IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

August 31, 2012

Ms. Jean Parrish, Administrator
Prime Living Apartments
108 1st Avenue NW
LeMars, IA 51013

RE: Final Recertification Monitoring Evaluation Report – Prime Living Apartments, LeMars, IA

Dear Ms. Parrish:

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) chapters 481—67 and 481—69.

DIA has completed the review of your Plan of Correction (POC) in response to the **Preliminary Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0197** with effective dates of **September 30, 2012** through **September 29, 2014**.

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

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If you have any questions in regard to this certification, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Recertification Monitoring Evaluation Report

Assisted Living Program:

Jean Parrish, Administrator
Prime Living Apartments Assisted Living
108 1st Ave. N.W.
LeMars, IA 51013

Date of Monitoring Visit:

June 25-26, 2012

Monitor(s):

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 were provided by the Program at the time of the on-site.

General Population Program	
Number of tenants without cognitive disorder:	25
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	27
TOTAL census of Assisted Living Program	27

Tenant/Family Satisfaction Results – A community meeting was held with 27 tenants in attendance. Tenants reported they liked living at the Program and reported housekeeping services were performed to their satisfaction and the building and grounds were clean, safe and sanitary. Staff treated tenants as they wanted to be treated, were respectful, were trained to provide the services they needed and responded to their call for assistance within five minutes of being called. Tenants reported feeling safe, made their own decisions related to personal and health related cares and received the services expected. There were enough activities offered by the Program and the food was good, with a variety of meats, fruits and vegetables offered. Tenants reported they would make the same decision to move to the Program and would recommend the Program to anyone.

Program History – There were no regulatory insufficiencies during this recertification period.

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

A. Evaluation of Tenant

Monitoring Observation: Four tenant files were reviewed. A review of Tenant #4's file indicated no issues related to evaluations.

Tenant #1, a 74 year old, was admitted on 4-30-12 and had diagnoses of: Hypertension (HTN), Bowel Obstruction, Anxiety, Coronary Artery Disease (CAD), Fibromyalgia, Depression, History of Bladder Repair, History of Back Fusion, Mild Dementia and Sigmoid Volvulus. On 4-30-12, Tenant #1 scored 28 out of 30 on a Mini Mental Status Exam, which indicated normal cognitive function. A functional evaluation completed on 4-30-12 indicated Tenant #1 was dependent with showers and staff was to shower Tenant #1 twice weekly. Tenant #1 was independent with other activities of daily living (ADLs).

Service notes of 5-3-12, written by RN #1, indicated Tenant #1was independent with showers. A staff care sheet for May, 2012 indicated Tenant #1 refused staff's assistance with showers on 5-1-12, 5-3-12, 5-8-12, 5-11-12, 5-18-12 and 5-22-12. Service notes of 5-27-12, indicated staff found Tenant #1 lying on Tenant #1's back on the sidewalk outside of the Program. Tenant #1 reported losing his/her footing and falling to the ground. Tenant #1 reported hitting Tenant #1's head and complaining of neck and left hip pain. Tenant #1 was transported to a local hospital emergency room and returned the same day with orders for pain medication every four hours as needed (prn).

Staff noted a bruise on the right elbow and Tenant #1 complained of back pain. Service notes of 5-28-12 indicated Tenant #1 complained of pain throughout the day and was still sore from the fall.

Service notes of 5-29-12 indicated staff heard Tenant #1 yell and found Tenant #1 sitting on the floor next to the bed. Tenant #1 reported he/she had taken a shower and couldn't handle showering independently, was too weak and couldn't stand independently. Tenant #1 complained of pain to the right upper side.

Service notes of 5-31-12 indicated Tenant #1 had woken from sleep and saw four men and an ex-spouse in the kitchen. Tenant #1 reported the ex-spouse said he/she wanted to move in, but hadn't brought any personal belongings. The ex-spouse and the three other men were eating all of Tenant #1's food. Service notes of the same date, but separate entry indicated Tenant #1 showed increased signs of confusion, telling staff stories that weren't real. Staff and family believed Tenant #1's behavior was possibly due to a urinary tract infection (UTI). Service notes of 6-1-12 indicated a urinalysis was negative.

Service notes of 6-7-12 indicated staff found Tenant #1 sitting on the floor in front of a recliner. Tenant #1 denied falling but reported feeling light headed and dizzy and Tenant #1's legs felt like jello and didn't think he/she could stand. Service notes of the same date, but separate entry indicated Tenant #1 was seen by a physician and was diagnosed with positional vertigo. Service notes of 6-11-12 indicated Tenant #1 was diagnosed with a UTI and was prescribed antibiotic therapy.

Evaluations indicated the Program administered medications, but service notes of 6-12-12 indicated a family member found prescription medications, including muscle relaxants in Tenant #1's drawer. Tenant #1's family member tried to remove the medications but Tenant #1 refused to have them removed. Family and staff tried to remove the medications, but Tenant #1 reported Tenant #1 hid them in a different place. Staff was able to remove some but not all of the medications.

Functional, cognitive and health evaluations were completed on 4-30-12 and 6-11-12. Evaluations were not timely and did not address Tenant #1's auditory and visual hallucinations, a diagnosis of positional vertigo, a UTI and antibiotic therapy (ATB), and Tenant #1 taking medications independently.

Tenant #2, a 77 year old, was admitted on 12-29-05 and had diagnoses of: HTN, Degenerative Joint Disease (DJD), Aortic Stenosis, Diabetes Mellitus (DM), Hypothyroidism, Constipation, Reflux, Incontinence, History of Detached Retina, Syncope, Vertigo, History of Heart Murmur, Hyponatremia, Sleep Apnea, History of Cataracts and Recurrent UTI's. A cognitive evaluation completed on 6-6-12 indicated normal cognition. Functional and health evaluations completed on 6-6-12 indicated Tenant #2 needed standby assistance with bathing and independent with all other ADLs.

Service notes of 4-19-12 indicated Tenant #2 had seen a physician for swelling of the left ankle with a sore. Tenant #2 returned with diagnoses of Cellulitis and Hyponatremia and ATB therapy was started for the Cellulitis. A nurse review completed on 4-26-12 indicated no adverse affects with ATB therapy and no change to health status was noted.

An incident report of 5-6-12 indicated staff found Tenant #2 lying on the floor. Tenant #2 reported feeling dizzy and had collapsed on the floor adjacent to the bed. Service notes of 5-7-12 indicated Tenant #2 was transported to a local hospital emergency room for evaluation. Tenant #2 returned later that day. Discharge instructions indicated Tenant #2 was diagnosed with a UTI and ATB therapy had been ordered. A second incident report of 5-7-12 and additional service notes of 5-7-12 indicated Tenant #2 needed assistance to getting off the toilet. Staff assisted Tenant #2 to the bedroom and Tenant #2 became very weak, unsteady and stumbled into the doorway. Staff guided Tenant #2 to the floor and Tenant #2 complained of shortness of breath and dizziness. Tenant #2 was transported to a local hospital emergency room and was later admitted. Tenant #2 returned to the Program on 5-14-12. Discharge instructions indicated new orders for medications, including antibiotic therapy, and a low sodium, diabetic diet. A nurse review was completed on 5-15-12 and indicated no change in health status or adverse affects to ATB therapy.

Service notes of 5-16-12 indicated Tenant #2 complained of weakness with fatigue. On 5-17-12, Tenant #2 complained of not feeling well, feeling weak, and was shaky. A nurse review was completed on 5-17-12 and indicated the reason Tenant #2 hadn't felt well was because he/she hadn't eaten breakfast. On 5-24-12, Tenant #2's physician was notified Tenant #2 had a six pound weight increase beginning 5-21-12. Tenant #2's right lower extremity had 2+ pitting edema and the left lower extremity had 1+ pitting edema. The physician ordered cardiac rehab to monitor.

Service notes of 6-2-12 indicated Tenant #2 had a seven pound weight gain overnight with orders to notify the physician of weight gain of five pounds or more. Service notes of 6-2-12 indicated Lasix 20mg was to be given twice and to notify the physician of Tenant #2's weight. On 6-6-12, functional, cognitive and health evaluations were completed and indicated no change in health status. A nurse review completed on 6-8-12, indicated Tenant #2 complained of left ankle pain. The Program nurse noted the area was tender, red and warm. Tenant #2 was seen in a local hospital emergency room and was diagnosed with Cellulitis. A physician's order for ATB therapy was ordered twice daily for seven days. Additional orders indicated Tenant #2 was to elevate the left leg as much as possible. Tenant #2's cardiac physician ordered an additional course of ATB therapy for an additional week.

Service notes of 6-9-12 at 1:30 a.m. indicated Tenant #2 complained of leg pain to both legs and refused lotion and wound care. The left leg was red and warm to the touch. On 6-10-12 Tenant #2 requested an ice pack for the right lower leg. At 6:30 a.m., staff indicated Tenant #2's right leg was reddened, tender and warm to the touch. Service notes of the same day, at 7:30 a.m., indicated Tenant #2's right leg was very red, tender and warm to the touch. Tenant #2 complained of throbbing pain. The Program nurse was notified at 11:00 a.m. and directed staff to send Tenant #2 to a hospital emergency room to be evaluated. Tenant #2 returned at 4:45 p.m. the same day with a diagnosis of Bilateral Cellulitis Infection. At 8:12 p.m. Tenant #2's family member took Tenant #2 to an out-of-state hospital for evaluation. On 6-11-12, Tenant #2's family member reported Tenant #2 had a "really bad" skin infection. On 6-15-12, Tenant #2 returned to the Program with orders for oral and topical ATB therapy.

Beginning 4-19-12 through 6-15-12, Tenant #2 had been diagnosed with a UTI, Left Leg Cellulitis which progressed to Bilateral Leg Cellulitis, ATB therapy, Weight gain, Shortness of Breath, suspected falls and needing assistance with transfers. Nurse reviews were completed on 4-26-12, 5-15-12, 5-22-12 and 6-8-12and indicated no change to functional, cognitive and health. Functional, cognitive and health evaluations were completed on 6-6-12, but not prior to 6-6-12 or after 6-6-12 with a change in health status.

Tenant #3, an 85 year old, was admitted on 9-24-10 and had diagnoses of: Dizziness, Macular Degeneration, HTN, Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Obstructive Chronic Bronchitis, Enlarged Prostate, Degenerative Disc Disease, CAD, Emphysema and a History of Cataracts. A cognitive evaluation completed on 4-4-12 indicated normal cognition. Functional and health evaluations completed on 2-1-12 and 4-4-12 indicated Tenant #3 needed assistance with bathing and was independent with all other ADLs.

Service notes of 2-18-12 indicated Tenant #3 called for staff assistance because Tenant #2 complained of shortness of breath, dizziness with standing, and pain in the stomach. Tenant #3 was transported to a local hospital and was admitted due to an enlarged, inflamed vein in the head and excessive fluid buildup. On 2-23-12 Tenant #3 returned to the Program. Discharge instructions included a diuretic, steroid taper and to notify the physician if Tenant #3 complained of shortness of breath, chest pain, edema and weight gain in excess of two to four pounds.

Service notes of 2-25-12 indicated Tenant #3 had swelling of both ankles and feet. A nurse review of 2-28-12 indicated no change to functional, cognitive and health status. On 2-29-12, Tenant #3 complained of dizziness and having increased fatigue. On 3-12-12 Tenant #3 called staff for assistance out of a recliner, as Tenant #3 was unable to do so independently. On 3-13-12, the Program nurse indicated physical therapy would evaluate the need for a lift chair. On 3-19-12 Tenant #3 told staff he/she was unable to get off the stool and staff needed to assist. Service notes of the same date, but separate entry, reported Tenant #3 complained of dizziness and shortness of breath and feeling "awful." Tenant #3 was transported to a local hospital and was admitted. On 3-23-12, Tenant #3 returned to the Program. Discharged orders included an increase in diuretics, ATB therapy, and record daily weights, to follow a "heart failure discharge instruction sheet and notify the physician if Tenant #3 complained of chest pain, shortness of breath and a weight gain more than two-to-four pounds.

Service notes of 3-25-12 indicated Tenant #3 continued to have swelling in both ankles and needed to use a walker to transfer from the toilet. Tenant #3 reported it was "pretty hard to get up." Services notes of the same date but separate entry indicated Tenant #3 was unable to stand from a sitting position independently. Tenant #3 reported his/her back and lower extremities were weak. Tenant #3 complained of shortness of breath and staff noted crackles when breathing. A nurse review of 3-26-12 indicated Tenant #3 returned to the Program from a hospitalization and was feeling much better. Tenant #3 reported he/she was using a walker to assist him/her up from the toilet and the lift chair was "beneficial." Tenant #3 continued to have 2+ pitting edema to both legs and complained frequently of urination, used continuous oxygen at two-liters per minute by nasal canula (L/min/NC). Cognitive, health and functional status stabilized and no changes were needed in the service plan.

Service notes of 4-3-12 at 12:00 p.m. indicated Tenant #3 had a four pound weight gain, 3+ bilateral edema to lower extremities and increased shortness of breath. Tenant #3 was seen by Tenant #3's physician and returned at 6:30 p.m., later that day. Physician orders included; if Tenant #3 had shortness of breath, staff was to administer Albuterol nebulizer and give an additional diuretic dosage as needed (prn) and continuous oxygen at 3L/min/NC. At 9:00 p.m., Tenant #3's family requested one-to-two hour checks and to administer a nebulizer treatment. At 11:30 p.m. staff noted Tenant #3's breath sounds sounded like there was fluid in the lungs when in bed. Tenant #3 denied feeling short of breath. Vital signs indicated low blood pressure. At 12:05 a.m. staff notified the Program nurse of decreased blood pressure. Staff was to push fluids and give a nebulizer treatment.

Service notes of 4-4-12 indicated the Program nurse charted Tenant #3 continued to decline, had increased shortness of breath, weight fluctuations and had increased care needs. Tenant #3 was admitted to hospice with a diagnosis of Congestive Heart Failure (CHF). Functional, cognitive and health evaluations were completed and indicated Tenant #3 needed staff assistance with dressing, bathing and medication management, including nebulizer treatments.

On 4-16-12, Tenant #3 called for assistance. Staff found Tenant #3 sitting on the floor and reported he/she slipped on the floor while trying to use the bathroom. A nurse review of the same date indicated no injuries and no change to function, health and cognition. On 4-17-12 Tenant #3 reported he/she was "afraid to fall again" and wanted to transfer from lying down to a seated position. Staff noted Tenant #3 was using strength of both arms to push the upper body up and was unable to sit up easily and Tenant #3's buttocks was too close to the edge of the bed.

Service notes of 5-3-12 indicated staff was to notify the hospice nurse if Tenant #3 had a two-pound weight gain in a day and to give a prn diuretic and repeat the dose the following day. On 5-23-12 staff noted an increase in weight and a prn diuretic was given. Tenant #3 was assisted by wheelchair by staff, and complained of shortness of breath. A nurse review of 5-24-12 indicated Tenant #3 had right lower extremity 2+ pitting edema and 3+ pitting edema to the left lower extremity. Hospice was contacted and a diuretic was increased to 60mg daily for 10 days and then increase the diuretic to 80 mg daily. Additional medications, including Gabapentin 100mg was to be given twice daily for seven days, then increased to 200 mg twice daily.

Service notes of 6-2-12 indicated Tenant #3 had a six pound weight gain overnight. The Program nurse and hospice nurse were notified. On 6-7-12, at 6:30 p.m., Tenant #3 complained of chest pain, with pain starting in the left shoulder and continued to the heart area. The pain spanned across the upper and lower abdominal region. Staff administered nitroglycerin. Service notes of the same date but at 9:45 p.m. indicated a second dose of nitroglycerin was given due to continued chest pain. Staff contacted the hospice nurse and was instructed to give another nitroglycerin if pain persisted. Tenant #3 reported the pain "comes and goes, but it hurts when its here." Staff contacted the hospice nurse and staff was instructed to increase oxygen to 4L/min/NC. The hospice nurse came to the Program to check on Tenant #3.

Service notes of 6-10-12 indicated Tenant #3 had an eight-pound weight gain between 6-8-12 through 6-10-12. Hospice was notified and a prn diuretic was given. On 6-22-12, the Program nurse noted Tenant #3 had a two-pound weight gain. A prn diuretic was given as ordered by the hospice nurse.

Service notes of 2-18-12 through 4-3-12 indicated Tenant #3's functional and health status changed. Tenant #3 experienced dizziness, fatigue, weight gain, pitting edema to both legs, a hospitalization and a decrease in the ability to ambulate and transfer independently. Functional, cognitive and health evaluations were not done timely and with a change in health status.

Functional, cognitive and health evaluations were completed on 4-4-12, when Tenant #3 was admitted to hospice and indicated Tenant #3 was independent with ambulation and transfer and needed assistance with bathing and dressing. Service notes of 4-17-12 through 6-22-12 indicated Tenant #3's functional and health status changed. Tenant #3 had continuous weight gain, complained of shortness of breath, was afraid of falling, had increased bilateral edema to both legs and had chest pain radiating from arm to chest which was unresolved by nitroglycerin medication. The evaluations did not reflect Tenant #3's current functional and health status.

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 services 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 Plan

Monitoring Observation: Tenant #1's service notes of 5-27-12 through 6-11-12, as cited above, indicated a change in health status and need for additional services related to personal and health-related cares. Service plans of 4-30-12, 5-30-12 and 6-11-12 were not updated when a change in health status occurred and did not establish interventions related to falls, auditory and visual hallucinations and a new diagnosis of positional vertigo, a UTI and antibiotic therapy. Service plans were not updated to reflect the Tenant #1's identified needs.

Tenant #2's service notes of 4-19-12 through 6-15-12 identified a change in health status and the need to establish interventions related to a diagnosis of a UTI, Left Leg Cellulitis which progressed to Bilateral Leg Cellulitis, ATB therapy, Weight gain, Shortness of Breath, needing assistance with transfers and suspected falls. The service plan of 9-9-11 was not updated to reflect Tenant #2's identified needs.

Tenant #3's service notes of 2-18-12 through 4-3-12 indicated a change in Tenant #3's health status and the need to provide additional personal and health related cares. Tenant #3 experienced dizziness, fatigue, weight gain, pitting edema to both legs, a decrease in the ability to ambulate and transfer independently. The service plan of 2-1-12 wasn't updated to reflect Tenant #3's identified needs.

A service plan was updated on 4-4-12, when Tenant #3 was admitted to hospice and indicated Tenant #3 was independent with ambulation and transfer and needed assistance with bathing and dressing. Service notes of 4-17-12 through 6-22-12 indicated Tenant #3's functional and health status changed. Tenant #3 had continuous weight gain, complained of shortness of breath, was afraid of falling, and had increased bilateral edema to both legs and chest pain radiating from arm to chest which was unresolved by nitroglycerin medication. The service plan of 4-4-12 wasn't updated to reflect Tenant #3's identified needs.

Tenant #4, an 80 year old, was admitted on 10-1-07 and had diagnoses of: COPD, Asthma CHF, Diabetes Mellitus, HTN and Constipation. A Global Deterioration Scale completed on 6-6-12 staged Tenant #4 at three, which indicated mild cognitive decline. Staff #1 was interviewed and reported Tenant #4 asked Staff #1 if he/she could "rub it." Staff #1 understood what Tenant #4 wanted was to rub Staff #1 in a sexual manner. Tenant #4 has also asked Staff #1 to sit and watch pornographic movies with him/her.

Staff RN #2 was interviewed and reported staff have come to her and reported Tenant #4 made sexually inappropriate remarks to staff. Tenant #4 has been known to watch pornographic movies when staff entered his/her apartment. The program did not establish interventions related to Tenant #4's behavior.

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))

Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum, a). the tenant's identified needs and preferences for assistance. (IAC r.481-69.26(4))

C. Medications

Monitoring Observation: A monitor observed Staff #1 administer medications to three tenants. During the course of administering medications Staff #1 documented she had given medications to Tenant #4 before she administered Tenant #4's medications. Staff #1 applied a topical ointment to Tenant #5. Staff #1 sanitized her hands before applying gloves, applied the topical ointment to Tenant #5, then removed the gloves and left Tenant #5's apartment without washing or sanitizing her hands. Staff #1 assisted a tenant who was leaving the Program and then sanitized her hands. Staff #1 did not administer medications to an applied standard of medication administration.

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))

D. Nurse Review

Monitoring Observation: Tenant #1's service notes of 5-27-12 through 6-11-12, as cited above, identified a significant change in Tenant #1's condition. Tenant #1 sustained injuries from falls, had auditory and visual hallucinations, a new diagnosis of positional vertigo, a UTI and antibiotic therapy. A nurse review was completed on 5-3-12 and 6-12-12, but indicated no change to Tenant #1's health status. The program did not consistently assess and document the health status of the tenant.

Tenant #2's service notes of 4-19-12 through 6-15-12, as cited above, identified a significant change in Tenant #2 condition. Tenant #2 had a diagnosis of a UTI, Left Leg Cellulitis which progressed to Bilateral Leg Cellulitis, ATB therapy, Weight gain, Shortness of Breath, needing assistance with transfers and suspected falls. Nurse reviews was completed on 4-26-12, 5-15-12, 5-22-12 and 6-8-12, but indicated no change to Tenant #2's health status. The program did not consistently assess and document the health status of the tenant.

Tenant #3's service notes of 2-18-12 through 4-3-12, as cited above, identified a significant change in Tenant #3's condition. Tenant #3 experienced dizziness, fatigue, weight gain, pitting edema to both legs, a decrease in the ability to ambulate and transfer independently. A nurse review was done on 2-28-12, 3-26-12 and 4-16-12, but the program did not consistently assess and document the health status of the tenant.

The program completed quarterly functional, cognitive and health evaluations as part of their 90-nurse review. Tenant #3 and #4 had either medication dosage changes or new medications were ordered as cited above. A review of Tenant #3's and #4's 90 day nurse review did not include a review of medications prescribed during the last 90-day period.

Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. 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 assess and document the health status of each tenant, to make recommendations at leave every 90-days and whenever there are changes in the tenant's health status.
(IAC r.481-69.27(2))

E. Staffing

Monitoring Observation: Six staff files were reviewed. No issues were found Staff #3, #4 and the Program nurse. A Registered Nurse (RN) #1 was hired 12-8-10 and left on 5-7-12. Registered Nurse (RN) #2 was hired on 5-7-12. Staff #2, a universal worker, was hired 12-11-08, Staff #5, a universal worker was hired 3-23-11 and Staff #6 was hired 12-14-10. A review of Staff #2, #5 and #6's indicated they had not been trained by either RN #1 or RN #2 on personal and health related cares and Staff #2, #5 and #6 did not demonstrate their competency to perform personal and health related to cares to RN #1 or RN #2.

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)