IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 32526-C
32492-C
29510-A

April 6, 2011

Catherine Hughes, RN MSN
Assisted Living Director
Senior Star at Elmore Place Assisted Living
4500 Elmore Avenue
Davenport, IA 52807

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

Dear Ms. Hughes:

I. Final Complaint Investigation & Initial Certification Revisit Report – Senior Star at Elmore Place Assisted Living, Davenport, IA

Enclosed is the **Final Complaint Investigation & Initial Certification Revisit 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 Tenant, Service Plan, Nurse Review and Other (non notification of DAA). **Senior Star at Elmore Place Assisted Living** ("Program") is being assessed a $2,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

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 **Jim Berkley** and remit the civil penalty assessed by check or money order in the amount of thirteen hundred dollars ($1300) 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 $2,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on March 28, 2011, has been reviewed and will constitute the final POC related to the on-site visit of January 18, 19, 20, 24, and 25, 2011.

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 Program Coordinator, Jim Berkley, at 515/281-4116.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint Investigation & Initial Certification Revisit Report

Assisted Living Program:

Catherine Hughes, RN MSN Assisted Living Director
Senior Star at Elmore Place Assisted Living
4500 Elmore Avenue
Davenport, IA 52807

Complaint Intake #: 32526-C
32492-C
29510-A

Date of Investigation:

January 18, 19, 20, 24, 25, 2011

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 and revisit on-site visit were conducted at Senior Star at Elmore Place Assisted Living on January 18, 19, 20, 24 and 25, 2011. 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:	58
Current number of tenants with cognitive disorder:	1
Total Population:	59

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 – The program received regulatory insufficiencies in the areas of: Occupancy Agreement, Service Plan, Nurse Review, Food Service, Staffing, Transportation, Activities, Structural Requirements, Record Checks and Other during this certification period.

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

A. Occupancy Agreement

The program received a regulatory insufficiency regarding Tenant #1 at the time of June/July 2010 visit related to the need for the occupancy agreement to be reviewed and updated to reflect any change or financial arrangements. The program also received a regulatory insufficiency related to not operating unless a written occupancy agreement is executed between the program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and providing at least thirty days written notice of changes.

- Monitoring Observation: Tenant #1 was discharged on 8-3-10.

  Tenant #13, an 88 year old, was admitted on 8-5-09 and had diagnoses of: Dementia, Hyperlipidemia, History of Dizziness, Diabetes Mellitus II (DMII), Coronary Artery Disease (CAD), Hypothyroidism, Vitamin D Deficiency, Dehydration, Hearing Loss and a History of Urinary Tract Infection (UTI). A cognitive evaluation was completed on 12-22-10 and staged the tenant at four on the Global Deterioration Scale (GDS), which revealed moderate cognitive decline. Nurse's notes of 10-29-10 revealed the tenant was admitted to skilled nursing care. The tenant returned to the program on 12-21-10. A service plan was updated on 12-21-10 and revealed an increase in level of care. Program records revealed the tenant was given a 30-day notice of a rental increase on 11-30-10 effective 1-1-11. Despite an increase in level of care, the tenant's cost of services did not increase.

  Tenant #16, an 85 year old, was admitted on 10-9-09 and had diagnoses of: DMII, Arthritis, Dementia, CAD, History of Non Insulin Dependent Diabetes, Left Sided Bells Palsy, Chronic Obstructive Pulmonary Disease (COPD) and Hypertension (HTN). A service plan was updated and signed by the tenant on 12-19-10 and revealed the tenant's Diabetes Mellitus had been controlled by oral medications, but now required insulin injections and diabetic monitoring. A care conference was held on 1-14-11 and the tenant and family were notified the tenant's diabetic monitoring and insulin injections increased the cost of services provided by the program. A 30-day notice of an increase in the cost of services provided by the program was given to the tenant and family effective 2-15-11.

  Six tenants were interviewed and the tenants reported they were getting what was promised in the occupancy agreement.

- Regulatory Insufficiency: None noted.

B. Evaluation of Tenant

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

- Monitoring Observation: Tenant #8, an 83 year old, was admitted on 9-20-10 and had diagnoses of: Right Hip Fracture, Lewy Body Dementia, Hypothyroidism, Anxiety, Hallucinations, Shortness of Breath (SOB), Panic Disorder, Osteoporosis and HTN. The tenant was discharged on 1-14-11. Nurse's Notes from 10-24-10 to 1-4-11 indicated the tenant had increased hallucinations, increased falls, decreased socialization, episodes of urinary and bowel incontinence, assistance of one to two

with cares at times, assistance of two with transfers at times, discoloration to the tenant's right foot and an order for anti-embolism stockings. Evaluations were not completed as needed.

Tenant #9, a 90 year old, was admitted on 12-22-10 and had diagnoses of: CAD, HTN and Depression. According to Nurse's Notes dated 12-23-10 the tenant needed two staff for transfers and personal cares. Notes dated 1-18-11 indicated staff completed a bed change twice. The tenant required total care in the morning and at night. Staff #1 stated the tenant required two for transfers occasionally. Evaluations were not completed as needed.

Tenant #11, an 86 year old, was admitted on 10-25-10 and had diagnoses of: Appendectomy, Left Knee Replacement, Pacemaker, Subdural Hematoma and Cerebral Vascular Accident (CVA). Nurse's Notes dated 12-3-10, indicated concerns regarding the tenant were discussed with family. The concerns included: the tenant came out of the public bathroom with pants and underwear or protective undergarments around the tenant's ankles and yelled for a lady to help. The tenant hoarded food in his/her bed and wrapped up dentures and refused to let staff clean them. Nurse's Notes dated 12-22-10 indicated the tenant had a trail of loose stools from the living room to the bathroom and was unaware it had happened. Nurse's Notes dated 1-15-11 indicated the tenant was agitated and hostile with kitchen and nursing staff. The notes indicated the tenant accused a staff of trying to steal his/her spouse. Evaluations were not completed as needed.

Tenant #12, an 85 year old, was admitted on 10-22-10 and had diagnoses of: Parkinson's Disease, HTN, Hyperlipidemia and a History of Hallucination. Functional and health evaluations were completed on 11-22-10 but a cognitive evaluation was not completed within 30-days of admission.

Tenant #13's file revealed functional, cognitive and health evaluations were completed on 12-17-10, prior to the tenant's returned from skilled nursing on 12-21-10. Nurse's notes of 12-22-10 revealed the tenant and spouse were fighting and the tenant said he/she wanted to die. On 12-28-10 the tenant was sitting on the toilet when he/she became pale and limp and the tenant's pupils became constricted. The tenant's physician was contacted and a stool softener was ordered. On 12-29-10 the tenant was hallucinating, reporting a cat was on his/her lap and was scratching his/her feet. Staff told the tenant there wasn't a cat. The tenant complained of being "very cold." The tenant's body temperature was 99.6 degrees. The tenant was fully dressed, was wearing two pairs of socks and covered in two blankets. The tenant's blood pressure was 80mm/hg over 30mm/hg. The tenant's physician ordered to hold blood pressure medications and Lorazepam until the tenant's systolic blood pressure was above 130mm/hg.

On 1-3-11 the tenant reported he/she wanted to die, as the tenant said he/she wasn't getting any better. The tenant told staff to just hit him/her "in the head with a hammer" and give him/her a poison pill so he/she could die. On 1-6-11 the tenant was verbally and physically abusive to staff and spouse, was a two staff assist with transfer and required "total care" for all morning cares. The tenant stated he/she wanted to " just die" and " I am going to kill myself." Later that day the tenant

required two staff assist with transfer and toileting. The tenant attempted to hit staff and refused to stand with cares. Evaluations were not completed as needed.

Tenant #14, a 78 year old, was admitted on 10-25-10 and had diagnoses of: History of a Colostomy, CVA, History of Rectal Cancer, CAD, HTN and Bradycardia. Functional, cognitive and health evaluations were last completed on 11-24-10. Nurse's notes of 12-21-10 through 1-3-11 revealed at least nine incidents of refusing to eat, refusing activities of daily living (ADLs), medications and refusing to get out of bed. On 12-23-10, an order was received to refer the tenant to hospice. Nurse's notes of the same date but separate entry revealed hospice would evaluate on 12-27-10. On 12-26-10, the tenant verbalized his/her "desire to end all of this." On 12-27-10, a physician reported family had received a phone call from the tenant, threatening suicide. The tenant was sent to a local hospital for evaluation and returned later that evening with no new orders. On 12-28-10, the program removed the tenant's shoe strings, belts and sharp objects from the tenant's apartment. Family was called to see if someone could come and sit with the tenant due to his/her suicidal threat. Staff checked on the tenant hourly and as much as possible in between times.

On 12-31-10, hospice completed a comprehensive assessment and care plan. Nurse's notes of 1-1-11 revealed the tenant's eyes were closed and the tenant wasn't responding to verbal stimulation. The tenant was repositioned from right to left for comfort at which time the tenant was grimacing and clenching his/her fist. Staff called the hospice nurse for medication for pain and anxiety. Nurse's notes of 1-2-11 through 1-3-11 revealed the tenant was "checked and changed," and turned and repositioned every two hours. The tenant was given oral care, refused scheduled medications and refused food and fluids. The tenant passed away on 1-3-11. Evaluations were not completed as needed.

Tenant #16's nurse's notes of 12-18-10 revealed staff educated the tenant on the use of insulin, the need to rotate sites of injection and the possible reactions and effectiveness of insulin injections. Functional and health evaluations were completed on 12-19-10; however; a cognitive evaluation was not completed when the tenant went from taking oral medication to injections.

- 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 r. 481-69.22(2))

C. Criteria for Exclusion of Tenants

Complaint Allegation #32492-C: It was alleged tenants exceeded the appropriate level of care. It was alleged a tenant had several falls and required two staff to get to bed. It was alleged a tenant had two hour checks and did not always use the tenant's walker. It was alleged a tenant had several falls and took two to three people to get off the floor. It

was alleged the tenant had two hour checks and was often found without a walker. It was alleged a tenant required two staff to transfer and dress. It was alleged a tenant stated he/she wanted to die. It was alleged a tenant required one to two staff for all cares. It was alleged a tenant poured liquid into a heating system and had cigarettes and a lighter. It was alleged a tenant took two to transfer intermittently. It was alleged a tenant was often incontinent of stool and the tenant's apartment had an odor. It was alleged a tenant stopped eating, taking medications and coming out for meals and declined and died.

- Monitoring Observation:

  Tenant #7, a 59 year old, was admitted on 9-22-10 and had diagnoses of: Bipolar Disorder, Anxiety, COPD, Anemia and Parkinson's Disease. Functional, cognitive and health evaluations were completed on 10-26-10. A 90-day review was completed and the service plan was updated on 12-23-10; however, there was not a significant change. Service plans dated 10-26-10 and 12-23-10 and notes indicated the tenant did not exceed occupancy and transfer criteria. Incident Reports and notes indicated the tenant had repetitive falls. The tenant's service plan addressed a managed risk agreement related to falls. The service plan identified the tenant had a history of falls. The managed risk agreement identified the tenant's fall history and the tenant put himself/herself at risk when not appropriately utilizing the tenant's walker. The agreement addressed the tenant not calling for assistance and requesting escorts inside and outside the community. The agreement also indicated rounds would be completed every two hours. The tenant, the tenant's legal representative and the Interim Executive Director signed the agreement. Staff #1, #14 and #16 did not identify any tenants that exceeded the appropriate level of care. Staff #1 and #16 stated service plans reflected the needs of the tenants. The tenant did not exceed the appropriate level of care.

  Tenant #8's file was reviewed. Functional, cognitive and health evaluations were completed on 10-20-10. The tenant's service plan was updated on 10-20-10. Review of the service plan and notes indicated the tenant did not exceed occupancy and transfer criteria. Nurse's Notes indicated the tenant required one to two assist at times with transfers and cares; however, not on a routine basis. Nurse's Notes did not identify pouring liquids into a heating system; however, Staff #1 reported the tenant poured water and coffee in the heater system. Staff #1 stated the tenant was moved to the memory care. The tenant's service plan addressed the tenant's smoking habits. Staff #1 and #16 stated service plans reflected the needs of the tenants. Staff #1, #14 and #16 did not identify any tenants that exceeded the appropriate level of care. The tenant did not exceed the appropriate level of care and was discharged on 1-14-10.

  Tenant #9's file was reviewed. Functional, cognitive and health evaluations were completed on 12-8-10. The service plan was signed on 12-22-10. Review of the service plan and notes indicated the tenant did not exceed occupancy and transfer criteria. Nurse's Notes dated 12-23-10 indicated the tenant took two staff for transfers and personal cares. Staff #1 stated the tenant required two for transfers occasionally. Staff #1, #14 and #16 did not identify any tenants that exceeded the appropriate level of care. Staff #1 and #16 stated service plans reflected the needs of the tenants. The tenant did not exceed the appropriate level of care.

Tenant #11's file was reviewed. Functional, cognitive and health evaluations were completed on 11-24-10. The service plan signed by the tenant on 12-7-10 and notes indicated the tenant did not exceed occupancy and transfer criteria. Nurse's Notes dated 12-3-10, indicated concerns regarding the tenant were discussed with family. The concerns included: the tenant came out of the public bathroom with pants and underwear or protective undergarments around the tenant's ankles and yelled for a lady to help. The tenant also hoarded food in his/her bed and wrapped up dentures and refused to let staff clean them. Nurse's Notes dated 12-22-10 indicated the tenant had a trail of loose stools from the living room to the bathroom and was unaware it had happened. The tenant's apartment was observed and did not have an odor. Staff #1, #14 and #16 did not identify any tenants that exceeded the appropriate level of care. Staff #1 and #16 stated service plans reflected the needs of the tenants. The tenant did not exceed the appropriate level of care.

Tenant #13's file was reviewed. Functional, cognitive and health evaluations were completed on 12-17-10. A service plan was updated on 12-21-10 and nurse's notes of 12-21-10 through 1-6-10 revealed the tenant did not exceed occupancy and retention criteria. Staff #1, #14 and #16 did not identify any tenants that exceeded the appropriate level of care.

Tenant #14's file was reviewed. Functional, cognitive and health evaluations were completed on 11-24-10. A service plan was updated on 11-24-10. Nurse's notes of 12-21-10 through 1-3-11 revealed the tenant did not exceed occupancy and retention criteria. Staff #1, #14 and #16 did not identify any tenants that exceeded the appropriate level of care. The tenant passed away on 1-3-11.

Tenant #15, a 79 year old, was admitted on 12-9-09 and had diagnoses of: Frontal Lobe Dementia, Osteoarthritis (OA), HTN and Parkinson's Disease. A cognitive evaluation was completed on 3-9-10, which revealed normal cognition. Functional and health evaluations were completed on 8-6-10 due to a change in health status related to decline in mobility status. A managed risk agreement was established on 10-8-10 due to continued falls in the previous four to five months. The tenant agreed to call staff to assist with all transfers, including toileting, showers and using the wheelchair for mobility. Functional and health evaluations were completed on 11-10-10, which indicated no change in health status. Staff #4, a registered nurse (RN) stated evaluations were completed quarterly as part of the 90-day nurse review.

The tenant's physician was notified the tenant had fallen on 11-20-10 and 12-24-10 when attempting to transfer independently. Nurse's notes of 12-13-10 through 12-31-10 revealed at least four incidents of falls or staff finding the tenant on the floor after the tenant attempted to ambulate and/or transfer independently. Nurse's notes of 12-14-10 revealed the tenant's physician ordered physical therapy (PT) for balance training. Service plan of 11-15-10 included interventions related to mobility, transfer, and fall risk prevention in addition to identified needs of the tenant. Staff #1, #14 and #16 did not identify any tenants that exceeded the appropriate level of care.

Review of 15 tenant files, staff interviews and monitor observations indicated none of the current tenants exceeded the appropriate level of care. Staff #4, an RN and Assistant Director, stated they were not looking for long term care placement for any tenants at the time of the visit.

- Regulatory Insufficiency: None noted.

D. Service Plan

The program received a regulatory insufficiency regarding Tenant #1, #2, #4 and #6 at the time of the June/July 2010 visit related to the development of a preliminary service plan. The program also received a regulatory insufficiency related to when a person needs personal care or health-related care, updating the service plan within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. The program also received a regulatory insufficiency related to the service plan being individualized and indicating the tenant's needs and preferences for assistance.

- Monitoring Observation: Tenant #1 was discharged on 8-3-10. Tenant #4 was discharged on 7-21-10.

  Tenant #2, an 89 year old, was admitted on 9-8-09 and diagnoses include: CHF, HTN, COPD, History of CVA and DM Type II with Insulin. The tenant's most current service plan reflected a private caregiver assisted with bathing. The tenant's service plan indicated staff were to monitor the tenant's blood sugars and insulin. The tenant's January 2011 Medication Administration Records (MARs) reflected the observation of blood sugars only. The service plan did not reflect the identified needs of the tenant.

  Tenant #6, an 84 year old, was admitted on 11-6-09 and diagnoses include: Atrial Fibrillation, HTN, Severe Leg Pain, Dyslipidemia and History of Transient Ischemic Attacks (TIAs). The tenant's most current service plan update with a significant change dated was signed appropriately.

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

Tenant #7's file was reviewed. Incident Reports and Nurse's Notes indicated the tenant had repetitive falls. The tenant's service plan addressed a managed risk agreement related to falls. The managed risk agreement identified the tenant's fall history and the tenant put himself/herself at risk when not appropriately utilizing the tenant's walker. The agreement addressed the tenant not calling for assistance and requesting escorts inside and outside the community. The agreement indicated rounds would be completed every two hours. The tenant's most current service plan of 12-23-10 did not reflect the two hour checks. The service plan did not reflect the identified needs of the tenants.

Tenant #8's file was reviewed. Nurse's Notes from 10-24-10 to 1-4-11 indicated the tenant had increased hallucinations, increased falls, decreased socialization, episodes of urinary and bowel incontinence, assistance of one to two with cares at times, assistance of two with transfers at times, discoloration to the tenant's right foot and an order for anti-embolism stockings. The service plan was not updated as needed and did not reflect the identified needs of the tenant.

Tenant #9's file was reviewed. According to Nurse's Notes dated 12-23-10 the tenant needed two staff for transfers and personal cares. Notes dated 1-18-11 indicated staff

completed a bed change twice. The tenant required total care in the morning and at night. Staff #1 stated the tenant required two for transfers occasionally. The service plan was not updated as needed and did not reflect the identified needs of the tenant.

Tenant #11's file was reviewed. A service plan was not developed within 30 days of taking occupancy. Nurse's Notes dated 12-3-10 indicated concerns regarding the tenant were discussed with family. The concerns included: the tenant came out of the public bathroom with pants and underwear or protective undergarments around the tenant's ankles and yelled for a lady to help. The tenant also hoarded food in his/her bed and wrapped up dentures and refused to let staff clean them. Nurse's Notes dated 12-22-10 indicated the tenant had a trail of loose stools from the living room to the bathroom and was unaware it had happened. Nurse's Notes dated 1-15-11 indicated the tenant was agitated and hostile with kitchen and nursing staff. The notes indicated the tenant accused a staff of trying to steal his/her spouse. The service plan was not updated as needed and did not reflect the identified needs of the tenant.

Tenant #12's 30-day updated service plan of 11-23-10 was supported by functional and health evaluations on 11-22-10, but was not supported by a cognitive evaluation.

Tenant #13's nurse's notes of 12-22-10 revealed the tenant and spouse were fighting and the tenant said he/she wanted to die. On 12-28-10 the tenant was sitting on the toilet when he/she became pale and limp and the tenant's pupils became constricted. The tenant's physician was contacted and a stool softener was ordered. On 12-29-10 the tenant was hallucinating, reporting a cat was on his/her lap and was scratching his/her feet. Staff told the tenant there wasn't a cat. The tenant complained of being "very cold." The tenant's body temperature was 99.6 degrees. The tenant was fully dressed, was wearing two pairs of socks and covered in two blankets. The tenant's blood pressure was 80mm/hg over 30mm/hg. The tenant's physician ordered to hold blood pressure medications and Lorazepam until the tenant's systolic blood pressure was above 130mm/hg.

On 1-3-11 the tenant reported he/she wanted to die as he/she wasn't getting any better. The tenant told staff to just hit him/her "in the head with a hammer" and give him/her a poison pill so the tenant could die. On 1-6-11 the tenant was verbally and physically abusive to staff and spouse, was a two staff assist with transfer and required "total care" for all morning cares. The tenant stated he/she wanted "just die" and "I am going to kill myself." Later the same day the tenant required two staff assist with transfer and toileting. The tenant attempted to hit staff and refused to stand. The service plan was not updated as needed and did not reflect the identified needs of the tenant.

Tenant #14's service plan was last completed on 11-24-10. Nurse's notes of 12-21-10 through 1-3-11, revealed at least nine incidents of the tenant refusing to eat, refusing ADLs, medications and refusing to get out of bed. On 12-23-10, an order was received to refer the tenant to hospice. Nurse's notes of the same date but separate entry revealed hospice would evaluate on 12-27-10. On 12-26-10 the tenant verbalized his/her "desire to end all of this." Later that day, a physician notified the program family had received a phone call from the tenant threatening suicide. The tenant was sent to a local hospital for evaluation and returned later that evening with no new orders. On 12-28-10 the program removed the tenant's shoe strings, belts and

sharp objects from the tenant's apartment. Family was called to see if someone could come and sit with the tenant due to his/her suicidal threat. Staff checked on the tenant hourly and as much as possible in between times.

On 12-31-10 hospice completed a comprehensive assessment and care plan. Nurse's notes of 1-1-11 revealed the tenant's eyes were closed and was not responding to verbal stimulation. The tenant was repositioned from right to left for comfort at which time the tenant was grimacing and clenching his/her fist. Staff called the hospice nurse for medication for pain and anxiety. Nurse's notes of 1-2-11 through 1-3-11 revealed the tenant was "checked and changed," and turned and repositioned every two hours. The tenant was given oral care, refused scheduled medications and refused food and fluids. The service plan was not updated as needed and did not reflect the identified needs of the tenant.

Tenant #16's file revealed the tenant's Diabetes Mellitus had been controlled by oral medications, but now required insulin injections and diabetic monitoring. Nurse's notes of 12-18-10 revealed staff educated the tenant on the use of insulin, the need to rotate sites of injection, possible reactions and effectiveness of insulin injections. Functional and health evaluations were completed on 12-19-10, but a cognitive evaluation was not done. The service plan of 12-21-10 and medication administration records (MARs) for January 2011 did not establish interventions related to signs and symptoms of Hyperglycemia. MARs for 1-1-11 through 1-18-11 revealed at least 11 incidents of blood sugars greater than 200ml/dl, indicating hyperglycemia. The service plan was not updated as needed and did not reflect the identified needs of the tenant.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1))

- 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 significant change, but not less than annually. (IAC r. 481-69.26(3))

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

E. Medications

Complaint Allegation #32526-C: It was alleged physician orders were not followed and a tenant did not receive the appropriate medication.

- Monitoring Observation: Tenant #3, an 88 year old, was admitted on 8-14-09 and had diagnoses of: Arthritis, HTN, History of Breast Cancer, Osteoporosis and History of Hip and Pelvic Fracture. A physician's order of 11-4-10 revealed morphine 15mg ES was to be given twice daily. A physician's order of 1-6-11 revealed an order to stop the evening morphine and to give Vicodin 7.5mg/750mg ES

at 6:00 p.m. daily. Nurse's notes of 1-6-11 revealed the tenant's morphine was discontinued and Vicodin ES daily at 6:00 p.m. was started. Nurse's notes of 1-8-11 revealed the tenant complained of not feeling well, complained of loose stool and refusing to eat dinner. On 1-9-11 the tenant refused breakfast and complained of back pain. The physician was contacted and a new order was given for morphine 15mg – twice daily. Vicodin 7.5mg/750mg ES was discontinued.

An incident report of 1-9-11 revealed staff made a transcription error. Family reviewed with staff recent medication changes and the tenant's back pain. Staff stated the tenant's morphine had been discontinued. Family asked if both the morning and evening dose of morphine had been discontinued. Staff checked the MARs, the nurse's notes and the original physician order and determined both the morning and evening dose had been discontinued. The physician's order of 1-6-11 revealed the evening dose of morphine had been discontinued and not the morning dose of morphine. Staff notified the physician of the medication error. MARs for 1-6-11 revealed morphine 15mg was not administered at 6:00 p.m. on 1-6-11 and the morning dose was not administered on 1-7-11 and 1-8-11 as ordered. MARs of 1-9-11 revealed morphine 15mg twice daily was started.

- Regulatory Insufficiency: None noted.

F. Nurse Review

The program received a regulatory insufficiency at the time of the June/July visit related to not consistently documenting physician orders with time, date and signature.

- Monitoring Observation: Review of 15 tenant files indicated physician orders were consistently documented with time, date and signature.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation:

  Tenant #8's file was reviewed. Nurse's Notes dated 1-3-11 indicated the tenant's right foot was cold to touch, blue in color and faint pulses were noted. The tenant was able to move the right foot and all digits without difficulty. Nurse review was completed; however, it was not completed by an RN. On 1-4-11 the tenant's doctor was faxed and the doctor ordered anti-embolism stockings and to elevate the tenant's foot. On 1-5-11 at 9:40 a.m. notes indicated the doctor was faxed for the second time regarding the tenant's right foot. The foot was ice cold to touch, 2+ pitting edema and was blue in color to mid-calf. The note was completed by a licensed practical nurse (LPN). The LPN notified the Interim Executive Director, an RN, of the tenant's foot discoloration and the tenant was sent to the emergency room (ER). The Interim Executive Director completed a nurse review related to the issue. Notes dated 1-5-11 indicated the tenant was admitted for 23-hour observation and the tenant's enzymes were elevated. The notes indicated the tenant did not have a blood clot; however, a possible stroke. On 1-6-11, the tenant's family called and reported the tenant was going to remain in the hospital overnight. The next entry in the notes was

dated 1-11-11 and indicated the tenant was transferred to the shower by staff and the tenant had a small skin tear on outer right left. There was not an entry in notes regarding the tenant's return from the hospital. Nurse review was not completed with a significant change.

Tenant #14's nurse's notes of 12-21-10 through 1-3-11, revealed at least nine incidents of the tenant refusing to eat, refusing ADLs, medications and refusing to get out of bed. On 12-23-10, an order was received to refer the tenant to hospice. On 12-26-10 the tenant verbalized his/her "desire to end all of this." Later that day, the physician notified the program family had received a phone call from the tenant threatening suicide. The tenant was sent to a local hospital for evaluation and returned later that evening with no new orders. On 12-28-10 the program removed the tenant's shoe strings, belts, sharp objects from the tenant's apartment. Family was called to see if someone could come and sit with the tenant due to his/her suicidal threat. Staff checked on the tenant hourly and as much as possible in between times.

On 12-31-10 hospice completed a comprehensive assessment and care plan. Nurse's notes of 1-1-11 revealed the tenant's eyes were closed and was not responding to verbal stimulation. Nurse's notes of 1-2-11 through 1-3-11 revealed the tenant was "checked and changed," and turned and repositioned every two hours. The tenant was given oral care, refused scheduled medications and refused food and fluids. A licensed practical nurse (LPN) completed a nurse review at least 15 times in relation to the events listed above; however, an RN did not complete the nurse reviews with significant change.

- 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 r. 481-69.27(3))

G. Food Service

The program received a regulatory insufficiency regarding Staff #6, #7, #8 and #9 at the time of the June/July 2010 visit for not having an orientation on sanitation and safe food handling prior to handling food.

- Monitoring Observation: Staff #7's termination date was 7-31-10. Staff #6, #8 and #9 had documented food safety training. New employee files were reviewed related to food safety training. Staff #10, #12 and #13 had food safety training completed appropriately.

- Regulatory Insufficiency: None noted.

H. Staffing

The program received a regulatory insufficiency at the time of the June/July 2010 visit related to not having a sufficient number of trained staff available at all times to fully meet tenants' identified needs.

- Monitoring Observation: A monitor observed staff administering medications to tenants on 1-18-11 and 1-19-11. Medications were administered appropriately and on-time.

  Six tenants were interviewed and the tenants reported medications were administered on time. The tenants stated they received the cares they requested. Nursing services were available as needed and there were sufficient staff to meet their needs. Staff #1 and #14 stated medications were administered on time. Staff #4, an RN and Assistant Director, stated medications were delivered on time.

- Regulatory Insufficiency: None noted.

Complaint Allegation #32492-C: It was alleged there were not sufficient staff. It was alleged staff neglected the tenants for other duties.

- Monitoring Observation: Six tenants were interviewed. The tenants stated they received the cares they requested. Nursing services were available as needed and there were sufficient staff to meet their needs. The tenants reported housekeeping services were available and they were getting what was promised in the occupancy agreement. Staff #1 reported there were enough staff to meet the needs of the tenants. Staff #14 stated at times there were sufficient staff and at other times there were not enough staff; however, the work was completed. Staff #16 stated there was not always enough staff; however, the work was completed. There were four to five staff on first shift, three to four staff on second shift and two staff on third shift. Staff #4, an RN and the Assistant Director, stated there were enough staff and staff did not neglect tenants.

- Regulatory Insufficiency: None noted.

Complaint Allegation #32492-C: It was alleged staff were instructed not to document falls or call family for a tenant. It was alleged staff were not informed of a change in condition for a tenant.

- Monitoring Observation: Staff #14 and #16 stated they were not instructed to not chart on falls or not to call family. Staff #1 stated nurses charted on falls. Staff #1, #14 and #16 stated they were informed of change of condition of tenants. Staff #4, an RN and Assistant Director, stated she did not instruct staff to not chart on falls or call family, with the exception of if a tenant fell in the middle of the night and did not have any injury, staff were to call first thing in the morning. She stated staff were informed of a change in condition and staff were informed of Tenant #14's decline.

Regulatory Insufficiency: None noted.

I. Transportation

The program received a regulatory insufficiency at the time of the June/July 2010 visit related to each vehicle not having a first aid kit, fire extinguisher, safety triangles and a device for two-way communication in the program's van..

- Monitoring Observation: The bus and van were inspected and both vehicles had the required equipment including: a first aid kit, fire extinguisher, safety triangles and the drivers had a device for two-way communication. Vehicle Pre-Trip Inspection records were maintained for both vehicles. These records indicated safety equipment was consistently documented as present in the vehicles.

- Regulatory Insufficiency: None noted.

J. Activities

The program received a regulatory insufficiency at the time of the June/July 2010 visit related to not providing appropriate activities for each tenant.

Complaint Allegation #32492-C: It was alleged there were no weekend activities.

- Monitoring Observation: Staff #17, the Program Director, was interviewed and stated there were sufficient activities. She stated she planned the activity calendar and the activities on the schedule were carried out. Nursing staff and volunteers assisted with weekend and evening activities. She stated supplies were available for activities and it was her job to ensure the supplies were available. She was not aware of any tenant or staff complaints regarding activities. Staff #1 and #14 stated there were sufficient activities and Staff #16 stated at times there were enough activities. They stated supplies were available for activities. Six tenants were interviewed and indicated there were sufficient activities offered. Activity calendars for the past three months reflected activities scheduled seven days per week. Town Hall meeting minutes for the past three months were reviewed. The meeting minutes provided updates, reminders and information related to activities. Six tenants were interviewed and indicated there were sufficient activities offered, including weekend activities. Activity calendars for the past three months were provided and reflected activities scheduled seven days per week.

- Regulatory Insufficiency: None noted.

K. Structural requirements

The program received a regulatory insufficiency at the time of the June/July 2010 visit related to not conducting fire drills as required.

- Monitoring Observation: Fire Drill Report records were reviewed. According to the records, from 8-20-10 to 12-30-10 there were five documented drills. The drills were completed on a monthly basis. The drill on 8-20-10 occurred at 11:05 p.m. and the drill on 11-23-10 occurred at 11:16 p.m. Six tenants were interviewed. The tenants reported they had fire drills and the alarms were loud enough to hear. Town Hall meeting minutes

for the past three months were reviewed. The meeting minutes indicated there were monthly fire drills.

- Regulatory Insufficiency: None noted.

L. Record Checks

The program received a regulatory insufficiency regarding Staff #1, #2, #3, #4 and #5 at the time of the June/July 2010 visit related to not completing criminal history checks as required.

- Monitoring Observation: The program's plan of correction indicated the involvement of the Iowa Department of Public Safety in background checks was to be completed from 8-9-10 forward on new employees. New employee files were reviewed related to background checks. Staff #10, #11, #12, #14 and #15 had background checks completed appropriately.

- Regulatory Insufficiency: None noted.

M. Other

The program received a regulatory insufficiency regarding Staff #1 and #3 at the time of the June/July 2010 visit related to not completing dependent adult abuse training within six months of employment.

- Monitoring Observation: Staff #3's termination date was 6-30-10. Staff #1 had mandatory dependent adult abuse training completed on 8-19-10. New employee files were reviewed related to mandatory dependent adult abuse training. Staff #14 and #15 had mandatory dependent adult abuse training completed appropriately.

- Regulatory Insufficiency: None noted.

The program received a regulatory insufficiency regarding Staff #2 at the time of the June/July 2010 visit related to treating tenants with consideration, respect, and full recognition of personal dignity and autonomy.

- Monitoring Observation: Staff #2's termination date was 11-9-10. Prior to termination, Staff #2 had completed the Assisted Living Customer Service course on 8-9-10. Staff #1, #14 and #16 stated tenants were treated with respect. Staff meeting records indicated on 7-2-10 a Culture Training for staff education was held. Six tenants were interviewed and stated they were treated with respect.

- Regulatory Insufficiency: None noted.

Complaint Allegation 29510-A: It was alleged tenants were missing medications.

- Monitoring Observation: Program records revealed on 2-12-10 staff were conducting an end of shift narcotic count of medications and reported diversion of narcotics for Tenant #3, Tenant #17 and Tenant #18. An internal investigation revealed Tenant #3

had 25 tablets of Oxycodone/APAP – 7.5mg/500mg replaced with a non narcotic tablet; Tenant #17 was missing 20 tablets of Oxycodone/APAP - 5mg/325mg and Tenant #18 was missing nine tablets of Oxycodone/APAP – 5mg/325mg. Each tenant was a dependent adult, as each received personal and health related cares, including medication administration.

Narcotics were stored in a locked medication cart, accessible only by staff trained and authorized to administer medications to tenants. Narcotics were counted by two staff at the beginning of each shift. On 2-14-10, a staff person authorized and trained to administering medications admitted to taking the medication. The program notified the Department on 2-24-10, but did not report within 24-hours as required.

- Regulatory Insufficiency: A staff member or employee of a facility or program who, in the course of employment, examines, attends, counsels, or treats a dependent adult in a facility or program and reasonably believes the dependent adult has suffered dependent adult abuse, shall report the suspected adult abuse to the department. (235E.2(2))

Dated this 5th day of April, 2011.