IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 38210-C

May 17, 2012

Ms. Kara Bernsee, Administrator
Silvercrest at Woodlands Creek
12605 Woodlands Parkway
Clive, IA 50325

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

Dear Ms. Bernsee:

I. Final Complaint/Incident Investigation Report – Silvercrest at Woodlands Creek, Clive, 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: Evaluation, Service Plans, Level of Care and Staffing. **Silvercrest at Woodlands Creek** ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Department has received the civil penalty.

II. Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of six hundred fifty dollars ($650) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

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

IV. Conclusion

The Program is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on May 4, 2012, has been reviewed and will constitute the final POC related to the on-site visit of March 28, 29, 30, April 3 and 4, 2012.

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:

Complaint/Incident Intake #: 38210-C

Kara Bernsee, Administrator
Silvercrest at Woodlands Creek
12605 Woodlands Parkway
Clive, IA 50325

Date of Complaint/Incident Investigation:

March 28th, 29th, 30th, April 3rd & 4th, 2012

Monitor(s):

Hal L. Chase, RN BSN MPH
Lori Miner, RN BSN
Ann Martin, RN, Bureau Chief
Rose Boccella, MA

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:	44
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	51
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	5
Number of tenants with cognitive disorder:	10
Total Population of Program at time of on-site	15
TOTAL census of Assisted Living Program	66

Program History – – The program received regulatory insufficiencies in the areas of: Tenant Documents, Service Plan, Medications, Nurse Review, Staffing, Policies and Procedures, Life Safety and Structural during the Complaint and Incident Investigation of July 2011.

During the Complaint Revisit (34794-C, 34822-C, 34948-C) of November 29 and 30 and December 1, 2, 4 and 4, 2011, the program received regulatory insufficiencies in the areas of: Policy and Procedure, Medications, Level of Care, and Structural.

During the second Complaint Revisit (34794-C, R2, 34822-C, R2, 34948-C, R2) of Febraury 15 and 16, 2012 the program received an insufficiency in the area of Structural.

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

A. Evaluation

Complaint/Incident Allegation: It was alleged the nurse did not evaluate a tenant when a urinary catheter had no output.

- Monitoring Observation: Tenant #19, 93 year-old, was admitted on 4-13-06 and had diagnoses of: Osteoporosis, History of Bimalleor Fracture, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Anemia, Angina, Peptic Ulcer, Trans Ischemic Attacks (TIA), Hyperlipidemia, Spinal Stenosis, Cataract Removal, Sleep Apnea, Depression, Hypertension (HTN) and a History of Pneumonia. Tenant #19 was admitted to hospice on 5-2-11 with an admitting diagnosis of CHF.

A service plan of 12-23-11 indicated Tenant#19 needed an assist of one with toileting. Tenant #19 was incontinent of bowel and bladder and had a history of urinary tract infections (UTI). Tenant #19's physician was contacted on 12-28-11, requesting placement of a Foley catheter to increase the quality of life. Clinical notes of 1-3-12 indicated Tenant #19's physician ordered placement of a Foley catheter and for the hospice nurse to change monthly and as needed. The same day, a hospice nurse attempted to place the Foley catheter without success. Clinical notes of 1-13-12 indicated a Foley catheter was placed. A nurse review of the same date indicated the Foley catheter was patent and draining clear yellow urine. Clinical notes of 1-27-12 indicated the Foley catheter was in place, urine was cloudy and had mucous. A foul odor was noted. A yellow discharge was noted in the vaginal area. On 1-27-12 the Program notified the physician and an order was obtained for a urinalysis culture and sensitivity. Once the urine was obtained Cipro 500mg twice daily for 10 days was initiated.

Clinical notes of 2-3-12 indicated a nurse review was completed as a catheter was in place for comfort, placed by hospice and staff was to perform catheter cares every shift. Clinical notes of the same entry indicated placement of a Foley catheter was "not a change of condition, as there is no change in the tenant's health, cognitive, or functional status." On 2-16-12 Tenant #19 complained urine was leaking around the Foley catheter. The Foley catheter was intact but no urine noted in leg bag. The hospice nurse was notified and she would be out the same day to look at or change the Foley catheter. Clinical notes of 2-22-12 indicated staff reported the urine was dark. A nurse described the urine to be amber in color with mucous, with no odor noted. Clinical notes of 2-24-12 indicated redness and a blister on Tenant #3's thigh where the leg bag straps to Tenant #19's leg. The physician and hospice nurse were notified.

Clinical notes of 3-15-12 indicated the Foley catheter was removed at the request of Tenant #19, as it was leaking. The hospice nurse received an order from Tenant #19's physician to discontinue the Foley catheter.

When the Foley catheter was not working, Hospice was notified and attended to the catheter. Urine was noted to be draining, but not through the catheter.

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

- Monitoring Observation: Tenant #19's physician was notified on 1-9-12 Tenant #19 was wheezing and possibly had a cold. The physician requested Tenant #19's wheezing be evaluated. An order was given for Amoxicillin 875mg twice daily for seven days. On 1-23-12 the physician was contacted and advised Tenant #19 had a cough with wheezing for the past two weeks. Lungs were diminished and wheezy. The Program asked for any new orders. The physician responded he couldn't evaluate Tenant #19 by means of a Fax. Urine testing results of 3-21-12 indicated a culture was indicated. The physician ordered Cipro 250mg one tablet twice daily for five days.

  The Program did not complete functional, cognitive and health evaluations with a significant change as demonstrated by placement of a Foley catheter, complications with patency of the Foley catheter, antibiotic therapy due to urine culture positive and

increased wheezing and diminished lungs and redness and blister of Tenant #19's thigh where the Foley catheter leg bag strap was placed.

- Monitoring Observation: Tenant #15, an 83 year-old, was admitted on 10-15-04 and had diagnoses of: Depression, B-12 Deficiency, Anemia, History of Colon Cancer with Resection, Mastectomy, Recurrent C. Difficile, Paroxysmal Atria Fibrillation, Anxiety, and Alzheimer's Disease. Tenant #15 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. Tenant #15 resided in the locked dementia unit. Tenant #15 was admitted to hospice in July 2011 for Dementia according to the hospice nurse. The hospice nurse reported Tenant #15 was admitted to hospice with a weight of 138 pounds. The most recent weight taken on 3-2-12 was 107 pounds. The hospice nurse reported Tenant #15 had lost five pounds in the last two months. Functional, cognitive and health evaluations were completed on 2-1-12 after staff reported to the Nurse Consultant Tenant #15 was having episodes of cycling with the need for more assistance with transfers at times, an intermittent poor appetite, becoming sleepy in the afternoon, and a reddened perineal area. The functional assessment indicated Tenant #15 required the assist of one with mobility/locomotion, and required two staff assist with transfers if Tenant #15 was weak. Staff was to use a gait belt with ambulation. Tenant #15 was noted to have a shuffled gait at times. Tenant #15 needed verbal cueing for eating and was on a regular diet. The assistance of one was required for toileting, and bowel and bladder incontinence. Tenant #15 was on an every two-hour toileting schedule. The health assessment indicated Tenant #15 was drowsy, had a weak grip with the right hand and tight muscles were noted in the neck. Tenant #15 was noted to become agitated with cares at times and yell at staff.

  A hospice visit was completed on 2-21-12. The assessment completed indicated Tenant #15 had limited range of motion, required assistance with ambulation, and had balance problems while walking and standing. Tenant #15 was noted to be disoriented at all times, and occasionally agitated. Tenant #15 was noted to be on routine and "as needed" Haldol. Tenant #15 was noted to have increased weakness and fatigue. Tenant #15's body was noted to be very stiff and Tenant #15 was unable to hold his/her head up independently.

  On 3-5-12 a nurse review was completed after staff notified the nurse of reddened skin areas on Tenant #15. The Nurse Consultant noted no areas of redness on the right hip. The outer aspect of the left heel had a reddened area, but the area was not open. Hospice was notified and indicated protective boots for both feet were ordered as well as an air mattress for the bed. Every two-hour repositioning was initiated. Barrier cream was to be applied to the heel and buttocks. Because Tenant #15 had a history of reddened areas, the Nurse Consultant noted this was not a change of condition.

  A hospice visit completed 3-16-12 indicated Tenant #15 was unable to ambulate. A hospice visit was completed on 3-20-12. The assessment completed indicated Tenant #15 was unable to ambulate, was incontinent, was speaking one-to two words, and told the nurse to "go away" during the assessment.

  The hospice visit of 3-23-12 documented Tenant #15 was able to feed self slowly, was incontinent of bowel and bladder, was speaking short phrases and asking the

same questions over and over, "not germane to conversation," and transferred with the assist of one. In an interview, the hospice nurse stated she had not assessed Tenant #15's ability to bear weight in determining Tenant #15's need for assistance of only one person to transfer. The hospice nurse indicated she personally had good muscle strength and was able to pick up Tenant #15 and transfer him/her. When asked about Tenant #15's upper body strength, the hospice nurse stated Tenant #15 could feed himself/herself, and could push away.

On 3-30-12 a nurse review was completed after staff members reported to the nurse Tenant #15 was cycling and needed two-person assist at times. A transfer tool was put in place to monitor Tenant #15's need for assistance with transfers. The Nurse Consultant stated Tenant #15 was starting to get contractures. The nurse review noted this was not a change of condition, as Tenant #15 had a history of "cycling" and needing a two-person assist at times with transfers.

Staff interviews were conducted. Staff #2 who worked in the locked dementia unit, stated staff members dressed Tenant #15 from head to toe every day in bed, Tenant #15 did not assist with grooming, and was incontinent. Tenant #15 was unable to bear weight, was unable to ambulate and was not safe to transfer with the assistance of one. Staff #2 stated Tenant#15 was routinely a two-person transfer.

Staff #43 who worked in the locked dementia unit, stated Tenant #15 was unable to walk, and used a wheelchair which staff members pushed. Staff #43 stated Tenant #15 was not always able to bear weight and that determined whether Tenant #15 was a one-or two-person transfer. Staff #43 described Tenant #15 as a two-person transfer 50 percent of the time.

Staff #46 who worked in the locked dementia unit, identified Tenant #15 as a routine two-person transfer and indicated Tenant #15 had been a two-person transfer for about a month.

On 3-28-12 Staff #54 who worked in the dementia unit by design stated Tenant #15 needed to be fed over 50 percent of the time, was non-weight bearing, and was routinely a two-person transfer within the last few days. Tenant #15 ambulated by way of staff members pushing a wheelchair. Tenant #15 was described as not assisting with undressing or toileting.

Tenant #15 was observed on four different days of the monitoring visit. Tenant #15 was observed to have contractures and was observed on five occasions to be non-weight bearing. On two occasions, Tenant #15 was observed in bed. Tenant #15 was observed to have reddened areas on the inner aspect of the legs where a knee had been resting on the other leg. Tenant #15 was observed eating, and ate with his/her fingers.

The Program did not complete functional, cognitive and health evaluations with a significant change as demonstrated by weight loss, contractures, the inability to bear weight, the development of areas of skin redness and the use of protective boots and barrier cream. (When staff members reported to the nurse the need for two-person transfers, the assessment of the ability to transfer safely was left to the unlicensed staff by the use of a transfer study). A nursing assessment was not completed to

assess Tenant #15's ability to assist with a transfer. Evaluations were not completed related to Tenant #15's upper body strength, ability to bear weight, and cognitive ability to participate safely during transfer.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Service Plans

Complaint/Incident Allegation: It was alleged a tenant had a sexually transmitted disease and staff members were not notified to use special precautions when working with the tenant.

- Monitoring Observation: Tenant #11, an 83 year-old, was admitted on 4-27-10 and had diagnoses of: Anemia, Cellulitis, Dementia, Hyperlipidemia, HTN, TIA, Venous Stasis and a History of Herpes Simplex Type II. Tenant #11 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #11 resided in the dementia unit by design. A service plan of 1-25-12 indicated Tenant #11 had a history of Herpes Simplex Type II with affected areas to the left and right shoulder and above the coccyx. Staff was directed to notify the nurse of any reddened areas or blisters. Staff was to provide standard precautions and wear gloves if touching the affected areas. In an interview with the Program Nurse, she revealed staff members were given training on Herpes Simplex II using Centers for Disease Control (CDC) information to make staff members more comfortable. The Program provided CDC information on Herpes Zoster as training materials used.

  The Program updated Tenant #11's service plan with precautions to use for a person with Herpes Simplex II. Staff education was also provided.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: Tenant #19's physician was contacted on 12-28-11, requesting placement of a Foley catheter to increase the quality of life. Clinical notes of 1-3-12 indicated Tenant #19's physician ordered placement of a Foley catheter and for the hospice nurse to change monthly and as needed. The same day, a hospice nurse attempted to place the Foley catheter without success. Clinical notes of 1-13-12 indicated a Foley catheter was placed.

  Tenant #19's previous service plan of 12-23-11 indicated Tenant #19 was incontinent of bladder and bowel and needed staff assistance with toileting and had a history of urinary tract infections. The service plan was updated on 2-3-12, but was not

supported by evaluations. Staff was to assist with incontinence and peri-care and staff was to provide catheter care. Staff was to change the collection bag at night to a leg bag during the day.

The service plan of 12-23-11 was not updated with a significant change in status as demonstrated by the placement and care of a Foley catheter placed on 1-13-12. The service plan was updated on 2-3-12, but was not supported by evaluations.

- Monitoring Observation: On 2-1-12 evaluations were completed for Tenant #15 who was continuing to decline. The most recent service plan dated 3-6-12 and updated on 3-30-12 during the onsite visit indicated Tenant #15 was a one- to two-person transfer and used a walker with transfers. The service plan identified Tenant #15 as having a shuffling gait which was unsteady at times, and indicated Tenant #15 enjoyed walking in the halls. Staff members were to walk with Tenant #15 using a gait belt. Beginning with the hospice visit of 3-16-12, Tenant #15 was identified as being unable to ambulate. Tenant #15 was identified by staff members and by observation to be non-weight bearing routinely, and required the assistance of two persons routinely for transfers. Tenant #15 also had contractures present, especially noted in the lower limbs upon observation by a monitor.

  The service plan of 3-30-12 was not updated with a significant change in status as demonstrated by Tenant#15's inability to ambulate, the presence of contractures, and the need for two-persons to routinely transfer for safety. The service plan did not meet the identified needs of Tenant #15.

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

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30-days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r.481-69.26(3))

C. Criteria for Admission and Retention

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

- Monitoring Observation: Staff #2, #46, and #54 identified Tenant #15 as routinely needing two persons to assist with transfers. Staff #43 stated Tenant #15 required too much care to be in an assisted living program. Staff #55 stated Tenant #15's incontinence was constant. Staff #2, #43, #46, and #54 worked in the locked dementia unit.

  Tenant #15, an 83 year-old, was admitted on 10-15-04 and had diagnoses of: Depression, B-12 Deficiency, Anemia, History of Colon Cancer with Resection, Mastectomy, Recurrent C. Difficile, Paroxysmal Atria Fibrillation, Anxiety, and

Alzheimer's Disease. Tenant #15 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #15 resided in the locked dementia unit..

Tenant #15 was admitted to hospice in July 2011 for Dementia according to the hospice nurse. The hospice nurse reported Tenant #15 was admitted to hospice with a weight of 138 pounds. The most recent weight taken on 3-2-12 was 107 pounds. The hospice nurse reported Tenant #15 had lost five pounds in the last two months.

A review of the clinical file revealed the Program had identified Tenant #15 as "continuing to decline" and was "cycling" according to clinical notes dated 2-1-12. Tenant #15 was cycling in the amount of assistance needed with transfers. Tenant #15 was also noted to have a decreased appetite, and was having reddened skin in the perineal area. Hospice notes for March 2012 revealed Tenant #15 was no longer ambulatory and Tenant #15's body was very stiff.

The following observations of Tenant #15 were made by a monitor:

3-28-12, 11:17 a.m. Tenant #15 was observed sleeping in a lift-chair recliner in the common area of the dementia unit by definition. Staff #2 and #59 were observed using the lift chair to raise Tenant #15. Each staff member was observed placing their arms under the arms of Tenant #15. Tenant #15 was transferred with the assist of two persons from the lift chair to the wheelchair. Tenant #15 was observed to be staring, legs were bent, and was non-weight bearing. Tenant #15 did not straighten his/her legs. Tenant #15 was holding his/her arms against the body and did not move them. Tenant #15 was wheeled to the dining room table. Tenant #15 did not participate in the transfer and required two staff persons for safety.

3-29-12, 7:45 a.m. Staff #46 awoke Tenant #15. Tenant #15 was lying in bed in the apartment. Foam boots were present on the feet. The legs were noted to be pulled up. Tenant #15 was rolled to the side by Staff #46. Tenant #15 did not assist with the turn and made no attempt to hold himself/herself on the side. A wet brief was removed and perineal care was done. Tenant #15's legs were stiff which made applying a clean diaper/brief difficult. The right hip was reddened where Tenant #15 had been lying. A reddened area was present between the knees where one knee had been resting against the other. Staff #46 stated Tenant #15 did not straighten his/her legs. Tenant #15 was dressed by Staff #46. Tenant #15 did not assist with dressing. Staff #46 placed a pillow between the knees. At 8:09 a.m. Staff #60 came in to assist. Tenant #15 was raised to sit on the edge of the bed by Staff #46 and #60. Tenant #15 was leaning backwards and Staff #60 provided support so Tenant #15 would not fall backwards while seated on the edge of the bed. A gait belt was applied. Staff #46 and #60 transferred Tenant #15 from the bed to the wheelchair. Tenant #15 did not bear weight, and legs were stiff when transferred with the assist of two from bed to wheelchair. Tenant #15 did not assist with the transfer and required two staff persons for safety.

3-29-12, 11:11 a.m. Tenant #15 was sitting in the lift-chair recliner in the common area of the dementia unit by dedication. A gait belt was applied to Tenant #15 by Staff #46. Staff #60 was also present. Two persons were used to transfer Tenant #15 from the chair to the wheelchair. Tenant #15's legs remained bent and Tenant #15 did not bear weight. Tenant #15 did not verbalize, and did not use arms to assist with

transfer. Tenant #15 was wheeled to the restroom. Tenant #15's arms were stiff across the chest. Two persons were used to transfer from the wheelchair to the toilet. Tenant #15 did not pull down pants or brief. Staff #46 brushed Tenant #15's hair. After toileting, two staff persons, #46 and #60 lifted Tenant #15 off the toilet. Staff had their arms underneath Tenant #15's arms at the armpit. As staff members leaned over to provide perineal care, Tenant #15's legs slid across the floor. Tenant #15 did not assist with perineal care, pulling up the brief, or pulling up pants. Tenant #15 did not verbalize or assist with cares. Tenant #15 did not assist with the transfer and required two staff persons for safety.

3-30-12, 10:00 a.m. Staff #44 stated Tenant #15 was a one-person transfer, but she wanted to wait for Staff #60 to return to the unit to complete the transfer. Staff #44 stated she always had a second person available "just in case." Tenant #15, in a wheelchair, was wheeled to the lift chair recliner. Staff #44 raised the lift chair, and placed a gait belt on Tenant #15. Staff #60 stated to Staff #44 that Tenant #15 always required two persons to transfer. Staff #44 and #60 placed their arms underneath the arms of Tenant #15. The gait belt was on, but staff members did not use the gait belt to lift. Tenant #15's legs were bent and his/her legs did not straighten during the transfer. Tenant #15's legs were against the floor but not bearing weight. The legs were not supported during the transfer. Tenant #15 did not assist with the transfer from the wheelchair to the lift chair recliner. Two staff persons were required for safety.

4-3-12, 4:00 p.m. Staff #46 and #60 were observed in Tenant #15's apartment by a monitor and the Bureau Chief. Tenant #15 was in bed. Tenant #15 was rolled to the side. A wet brief was removed and perineal care was done. Staff #46 was observed having a difficult time performing perineal care and applying a dry diaper/brief as Tenant #15's legs were drawn up and tight. After perineal care was performed, Staff #46 and #60 raised Tenant #15 from a lying position to a seated position on the bed. Both staff members supported Tenant #15 at the back and stated if they were to let go, Tenant #15 would fall backwards onto the bed. A gait belt was applied. Staff #46 and #60 placed their arms under Tenant #15's arms, and grabbed the gait belt to raise Tenant #15 from the bed and transfer him/her to the wheelchair. Tenant #15 did not bear weight and did not assist with the transfer. Staff #46 and #60 struggled to transfer Tenant #15. Two persons were required for safety.

Documentation indicated Tenant #15 was "cycling" and was declining. Tenant #15 had not been ambulatory and was stiff according to March 2012 hospice notes. The Program last completed functional, cognitive, and health evaluations on 2-1-12. Tenant #15 was observed during transfers on five separate occasions. Two persons were required to transfer Tenant #15 safely as Tenant #15 did not bear weight, was stiff, and did not assist with transfers. Tenant #15 was a routine two-person transfer for safety.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: (b) Requires routine, two-person assistance with standing, transfer or evacuation. (IAC r.481-69.23(1)(b))

D. Staffing

Complaint/Incident Allegation: It was alleged there was only one staff member working in the assisted living program between the hours of 5 a.m. and 7 a.m., and that was not enough staff to meet the needs of the tenants.

- Monitoring Observation: The staff schedule for February and March 2012 was reviewed. The schedule indicated on occasions a staff member was scheduled to leave at 5 a.m. Staff #4, #46, and #53 stated when a staff member left at 5 a.m., another staff member came in early and the night shift was not left short. Staff #23 stated she came in early to cover a staff member leaving at 5 a.m. and the night shift was not left short. Staff #33 stated the night shift had never been short a staff member, and if someone left early another staff member came in to cover the shift. Staff #33 stated three tenants got showers before 7 a.m. and the night shift has never reported showers not completed. Staff #43 stated she was not aware of staff members leaving at 5 a.m., but was aware of a staff member leaving at 9 p.m. and another staff member came in to cover the shift.

  Based on the schedule and staff interviews, five dates were selected: February 18 and 19, and March 18, 19, and 26, 2012. Call light response times were reviewed for the hours of 5 a.m. to 8 a.m. and/or 8 p.m. to midnight. Of the time frames reviewed, three calls exceeded 20 minutes. The remaining 162 calls were answered in a timely manner.

  Staff members reported they were not left short staffed because a staff member left a shift early. Other staff members came in to cover the shift. Call light response times indicated tenants requests for assistance were being met.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged nursing staff was required to perform housekeeping duties. Part of the duties included picking up dog feces from the yard which was cross-contamination.

- Monitoring Observation: The Program provided documentation of housekeeping duties assigned by shift to staff members. The documentation indicated the 11:00 p.m. to 7:00 a.m. shift was to empty dog waste receptacles in the courtyard. Nine staff were interviewed (#2, #4, #23, #33, #43, #46, #53, #56, #58) and revealed they had either picked up dog waste, emptied cat litter boxes at the Program, or verbalized an understanding of how to handle animal waste. All nine interviewed verbalized the need to use gloves and wash hands when handling animal waste. Staff training records revealed staff members had received training on universal precautions.

  Staff members were trained in and were using universal precautions when handling animal waste.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged a corporate nurse has been covering in the absence of a Program nurse. The corporate nurse was out of state and not available for emergencies.

- Monitoring Observation: The staff schedule for the month of February indicated the Nurse Consultant, the Operations Manager, and the Nurse rotated on-call. A new Program Nurse, in addition to the Nurse, was hired 3-4-12. Upon interview with the Program Nurse, it was revealed the Nurse Consultant and the Program Nurse did not live in the proximate area. The Nurse Consultant stayed in the area when she was on-call. The Program Nurse detailed the on-call schedule and indicated if a nurse who was not in the proximate area was on-call, a nurse in the proximate area was available for emergencies.

  Interviews were conducted. Staff #23, #33,#43, #46, #53, #55, #57, and #58 stated they have had no trouble contacting the on-call nurse and the nurse had been willing to come to the Program if needed. Staff #2, #4, and #54 have not needed to contact an on-call nurse.

  There was no evidence an on-call nurse was not available for emergencies.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: Tenant #48, an 80 year-old, was admitted on 2-24-12 and had diagnoses of: Colostomy Placement, Diabetes Mellitus, Anxiety, History of Deep Vein Thrombosis, History of Lung Cancer, History of Femur Fracture, Chronic Pain, Depression, Reflux Disease, HTN, and Osteoarthritis. A service plan of 2-24-12 indicated staff members were to provide colostomy care. A review of staff training files for 11 staff members (#2, #4, #33, #46, #47, #48, #49, #50, #51, #52, #56) indicated each did not have nurse delegated training and return demonstration of colostomy care.

  The Program did not complete nurse delegated training to provide colostomy care as indicated in Tenant #48's service plan.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r.481-67.1)

E. Tenant Rights

Complaint/Incident Allegation: It was alleged a staff member was verbally abusive and rude to tenants.

- Monitoring Observation: Tenant #47 was interviewed and reported Staff #50 told him/her she had one-half hour to help him with cares. Staff #50 said "hurry up" as Tenant #47 wasn't moving fast enough. Tenant #47 reported Staff #50 had been unpleasant to other tenants. Tenant #47 told Staff #50 not to come back to help

him/her. Tenant #47 reported he/she had told Operations Manager of this incident. Operations Manager confirmed what Tenant #47 had reported.

Tenant #49 was interviewed and reported Staff #50 challenged him/her as to the need to switch from an oxygen concentrator to liquid oxygen at night. Staff #50 was reported to state "You called me in to change your socks?" Tenant #49 reported the incidents to management and Staff #50 has not returned to help him/her.

Staff #50 reported Tenant #49 used the call light and she, Staff #50, wasn't "meshing well, not getting along with" Tenant #49. Staff #50 reported she had asked another staff person to assist Tenant #49.

The Program Nurse was interviewed and was asked if there had been any complaints or concerns raised in the care given by Staff #50 to tenants. In a written statement the Program Nurse reported on 3-20-12, a tenant confirmed there had been a number of occasions where Staff #50 was "short" with him/her, but not degrading. The Program Nurse told Staff #50 if there were any further concerns voiced by staff, family, or tenants about her presentation of wording/tone/care/attendance or any violations of expectations for delivery of care to tenants there would be formal disciplinary action taken based upon an incident.

The Program was aware of tenant concerns in regards to Staff #50. The Program took corrective action.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in rule 67.3(1) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged children were in the nursing office and within hearing range when staff members were communicating about tenants.

- Monitoring Observation: Nine staff were interviewed (#4, #23, #33, #43, #46, #53, #54 #56, #58). All reported they had seen staff member's children in the building, but none reported the children were able to hear communication about tenants, and none were seen to be handling tenant files or medications. The Operations Manager was interviewed and revealed her child had been at the Program. The hours and days her child was present varied from week to week. The Operations Manager reported her child was in junior high school, and was not present for verbal tenant report, and did not have access to tenant records or medications. The Operations Manager reported administrative staff was aware the child was present at times. The Administrator was interviewed and stated she was aware of the presence of the Operations Manager's child. The Administrator stated the child was of the age to volunteer and assist tenants, which the child did. No children were observed to be present at the Program during the onsite visit.

- Regulatory Insufficiency: None noted.

F. Other

Complaint/Incident Allegation: It was alleged administrative staff and nurses have been going out with employees to the bars, flirting, and asking persons for phone numbers. It was alleged, the next day, a nurse could not remember multiple conversations.

- Monitoring Observation: This allegation was not investigated, as there were no assisted living rules related to off-duty employee activities.

- Regulatory Insufficiency: None noted.