IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint/Incident Intake #'s: 38689-C
38692-C
38651-C

June 5, 2012

Ms. Pamela Wells, Administrator
Glenwood Place Assisted Living
2907 S. 6th Street
Marshalltown, IA 50158

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

Dear Ms. Wells:

I. Final Recertification Monitoring Evaluation Report – Glenwood Place Assisted Living (Program), Marshalltown, 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: Policies and Procedures, Transportation, Evaluation, Service Plan, Program Reporting to Department, Medications, Staffing, Food Service and Dementia Specific Education. Glenwood Place Assisted Living is being assessed a $2500 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 to the State of Iowa in the amount of one thousand six hundred twenty five dollars ($1625) 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 **S0086** with effective dates of **July 7, 2012** through **July 6, 2014**.

V. Conclusion

The Program is being assessed a $2500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The POC submitted on May 24, 2012, has been reviewed and will constitute the final POC related to the on-site visit of April 17, 18, 19, 23 and 24, 2012.

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 or **James.Berkley@dia.iowa.gov**

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Recertification and Complaint/Incident Investigation Report

Assisted Living Program:

Pamela Wells, Administrator
Glenwood Place Assisted Living
2907 S. 6th Street
Marshalltown, IA 50158

Complaint/Incident Intake #: 38689-C
38692-C
38651-C

Date of Complaint/Incident Investigation:

April 17, 18, 19, 23, and 24, 2012

Monitor(s):

Lori Miner, RN BSN
Hal L. Chase, RN BSN MPH

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.

General Population Program	
Number of tenants without cognitive disorder:	37
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	39

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	8
TOTAL census of Assisted Living Program	47

Tenant/Family Satisfaction Results – A community meeting was held with 34 tenants in attendance. Tenants reported they never regretted moving to the Program. Housekeeping services were weekly and completed to their satisfaction. The building and grounds were clean safe and sanitary. Staff responded within five minutes of being called and knew what assistance they needed. The nurse was available when needed and each reported they were getting the services they expected. The food was good with a variety of meats, vegetables and fruits offered. There were plenty of activities offered during the week, but the weekend was kind of quiet, with few activities offered. Tenants felt safe, made their own decisions, were generally satisfied with the Program, and would recommend the Program to others.

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

A. Policies and Procedures

Complaint/Incident Allegation: It was alleged an injury occurred to a tenant while being transported by the Program and an incident report was not completed. (#38651-C)

- Monitoring Observation: Tenant #1, a 75 year-old, was admitted on 9-4-05 and had diagnoses of: Hypertension (HTN), Primary Lateral Sclerosis, Spinal Cerebellar Ataxia Type 2, and Coronary Artery Disease. Tenant #1 was not cognitively impaired. Tenant #1 was no longer able to transfer safely with assist of one following a physical therapy consultation and Tenant #1 was voluntarily discharged from the Program on 4-9-12 according to the nurse's notes. An incident reported dated 4-6-12 documented when the Program vehicle turned, Tenant #1 fell to one side. Tenant #1 stated he/she was not hurt. An incident report was completed.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: The Program's policy and procedure for the administration of medication, including narcotics, indicated narcotics administered by the Program would be counted and recorded at the end/beginning of each shift and after the administration of any narcotics. All medication managers were required to complete a thorough check of the medication administration records (MARs) and narcotic counts and the end of their shift with another staff member. Staff members were to consistently follow the six rights for proper and accurate administration of medications, including recording the initials of the staff member who administered the medication on the MARs, indicating the six rights were followed correctly. If medication had been dispensed and refused, an incident report was to be filled out and documented on the MARs. Solid medications refused were to be put into an envelope and given to the nurse. Any medications flushed down the toilet needed to be witnessed by two staff and both staff who witnessed the destruction of the medication would sign on the back of the MARs. A signature key was to be used by staff who administered medications. A signature key identified the staff person's initials when documenting a medication had been administered.

  MARs and narcotic count sheets for the month of April 2012 were reviewed for Tenant's #8, #9, #10, #11, #12, #13, #14, #15, #16, and #17. The MARs indicated staff members did not consistently document narcotics administered, did not complete narcotic counts at the beginning and end of each shift with two staff, and did not follow the six rights for proper and accurate administration of medications. Staff members, who administered medications, including narcotics, did not complete an incident report when medications were refused, did not put solid medications into an envelope and give to the nurse, and did not consistently document medications, including narcotics on the MARs. A signature key, used to identify staff members who administered medications, was not used to identify each staff's initials on the narcotic count sheet or MARs.

  Tenant #4 eloped from the program on 4-10-12. The policy for elopement stated if any door alarm sounded the inside and outside area triggered by the alarm was to be thoroughly checked. Staff #8's pager went off which indicated both the south side and north side doors from the dementia unit to the courtyard were opened. Staff #8 stated she went to look out into the courtyard and saw no one. Staff #8 stated tenants would "loop" and go out one door and in the other. Because she saw no one in the courtyard, she thought that was what had occurred, and did not know anyone had left the building. Staff #8 went back to emptying trash and was in a tenant's apartment in the dedicated dementia unit when she saw Tenant #4 outside. Staff #8 did not check the inside area triggered by the pager alarm. The policy for tenant elopement was not followed.

  Staff #4 was interviewed and stated when door alarms went off the alarm was cleared if no one was seen or other staff members would be radioed to clear the alarm. Staff #10 stated when the door alarms go off, staff members check to make sure everything is "ok." The door alarm was reset if there were no problems. In interviews, staff

members did not identify the need to check the area inside when an alarm sounded to identify any missing tenants.
Tenant #1 tipped while being transported in a program vehicle. A review of the Policy and Procedure for Resident Transport revealed all employees providing transportation services would have training including a video and a return demonstration of the proper procedure for securing tenants in a vehicle. A certificate of completion was to be placed in the employee's file. The Program identified three persons as providing transportation for tenants: Maintenance, the Administrator, and the Activities Coordinator. The Administrator stated training had been completed but there was no documentation of the in-service. Maintenance stated he had training. The Program did not provide documentation of staff training on tenant transport as outlined in the policy and procedure.

- Regulatory Insufficiency: The program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by the program. All programs shall policies and procedures related to the reporting of incident including allegations of dependent abuse. (IAC r. 67.2(1))

B. Transportation

Complaint/Incident Allegation: It was alleged a tenant was not secured in the Program vehicle during transport and an injury occurred. (#38651-C)

- Monitoring Observation: An incident report dated 4-6-12 revealed when the bus turned the corner, Tenant #1 fell to one side. The driver of the bus, Maintenance, stopped the bus, pushed Tenant #1 upright, and readjusted the straps. It was documented the safety strap kept Tenant #1 from falling all the way over.

  Tenant #1 was interviewed at the current place of residence on 4-18-12. Using a communication board, Tenant #1 stated approximately two weeks ago, when returning to the Program from an appointment in a Program vehicle, Tenant #1 was in a motorized chair and Maintenance attempted to secure the chair. Tenant #1 stated when turning the corner, the chair tipped with Tenant #1 in it. The vehicle was stopped and Maintenance up righted Tenant #1. Tenant #1 did not know if the chair was secured after tipping. Tenant #1 states there were no other incidents in the vehicle. Tenant #1 reported there was no injury.

  Maintenance was interviewed and stated upon completion of an appointment he placed Tenant #1 in a Program vehicle to transport back to the Program. Maintenance stated he did not hook up the straps correctly because it was hard to secure the scooter with the straps. Maintenance stated when he turned the corner, Tenant #1 tipped. One of the straps held Tenant #1, so Tenant #1 did not fall completely over. Maintenance stated Tenant #1 was not hurt. Tenant #1 returned to the Program after the straps were repositioned. Maintenance reported the incident to the Administrator. The incident report indicated a coach company was contacted to obtain additional straps.

  Tenant #1 was not adequately secured during transport.

- Regulatory Insufficiency: Vehicles shall have adequate seat belts and securing devices for ambulatory and wheelchair-using passengers. (IAC r. 481-69.33(3))

C. Evaluation

Complaint/Incident Allegation: It was alleged functional, cognitive and health evaluations were not completed as required. (#38692-C)

- Monitoring Observation: Eleven tenant files were reviewed. Tenant #1, #3 #6, #8, #9, #11, #12 and #14 had evaluations and service plan completed appropriately.

  Tenant #4, an 82 year-old, was admitted on 10-18-08 and had a diagnosis of Alzheimer's Dementia. Tenant #4 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. Tenant #4 resided in the dementia unit. Functional, cognitive, and health evaluations were completed on 10-21-10. An annual service plan was completed on 10-10-11; however, annual evaluations were not completed in 2011.

  Tenant #7, a 92 year-old, was admitted on 4-14-05 and had diagnoses of: Orthostatic Hypotension, Osteoporosis, Benign Prostatic Hypertrophy, Bradycardia, and History of Anemia. Functional, cognitive, and health evaluations were completed on 12-21-11 and the service plan was updated following a change of condition. The health evaluation indicated Tenant #7 had a mass in the lung and had chronic pain from Shingles. The Nurse's Notes dated 12-21-11 revealed Tenant #7 refused to let the nurse assess an area of previous skin breakdown. Nurse's notes dated 3-6-12 indicated Tenant #7 was "very incontinent" and skin was prone to breakdown. Tenant #7 was noted to have a wet, productive cough. Notes dated 3-8-12 revealed Tenant #7 "has declined physically and is now needing 2 person transfer." Tenant #7 was transferred to a higher level of care on 3-29-12. Evaluations of function, cognition, and health were not completed with a significant change of condition.

  Tenant #11, a 92 year-old, was admitted on 11-8-05 and had diagnoses of: Depression, Hypothyroidism, Atrial Fibrillation and Congestive Heart Failure. Cognitive, functional, and health evaluations were completed on 4-6-12. A review of nurse's notes indicated no issues or concerns related to Tenant #11's care and health needs.

- 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))

D. Service Plans

Complaint/Incident Allegation: It was alleged service plans were not completed as required. (#38692-C)

- Monitoring Observation: Eleven tenant files were reviewed. Tenant #1, #3 #6, #8, #9, #11, #12 and #14 had evaluations and service plan completed appropriately.

  Tenant #4 eloped from the building on 4-10-12. Staff #2 stated Tenant #4 liked fresh air and went outside in the courtyard to walk around. Staff #3 stated Tenant #4 liked to be outside and was a "flight risk." Staff #7 stated Tenant #4 looked for ways to get out. Staff #8 stated Tenant #4 liked to be outside and wanted to "get things out of the car." The service plan dated 10-10-11 indicated Tenant #4 needed redirection if attempts were made to open the doors. The service plan did not identify Tenant #4's desire to be outside and interventions for safety following an elopement. The service plan indicated Tenant #4 was receiving physical therapy (PT) which had been discontinued. The service plan of 10-10-11 was not based on functional, cognitive and health evaluations.

  Tenant #5, an 86 year-old, was admitted on 5-27-11 and had diagnoses of: Coronary Artery Disease, HTN, Gastric Ulcer, Cerebrovascular Accident (CVA), Peripheral Vascular Disease, Rheumatoid Arthritis, and Colitis. Tenant #5 had falls documented 3-20-12, and 3-22-12. After the fall on 3-22-12 Tenant #5 was observed to have a skin tear on the right calf and a scrape on the back. A dime-sized blister was present on the left calf. Tenant #5 was referred to the wound care clinic for the leg wounds on 3-27-12. PT was requested on 3-29-12 following the falls. The service plan was updated 4-2-12 because of PT and the leg wounds. Evaluations of function, cognition, and health were not completed until 4-6-12. The service plan was not based on evaluations.

  Nurse's Notes dated 3-6-12 and 3-8-12 revealed Tenant #7 was prone to skin breakdown and needed two persons for transfer. The service plan dated 12-21-11 indicated Tenant #7 had a history of skin breakdown but did not identify interventions for the identification or prevention of skin breakdown. The service plan did not identify the need for two persons to assist for safe transfers. The service plan of 12-21-11 did not meet the identified needs of Tenant #7.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.221(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: 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 provider(s), of other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy. (IAC r.481-69.26(4)(a)(c))

Complaint/Incident Allegation: It was alleged a tenant was aggressive and hit other tenants. (#38692-C)

- Monitoring Observation: Tenant #9, an 85 year old, was admitted on 5-31-09 and had diagnoses of: Dementia, Diabetes Mellitus Type II, HTN, Lower Extremity Edema, Chronic Kidney Disease, Stroke Syndrome and Hard of Hearing. Tenant #9 resided in the dementia unit. A GDS was completed on 1-26-12 and staged Tenant #9 at five, which indicated moderate severe cognitive decline. Tenant #9 was admitted to hospice on 1-25-12. A service plan of 1-26-12 indicated Tenant #9 became agitated with other tenants, especially if they entered his/her room or were in his/her personal space. Tenant #9 was administered medications by the Program.

  An incident report of 2-16-12 indicated staff gave Tenant #9 a medication which Tenant #9 refused to take. Staff asked Tenant #9 for the medication and when staff reached out for the medication, Tenant #9 grabbed staff's wrist and bent it "all the way back." Nurse's notes of 1-20-12 through 2-23-12 revealed no incidents of aggression toward staff or other tenants.

  Staff interviews were conducted. Staff #2, #3, #4, #5, #6, and #9 did not identify any tenants as being aggressive. Staff #8 was interviewed and stated there were no tenants in the dementia unit that were physically aggressive.

- Regulatory Insufficiency: None noted.

E. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant was a routine two-person transfer. (#38651-C, #38692-C, and #38689-C)

- Monitoring Observation: In an interview with the Administrator, she stated the last week of March, several tenants had the flu with vomiting and diarrhea, including Tenant #5. The Administrator stated Tenant #5 had a history of falls and PT was recommended because of weakening. She stated the Program provided two persons to Tenant #5 for transfers for safety until Tenant #5 improved.

  Nurse's Notes dated 3-6-12 revealed Tenant #5 had recovered from the flu. Incident reports and Nurse's Notes documented Tenant #5 fell on 3-20-12, 3-22-12, and was unable to sit up in bed on 3-24-12. Notes of 3-22-12 indicated Tenant #5 was reminded to call for assistance with transfers. An order to start PT was requested on 3-29-12.

  Staff #1 was interviewed and stated Tenant #5 was getting better, was a one-person transfer and for the last two weeks Tenant #5 has been able to transfer independently. Staff #2 stated Tenant #5 was a two-person transfer for a while, but was doing better now. Staff #3 stated Tenant #5 had been transferring independently lately. Staff #4 stated Tenant #5 took two persons to transfer for two weeks, but has gotten better and does not always take two persons to transfer. Staff #5 stated Tenant #5 had gotten

better with therapy and could grab a railing and chair and pivot with assist of one person. Staff #6 stated Tenant #5 can be transferred with one and Tenant #5 assists with the transfer. Staff #7 stated Tenant #5 had gone to therapy and was better. On occasion, Tenant #5 was still a two-person transfer. Staff #8 and #9 stated no one was routinely a two-person transfer.

A monitor observed Staff #4 assist Tenant #5 with transfer. Tenant #5 sat self up in bed and scooted self to the edge of the bed. Tenant #5 grabbed the motorized scooter and the grab bar and pulled self towards the scooter. Staff #4 supported Tenant #5 in the pivot and Tenant #5 completed the transfer to the scooter.

On 4-18-12 Tenant #5 was interviewed and stated he/she had the flu and did not get out of bed. Tenant #5 stated staff members were attentive and two staff would assist with transfers for safety. Tenant #5 stated he/she was now able to transfer independently and did not need assistance.

- Regulatory Insufficiency: None noted.

F. Program Reporting to the Department

Complaint/Incident Allegation: It was alleged a tenant, who resided in the dementia unit, eloped from the Program. (#38689-C)

- Monitoring Observation: Tenant #4, an 82 year-old, was admitted on 10-18-08 and had a diagnosis of Alzheimer's Dementia. Tenant #4 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #4 resided in the dementia unit. An incident report dated 4-10-12 and timed 1:50 p.m., and an interview with Staff #8 revealed Staff #8 was emptying trash in tenants' rooms in the dementia unit. Staff #8's pager went off which indicated both the south side and north side doors from the dementia unit to the courtyard were opened. Staff #8 stated she went to look into the courtyard and saw no one. Staff #8 stated tenants would "loop" and go out one door and in the other. Because she saw no one in the courtyard, she thought that was what had occurred, and did not know anyone had left the building. Staff #8 went back to emptying trash and was in a tenant's apartment in the dementia unit when she saw Tenant #4 outside, on the road near the driveway of a townhome located on the north side of the building. Staff #8 immediately paged other staff members Tenant #4 was out of the building. Staff #8 stated Nurse #1 and the Administrator responded. Nurse #1 stated she located Tenant #4 at the north side of the building. Nurse's Notes documented Tenant #4 was not injured or agitated. Tenant #4 wanted something out of the car. Tenant #4 was returned to the dementia unit. Staff #8 and Nurse #1 reported Tenant #4 was out of the building less than two minutes, and was dressed with a jacket and shoes on. Nurse #1 stated it was a windy day.

  The State Climatologist gave the following weather conditions for Marshalltown on 4-10-12 at approximately 2 p.m.: Temperature 54 degrees, Northwest wind at 25 miles per hour (mph) with gusts to 33 mph. The skies were clear.

A monitor walked outside the gated area in an attempt to retrace the possible path taken by Tenant #4. The gate exits to a grassy yard and slopes downward to a driveway located on the west side of the building. The driveway curved to the west. The monitor walked 122 steps from the gate to the driveway in front of the townhome as the place indicated by Staff #8 as the place where she saw Tenant #4. The monitor walked another 84 steps to the location on the north side of the building where Nurse #1 indicated she found Tenant #4. Tenant #4 may have walked through the yard or taken a paved sidewalk to get to the building. The area behind and to the west of the townhome had a steep drop-off which led to a sidewalk and a pond.

The incident report and interview with Staff #8 revealed the gate surrounding the courtyard outside the dementia unit had no padlock at the time of the elopement. A search was made for the padlock without success. A new padlock was obtained and placed on the gate immediately. Staff #8 guarded the gate until the padlock arrived.

Maintenance was interviewed and stated the gate was unlocked for mowing once a week, but did not recall when the dementia unit courtyard was mowed. Staff #8 does not recall that mowing was completed on the morning of the incident.

In an interview, the Administrator stated she had counseled Maintenance on the gate locks. Staff checks were instituted with every shift to make sure the lock and gate were secured. The Program provided documentation of shift task logs that identified gate checks. A monitor checked the gate daily during the onsite visit from April 17th through the 19th and the gate was padlocked and secured.

On 4-10-12 Tenant #4, who was cognitively impaired as evidenced by a GDS score of five left the building without the knowledge of staff members, which constituted an elopement. The Program did not report the incident to the department as required.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available when a tenant elopes from a program. (IAC r. 481-67.4(4))

G. Medications

Complaint/Incident Allegation: It was alleged staff members took narcotics from one tenant's medication supply and gave it to another tenant. (#38692-C)

- Monitoring Observation: Staff interviews were conducted. Staff #1, #3 and #9 stated they had been asked to take medication from one tenant and give to another tenant when a medication did not come in. All indicated they were asked by a nurse weeks to months ago to administer medications in this way. Staff members indicated the medication was Hydrocodone and they had not done what the nurse asked.

  Nurse #2 was interviewed. She did not recall the dates or the tenants involved, but stated she took medication from one tenant, did not leave that tenant short of medication, and gave the medication to another tenant who was out of medication in the middle of the night. Nurse #2 believed the medication to be Lorazepam or Alprazolam.

Medications were not administered according to accepted nursing practice standards.

During the course of the investigation, the following was noted:

- Monitoring Observation: A review of narcotic count sheets and MARs listing medications administered to Tenant #3, #8, #11, #12, and #13, #14 #15, #16 and #17 were reviewed. MARs, narcotic count sheets and physician's orders for each tenant listed were not consistently transcribed. Medication was identified, but dosages and times given were not consistently documented.

  Tenant #3's MARs for April 2012 indicated Alprazolam 0.25mg – ½ tablet at 8:00 a.m. and 6:00 p.m. and Alprazolam 0.25mg tablet – ½ to one tablet four times daily as needed (PRN). Narcotic count sheets were reviewed and indicated the following: Alprazolam 0.25mg ½ tablet at 8:00 a.m. and 6:00 p.m. was signed out by one staff on 4-14-12 through 4-18-12 for the 8:00 a.m. and 6:00 p.m. scheduled dose, but the MARs for the same period indicated another staff administered the medications.

  MARs for April 2012, indicated Tenant #3 refused Alprazolam 0.25mg- ½ tablet on 4-11-12, 4-17-12, and 4-19-12 at 8:00 a.m. The narcotic count sheet for April 2012 indicated on 4-17-12 the Alprazolam 0.25mg – ½ tablet had been recorded as signed out, but had been lined out and "error" written adjacent to the entry. The Corporate Nurse reported staff had returned the Alprazolam 0.25mg – ½ tablet to Tenant #3's bottle or bubble pack. The narcotic count sheet for the same entry indicated Alprazolam 0.25mg – ½ tablet count was corrected to show the 8:00 a.m. dose was not given.

  Tenant #3's MARs for April 2012 included Alprazolam 0.25mg – ½ tablet to one tablet four times daily prn. This medication was recorded as given on 4-10-12 and 4-12-12. A narcotic count sheet for this period was not found. Nurse #1 reported there wasn't a narcotic count sheet for this medication.

  Tenant #8's MARs for April 2012, indicated Vicodin 5mg/500mg Acetaminophen – one tablet three times daily with each meal – at 8:00 a.m., 12:00 p.m. and 5:00 p.m. This entry was handwritten in the MAR and indicated it was started 4-9-12. The first dose was given on 4-9-12 and three times daily through 4-18-12 at 8:00a.m., 12:00p.m., and 5:00p.m.

  A narcotic count sheet, (for the same medication listed above) indicated Hydrocodone 5mg/500 Acetaminophen (Vicodin) – one tablet three times daily and every four hours prn for pain indicated a start date of 4-22-12.

  A second narcotic sheet indicated Hydrocodone/APAP 5mg/500mg – (Vicodin 5mg/500mg Acetaminophen as listed above) every six hours prn for pain. This narcotic count sheet indicated medication was given on 4-7-12 at 1:00p.m. and 10:00 p.m.; 4-8-12 at 8:15 a.m., 2:00p.m., and 8:15p.m.; on 4-9-12 at 8:00 a.m. and 8:00p.m.; on 4-10-12 at 8:00a.m., 12:00p.m., and 8:00 p.m.; on 4-11-12 at 8:00 a.m., 12:00 p.m., and 6:00p.m.; on 4-12-12 at 8:00a.m., 12:00p.m., and 6:00p.m.; on 4-13-12 at 8:00a.m., 12:00p.m., and 6:00p.m. On 4-14-12 through 4-18-12 – Hydrocodone 5mg/500mg Acetaminophen was consistently given at 8:00a.m., 12:00p.m and 5:00p.m.

MARs for April 2012, for Vicodin 5mg/500mg Acetaminophen – one tablet three times daily with meals (as listed above) and the narcotic count sheet for Hydrocodone 5mg/500mg Acetaminophen did not consistently match related to the date and time given. Staff's initials signing out the medication on the narcotic count sheet did not match the staff who recorded the same medication administered to Tenant #8.

MARs for April 2012, for Vicodin 5mg/500mg Acetaminophen – one tablet every six hours prn for break through pain indicated none of the medication was administered on the front of the MARs from 4-1-12 through 4-18-12. Entries were made on the back of the MARs – (nurse's medication notes), as indicated on the second narcotic count sheet, however, medication recorded as given by one staff on the MARs did not match the same staff who signed out the same medication on the narcotic count sheet.

Medication entry for Vicodin 5mg/500mg Acetaminophen – one tablet three times daily with each meal and Hydrocodone /Acetaminophen 5mg/500mg – one tablet every six hours prn for break through pain were handwritten in the April, 2012 MARs. A physician's order for both medications was not found in Tenant #8's file.

MARs for April, 2012 indicated Vicodin 5mg/500mg Acetaminophen tablet – one tablet twice daily was discontinued on 3-6-12. A physician's order to discontinue this medication was not found in Tenant #8's file.

A narcotic count was completed on the tenants cited above, including Tenant #8, by a monitor, the Corporate Nurse and Nurse #1 at approximately 3:00 p.m. on 4-18-12. A review of the narcotic count sheet for Tenant #8 indicated Vicodin 5mg/500mg Acetaminophen – (no quantity listed) – to be given every six hours prn for pain indicated. Vicodin 5mg/500mg Acetaminophen – one tablet had been documented as given to Tenant #8 at 5:00 p.m. An end of shift count had been documented as completed at 10:00 p.m. that evening. Staff #3, identified as documenting Vicodin 5mg/500mg Acetaminophen was given at 5:00 p.m. and an end of shift count at 10:00 p.m. admitted she had signed out and removed one tablet of Vicodin 5mg/500mg Acetaminophen and had placed the tablet in a small container located in her pocket. Staff #3 showed the Corporate Nurse, the Nurse #1 and the monitor several tablets which Staff #3 reported belonged to Tenant #8, along with other narcotics belonging to other tenants. Staff #3 also admitted to completing the 10:00 p.m. end of shift narcotic count when she arrived at work at 2:00 p.m. that afternoon.

Tenant #8's MARs for April 2012 indicated Fentanyl Transdermal patch – place one patch to skin every 72 hours and rotate site, was administered on 4-10-13, 4-16-12 and 4-19-12. A narcotic count sheet indicated a Fentanyl Patch 25 microgram (mcg) was signed out on 4-10-12 at 1:00 p.m., 4-13-12 at 11:00a.m., and 4-16-12 at 8:00a.m. and 4-19-12 at 11:00 a.m. The Fentanyl patch was not administered every 72 hours as ordered. Staff initials, which indicated who had signed out the Fentanyl on the above dates were not the same initials indicated on the MAR.

Tenant #11's MARs for April 2012 indicated Lorazepam 0.5mg – one tablet at bedtime was given routinely beginning 4-1-12 through 4-18-12. A narcotic count sheet indicated Lorazepam 0.5mg was signed out consistently at 9:30 p.m. for dates listed above, but the initials of staff who signed out the Lorazepam 0.5mg on the

narcotic count sheet did not match the staff initials on the MAR for the same time period.

Tenant #11's April 2012 MARs also listed Lorazepam 0.5mg – one tablet every six hours prn for anxiety. The MAR listing Lorazepam 0.5mg every six hours prn indicated this medication was not administered. A narcotic count sheet which listed Lorazepam 0.5mg – one tablet every six hours prn for anxiety indicated the medication was signed out at 8:30p.m. for the same time period.

Tenant #12's MARs for April 2012, indicated Lorazepam 0.5mg – one tablet twice daily – 8:00 a.m. and 4:00 p.m. was ordered 4-2-12. The MARs indicated Lorazepam 0.5mg was administered at 8:00a.m. on 4-5-12 and 4-6-12, with no other doses recorded on the MARs. A narcotic count sheet for the same period indicated Lorazepam 0.5mg was signed out beginning 4-5-12 at 8:00 a.m. and 4:00 p.m.; on 4-6-12 at 8:00 a.m.; and 4-7-12 through 4-18-12 at 8:00 a.m. and 4:00 p.m.

Tenant's #13, #14 #15, #16 and #17 had similar errors related to medications not being administered as ordered. Staff initials (used to identify which staff person gave the medications) on the MARs were different from the staff initials who signed out narcotic medications. Staff #3 stated she had signed out narcotics hours before the medication was to be given. Staff #3 stated she completed end of shift narcotic counts at the beginning of the shift and only one staff completing narcotic counts when two staff were required to complete narcotic counts. Staff #3 reported the practice of signing out medications hours before it was time to give a tenant their medication and completing end of shift narcotic count sheets at the beginning of the shift was common practice.

- Monitoring Observation: A medication pass was observed with Staff #5. The MAR for Tenant #2 showed a handwritten entry, which indicated Naproxen 200 milligrams (mg), was to be given twice a day. The label on the bottle of pills indicated Naproxen 220 mg was supplied. A review of the physician's ordered indicated Naproxen 220 mg was ordered. The order was not correctly transcribed from the physician's order to the MAR.

  Staff #5 was observed taking a half pill as ordered out of the bottle and signing out Alprazolam from the narcotic box for Tenant #3 on 4-19-12 at approximately 8:00 a.m. Tenant #3 refused the medication. Staff #5 returned the unused half pill to the bottle and drew a line through the entry on the narcotic sign-out sheet. The Corporate Nurse was interviewed and she stated staff members were expected to destroy unused medications and not return them to the bottle.

  Staff #5 was observed administering nasal spray to Tenant #8. Staff #5 did not apply gloves prior to the administration of the spray. Hand washing or sanitizing was not completed after the administration of the nasal spray. Staff #5 applied a glove and administered eye drops. The glove was removed. Hand washing or sanitizing was not completed after the removal of the glove or prior to leaving Tenant #8's apartment. The Corporate Nurse was interviewed and stated there was no procedure for the administration of nasal spray but the expectation was hands would be washed or sanitized after the administration of the spray. The delegation form for eye drop administration indicated after gloves were removed, hands were to be washed.

Medications were not administered according to accepted nursing practice standards.

- Regulatory Insufficiency: When medications are administered traditionally by the program (a) 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. (IAC r. 481-67.5(6)(a))

H. Staffing

Complaint/Incident Allegation: It was alleged the Program did not have enough staff to assist with a two-person transfer. Staff was "bribed" with a gift card to assist a tenant. Dementia care staff had left the dementia unit unattended while they went to assist with the transferring a tenant in the general population. (#38651, 38692, and 38689)

- Monitoring Observation: Staff members were interviewed. Staff #2, #4, #5, #6, and #8 stated tenants have never been left alone in the dementia unit. Staff #1, who worked the overnight shift, stated a staff member came out of the dementia unit to assist in the general population twice, when a tenant fell. Evening shift staff members have been asked to stay late or volunteers have been requested to be on call to assist while a tenant temporarily required two persons to transfer. Staff #3 stated she was told night shift staff came out of the dementia unit to assist after a tenant fell. Staff #7, who worked the overnight shift, stated staff members have been called out of the dedicated dementia unit less than six times in the last six months. The last time was approximately two weeks ago. Staff members were asked to come in to assist with the transfer while a tenant required two persons for transfer. Staff #9 stated staff members were called out of the dementia unit to assist with a transfer. All staff interviewed stated the tenant had improved and no longer needed routine assistance of two persons for transfer. Staff members reported there were no incidents with the tenants in the dementia unit as a result of staff members being in the general population.

  The Administrator was interviewed. She stated the last week of March, several tenants in the building had the flu with vomiting and diarrhea. The Administrator stated a tenant had been ill with the flu and had a history of falls. PT was recommended for the tenant because of weakening. The Administrator stated staff members stayed late to assist the tenant getting into bed. Gift cards were also offered to staff member who came in to assist with transfers, because the amount of time clocked in was not seen as enough compensation for the staff member's time. The Administrator stated the tenant improved within a week and no longer required the assistance of more than one staff member. The Administrator stated the dementia unit was not to be left unattended.

  The Corporate Nurse stated in an interview there was not a specific policy stating staff members were not to leave the dementia unit. She stated, however, it was an expectation the dementia unit is not left unattended.

Four of nine staff interviewed stated staff members had left the dementia unit unattended to assist in the general population. There were no reports of any incidents with tenants in the dementia unit while being left unattended. Administrative staff reported an expectation the dementia unit was not to be left unattended, however, there was not a policy prohibiting it.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged staff had not completed annual dependent adult abuse training had been completed. (#38692-C)

- Monitoring Observation: A review of Staff #3's, #4's, #5's, #6's, #7's, #9's, #10's, #11's, #12's and #13's personnel file indicated each had completed two-hours of dependent adult abuse in the last five years as required. Iowa Code requires dependent adult abuse training every five years.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged a nurse has not provided documentation of current licensure as a registered nurse. (#38692-C)

- Monitoring Observation: The Program provided documentation of current licensure as a registered nurse in the state of Iowa for Nurse #1 and Nurse #2.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged the current Program Nurse has not completed nurse-delegated training. (#38692-C)

- Monitoring Observation: Nurse #1 was hired on 2-27-12. A review of staff personnel files indicated Staff #3's, #4, #5, #6, #7, #9, #10, and #11, #12 and #13 were universal workers and provided personal and health related cares, including medication administration. A review of each staff's file indicated Nurse #1 had not completed nurse delegated training related to personal and health related cares, including medication administration.

During the course of the investigation, the following was noted:

- Monitoring Observation: An incident reported dated 4-6-12 documented when the Program vehicle turned, Tenant #1 fell to one side. Tenant #1 stated he/she was not hurt. Maintenance stated he did not hook up the straps correctly because it was hard to secure the scooter with the straps. Maintenance stated when he turned the corner, Tenant #1 tipped. One of the straps held Tenant #1 so Tenant #1 did not fall completely over. Maintenance stated Tenant #1 was not hurt. Tenant #1 returned to the Program after the straps were repositioned to a better location. The Program identified three persons as providing transportation for tenants: Maintenance, the Administrator, and the Activities Coordinator. The Administrator stated training had been completed but there was no documentation of the in-service. The correct

application of securing devices in a Program vehicle was not demonstrated as evidenced by Tenant #1 tipping while being transported.

Tenant #4 eloped from the program on 4-10-12. Staff #8 did not check the inside of the dementia unit after the pager alerted her to dementia unit doors opening. Staff # 4 and #10 were interviewed and did not indicate the need to thoroughly check the inside of the building when a pager alerted them to a door alarm. Staff members did not demonstrate or verbalize an understanding of the elopement policy.

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

I. Food Service

Complaint/Incident Allegation: It was alleged kitchen staff didn't wear gloves and hairnets. Staff members didn't wash hands upon return to the kitchen after providing tenant cares. (#38692-C)

- Monitoring Observation: The Program's policy related to quality control and food safety indicated staff was to wash hand and fingernails before starting work, during all food preparation, before and after touching raw meat, poultry and fish, before handling ready-to-eat foods with bare hands. Staff was to wash their hands after using the restroom, after eating, drinking or smoking, after coughing, sneezing or blowing their nose, after touching dirty dishes, equipments or utensils, after touching trash, floors, or dirty linens and after using cleaners or chemicals. Staff was to use gloves and hairnets/hats when in the food service area.

  A monitor observed the preparation and serving of food at lunch time and supper time on 4-18-12 and 4-19-12 and lunch on 4-23-12. Staff entering the kitchen area was observed washing hands upon entering. Staff who prepared and plated food wore aprons, hairnets and gloves. Staff serving the food to tenants wore aprons and hairnets.

  The Dietary Manager was interviewed and reported she and the evening cook would prepare and plate food. All staff who prepared and plated food wore aprons, hairnets and gloves. Staff who served the food to tenants wore aprons and gloves. The Dietary Manager reported she watched to make certain staff that serve food, wash their hands prior to serving, no exceptions. She reported there had not been any employee reprimands related to staff not following this policy and tenants have not reported any concerns.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: Staff #6 and #10 were universal workers who also serve food to tenants. A review of their personnel files indicated each had not completed an annual in-service on food safety/sanitation training. Staff #6 received training on 6-10-12 and Staff #10 received training on 12-11-10.

- Regulatory Insufficiency: Personnel who are employed by or contract with the program and who are responsible for food preparation or services, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (IAC r. 481-69.28(5))

J. Dementia-Specific Education

- Monitoring Observation: A review of Staff #6's, #7's, #9's, #10's, #11's, #12's and #13's file indicated each had not received eight hours of dementia training annually. Each staff listed provided personal and health care to tenants with dementia.

- Regulatory Insufficiency: All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. Direct-contract personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. (IAC r.481-60.30(3))

K. Structural Requirements

Complaint/Incident Allegation: It was alleged the dementia unit was not being cleaned and family members had to do the cleaning. (#38651-C)

- Monitoring Observation: A monitor completed a physical inspection of each tenant's apartment who resided in the dementia unit in addition to the common areas, kitchen and dining room on 4-18-12, 4-19-12, 4-23-12 and 4-24-12. Each tenant's apartment was clean, safe and sanitary. No soiled areas, stains or odors were present in tenant's apartments, common areas, kitchen and dining room. Tenant apartments were clear of obstacles or impediments to tenant movements. Apartments within the dementia unit not occupied were also inspected.

  Staff #8, who worked in the dementia unit full time, reported staff emptied trash, picked up dishes and vacuumed daily in each tenant's apartments, including the common areas of the unit. Staff #8 reported she knew of one family who complained of cleanliness of a tenant's apartment and cleaned the apartment while visiting.

- Regulatory Insufficiency: None noted.