10 at 12:00 p.m.
Tenant #5	Accuchecks, once daily.	Not documented as completed on 4-2-10 and 4-3-10.
Tenant #6	Anagrelide HCL, 0.5 mg capsule, take 2 capsules by mouth daily.	This medication was to be discontinued on 4-12-10 but was initialed as administered on 4-13-10. The initials were also circled and there was no explanation on the back of the MAR.
Tenant #6	Aspirin, 81 mg tablet EC, take 1 tablet by mouth daily.	Not administered or not documented on 4-18-10.
Tenant #6	Folic Acid, 1 mg tablet, take 1 tablet by mouth daily.	Not administered or not documented on 4-18-10.
Tenant #6	Furosemide, 40 mg tablet, take 1 tablet by mouth daily.	Not administered or not documented on 4-18-10.
Tenant #6	Klor-CON, 10 Meq tablet, take 1 tablet by mouth daily.	Not administered or not documented on 4-18-10.
Tenant #6	Levothryroxine, 88 mcg tablet, take 1 tablet by mouth once daily	Not administered or not documented on 4-18-10.
Tenant #6	Metoprolol SUCC ER, 25 mg, take 1 tablet by mouth once daily.	Not administered or not documented on 4-18-10.
Tenant #6	Omeprazole DR, 20 mg capsule, take 1 capsule by mouth daily, ½ hour before breakfast.	Not administered or not documented on 4-18-10.

Tenant #6	Allanderm-T ointment, apply to affected area twice daily	Not administered or not documented on 4-18-10.
Tenant #6	Bacitracin Zinc Ointment, apply topically to both nares twice daily.	Not administered or not documented on 4-18-10. at 8:00 a.m.
Tenant #6	Budesonide, 0.25% mg/2 ml S, inhale 1 vial per nebulizer, twice daily.	Not administered or not documented on 4-18-10. at 8:00 a.m.
Tenant #6	Hydrocortisone, 1% cream, apply topically to affected areas twice daily.	Not administered or not documented on 4-18-10. at 8:00 a.m.
Tenant #6	Phenytoin Sod EXT, 100 mg, take 2 capsules by mouth twice daily.	Not administered or not documented on 4-18-10. at 8:00 a.m.
Tenant #6	Saline Nasal, 0.65% spray, instill 1 spray into each nostril twice daily.	Not administered or not documented on 4-18-10. at 8:00 a.m.
Tenant #6	Ipratr-Albuterol, 0.5-mg, inhale 1 vial in nebulizer four times daily.	Not administered or not documented on 4-3-10 and 4-4-10 at 12:00 p.m. and on 4-18-10 at 8:00 a.m. and 12:00 p.m.
Tenant #6	Cont. oxygen, 3L via nasal cannula.	Not administered or not documented on 4-3-10, 4-4-10 and 4-17-10 on first shift and on 4-19-10 on third shift.
Tenant #6	Oxygen saturation to be checked one time per shift.	Not checked or not documented as checked on 4-8-10 on third shift, 4-18-10 on first shift or 4-19-10 on third shift.
Tenant #6	Boost three times a day	4-4-10 ,4-18-10 at 10:00 a.m.4-19-10 at 8:00 p.m. not documented as administered
Tenant #6	Agrylin, 1 mg, one tablet twice daily.	Not administered or not documented on 4-18-10. at 8:00 a.m.
Tenant #7	Nitrogylcerin, 0.4 mg/hr, apply 1 patch topically every day and remove at bedtime.	Not applied or not documented on 4-16-10, as being applied.
Tenant #7	Pacerone, 200 mg tablet, take 1 tablet by mouth daily.	Not administered or not documented on 4-9-10.

- Regulatory Insufficiency: When medications are administered traditionally by the program: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655—Chapter 6 governing nurse delegation. (IAC r.481-67.5(6))

E. Nurse Review

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

Monitoring Observation: Twelve tenant files and one tenant file of a discharged tenant were reviewed.

Tenant #1's file was reviewed and Staff #8, an LPN, stated the tenant had good days and bad days regarding confusion. She stated the tenant had been incontinent of bowels in his/her apartment in locations other than the bathroom and since that occurred, staff provided reminders for toileting every two hours. Staff #1 stated about one time per month the tenant came out without appropriate clothing on from the waist down. Staff #2 stated the tenant urinated in another tenant's garbage can that had been left in the hall. 24 hour report sheets indicated the tenant had episodes of confusion, incontinence and needed toileting assistance and was wandering into another tenant's apartment. A nurse review was not completed as needed.

Tenant #2's file was reviewed. According to Nurse's Notes dated 2-18-10 through 3-19-10, the tenant had recurring vomiting and nausea, refused medications, refused meals and had difficulty swallowing. The tenant was prescribed Zofran and then Phenergan, as needed. The tenant's service plan stated (under Meals) that staff and the program provided three meals a day and snacks upon request. The tenant was on a low salt diet. The tenant's service plan did not address the recurring vomiting, nausea, refusals of medications and refusals of meals. Staff #8, LPN, completed narrative nurse reviews; however, an LPN cannot complete the nurse review with significant changes. Nurse review was not completed by an RN as needed.

Tenant #8's file was reviewed. Nurse's Notes dated 2-21-10 through 2-27-10 indicated the tenant went to the ER and returned with a foley catheter, had rolled out of bed, was ambulating very slowly at times and had difficulty rising. Staff #8, LPN, completed narrative nurse reviews; however, an LPN cannot complete the nurse review with significant changes. Nurse review was not completed by an RN as needed.

Tenant #13's file was reviewed. Nurse's Notes dated 2-23-10 indicated the tenant had choking episode in the dining room and was sent to the ER. The tenant returned on 2-24-10. The tenant's service plan was updated on 2-25-10 and indicated the tenant was on an antibiotic for food aspiration and choking. The Nurse was to take the tenant's temperature, oxygen saturations and listen to lung sounds daily, until the antibiotic was finished. All staff were to monitor the tenant in the dining room when eating and encourage tenant to eat slowly and take small bites. Staff #8, LPN, completed narrative nurse reviews; however, an LPN cannot complete the nurse review with significant changes. Nurse review was not completed by an RN as needed.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC 481-r.69.27(3))

F. Staffing

Complaint Allegation #28353-C: It was alleged adverse observations were dismissed and tenants' requests to see the nurse were ignored.

Monitoring Observation: The RN was interviewed. She stated staff reported to the nurses when a tenant requested a nurse and the nurses always saw tenants when asked.

Staff #8, LPN, was interviewed and stated there had not been any times when a tenant asked to see a RN and there was not a follow up. She stated it might take a few minutes, but if it was an emergency she would respond immediately.

The Manager was interviewed. She stated if a tenant requested to see a nurse, the nurse followed up with them. She stated the RN, Staff #8, LPN, and the Manager were on-call.

Tenants and family members were interviewed. They did not identify any issues with nurse follow up.

- Regulatory Insufficiency: None noted.

Complaint Allegation #27914-C: It was alleged staff did not have appropriate training regarding nurse delegated tasks, including catheter care. It was alleged staff were injured on duty.

Monitoring Observation: The RN was interviewed and stated staff were trained on all personal and health related cares. She stated staff was given demonstration and returned demonstration by either the RN or LPN and there is peer to peer observation of giving cares to tenants to learn the routine. The RN stated staff were asked to come to the RN or LPN if they had concerns about training before giving cares. She stated she was not aware of any staff that had injuries or needle sticks.

Staff #8, LPN, was interviewed and stated staff were trained on all tasks. She stated staff received training on oxygen; however, the training was not documented but staff did not complete the task before the nurse did the training. She stated one staff had a needle stick and reported it to the Manager.

The Manager was interviewed. She stated training on all tasks was completed by the nurse and she was not aware of any peer to peer teaching. She stated there were no needle sticks reported to her.

Five staff files were reviewed regarding nurse delegation training. Staff #1, #2, #3, #4 and #5 had documented nurse delegation training regarding medication administration, blood sugar checks and drawing up insulin. Staff #1 did not have documented training on ADLs. None of the staff had documented training on oxygen.

Staff #1 stated new staff observed other caregivers, then the RN trained staff and then they did the tasks independently. She stated staff were trained on blood sugar checks and oxygen from other caregivers. Staff #2 stated she did not have training on oxygen. Staff #3 stated another caregiver completed her training on oxygen.

Staff #1, #2, #3 and #4 stated they did not provide catheter care. Staff #1, #3 and #4 did not identify any staff that had a needle stick. Staff #2 stated someone left a used lancet and a staff poked herself. There were no staff incident reports.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs (IAC 481-r.67.9(1))

G. Structural requirements

Complaint Allegation #28353-C: It was alleged call lights did not function properly because non-professional people were allowed to work on the electrical system.

Monitoring Observation: Maintenance logs dated 11-24-09 through 4-21-10, were reviewed and there was one entry regarding a call light not working. The entry was dated 12-31-09 and the entry stated an electrician was called. Staff #6, maintenance staff, was interviewed and stated there were no issues with the call light system and the call lights ring to the correct apartments. He stated when the electrical system needed repair an electrician was called. He stated no one works on the electrical system except contract employees.

Staff #1 stated the call lights functioned appropriately and they were checked twice a week. She also stated there used to be two tenant apartments where if one light went off the other would too. Staff #2 stated the call lights functioned appropriately but one tenant's light showed the wrong hall. Staff #3 & #4 stated call lights worked appropriately and the system was checked.

The RN was interviewed and indicated the call lights worked appropriately and identified the correct apartment.

Staff #8, LPN, was interviewed and stated the call lights worked appropriately. She stated they were checked one to two times per week.

The Manager was interviewed and stated the call lights were checked and worked appropriately. She stated electrical work was completed by an electrical company.

Tenant and family interviews indicated call lights were answered promptly and there were no issues with the call light system.

There were documented checks of the call system.

- Regulatory Insufficiency: None noted.

Complaint Allegation #28353-C: It was alleged windows leaked and water dripped into electrical outlets, Administration told staff to cover outlets with plastic wrap and buckets were placed in apartments where the ceilings leaked.

Monitoring Observation: Maintenance logs dated 11-24-09 through 4-21-10, were reviewed and there were two entries regarding leaking ceiling tiles and windows. One dated 12-19-09, was in regard to water coming in by the salon door and the ceiling tile above the door. The other entry dated 1-13-10, indicated a tenant's living room window was leaking.

Staff #6, maintenance staff, was interviewed and stated if the windows were not sealed the windows leak water. He stated there were no issues when the windows were locked and sealed appropriately. He stated one tenant's apartment had an issue with the ceiling leaking. The tenant moved out of that apartment and the outlets were not covered with plastic wrap. He stated there was a bucket in the room and there was no mold in the building.

Staff #1 stated one time a tenant's window leaked and the tenant's drapes were wet; however, they were plastic backed. She stated there were no other issues and it was fixed. She stated there were no issues with outlets and there were no issues with outlets covered with plastic wrap. She stated at one time a ceiling in the B hall leaked and it was repaired.

Staff #2 stated a tenant had a leaking window and the drapes were wet. She stated two other tenants had leaks around the window. One of the tenants moved to another apartment and had buckets of water in the apartment. She stated she was instructed to put plastic wrap on the outlet.

Staff #3 stated there were no issues with leaking windows and ceilings. She stated there were no issues with plastic wrap on the outlets.

Staff #4 stated there were no issues with windows leaking and there were no issues with leaking and electrical outlets. She stated a ceiling was leaking in a tenant's apartment and the tenant moved because the tenant's family wanted him/her to be moved closer to the dining room. She stated there was a bucket in the tenant's room for one day and only one time. She stated there were no issues with electrical outlets covered with plastic wrap and there were no issues with water near the outlets.

The RN stated there was a problem with a leaking window in one tenant's apartment. The tenant was moved to another apartment and no one currently resided in that apartment. She stated no staff had been told to cover the outlets with plastic wrap. She stated there was a roof leak in the same tenant's apartment with the window leak.

Staff #8, LPN, was interviewed and stated there were no windows leaking and outlets were not covered by plastic wrap. She stated one apartment had a ceiling leak when the snow melted. The tenant was offered another room, initially refused and then moved two weeks later to be closer to the dining room. She stated there was a bucket in the apartment and there were no negative outcomes for the tenant related to moisture.

The Manager was interviewed. She stated there had been no recent issues related to leaking windows. She stated she had not instructed staff to put plastic wrap on outlets; however, she had asked staff to put plastic down on the floor to protect the carpet. She stated one apartment had a ceiling leak in a tenant's bedroom and the tenant was offered another apartment and the tenant's family opted to wait. The tenant moved to another apartment and the tenant's rent was reduced for a month. She stated there were no health effects for the tenant. The apartment has subsequently been repaired and was currently empty.

Tenants and family members were interviewed and did not identify any problems with leaking windows or ceilings.

- Regulatory Insufficiency: None noted.

Complaint Allegation #28353-C: It was alleged there was an issue with snow removal.

Monitoring Observation: Staff #6, maintenance staff, was interviewed. He stated he cleared the sidewalks and the snow removal for the parking lot was contracted.

Tenant and family members did not voice any concerns regarding snow removal.

At the time of the investigation, there was no snow or ice present. (This issue was investigated as part of a recertification and complaint investigation conducted on 1-13-10. A regulatory insufficiency was not given at the time of the visit).

- Regulatory Insufficiency: None noted.

H. Other

Complaint Allegation #28353-C: It was alleged administrative staff throw away mail from previous tenants. It was alleged tenants were confused and were taking other tenants' mail.

Monitoring Observation: Staff #1 stated she had seen first shift throw away mail on day shift and it was usually mail from discharged tenants. Staff #2 stated she had seen the Manager throw mail away that belonged to past tenants. Staff #3 stated she had not seen anyone throw mail away. They keep it and send it back. Staff #4 stated they put the mail in a drawer and send it back out. Staff #1, #3 and #4 did not report any issues with tenants taking others mail. Staff #2 stated Tenant #1 took other tenants' mail.

The RN was interviewed and stated she was not aware of staff throwing tenants mail away.

Staff #8, LPN, stated the mail was put in the front desk and family and tenants were notified.

The Manager stated none of the current tenants' mail was thrown away. If mail was received for discharged/deceased tenants from two to three years ago, advertisements were thrown away. She stated none of the past tenants' bills, medical information or personal information was thrown away. If the tenants were living and not residing at the

program, she would package it up and families would pick it up or they would try to forward the mail. The Manager stated the only things thrown away would be advertisements from past tenants.

Tenant interviews were held. The tenants did not identify any issues with receiving mail.

- Regulatory Insufficiency: None noted.

Complaint Allegation #28353-C: It was alleged a former staff member was selling prescription medications, this was reported to Administrative staff and dismissed until a tenant reported it to Administrative staff.

Monitoring Observation: Staff #1 stated, Staff #7 (a former staff), told staff and tenants that she and her significant other were selling prescription drugs. Staff #2 stated Staff #7 told staff and tenants that she was selling prescription drugs to pay her rent. Staff #2 stated it did not involve tenant medications. Staff #4 stated she overheard a former staff stating that she and her significant other went to the doctor for a controlled medication and were going to sell the extra for rent money. Staff #1, #2 and #4 stated there were no issues with the count of medications at the program and no one had come to the program to purchase prescription drugs.

The Manager had a written statement dated 12-30-09. According to the Manager's statement, staff had come to the Manager and informed her of conversations Staff #7 had with them. The statement indicated Staff #7 stated that her boyfriend had increased his prescription for Percocet and they were selling the medications out of their home for $10.00 per pill, in order to pay rent. The Manager expressed concerns regarding Staff #7's accessibility to tenants' medications and narcotics and concerns for their safety. The Manager stated she could no longer give Staff #7 access to medications or allow the staff to perform as a CMA. At the end of the written statement dated 12-31-09, the Manager spoke with Staff #7 who handed in her resignation and left.

Staff #7 had background checks completed appropriately prior to hire.

The Manager provided a written statement dated 4-22-10, regarding Staff #7. There had not been any medication missing and the narcotic count was correct. None of the staff, tenants or visitors made any allegation regarding medication being sold or missing from the program. The Manager indicated no one had come to the program to purchase drugs. The Manager stated staff first informed her of the allegation after Staff #7 had left for the day. The Manager tried to call Staff #7 that evening and eventually talked to her the next day.

Staff #7 provided a written statement dated 12-31-09 that indicated she quit as of 12-31-09, due to personal problems at home.

- Regulatory Insufficiency: None noted.

Complaint Allegation #28353-C: It was alleged tenants had money missing and they were told by administrative staff to "keep their mouth shut" to protect the reputation of the place or they would not have a place to live. It was alleged tenants were told they would have to move if they complained.

Monitoring Observation: Staff #1 and #2 stated they heard from Tenant #7 that he/she had money missing and the tenant was told not to complain or he/she would have to move.

The tenant's legal representative was interviewed and indicated the tenant had money missing and the tenant did not see who took the money. He/she stated the tenant was not told he/she would have to move if the tenant discussed the missing money. He/she stated the Manager had a good rapport with the tenants and the tenant and family could go to her with concerns. He/she did not have any concerns about retaliation and indicated the Manager was responsive to concerns.

The RN stated she was not aware of any retaliation towards tenants if they complained or had concerns. She had told tenants to report any concerns or complaints.

Staff #8, LPN, she was not aware of any retaliation towards tenants. She stated none of the administrative staff told tenants to keep quiet about missing items or they would have to move.

The Manager stated there was no retaliation towards tenants. She stated tenants were not told not to report things missing; instead, she encouraged them to report. She did not tell tenants if they reported something missing they would have to move.

Tenant and family interviews did not identify any concerns with retaliation.

- Regulatory Insufficiency: None noted.

Complaint Allegation #28353-C: It was alleged administrative staff intimidated staff and tenants and tenants were afraid of administrative staff.

Monitoring Observation: Staff #1, #3 and #4 stated there was no intimidation towards staff or tenants. Staff #2 stated the Manager was intimidating and did not listen to what the tenants reported.

The RN stated there had not been any intimidation towards tenants or staff.

Staff #8, LPN, stated there was no intimidation from administrative staff towards staff or tenants.

The Manager was interviewed. She stated there was no intimidation towards staff or tenants. She stated staff hours were cut due to decreased census and hiring another LPN. She stated hours were not cut related to retaliation.

Tenants and family members were interviewed and did not identify any concerns related to intimidation.

- Regulatory Insufficiency: None noted.

Dated this 1st day of June, 2010.