IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED

August 5, 2011

Cathy Hughes, Executive Director
Senior Star at Elmore Place
4500 Elmore Avenue
Davenport, IA 52807

RE: I. Final Recertification Monitoring Evaluation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Standard Certification
V. Conclusion

Dear Ms. Hughes:

I. Final Recertification Monitoring Evaluation Report – Senior Star at Elmore Place, Davenport, IA

Enclosed is the **Final Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapter 481—67 and 481—69. The Report notes the Regulatory Insufficiencies in the area(s) of: Service Plans, Medications and Nurse Review. Senior Star at Elmore Place ("Program") is being assessed a $2,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

DIA is accepting the Plan of Correction (POC) following the Program's submission of information.

II. Civil Penalty

If, within thirty (30) days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant in accordance with IAC 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 cover letter to the attention of **Jim Berkley** and remit the penalty assessed by check or money order in the amount of one thousand three 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 30 days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to IAC chapter 481—10. If the Program appeals, the civil penalty will be suspended, pending the appeal process. If the Program does not appeal, the fine is due within 30 days of notice.

IV. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0295** with effective dates of **July 15, 2011** through **July 14, 2013**.

V. 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 POC submitted on August 2, 2011, has been reviewed and will constitute the final POC related to the on-site visit of July 5 and 6, 2011.

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

If you have any questions in regard to this letter and 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 Recertification Monitoring Evaluation Report

Assisted Living Program:

Cathy Hughes, Executive Director
Senior Star at Elmore Place
4500 Elmore Ave.
Davenport, IA 52807

Date of Monitoring Visit:

July 5 and 6, 2011

Monitor(s):

Joyce Kix, RN
Lori Miner, BSN

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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. [481 IAC 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 Recertification Monitoring Evaluation 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 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site monitoring evaluation was conducted at Senior Star at Elmore Place on July 5 and 6, 2011. In preparing this report, the following information was considered:

Assisted Living Programs are defined by the type of population served. **Note**: The census numbers were provided by the Program at the time of the on-site.

General Population Program – A Program that is not Dementia-Specific, but may have tenants with cognitive disorder.

Number of tenants without cognitive disorder:	57
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	57

Tenant/Family Satisfaction Results – A meeting was held with 11 tenants and one family member. According to the tenants, the best thing about the program was the staff. Housekeeping was completed to the tenants' satisfaction in apartments and common areas. Staff members responded to calls for assistance in five to ten minutes. The care was described as good and the staff members were described as knowledgeable to provide care. The staff knew the tenants' names. The food was not always good. Sometimes the food was not hot. At times, the kitchen ran out of some juices and fruits. The tenants indicated there were enough activities but sometimes there was no leader to run the activity. The tenants indicated they participated in fire drills but would like more information on maintaining their safety in the event of an actual fire. Generally the tenants felt safe and were satisfied with the program.

Program History – There were substantiated Regulatory Insufficiencies found during this certification period for Service Plan, Medications, Nurse Review and Record Checks.

On-Site Monitoring Evaluation – The monitors reviewed records for Tenant #1, #2, #3, #4, #5, #6, #7, #8, and #9 and found deficient practice with Tenant #1, #2, #3, #4, #5, #7, #8 and #9 as detailed below.

A. Service Plan

Monitoring Observation: Tenant #1(the Tenant), an 80-year old, was admitted to the general population 9-11-09 with diagnoses of: Frontal Lobe Dementia, Renal Insufficiency, Ataxia, Osteoporosis, and Parkinson's Disease. The clinical record lacked documentation of a service plan developed after evaluations completed 2-16-11. Upon request, the program provided a computer copy of a service plan dated 2-20-11. The program Nurse reported she could not find a signed copy of the plan. The unsigned plan did not identify the Tenant's preference for a nursing home should a higher level of care become necessary. The Tenant moved to the Program's dementia unit 5-3-11.

Tenant #3 (the Tenant), an 88 year-old, was admitted on 2-12-11 with diagnoses of: Arthritis, Cancer of the Pancreas, and Depression. The Tenant was staged at three on the Global Deterioration Scale (GDS) which indicated mild or no cognitive impairment. 30-day evaluations were completed on 3-17-11. The clinical record lacked documentation of a service plan developed after evaluations completed 3-17-11. Upon request, the program provided a computer copy of a service plan dated 3-17-11. The program Nurse reported she could not find a signed copy of the plan. The Tenant was admitted to hospice on 4-25-11. Hospice provided an aide twice a week. The hospice aide visit note indicated the aide provided personal cares including bathing.

The service plan signed 4-25-11 indicated the Tenant required the assistance of the spouse or staff with all bathing cares. The service plan failed to identify the frequency of bathing and failed to indicate hospice-provided bathing services. Physician orders dated 6-7-11 indicated the Tenant had open areas on the buttocks and medication was ordered. The service plan dated 4-25-11 indicated the Tenant had no open or compromised areas. Handwritten notes on the service plan dated 6-24-11 indicated staff was to assist the Tenant with position changes every two hours. The service plan failed to identify the Tenant's wound care needs. The unsigned plan did not identify the Tenant's preference for a nursing home should a higher level of care become necessary.

Tenant #5 (the Tenant), a 95 year-old, was admitted on 6-23-11 with diagnoses of Arthritis and High Blood Pressure (HTN). The Tenant was staged at two on the GDS which indicated little cognitive decline. The functional assessment dated 6-14-11, under the category of cognition, indicated the Tenant needed assistance with medications. The service plan dated 6-23-11 indicated the Tenant self-administered medications. The service plan was not developed based on the evaluation. An interview with Staff#1 indicated the Tenant was confused and could not tell the toilet from the floor. Staff #1 indicated the Tenant had incontinence and was wet more times than dry. An interview with Staff #10 indicated the Tenant was confused and needed constant redirection. The Tenant was reported to be non-cooperative. Staff #10 indicated the Tenant had incontinence and was wet more times than dry. The Tenant was reported to refuse personal care and to urinate in plants in the hallway. An interview with Staff #11 indicated the Tenant had dementia and refused personal cares including the changing of absorbent undergarments. The Tenant was described as aggressive and not easily redirected. Staff #11 indicated the Tenant did not always wear absorbent undergarments or allow staff to assist. The Tenant was noted to have urinated in the hallway. An interview with Staff #12 indicated the Tenant refused personal cares and was always wet from urine. It was reported the Tenant did not want assistance with showers. The Tenant was reported to have incontinence and needed redirection related to behavior. An interview with Staff #12 indicated the Tenant refused personal care and would not let staff assist with showers. Staff # 13 indicated the Tenant had taken the first shower for her on 7-6-11. She also indicated the Tenant had incontinence. Nurse's noted dated 6-26-11 indicated the Tenant urinated all over the bathroom floor. Notes dated 6-28-11 indicated the Tenant refused a shower. Notes dated 7-4-11 at 8:40 a.m. indicated the Tenant was on the bed, fully dressed with no absorbent undergarments in place. The Tenant had on two pairs of socks that were soaked with urine. The bathroom, the entire room, was noted to be a "layer of urine." Nurse's notes date 6-27-11 indicated the program considered a risk agreement related to the Tenant's confusion and not consistently using a walker for ambulation. Notes dated 6-28-11 indicated the risk agreement was cancelled because the Tenant had been consistently using a walker and had been using absorbent undergarments. The service plan dated 6-23-11 indicated the Tenant did not display any inappropriate behavior. A notation on the service plan dated 6-23-11 indicated the Tenant needed reminders to change underwear daily. On 6-27-11 the notation was added to indicate absorbent undergarments would be worn daily. The service plan failed to indicate interventions for refusal of personal cares and incontinence. The service plan did not identify the Tenant's preference for a nursing home should a higher level of care become necessary.

Tenant #9 (the Tenant), an 88 year-old, was admitted 8-21-10 with a diagnosis of Cerebral Vascular Accident. The service plan of 4-4-11 directed for monthly monitoring of vital signs. The Monthly Record of Vital Signs contained in the Tenant's clinical record lacked documentation of completion of vital signs assessment for the months of February, March, and April. The service plan lacked indication of the Tenant's preference for nursing home placement.

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))

Regulatory Insufficiency: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant, and at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: a.) The tenant's identified needs and preferences for assistance., c.) The service providers, if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy, e.) Preferences, if any of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. (IAC r. 481-69.26(4) a, c and e))

B. Medications

Monitoring Observation: During observation of medication administration completed 7-5-11 at 3:30 p.m. revealed Staff #9 gave the medication Omeprazole to Tenant #7. The medication was ordered by the physician to be given twice a day with food. The Medication Administration Record (MAR) indicated the medication was to be given at 5:00 p.m. Staff #9 gave the medication outside the time requirements and without food.

Tenant #8, an 86-year old, was admitted 3-25-11 with diagnoses of: HTN, Parkinson's Disease, Depression, Osteopenia, and Renal Insufficiency. The service plan of 5-16-11 documented that program staff will administer medications. The MAR directed for Natural Tears to be instilled in each eye twice a day and Polyeth Glycol Powder (Clear Lax) one capful in eight ounces of water every other day. During observation of medication administration, the monitor observed Artificial Tears eye drops and a bottle of Clear Lax inside Tenant #8's apartment on the counter. All other medications were maintained by the program in a locked medication cart. The clinical record did not document that the tenant requested to self-administer any medications or that the registered nurse had recommended partial self administration of 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. 481-69.5(6) b.)

C. Nurse Review

Monitoring Observation: The clinical record for Tenant #1 (the Tenant) contained documentation of the Tenant either falling or being found on the floor at least five times from 4-9-11 to 4-21-11. The clinical record lacked documentation of a nurse review to determine if complete evaluations and/or changes to the service plan were necessary. The Tenant moved to a dementia unit 5-3-11. The Nurse failed to complete a review of the tenant's medications every 90 days and failed to complete a nurse review after the multiple falls the Tenant experienced.

Tenant #4 (the Tenant), an 80-year old, was admitted on 6-2-11 with diagnoses of: Dementia, Debility, Mild Normal Pressure Hydrocephalus, Chronic Low Back Pain, and Hypothyroidism. The Tenant scored 25 on the admission Mini Mental Status Examination (MMSE) which indicated normal to very mild impairment. The service plan dated 6-20-11 indicated the Tenant was given reminders three times a day for medication administration. Nurse's notes dated 6-5-11 indicated the Tenant had "intermittent confusion concerning meds." Notes dated 6-17-11 and timed at 4:30 p.m. indicated all medications in the med manager were gone and the Tenant stated no medications were taken on that day. Notes dated 6-27-11 indicated staff went to remind the Tenant to take noon pills. The staff person noticed the Tenant had consumed all the pills for the day. A nurse review was not completed with a change in condition.

Tenant #7 (the Tenant), a 95 year-old, was admitted 3-29-11 with diagnoses of: HTN, Coronary Artery Disease, Anemia, and Renal Insufficiency. The service plan of 3-25-11 directed program staff will administer medications as ordered by the physician. The Nurse's Notes dated 3-31-11 documented the Tenant's legal representative did not want the program to administer medications because the program's medication list was not correct. The next Nurse's Note 4-18-11 documented the Tenant's physician faxed a current list of medications and asked why the program was administering Diltiazem. On 4-19-11 another physician discontinued the medication Diltiazem. The Nurse's Note of 6-8-11 indicated the Tenant reported a high blood pressure reading which the nurse verified as 197/97. The Tenant was transferred to the emergency room on 6-11-11 for blood pressure reading of 188/121 and 203/84. The physician increased the Tenant's blood pressure medication. The clinical record lacked documentation of completion of a nurse review with multiple changes in condition and medications.

The service plan for Tenant #9 (the Tenant) indicated the Program provided assistance with medication administration. The Nurse's Notes on 3-1-11 documented the Tenant received a medication Prednisone for seven days for skin rash. Another note on 3-29-11 documented the Tenant was given Vicodin (narcotic for pain) for neck pain reported at "9" on a scale of 1 to 10 with 10 being the worst. The Program Director reported the required 90 day medication review was within the quarterly functional and health evaluations. The documentation under medications dated 4-4-11 for the Tenant stated only that the Tenant requires medication assistance/supervision by staff twice or more daily, or needs extensive supervision or assistance to take medications. The documentation made no reference to the medication changes of the past 90 days and thus was not a 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))

Regulatory Insufficiency: 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))

Dated this 4th day of August 2011.