IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 33811-C
33653-C
33852-M

June 9, 2011

Jack Collins, Administrator
Walnut Ridge
1701 Campus Drive
Clive, IA 50325

RE: I. Amended Final Second Recertification Revisit, Complaint and Incident Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Mr. Collins:

I. Amended Final Second Recertification Revisit, Complaint and Incident Investigation Report – Walnut Ridge, Clive, IA

Enclosed is the **Amended Final Second Recertification Revisit, Complaint and Incident 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 Tenant, Service Plan, Medications, Nurse Review, Staffing, Tenant Rights, Program Notification to Department and Monitoring, Plans of Correction and Requests for Reconsideration. **Walnut Ridge** ("Program") is being assessed a $8,000 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 **Rose Boccella** and remit the civil penalty assessed by check or money order in the amount of five thousand two hundred dollars ($5200) 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 $8,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on June 2, 2011, has been reviewed and will constitute the final POC related to the on-site visit of April 26, 27 and May 3, 4, 5, 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, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Amended Final Second Recertification Revisit, Complaint and Incident Investigation Report

Assisted Living Program:

Jack Collins, Administrator
Walnut Ridge
1701 Campus Drive
Clive, IA 50325

Complaint Intake #: 33811-C
33653-C
33852-M

Date of Investigation:

April 26, 27 and May 3, 4, 5, 2011

Monitor(s):

Joyce Kix, RN
Maribeth Freland, RN
Ann Martin, RN

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations. 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 and incident investigation on-site visit was conducted at Walnut Ridge on April 26, 27 and May 3, 4, 5 2011. In preparing this report, the following information was considered:

Current Program Census:

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS):	5
Current number of tenants without cognitive disorder:	28
Total Population:	33

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	16

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

Program History – The program received the following regulatory insufficiencies as the result of the January 12, 18 and 19th, 2011 on site: Evaluation, Criteria for Exclusion of Tenants, Service Plan, Medications, Nurse Review, Staffing, Tenant Rights and Other, (non-notification of elopement). During the April 14th 2011 on-site, the program received regulatory insufficiencies in the areas of: Tenant Rights and Other (not following plan of correction).

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

A. Evaluation of Tenant

Complaint Allegation 33811-C: It was alleged a tenant had an infected toe.

- Monitoring Observation: The monitors noted one tenant, who resided in the memory care unit, had an infected great toe wound. The tenant had a documented diagnosis of diabetes with peripheral neuropathy manifestations. Documentation reflected timely nurse evaluation of the toe and adequate follow up with the physician related to the deterioration of the toe. The program treated the toe wound per physician's orders, documenting the deterioration of the toe. The tenant required surgical amputation of the toe, resulting in discharge of the tenant from the program to a skilled nursing facility.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: Tenant #1, a 67 year old, was admitted 12-13-10 to the general population with diagnoses of: Parkinson's Dementia, Osteopenia, and Atrial Fibrillation. The tenant scored 28 of 30 on the Mini Mental Status Examination, MMSE), of 12-8-10 indicating normal cognitive function. According to documentation found in the clinical record and the communication notes, the tenant exhibited hallucinations on 12-30-10, 1-13-11 and 3-4-11 and fell on 2-23, 4-15 and 4-16-11 and exhibited confusion with increased wandering on 1-6-11. The clinical record lacked documentation of completion of a cognitive evaluation at 30 days after admission. The cognitive evaluation completed 3-10-11 indicated the tenant's cognition had changed to moderate decline.

  Tenant #4, an 80 year old, was admitted to the general population 12-11-10 with diagnoses of: Parkinson's Disease with Dementia, Hypertension (HTN), Atrial Fibulation and Osteoarthritis. The clinical record contained multiple documentations of increased confusion with hallucinations, low blood pressures and anxiety at meal times due to self consciousness regarding tremors and drooling. Physical therapy was ordered 2-9-11 for weakness and poor mobility. A cognitive evaluation completed 2-22-11 scored the tenant at 4 on the Global Deterioration Scale (GDS) indicating moderate cognitive decline. The tenant was transferred to the dementia unit 2-15-11. Functional and health evaluations were not completed until 3-8-11.

  Tenant #5, an 86 year old, was admitted 5-24-10 with diagnoses of: Depression, Anxiety, Atrial Fibrillation, Type II Diabetes and Coronary Artery Disease. The tenant scored 2 on the GDS dated 2-15-11, which indicated very mild cognitive decline. According to the Nurse Review, dated 2-15-11, Tenant #5 was independent with all activities of daily living (ADL's), requiring assistance only with medication administration and housekeeping duties. Tenant #5 fell on 4-13-11 receiving a large skin tear to the right hand which required medical attention at an emergency room. The tenant returned to the program later that same evening. On 4-26-11, the monitors noted no documentation in the tenant's clinical record related to the fall on 4-13-11 or any follow up to this incident. The nurse indicated the tenant returned to the program the same day with the right hand bandaged and no new orders. The program's communication note book contained an entry dated 4-13-11 documenting the tenant's fall earlier in the day resulting in a large skin tear to the right hand which required the application of tegaderm. The documentation directed staff to leave the tegaderm in place, cover the tenant's hand for him/her when showering with a plastic bag and tape to secure to prevent the dressing from getting wet. The documentation alerted staff to the initiation of an arm sling that would need to be applied for the tenant when dressing and indicated the tenant would now use his/her emergency response pager to alert staff to his/her need for assistance in getting up during the night. The entry did not indicate who completed this documentation. During interview, the nurse reported she had put the entries into the communication book. The tenant's injury obtained during the fall required staff to assist the tenant with daily dressing changes, wrapping of the tenant's hand prior to the tenant taking a shower, assist the tenant with the application of an arm sling and assisting the tenant at night when needed. The tenant was independent with all ADL's prior to the fall on

4-13-11. The tenant's injury sustained during the fall required staff to: assist with daily dressing changes, wrap the tenant's hand prior to taking a shower, assist with the application of an arm sling and assist the tenant at night when needed. The tenant's clinical record lacked documentation of an evaluation following the tenant's fall with injury, despite the change in the tenant's need for assistance. During interview, the nurse reported she had not had time to complete the documentation of the required evaluation.

Tenant #13, an 82 year old, was admitted 4-24-10 with diagnoses of: Dementia, HTN, Back Pain and Osteoarthritis. The nurse scored the tenant at a 5 on the GDS, dated 3-16-11, which indicated moderately severe cognitive decline. The nurse documented Tenant #13 matched five of eight characteristics under stage 6 on the GDS, which would indicate severe cognitive decline; however, the nurse did not stage the tenant at a 6.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall 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 with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Criteria for Exclusion of Tenants

Complaint Allegation #33653-C: It was alleged a confused tenant left the building without staff in attendance, attempting to get into a locked car. It was also alleged that two confused tenants in the memory care unit were sexually inappropriate with each other.

- Monitoring Observation: Following multiple staff interviews, review of the tenant's clinical record and review of the program's communication notebook, the monitors were unable to determine the tenant had ever left the program without staff knowledge.

  Multiple staff interviews revealed no evidence of any tenant sexual inappropriateness currently occurring in the memory care unit. Both tenants identified in the allegation no longer reside in the program. The monitors made multiple general observations of the memory care unit, identifying no concerns.

- Regulatory Insufficiency: None noted.

C. Tenant Documents

Complaint Allegation #33653-C: It was alleged that staff were told they would be terminated if they documented certain information in tenant's charts.

- Monitoring Observation: Interviews with multiple staff revealed no reports of restrictions imposed by administration regarding documentation. No staff

interviewed reported being advised or directed to omit pertinent tenant information from tenant clinical records or the communication notebook.

- Regulatory Insufficiency: None noted.

The following information was identified during the course of the investigation:

D. Service Plan

- Monitoring Observation: Tenant #1 scored 28 of 30 on the MMSE on 12-8-10 indicating normal cognitive function. According to documentation found in the clinical record and the communication notes, the tenant exhibited hallucinations on 12-30-10, 1-13-11 and 3-4-11 and fell on 2-23, 4-15 and 4-16-11 and exhibited confusion with increased wandering on 1-6-11. The cognitive evaluation completed 3-10-11 indicated the tenant's cognition had declined to moderate. The clinical record lacked evidence of completion of a service plan to address the changes indicated by the evaluations completed 3-11-11.

  Tenant #4's clinical record contained multiple documentations of increased confusion with hallucinations, low blood pressures and anxiety at meal times due to self consciousness regarding tremors and drooling. Physical therapy was ordered 2-9-11 for weakness and poor mobility. A cognitive evaluation completed 2-11-11 scored the tenant at 4 indicating moderate cognitive decline. The tenant was transferred to the dementia unit 2-15-11. Functional and health evaluations were not completed until 3-8-11 and the service plan to address the changes was not completed until 3-9-11. The tenant sustained a fall on 4-13-11. The service plan did not address specific identified needs of the tenant for dining, mobility or interventions for confusion and hallucinations.

  According to Tenant #5's service plan, dated 6-23-10, Tenant #5 was independent with all ADL's, requiring assistance only with medication administration and housekeeping duties. Tenant #5 fell on 4-13-11 receiving a large skin tear to the right hand which required medical attention at an emergency room. The tenant returned to the program later that same evening. On 4-26-11, the monitors noted no documentation in the tenant's clinical record related to the fall on 4-13-11 or any follow up to this incident. The nurse indicated the tenant returned to the program the same day with the right hand bandaged and no new orders. The program's communication note book contained an entry dated 4-13-11 documenting the tenant's fall earlier in the day resulting in a large skin tear to the right hand which required the application of tegaderm. The documentation directed staff to leave the tegaderm in place, cover the tenant's hand for him/her when showering with a plastic bag and tape to secure to prevent the dressing from getting wet. The documentation alerted staff to the initiation of an arm sling that would need to be applied for the tenant when dressing and indicated the tenant would now use his/her emergency response pager to alert staff to his/her need for assistance in getting up during the night. The entry did not indicate who completed this documentation. During interview, the nurse reported she had put the entries into the communication book. The tenant's injury obtained during the fall required staff to assist the tenant with daily dressing changes, wrapping of the tenant's hand prior to the tenant taking a shower, assist the tenant with the application of an arm sling and assisting the tenant at night when needed. The tenant

was independent with all ADL's prior to his/her fall on 4-13-11. The tenant's injury obtained during the fall required staff to: assist the tenant with daily dressing changes, wrap the tenant's hand prior to taking a shower, assist with the application of an arm sling and assist the tenant at night when needed. The tenant's service plan had not been updated to reflect the changes in the tenant's need for assistance. During interview, the nurse reported she had not had time to update the service plan.

Tenant #13's clinical record contained an evaluation, dated 3-16-11. The nurse documented the tenant's primary mode of mobility to be a wheelchair requiring staff assistance to propel it. The nurse documented the tenant used a wheeled walker in his/her apartment; however, she did not indicate the tenant did so independently. Documentation indicated the tenant's equilibrium to be poor.
The clinical record indicated the tenant was seen twice daily by a physical therapist from 1-26-11 through 3-22-11, at which time the therapist discontinued the services due to the tenant achieving his/her maximum potential with an inability to meet the goals set by the therapist, including the goal for the tenant to be able to ambulate greater than 100 feet safely without cueing or assistance by staff.
The clinical record documented Tenant #13 experienced falls without injury nine times between 1-10-11 and 3-7-11. The tenant's service plan, dated 3-16-11, indicated Tenant #13 ambulated independently with a wheeled walker in his/her apartment and lacked any interventions related to falls or fall prevention. The service plan did not accurately reflect the tenant's identified needs.

- 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 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))

E. Medications

Complaint Allegation #33811-C: It was alleged the medication cart lock was broken and narcotic keys were kept in the top drawer which left narcotic medications without the required second lock. It was also alleged that medications were left accessible to confused tenants in the dementia unit. It was also alleged that a bowl used to crush medications in the dementia unit was used for multiple tenants without cleansing in-between. It was alleged that creams and eye drops were not separated on the medication cart. It was alleged that one tenant's pain patch was not applied per the physician's order.

Complaint Allegation #33653-C: It was alleged the medication administration record (MAR) was not available to staff use on 4-1-11, so staff passed medication and did not sign them off until the next day. It was also alleged that the registered nurse did not complete the weekly medication changeover. It was also alleged there were medication errors.

Incident Allegation #33852-M: The program reported the narcotic medications for two tenants were missing.

Monitoring Observation: During medication administration observation, the monitor observed the bowl and pestle used to crush medications had yellow and white residue remaining. Staff #2 stated that the bowl was supposed to be cleansed after every use.

Observation of the medication cart revealed the storage of creams and eye drops was appropriate.

Review of Narcotic count records and MAR's for Tenant #6 for Narcotic patch application revealed no discrepancies in the application of the patch to the physician's order for the month of April 2011.

During interview with Staff #11, Resident Care Attendant (RCA), she reported not having MARs for all tenants on 4-1-11 prior to beginning medication pass that morning. Staff #11 reported she noted the MARs for approximately six tenants on the second floor and two tenants on the third floor were not included in the MAR book for staff use when passing medications. The RCA reported going by memory for those approximate eight tenants when passing medications on 4-1-11, writing each medication given onto a piece of notebook paper. Upon return to work on the following day, on 4-2-11, the RCA noted the MARs to be present in the MAR book. She reportedly compared the medications she actually gave to the medications listed on the MARs and then signed the MARs as given. The RCA indicated she then shredded the piece of notebook paper.

The registered nurse is not required by regulation to complete the medication changeover. Other staff members can be delegated for that task.

The following medication administration/documentation discrepancies were noted on the April 2011 MARS.

Tenant Number	Physician's order	Dosage	Observation
Tenant #8	Benazepril 40 mg	½ tablet opposite days of Amlodipine	Documented as given 4/3/11 same day as Amlodipine
Tenant #8	Amlodipine 10 mg	½ tablet opposite days of Benazepril	Documented as given 4-2-11 same day as Benazepril
Tenant #8	Benazepril 40 mg	½ tablet opposite days of Amlodipine	No initials on 4-18-11 to indicate administration
Tenant #9	Vitamin D3 1000 units	Every day 8:00 a.m.	Initialed as given and circled with no documentation as to reconciliation
Tenant #9	Aspirin 81 mg	Every day 8:00 a.m.	Initialed as given and circled with no documentation as to reconciliation
Tenant #9	Omeprazole 20 mg	Every day at 8:00 a.m.	Initialed as given and circled with no documentation as to

			reconciliation
Tenant #10	Fentanyl 50 mcg patch	One patch change every 3 days	Initialed as given then circled with explanation of "not available"

Upon entrance to the program on 4-26-11, the medication cart was observed by the monitor to be unobserved by staff in the unlocked room adjacent to the medication room. The cart itself was not locked and the key to the narcotic box was located in the unlocked top drawer making the drugs accessible. During interview, Staff #11, a RCA reported routinely pushing the medication cart when passing medications for second and third floor tenants, leaving the cart in the hallways while giving medications to each individual tenant in his/her apartment. The RCA reported having knowledge of the broken lock on medication cart and had expressed concern related to the safety of the unlocked medications to the Director. The Director had acknowledged the broken lock, however, indicated the cart would not be replaced because the program planned to put locked drawers in each tenant room and cease use of the cart on 6-1-11. Staff #11 reported she had never been told not to push the cart due to the broken lock so she continued this practice. She reported she routinely pushed in both locks so the cart would appear to be locked to others. On 4-27-11 at approximately 1:00 PM, the monitor knocked on the locked Resident Aide Office door. Staff #4, RCA, opened the door for the monitor. Staff #4 was the only staff present in the immediate area. The monitor noted the door to the nurse's office, which is located directly off of the Resident Aide Office, to be closed completely. The monitor requested Staff #4 unlock the medication room door. Staff #4 reported she does not pass medications so she knocked on the door of the nurse's office to get assistance. While Staff #4 sought the nurse, the monitor noted the medication room door was propped open with a brown door stop. The monitor noted no staff to be present in the medication room. The nurse and nurse consultant were in the nurse's office and responded to Staff #4's request for assistance. When the nurse consultant exited the nurse's office, the monitor asked why the medication room door was propped open. The nurse consultant stated "because we are in here." The nurse and nurse consultant were in a separate room with the door completely closed, barring any visual supervision of the medication cart which was located in the medication room which had been propped open. The lock on the medication cart was broken. The key to the narcotic drawer was kept in one of the unlocked drawers, allowing access to tenants' narcotics. The cart was left accessible to staff who did not pass medications and should not have had access to the medication cart. On 5-2-11 the program reported narcotic medications missing from the second floor medication cart, believing the medications were taken between 4-26-11 and 4-30-11. Tenant medications were left accessible to anyone. The program had been aware of the broken lock on the cart for over a month.

On 4-26-11 at approximately 9:20 AM, the monitor visited with Tenant #7 in his/her apartment. The tenant resides in the program's memory care unit and was scored at a 4 on the GDS scale, indicating moderate cognitive decline. According to the tenant's April 2011 MARS, the tenant's family member sets up the tenant's medications into the planner and staff ensure the tenant takes the medications each morning. The

monitor noted a seven day medication planner sitting on the bathroom countertop. The planner had tenant medications in the Wednesday through Saturday slots. Upon further review of the tenant's bathroom, the monitor noted two bottles of B12 Complex Vitamins, two bottles of Caltrate Supplement, one bottle of Vitamin D and two bottles of Ocuvite with Lutein Supplement being stored in the unlocked medicine chest. The tenant's apartment door remains unlocked at all times as the tenant resides in the memory care unit. The program reported 16 tenants with GDS scores of 4 or greater, indicating moderate to severe cognitive decline, reside in the memory care unit. The medications being kept unlocked in Tenant #7's apartment allows all 16 tenants access to the medications.

According to the program's policy, titled "Medication Program: Policies and Guidelines" (dated as revised on 3- 2010), when the program supervises or administers tenant medications, staff will document the date, time and name of the person administering the medication. According to the program's policy, titled "Medication Program: Assisting with Medications" (dated as revised on 4- 2010), when staff are required to administer an as needed (PRN) medication, staff are to initial and document the time given on the first page of the MAR and document the date, time and reason for giving the medication on the second page of the MAR. Staff should follow up with the tenant within 30 minutes to determine the effectiveness of the medication, documenting the results on the second page of the MAR. During review of January, February, March, April and May 2011 MARs, the monitors noted the following discrepancies for Tenant #6 and Tenant #12: Tenant #6's MARs showed multiple staff removed Vicodin, a PRN narcotic pain medication, from the narcotic drawer, marking the narcotic sheet as given to the tenant; however, staff failed to document the medication as given on the MARs and failed to monitor the medications effectiveness on the MARs 15 times between January 2011 and May 2011; Tenant #12's MARs showed multiple staff removed Vicodin, a PRN narcotic pain medication, from the narcotic drawer, marking the narcotic sheet as given to the tenant; however, staff failed to document the medication as given on the MARs and failed to monitor the medications effectiveness on the MARs 10 times between January 2011 and May 2011. Staff failed to follow the program's policy related to medication documentation and follow up when giving PRN medications.

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

- Regulatory Insufficiency: When medications are administered traditionally by the program: Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. (IAC r. 481-67.5(6) b.)

- Regulatory Insufficiency: Each program shall follow its own written medication policy. (IAC r. 481-67.5)

- Regulatory Insufficiency: When medications are administered traditionally by the program: The program shall maintain a list of each tenant's medications and document the medications administered. (IAC r. 481-67.5(6) c.)

F. Nurse Review

Complaint Allegation #33653-C: It was alleged issues that occurred with tenants were not addressed by nursing staff.

- Monitoring Observation: Tenant #1 scored 28 of 30 on the MMSE of 12-8-10 indicating normal cognitive function. According to documentation found in the clinical record and the communication notes, the tenant exhibited hallucinations on 12-30-10, 1-13-11 and 3-4-11 and fell on 2-23, 4-15 and 4-16-11 and exhibited confusion with increased wandering on 1-6-11. The clinical record lacked documentation of completion of a nurse review following the changes in behavior and falls. The nurse reported she was aware of the falls but had not had time to address the falls.

  Tenant #4's clinical record contained multiple documentations of increased confusion with hallucinations, low blood pressures and anxiety at meal times due to self consciousness regarding tremors and drooling. Physical therapy was ordered 2-9-11 for weakness and poor mobility. A cognitive evaluation completed 2-11-11 scored the tenant at 4 indicating moderate cognitive decline. The tenant was transferred to the dementia unit 2-15-11. Functional and health evaluations were not completed until 3-8-11. The tenant experienced a fall 4-13-11. The clinical record lacked documentation of completion of nurse reviews for the changes in health and cognitive condition. The nurse reported she was aware of the fall but had not had time to complete the nurse review.

  According to Tenant #5's service plan, dated 6-23-10, Tenant #5 was independent with all ADL's, requiring assistance only with medication administration and housekeeping duties. Tenant #5 fell on 4-13-11 receiving a large skin tear to the right hand which required medical attention at an emergency room. The tenant returned to the program later that same evening. On 4-26-11, the monitors noted no documentation in the tenant's clinical record related to the fall on 4-13-11 or any follow up to this incident. The nurse indicated the tenant returned to the program the same day with the right hand bandaged and no new orders. The program's communication notebook contained an entry dated 4-13-11 documenting the tenant's fall earlier in the day resulting in a large skin tear to the right hand which required the application of tegaderm. The documentation directed staff to leave the tegaderm in place, cover the tenant's hand for him/her when showering with a plastic bag and tape to secure to prevent the dressing from getting wet. The documentation alerted staff to the initiation of an arm sling that would need to be applied for the tenant when dressing and indicated the tenant would now use his/her emergency response pager to alert staff to his/her need for assistance in getting up during the night. The entry did not indicate who completed this documentation. During interview, the nurse reported she had put the entries into the communication book. The tenant's injury obtained during the fall required staff to assist the tenant with daily dressing changes, wrapping of the tenant's hand prior to the tenant taking a shower, assist the tenant with the application of an arm sling and assisting the tenant at night when needed. The tenant's clinical record lacked documentation of a nurse review following the tenant's

fall with injury. During interview, the nurse reported she had not had time to complete the documentation of the required nurse review.

- Regulatory Insufficiency: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions and referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r. 481-69.27 (1))

G. Staffing

Complaint Allegation #33653-C: It was alleged that staff did not follow program policy for monitoring blood sugars by using an alcohol swab prior to finger stick.

Monitoring Observation: During observation of medication administration, the monitor observed the process of assessment of blood sugar. Staff #3 used an alcohol swab to cleanse the tenant's finger prior to puncturing.

Regulatory Insufficiency: None noted.

The program received a regulatory insufficiency during the onsite recertification visit in January 2011 related to the omission of documentation indicating actual nurse observation of direct care staff performance of assigned tasks to determine competency prior to delegation of the task to non-licensed staff for Staff #5 and #8. The monitors reviewed the personnel files of Staff #5 and #8 and multiple other direct care employees.

Monitoring Observation: During interview, Staff #5, RCA, reported attending delegation training on 4-18-11. The RCA reported the program nurse directly observed her demonstrate all care tasks, including medication pass, catheter insertion and digital stimulation on that day as the RCA was working with tenants following the meeting.

During interview, Staff #8, RCA, reported attending delegation training on 4-18-11. The RCA indicated the program nurse observed her complete a demonstration of catheter insertion and digital stimulation on that day. She reported the nurse presented a training related to personal care tasks then asked the RCA to sign delegation paperwork indicating the nurse had seen the RCA perform tasks enough to know she was competent to perform all tasks, although the nurse had not observed the RCA perform all tasks as required by regulation. The forms kept by the nurse had all been signed by Staff #8 on 4-18-11, including all personal care tasks, foot dressing changes and care of a skin tear.

The following additional information was identified:

During interview, Staff #2, RCA, reported the program nurse observed her complete a demonstration of catheter insertion, passing medications and insulin administration on 4-26-11 and 4-27-11. She reported the nurse asked the RCA to sign delegation paperwork indicating the nurse had seen the RCA perform tasks enough to know she

was competent to perform all tasks, although the nurse had not observed the RCA perform all tasks as required by regulation. The forms kept by the nurse had all been signed by Staff #2 on 4-26-11, including all personal care tasks, foot dressing changes, care of a skin tear, nitroglycerin administration and rectal digital stimulation.

During interview, Staff #3 indicated the nurse asked if she felt comfortable with catheterization and rectal digital stimulation during an in-service held 4-18-11. Staff #3 was told to sign the delegation papers even though a return demonstration to evaluate competency did not occur.

During interview Staff #11, RCA, reported attending delegation training on 4-19-11. The RCA indicated the program nurse did not observe her complete a demonstration of any tasks on that day. She reported the nurse presented a training related to personal care tasks then asked the RCA to sign delegation paperwork indicating the nurse had seen the RCA perform tasks enough to know she was competent to perform all tasks, although the nurse had not observed the RCA perform all tasks as required by regulation. The forms kept by the nurse had all been signed by Staff #11 on 4-19-11, including all personal care tasks, foot dressing changes, nitroglycerin administration, insulin administration, catheter insertion, care of a skin tear and rectal digital stimulation.

During interview on 5-4-11, the RN reported she had not delegated administration of medications to Staff #13 by observation of return demonstration. Staff #13 worked the night shift from 10 PM to 6 AM which required she administer medications.

During interview on 5-5-11, Staff #12 reported she began counting narcotics on the 10-6 shift on 5-12-11; however she had never been delegated to do so.

The program did not complete delegation of nursing tasks by observing the staff perform the task to evaluate for competency.

- Regulatory Insufficiency: The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. (IAC r. 481-69.29(3))

H. Structural requirements

Complaint Allegation #33811-C: It was alleged potential cross contamination could occur due to the placement of the biohazard waste bin next to the medication cart and supply shelves in the medication room on the second floor. It is also alleged that a room has ants and the floor in one room is weak.

- Monitoring Observation: Observation of the second floor medication room revealed the biohazard waste bin was located next to a shelf containing tenant charts and was not near the shelf containing clean supplies or the medication cart.

The monitors toured multiple tenant rooms finding no evidence of insects. During interview, the Director reported the program had found ants in three rooms located in

the memory care unit however extermination had occurred prior to the initiation of the complaint investigation.

The structural concerns have been investigated by the city of Clive building department and reported to the program.

- Regulatory Insufficiency: None noted.

I. Tenant Rights

Complaint Allegation #33811-C: It is alleged a tenant waited for over one hour to get a call light answered as the tenant did not want a male to assist him/her.

- Monitoring Observation: Following review of the program's computerized call light response times; the monitors noted program staff took greater than 15 minutes to answer tenant call lights in the program's memory care unit 62 times between February 1, 2011 and April 27, 2011. Of the 62 times, 9 response times exceeded 30 minutes with the longest response time being 46 minutes. The program did not maintain any documentation of follow up related to the delayed response times. During interview, the Director reported all response times exceeding 15 minutes are given to nursing staff for follow up on however no documentation is kept to indicate the results of the follow up.

- Regulatory Insufficiency: All tenants have the right to receive from the manager and staff of the program a reasonable response to all requests. (IAC r. 481-67.3(5))

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

J. Program Notification to the Department

- Monitoring Observation: On 5-3-11 upon initiation of the incident investigation, the nurse reported Tenant #13 had fallen on 4-27-11, fracturing his/her hip, requiring hospitalization. The tenant had not yet returned to the program. Upon review of the tenant's clinical record, the monitors noted the tenant, an 82 year old, had the documented diagnosis of dementia, scored at a 5 on the GDS on 3-16-11, which indicated moderately severe cognitive decline.

  The program nurse indicated she had not reported the fall to the department as the tenant's service plan identified the tenant as being independent with mobility in his/her room however the tenant's clinical record revealed the following: The nurse documented the tenant's primary mode of mobility to be via wheelchair requiring staff assistance to propel the wheelchair; the tenant used a wheeled walker in his/her apartment; however, documentation did not indicate the tenant did so independently; the tenant's equilibrium was poor; the tenant had been seen twice daily by a physical therapist from 1-26-11 through 3-22-11, at which time the therapist discontinued the services due to the tenant achieving his/her maximum potential with an inability to meet the goals set by the therapist, including the goal for the tenant to be able to ambulate greater than 100 feet safely without cueing or assistance by staff. The tenant experienced 14 falls between 1-10-11 and 4-27-11 with the last fall resulting in the fracture of the tenant's hip.

Due to the tenant's moderately severe cognitive decline, the tenant' inability to ambulate safely per physical therapy report and the tenant's fall history resulting in a major injury, the program was required to report the fall with injury to the department.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury. A. "Major injury" shall be defined as any injury which: (1) results in death; or (2) Requires admission to a higher level of treatment. Other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician's extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based on the circumstances of the accident, the previous functional ability of the tenant, and the tenant's prognosis. (IAC r. 481- 67.4(1))

K. Monitoring, Plans of Correction and Requests for Reconsideration

Monitoring Observation: During interview, staff reported the program maintained communication notebooks and kept each notebook in the two resident assistant offices. The monitors reviewed the notebook from the memory care unit office.

During a meeting with the Director and the program nurse, the monitors requested to review the notebook from the second and third floor office. The nurse denied a communication notebook existed for the second and third floor staff to use. The nurse indicated all communication exchange and report was done verbally on these floors.

Interview with staff revealed the nurse then went to the second floor office, told staff to hide the communication notebook and instructed staff to tell the monitors that there was no communication notebook used in the second and third floor office. Staff revealed the hidden location of the communication notebook. While in the presence of the nurse, the monitors obtained the notebook from a box of biohazard waste bags located in the medication room. The book had been buried between the bags and was not visible. The nurse then acknowledged the communication notebook existed; however, she reported the staff no longer used the book for communication. Upon review of the notebook contents, the monitors noted communication notes extended through the current date and time period. The program administration made false statements and attempted to withhold documentation deemed necessary to evaluate program compliance.

The program's Plan of Correction, submitted to the Department on 2-22-11, included a plan of correction date of 5-1-11 to ensure completion of the correction for nurse delegation.

During interview on 5-4-11, the RN reported she had not delegated administration of medications to Staff #13 by observation of return demonstration. Staff #13 worked the night shift from 10 PM to 6 AM which required she administer medications.

During interview on 5-5-11, Staff #12 reported she began counting narcotics on the 10-6 shift on 5-12-11; however she had never been delegated to do so.

The program did not ensure that delegation included a return demonstration with direct observation by the nurse and did not have all delegations completed by 5-1-11 The program did not follow the Plan of Correction as presented to the Department.

- Regulatory Insufficiency: All records and areas of the program deemed necessary to determine compliance with the applicable requirements for certification shall be accessible to the department for purposes of monitoring. (IAC r. 481-67.10(2))

- Regulatory Insufficiency: The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. IAC r. 481-67.10(8)

Dated this 7th day of June 2011