IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 35062-C
35115-C
35787-C

October 28, 2011

Ms. K'Lee Lathum, Administrator
Shores of Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, IA 50327

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

Dear Ms. Lathum:

I. Final Complaint/Incident Investigation Report – Shores of Pleasant Hill, Pleasant Hill, IA

Enclosed is the **Final Complaint/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: Policies and Procedures, Medications, Staffing, Evaluation, Criteria for Admission and Retention, Tenant Documents and Nurse Review. **Shores of Pleasant Hill** ("Program") is being assessed a $6,500 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 four thousand two hundred twenty five dollars ($4,225) 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 $6,500 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on October 20, 2011, has been reviewed and will constitute the final POC related to the on-site visit of August 29, 30 & September 12, 13, 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
Final Complaint/Incident Investigation Report

Assisted Living Program:

K'Lee Lathum, Administrator
The Shores of Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, Iowa 50327

Complaint/Incident Intake #:

35062-C
35115-C
35787-C

Date of Complaint/Incident Investigation:

August 29, 30 2011 and September 12, 13 2011

Monitor(s):

Maribeth Freland RN
Joyce Kix RN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

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.

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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a

Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

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

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	42
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	51

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	3
Number of tenants with cognitive disorder:	23
Total Population of Program at time of on-site	26
TOTAL census of Assisted Living Program	77

Program History – The program received regulatory insufficiencies in the areas of: Evaluation, Service Plan and Medications during the recertification and complaint (30944) visit of 9-30 and 10-4-2010.

During thc complaint visit (32829, 32397, 32916) of 2-21, 22-2011, the program received regulatory insufficiencies in the areas of: Tenant Rights and Staffing

During the complaint visit (33891-C) of 6-1-11, the program received a regulatory insufficiency in the area of Occupancy Agreement.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Policies and Procedures

Complaint/Incident Allegation: 35115-C- It was alleged incident reports/medication error reports were not always completed following unusual occurrences involving tenants.

- Monitoring Observation: The monitors reviewed documentation of incident reports related to incidents occurring since 6-1-11. The monitors noted documentation of Incident/Accident Report forms completed during this time period involving Tenants #3, #7, #8, #10 and #11. After reconciliation of the incidents and clinical record documentation, the monitors found the program had fully and accurately completed an Incident/Accident Report Form for all documented incidents involving Tenants #3, #7 and #8.

According to the program's policy, titled Reporting and Documenting Incidents/Accidents, staff members were directed to fill out a report form when a tenant, visitor, family member or employee received an injury; when damage to the building occurred and when professional or community emergency response personnel were onsite and involved in the incident. The policy lacked direction to staff members related to completion of the program's Medication Error Form when medication errors occur, which would be considered an unusual occurrence affecting a tenant.

Tenant #10 (the Tenant), a 75 year old, was admitted 12-1-09 with diagnoses of: Peripheral Neuropathy, Osteoarthritis, Hypertension (HTN), Spinal Stenosis and a History of Multiple Transischemic Attacks (TIAs). The Tenant scored 0 on the program's Cognitive Ability Assessment, dated 6-2-11, which indicated no cognitive decline. The clinical record indicated Tenant #10 experienced a fall while in his/her bathroom, resulting in a laceration directly above the right eye. The Tenant required medical services in an emergency room, receiving multiple sutures to close the laceration.

According to the Incident/Accident Report, completed by Staff #3, a registered nurse (RN) on 7-7-11, Tenant #10 received a laceration above the right eyelid by the brow bone. The nurse listed Staff #10 and #17 as witnesses to the incident; however, the report lacked any documentation of statements completed by either. The report lacked any description of how the accident occurred.

Tenant #11 (the Tenant), an 86 year old, was admitted 3-20-08 with diagnoses of: Alzheimer's Disease, Congestive Heart Failure (CHF), Arthritis and HTN. The Tenant scored 2 on the Global Deterioration Scale (GDS), completed on 6-20-11, which indicated very mild cognitive decline. The clinical record indicated Tenant #11 visited the physician's office on 7-5-11. The physician's office nurse contacted the program reporting Tenant #11 had a bump on the forehead and was experiencing increased confusion. The nurse documented in the clinical record that the Tenant exhibited bruising on 7-6-11; however, she failed to document where the bruising was noted or describe the bruising characteristics. The nurse documented Tenant #11 reported being unaware of how the bruising occurred.

According to the Incident/Accident Reports, the program failed to complete an Incident/Accident Report form related to the bruising, the bump on the forehead and the noted increased confusion.

The monitors reviewed documentation of medication error reports maintained by the program related to errors since 6-1-11. The reports indicated only two errors occurred during this time period. The monitors reviewed the August 2011 Medication Administration Records (MARs) for all tenants receiving program-administered medications finding documentation of medication administration which was inconsistent with physician orders occurring in August 2011 for Tenants #3, #5, #9, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21 and #22. After reconciliation of the identified medication errors and the Medication Error Report forms, the program failed to maintain documentation of completed reports for any of the August 2011 errors identified by the monitors. The monitors also reviewed the

clinical records of Tenants #1, #2, #3, #4, #5, #9 and #11, all who currently received program-administered medications. The monitors found no concerns related to medication errors for Tenants #1, #2, #4, #5 and #9 prior to August 2011.

Tenant #3's clinical record contained July 2011 MARs documenting medication administration inconsistent with physician orders.

Tenant #11's clinical record contained June and July 2011 MARs documenting medication administration inconsistent with physician orders.

The program failed to maintain documentation of completed Medication Error Report forms for the June or July medication errors found by the monitors.

- Regulatory Insufficiency: The program's policies and procedures on incident reports, at a minimum shall include the following: b. an incident report shall be in detail and shall be provided on an incident report form; d. the incident report shall include statements from individuals, if any, who witnessed the incident and e. all accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. (IACr. 481-67.2(1)b.d.e.)

B. Tenant Rights

Complaint/Incident Allegation: 35115-C- It was alleged delayed staff member response to call lights.

- Monitoring Observation: The monitors reviewed the Arial Call Light Response Report for the week of 8-22-11 to 8-29-11, finding 24 of approximately 980 tenant call requests for assistance which took longer than 15 minutes for staff response, totaling less than three percent.

- Regulatory Insufficiency: None noted.

C. Medications

Complaint/Incident Allegation: 35115-C- It was alleged one tenant received a medication dosage increase in error and tenant medications were not always available to administer per physician order.

- Monitoring Observation: The monitors reviewed documentation of medication error reports maintained by the program related to errors since 6-1-11. The reports indicated only two errors occurred during this time period. The monitors reviewed the August 2011 Medication Administration Records (MARs) for all tenants receiving program-administered medications, finding documentation of medication administration which was inconsistent with physician orders occurring in August 2011 for Tenants #3, #5, #9, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21 and #22.

The monitors also reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #9 and #11, all who currently received program-administered medications. The monitors found no concerns related to medication errors for Tenants #1, #2, #4 and #5 prior to August 2011.

Tenant #3's clinical record contained July 2011 MARs documenting medication administration inconsistent with physician orders.

Tenant #9's clinical record documented a staff member did not administer his/her 7-3-11 morning dose of Seroquel and Prilosec as both medications were missing from the bubble packs sent by the pharmacy. The program maintained documentation of a Medication Error Report, dated 7-5-11, which indicated on 7-3-11 Staff #1 inadvertently administered Tenant #9's Seroquel and Prilosec after the medications had just previously been administered, resulting in Tenant #9 receiving twice the physician ordered dose of both medications. The DON documented physician notification to report the medication error; however, she did not complete the notification until 7-7-11, four days after the incident occurred.

Interview with Tenant #9, who is cognitively intact, indicated this medication error had occurred, which reportedly resulted in Tenant #9's increased drowsiness, dizziness and change in balance for one day. He/she denies similar medication errors occurring prior to the 7-3-11 incident or after.

Tenant #11's clinical record contained May, June and July 2011 MARs which documented medication administration inconsistent with physician orders.

The following medication administration inconsistencies were identified:

Tenant #	Physician's Order	Dates	MAR Documentation
Tenant #3	Xalatan Solution one drop to each eye daily	7-7,8,9-11	Xalatan eye drops not administered; no med available- med ordered
Tenant #5	Guaifenesin 10 ml. every 6 hrs x 5 days beginning on 8-1-11	8-1,2-11 all four doses; 8-3,4,5-11 two afternoon doses	Guaifenesin not given 8-1,2-11 as med not available; 8-3,4,5-11 order transcribed for twice daily instead of every 6 hours- didn't arrive yet
Tenant #5	DSS 10 ml. twice daily beginning on 8-1-11	8-1-11 one dose; 8-2-11 two doses; 8-3-11 one dose	DSS not given; no med available- didn't arrive yet
Tenant#9	Vitamin D3 1000u daily	Entire month of August 2011	Vitamin D3 not given as medication not available- no reason identified for unavailability
Tenant #11	Cymbalta 20 mg. twice	6-1,2-11 one dose	Cymbalta documented as omitted- no reason for omission

	daily		identified
Tenant #11	Famotidine 20 mg. twice daily	6-1,2-11 one dose.	Famotidine documented as omitted- no reason for omission identified
Tenant #11	Oxybutinin 5 mg. twice daily	6-17-11 one dose	Oxybutinin not given as waiting on med order
Tenant #11	Clotrimazole cream to affected areas twice daily and as needed	7-23,24,25,26,27,28,29,30,31-11 both applications	Clotrimazole not applied – no reason for omission identified
Tenant #11	Cipro 500 mg. twice daily x 5 days beginning 6-30-11	7-4,5-11 one dose	Cipro not given as no tablets left to give- should have been through one dose 7-5-11.
Tenant #12	Aricept 10 mg. at bedtime	8-3,4,5,6-11	Aricept not give as not available- medication ordered
Tenant #13	Exelon Patch one daily	8-27,28,29-11	Exelon patch not applied as not available- med ordered
Tenant #14	Milk of Magnesia 10 ml. every 48 hours	8-3-11	Milk of Magnesia not given as no medication available- went from 8-1-11 to 8-5-11 without med
Tenant #15	Fish Oil Omega 3 one every evening beginning 8-9-11	8-9,10-11	Fish Oil not given as medication not available yet
Tenant #16	Gabapentin 100 mg. twice daily	8-27-11	Gabapentin not given as not available
Tenant #16	Ativan 0.5 mg. three times daily	8-15-11 one dose; 8-16-11 two doses	Ativan not given as not available- requested family bring to program
Tenant #17	Naproxen 375 mg. every 8 hours beginning 8-18-11	8-18-11 4 pm dose	Naproxen not given as not available yet
Tenant #18	Potassium Chloride 20 mEq daily	8-8,9,10,11,12,13,14,15-11	Potassium not given as medication not available- medication ordered
Tenant #18	Celexa 10 mg. daily	8-16,17,24,25-11	Celexa not given as medication not available- reason not identified
Tenant	Aricept 10	8-1,2,3-11	Aricept not given as medication

#19	mg. daily		not available- reason not identified
Tenant #20	Lasix 40 mg. twice daily	8-16-11 noon dose	None available in bubble pack to give for noon dose
Tenant #20	Crestor 20 mg. at bedtime beginning 8-13-11	8-13,14,15,16,17,18,19,20,21,22,26,27,28-11	Crestor not given as medication not available- no reason identified
Tenant #21	Propranolol 60 mg. daily	8-19,20,21,22,23,24,25,26,27-11	Not given as medication not available- reason not identified
Tenant #22	Protonix 40 mg. daily	8-13,14,15-11	Not given as medication not available- reason not identified
Tenant #22	Naproxen 375 mg. twice daily	8-17,18-11 8:00am dose	Not given as medication not available- med ordered

The program failed to maintain adequate amounts of physician ordered medications for multiple tenants receiving program-administered medications. Staff members failed to administer tenant medications according to physician orders and failed to routinely indicate the reason for the omission when omission occurred. The program nurse did not routinely document identification of the staff member's failure to follow the medications as ordered by each physician and the program did not maintain documentation indicating physician notification of the above described inconsistencies.

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

D. Staffing

Complaint/Incident Allegation: 35115-C- It was alleged staff members were not well trained and staffing is not adequate to meet tenant needs. 35062-C- It was alleged staff members were not trained appropriately and staffing is not adequate to meet tenant needs. It was alleged testing and competency demonstrations had not occurred when training staff members to pass medications. 35787-C- It was alleged staffing is not adequate to meet tenant needs.

- Monitoring Observation: The monitors reviewed the training files for documentation pertaining to delegation of non-licensed staff members for Staff #1, #2, #4, #5, #6, #7, #8, #10, #11, #12, #13, #14, #15 and #16. The monitors interviewed Staff #1, #2, #4, #5, #9, #10, the DON and the Administrator.

  The following information was identified:

The DON and Administrator reported a skills fair is usually held one time annually. Both reported a skills fair was held once in April 2011. The Administrator reported a second skills fair was held the first week in September 2011, due to a large amount of staff member turnover. When the monitors reported the training file held multiple documents indicating a skills fair was held many other dates in 2011, the DON reported those documents were completed and signed by her and each employee in error as the document should not have been included in the packet of delegation paperwork.

Staff #1, a care attendant, had a hire date of 5-27-11. Staff #1's training file included documentation of delegation completion and skills fair attendance on 5-27-11. Staff #1 reported the DON gave her a stack of papers to go through and sign. The only reported delegation return demonstrations Staff #1 completed were for blood glucose testing, blood pressure readings, gait belt use and passing of medications. Staff #1 indicated she signed all of the other delegation sheets without completing a return demonstration for personal care tasks.

Staff #2, a care attendant, had a hire date of 6-30-11. Staff #2's training file included documentation of delegation completion and skills fair attendance on 7-8-11. Staff #2 reported she oriented to personal care tasks with Staff #9, another care attendant. She reported the DON has papers to go through and sign but she only teaches each task if you say you don't know how to complete the task. Staff #2 denied completing any return demonstrations with the DON or any other program nurse for personal care task delegation.

Staff #4, a care attendant, had a hire date of 7-22-11. Staff #4's training file included documentation of delegation completion and skills fair attendance on 8-9-11. Staff #4 reported that she had not yet been trained to pass medications and had not yet begun to do so. Staff #4 reported completing a return demonstration with the DON for blood glucose testing. She reported she went through a stack of papers and signed those for tasks she knew how to do. Staff #4 denied completing a return demonstration for those personal care tasks.

Staff #5, a care attendant, had a hire date of 8-3-11. Staff #5's training file included documentation of delegation completion and skills fair attendance on 8-8-11. Staff #5 reported that she had not yet been trained to pass medications and had not yet begun to do so. Staff #5 denied completing any return demonstration with the DON for personal care tasks. She reported her training occurred only with other care attendants with no training completion by a registered nurse; however, she understood a skills fair was schedule the next day at which time the DON would teach each task.

Staff #6, a care attendant, had a hire date of 4-13-11. Staff #6's training file included documentation of delegation completion and skills fair attendance on 4-14-11.

Staff #8, a care attendant, had a hire date of 7-20-11. Staff #8's training file included documentation of delegation completion and skills fair attendance on 7-22-11.

Staff #10, a care attendant, had a hire date of 6-15-11. Staff #10's training file included documentation of delegation completion and skills fair attendance on 6-17-11.

Staff #11, a care attendant, had a hire date of 7-18-11. Staff #11's training file included documentation of delegation completion and skills fair attendance on 7-22-11.

Staff #12, a care attendant, had a hire date of 8-4-11. Staff #12's training file included documentation of delegation completion and skills fair attendance on 8-8-11.

Staff #13, a care attendant, had a hire date of 8-3-11. Staff #13's training file included documentation of delegation completion and skills fair attendance on 8-8-11.

Staff #14, a care attendant, had a hire date of 4-15-11. Staff #14's training file included documentation of delegation completion and skills fair attendance on 4-27-11.

Staff #15, a care attendant, had a hire date of 6-13-11. Staff #15's training file included documentation of delegation completion and skills fair attendance on 6-15-11.

Staff #16, a care attendant, had a hire date of 5-6-11. Staff #16's training file included documentation of delegation completion and skills fair attendance on 5-9-11.

The monitors found paper documentation indicating Staff #1, #2, #4 and #5 completed nurse delegation with the DON, which would include teaching, shadowing and return demonstration by each staff to determine competency for each personal care task; however, all four care attendants denied teaching, shadowing and return demonstration were performed to determine competency of any personal care tasks. All indicated being instructed to sign the paper documentation attesting to nurse delegation if they believed themselves to be competent in each task.

Paper documentation indicated staff members attended a skills fair, a class set up as individual stations where staff members can return demonstrate tasks to determine competency of each care attendant for nurse delegation purposes, on 4-14-11, 4-27-11, 5-9-11, 5-27-11, 6-15-11, 6-17-11, 7-8-11, 7-22-11, 8-8-11 and 8-9-11, with the documentation being signed by both the employee and the DON. The Administrator and the DON reported the skills fair had only been held once in April 2011 and once in September 2011. The DON indicated all of the above stated documents had been completed and signed by both herself and each employee in error.

The monitors interviewed staff members, administration, family members and tenants related to staffing adequacy. The monitors reviewed the schedules and observed toileting. Tenant #10 reported often times he/she feels there are not enough staff members available to meet the needs of the tenants. He/she reported only receiving a shower once weekly rather than twice weekly due to unavailability of staff members.

Staff #2, a care attendant, reported routinely working alone in the secure dementia unit and believes that one staff is not enough to meet the toileting needs of five incontinent tenants.

Staff #9, a formerly employed care attendant, reported the program did not have enough staff members working to assure all tenants received showers as scheduled, therefore staff members "just didn't do them". Staff #9 reported a concern that tenants would be unsupervised if only one employee was present yet performing a shower of another tenant, therefore believed staff members omitted showering to avoid leaving unsupervised tenants.

Staff #18, a care attendant, reported if four staff members are not present on any one shift; the tenants have to wait for service provision.

A family member of Tenant #6, who had previously resided in the secure dementia unit, reported he/she visited on a daily basis. The family member reported routinely finding only one staff member working in the unit. The evening meal is to be served at 5:00 PM; however, it most often was not served until 6:00 PM, at which time the food was cold. The family member reported one incident occurring in June at which time he/she found Tenant #6 sitting in urine soaked clothes with an adult incontinent brief full of urine, which resembled a "balloon between his/her legs". The family member reported when staff members stood Tenant #6 up to change the brief, urine dripped onto the floor from the brief after pressure was applied in the removal process.

Observation of toileting Tenant #2 on 8-29-11 at 2:00 p.m. revealed the Tenant soiled and wet with his/her clothing wet from the back down.

The DON and Administrator reported the program attempts to schedule four staff members each shift, allowing one staff member on each floor and one staff member to float for assistance and cover for breaks; however, the program does not schedule for employees being sick or unable to come to work.

Upon review of the August/September 2011 schedules, the monitors noted the program had three or less staff members present during 76 of 129 shifts.

Tenants, staff members and family members expressed concerns related to staffing and reported all tenants do not get their needs met due to staffing shortage. Sixty percent of shifts were not scheduled to be staffed as determined optimal staffing by the program.

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

E. Occupancy Agreement

Complaint/Incident Allegation: 35787-C- It was alleged the program requires a 30 day notice to leave tenancy and billed inappropriately for structural damages after discharge from the building.

- Monitoring Observation: The monitors reviewed the clinical records and financial files of Tenants #6, #7 and #8, all discharged tenants. Each contained an occupancy agreement, signed by each tenant or tenant's representative. Each occupancy agreement included a requirement for each tenant to give a 30 day notice of plan to discharge from the program thereby requiring rent payment for 30 days; however, did not include requirement for tenants to remain in the building for 30 days. The Department of Inspections and Appeals regulations do not govern tenant/landlord billing discrepancies; therefore, the allegations of inappropriate billing for damages to an apartment were not investigated.

- Regulatory Insufficiency: None noted.

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

F. Evaluation

- Monitoring Observation: Tenant #1 (the Tenant), an 85 year old, was admitted 7-20-07 with diagnoses of : Dementia, Alzheimer's, Hypertension (HTN) , Osteoarthritis, and History of Cancer. The Tenant scored a 6 on the Global Deterioration Scale (GDS) of 9-8-11 which indicated severe cognitive decline. The Tenant currently resided in a secured dementia unit. Observation of grooming, hygiene and toileting assistance on 8-30-11 at 9:00 a.m. revealed the Tenant did not assist in any way. When the staff member removed the soiled brief, she placed a piece of toilet paper on Tenant #1's lap. The Tenant did not even attempt to use the paper. The Service Plan, dated 7-11-11, directed staff members to toilet Tenant #1 before and after meals, at night and as needed. The plan documented Tenant #1 was cooperative but unable to do these things for him/her self. The Functional Assessment, completed 7-11-11, documented the Tenant was both continent and incontinent. The Director of Nursing completed a cognitive evaluation, dated 9-8-11, which indicated the Tenant had deteriorated cognitively from 5 to 6. Cognitive, functional or health evaluations were not completed until the monitors identified concerns.

  Tenant #2 (the Tenant) scored a 6 on the Global Deterioration Scale (GDS) of 8-31-11, which indicated severe cognitive decline, and currently resided in a secured dementia unit. An initial observation of Tenant #2, completed 8-29-11 at 12:40 p.m., revealed the Tenant seated in a wheelchair at the dining room table with a plate of food in front of him/her. Tenant #2 placed the cloth napkin in his/her mouth and sucked on it. There were no staff members present. Observation of assisted toileting occurred on 8-29-11 at 2:00 p.m. Two staff members physically lifted Tenant #2 from the wheelchair to a standing position in the bathroom. The Tenant's outer clothing was visibly soaked through and the incontinent brief was soiled with bowel movement and urine. The Tenant momentarily stood independently with the use of the handicap bar. A staff person removed the Tenant's soiled clothing while the Tenant was seated on the toilet. The Director of Nursing, who was assisting with the toileting, stated the Tenant was totally incontinent. Staff #2 and #4 reported during interview that Tenant #2 required two persons to transfer. The clinical record contained documentation of a 90-day nurse review, completed 7-26-11; however, comprehensive health, functional and cognitive assessments were last completed 5-2-

11. The service plan of 5-2-11, under dining services, indicated the Tenant needed help to cut up food and verbal cues to eat. The same service plan, under personal hygiene, documented the Tenant needed assist off and onto the toilet, and assistance with changing the brief and cleaning his/herself. An undated handwritten note documented the Tenant may have one person assistance with standing and another person to clean and pull up the tenant's clothing. The program has currently applied for a waiver to exceed level of care and placed the Tenant into a hospice program. The program failed to complete functional, cognitive and health evaluations for the above stated condition changes until 8-31-11, after observation by the monitor.

Tenant #10's (the Tenant) clinical record included documentation of the program's cognitive assessment tool, dated 6-2-11, scoring him/her at zero, which indicated low risk for cognitive decline. On 8-19-11, the DON completed a nurse review, finding the Tenant to exhibit significant changes in his/her health status. On 8-19-11, following this determination, the DON completed an evaluation of Tenant #10's cognitive, functional and health status noting he/she was exhibiting changes in functional status and cognitive status. The program's cognitive assessment tool, dated 8-19-11, documented the Tenant's score at a six, which indicated a moderate risk for cognitive decline. The program's cognitive assessment tool directed staff to complete a GDS when a tenant scored a five or higher on the tool. The DON failed to complete a GDS following the 8-19-11 identification of cognitive changes.

- 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 often 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. (IACr. 481-69.22(2))

G. Criteria for Admission and Retention

Complaint/Incident Allegation: 35115-C- It was alleged multiple tenants required routine two person transfer assistance, exhibited unmanageable incontinency and experienced frequent falls with injury. It was alleged management directed staff members to lie about the tenants' abilities to monitors during a previous investigation completed by the Department of Inspections and Appeals. 35062-C- It was alleged multiple tenants exceed level of care requirements for an assisted living program due to unmanageable incontinency and requiring transfer assistance by two staff members. 35787-C- It was alleged one tenant required routine two person transfer assistance for several months prior to the program's advisement of the need to seek alternative placement.

- Monitoring Observation: The monitor's reviewed the clinical records of Tenants #1, #2, #3, #4, #6 and #10. The monitors also interviewed current and former staff and made multiple observations of care provided to Tenants #1, #2, #3, and #10.

  Documentation and monitor observation indicated Tenant #2 had begun experiencing a need for two person transfers and exhibited unmanageable incontinence; however, Tenant #2 was admitted to hospice services and the program is currently seeking a waiver to allow him/her to remain.

  Documentation and monitor observation indicated Tenant #3 was routinely transferred by one person with an occasional need for two persons to transfer. The monitors observed Tenant #3 during toileting, noting he/she participated during the toileting process. The monitors noted no level of care concerns.

  Documentation indicated Tenant #4 was routinely transferred by one person and stands appropriately for staff during toileting when prompted to do so. The tenant is incontinent; however, participates in his/her continence care. The monitors noted no level of care concerns.

  Documentation indicated Tenant #6 had begun experiencing a need for two person transfers; however, the program appropriately discharged the tenant to a higher level of care.

  Documentation and monitor observation indicated Tenant #10 had begun experiencing more difficulty with transfers and had experienced six falls in a three month period. Five of the six falls occurred while being assisted to transfer with only one staff. The program had initiated a timed evaluation of Tenant #10's transfer abilities, noting he/she required the assistance of one staff routinely; however, it was noted the frequency of two person assistance had been increasing therefore extended the timed evaluation to better identify changes which may occur. The monitors noted no level of care concerns.

  Tenant #1 (the Tenant) scored a 6 on the Global Deterioration Scale (GDS) of 9-8-11 which indicated severe cognitive decline. Tenant #1 currently resided in a secured dementia unit. Observation of grooming, hygiene and toileting assistance on 8-30-11 at 9:00 a.m. revealed the tenant did not assist in any way. When staff removed the soiled brief, she placed a piece of toilet paper on Tenant #1's lap. The Tenant did not even attempt to use the paper. The Service Plan dated 7-11-11 directed staff to toilet Tenant #1 before and after meals, at night and as needed. The plan documented Tenant #1 was cooperative but unable to do these things for him/her self. Tenant #1 exceeds the level of care due to unmanageable incontinence.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who is b. requires routine, two-person assistance with standing, transfer or evacuation or g. has unmanageable incontinence on a routine basis despite an individualized toileting program. (IACr. 481- 69.23(1) b.g.)

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

H. Tenant Documents

- Monitoring Observation: Tenants #1 and #2 resided in the secure dementia unit. Both scored six on the GDS which indicated severe cognitive decline. Observation revealed both tenants were unable to advocate for themselves and Tenant #2's clothing was soaked when staff provided assistance with toileting. The DON reported she did not utilize task sheets and indicated the staff members provided cares per the tenants' service plans. Staff members failed to provide cares and lacked the direction which would be provided on task sheets.

  On 8-31-11 the DON completed task sheets on all tenants residing in the secure dementia unit.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: q. when the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs). (IACr. 481- 69.23(1) q.)

I. Nurse Review

Complaint/Incident Allegation: 35115-C- The complainant alleged one tenant received medication in a dosage exceeding the physician's order and no follow up review was completed by the nurse.

The monitors reviewed clinical records of Tenant #1, #2, #3, #6, #9, #10 and #11. No concerns were identified for #1, #6 and #10.

- Monitoring Observation: Tenant #2 (the Tenant) scored a 6 on the Global Deterioration Scale (GDS) of 8-31-11, which indicated severe cognitive decline and resided in a secured dementia unit. An initial observation of Tenant #2 completed 8-29-11 at 12:40 p.m. revealed the Tenant seated in a wheelchair at the dining room table with a plate of food in front of him/her. Tenant #2 placed the cloth napkin in his/her mouth and sucked on it. There were no staff members present. Observation of assisted toileting occurred on 8-29-11 at 2:00 p.m. Two staff members physically lifted Tenant #2 from the wheelchair to a standing position in the bathroom. The Tenant's outer clothing was visibly soaked through and the incontinent brief was soiled with bowel movement and urine. The Tenant momentarily stood independently with the use of the handicap bar. A staff person removed the Tenant's soiled clothing while the Tenant was seated on the toilet. The Director of Nursing, who was assisting with the toileting, stated the Tenant was totally incontinent. Staff #2 and #4 reported during interview that Tenant #2 required two persons to transfer. The clinical record contained documentation of a 90-day nurse review completed on 7-26-11; however, comprehensive health, functional and cognitive assessments were last completed on 5-2-11. The service plan of 5-2-11, under dining services, indicated the Tenant needed help to cut up food and verbal cues to eat. The same service plan, under personal hygiene, documented the Tenant needed assistance off

and onto the toilet, assistance with changing the brief and cleaning self. An undated handwritten note documented the Tenant may have one person assistance with standing and another person to clean and pull up the Tenant's clothing. The program has currently applied for a waiver to exceed level of care and placed the Tenant into a hospice program. The program failed to complete a nurse review for the above stated condition changes until 8-31-11 after observation by the monitor.

Tenant #3 (the Tenant), an 86 year old, was admitted 4-6-11 with diagnoses of: Dementia, Glaucoma, Heart Disease, Parkinson's and Chronic Obstructive Pulmonary Disease. The Tenant scored a 1 on the GDS of 6-29-11 which indicated no cognitive decline. The Tenant currently resided in a secured dementia unit. An initial observation of Tenant #3, completed 8-29-11 at 12:20 PM, revealed the Tenant seated in a wheelchair at the dining room table with his/her head lying on the table. Observation of assisted toileting occurred on 8-29-11 at 1:45 PM. One staff member physically assisted Tenant #3 from the wheelchair to a standing position in the bathroom. The incontinent brief was soiled with bowel movement and urine. The clinical record contained documentation of an assessment, completed by a registered nurse 6-1-11, which indicated the tenant was continent of bowel and bladder. The service plan of 6-29-11, under personal hygiene, documented the Tenant was independent with toileting after staff member assistance with transfer to the toilet. A nurse review had not been completed to evaluate if changes were needed to the service plan due to functional and physical changes.

Tenant #9 (the Tenant), a 78 year old, was admitted 8-13-10 with diagnoses of: Dementia and Confusion. The Tenant scored 3 on the GDS, completed on 8-15-11, which indicated mild cognitive decline. Tenant #9's clinical record documented a staff member did not administer his/her 7-3-11 morning dose of Seroquel and Prilosec as both medications were missing from the bubble packs sent by the pharmacy. The program maintained documentation of a Medication Error Report, completed by the DON on 7-5-11, which indicated Staff #1 inadvertently administered Tenant #9's Seroquel and Prilosec after the medications had just previously been administered, resulting in Tenant #9 receiving twice the physician ordered dose of both medications. The DON documented physician notification to report the medication error; however, did not complete the notification until 7-7-11, four days after the incident occurred. The DON did not document Tenant #9's condition at the time of the medication error and failed to complete any follow up assessment to determine any effects which may have occurred subsequent to the medication double dosage.

Interview with Tenant #9, who is cognitively intact, indicated this medication error had occurred, which reportedly resulted in Tenant #9's increased drowsiness, dizziness and change in balance for one day. He/she denies similar medication errors occurring prior to the 7-3-11 incident or after.

Tenant #11's (the Tenant) clinical record indicated he/she visited the physician's office on 7-5-11. The physician's office nurse contacted the program reporting Tenant #11 had a bump on the forehead and was experiencing increased confusion. The nurse documented in the clinical record that the Tenant exhibited bruising on 7-6-11; however, she failed to document where the bruising was noted or describe the bruising characteristics. The nurse completed a nurse review, dated 7-8-11, however

failed to address Tenant #11's bump on the forehead or the increased confusion noted on 7-5-11.

- Regulatory Insufficiency: 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 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 or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders; and 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. (IACr. 481-69.27(1)(3))

Dated this 27th day of October 2011.