IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

AMENDED DEMAND LETTER
CERTIFIED
Complaint Intake #: 39911-C
39952-I

October 30, 2012

Ms. Kit Steiber, Administrator
Prairie Hills at Des Moines
2680 East Payton Avenue
Des Moines, IA 50320

RE: I. Final Complaint/Incident Investigation Report
II. Civil Penalty
III. Sanctions – Conditional Operation
IV. Appeals/Hearings
V. Conclusion

Dear Ms. Steiber:

I. Final Complaint/Incident Investigation Report – Prairie Hills at Des Moines, Des Moines, 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: Nurse Review, Evaluation, Service Plans, Tenant Rights, Medications and Staffing.

Prairie Hills at Des Moines ("Program") is being assessed a $7,000 civil penalty pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC 67.12(3)(a)(1)(2). The Program failed to comply with regulatory requirements which have been cited previously by the Department. The non-compliance resulted in imminent danger or a substantial probability of resultant death or physical harm to a tenant.

The Program's continued failure (or refusal) to comply with regulatory requirements within the prescribed time frame established has a direct relationship to the health, safety, or security of tenants. Program failed to meet the needs of the tenants. A tenant was left on the floor for

over 5 hours, pain medication was not available for a tenant, staff were not fully delegated, on-call staff were not available, and nurse review, service plans and evaluations were not completed with significant changes in tenants' condition.

II. Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order in the amount of four thousand five hundred and fifty dollars ($4550) within 30 business days after the receipt of this demand letter.

III. Sanctions

Due to the Program's noncompliance and current Regulatory Insufficiencies, the Program has been issued a Conditional Certificate effective August 14, 2012. Sanctions include: No new admissions and proof of nurse delegation completed within 30 days for all new staff until such time as the restriction and/or Conditional Certificate is lifted by the Department. Proof of nurse delegation completed within 30 days for all staff to be submitted to the Department.

IV. Appeals

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.

V. Conclusion

The Program is being assessed a $7,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on August 20, 2012, has been reviewed and will constitute the final POC related to the on-site visit of July 30, 31 and August 6, 2012. The Request for Reconsideration has been denied. A nurse review was not completed in a timely fashion for a tenant who was not receiving pain medication as ordered.

Due to the Program's noncompliance and current Regulatory Insufficiencies, the Program has been issued a Conditional Certificate effective August 14, 2012. Sanctions include: No new admissions and proof of nurse delegation completed within 30 days for all new staff until such time as the restriction and/or Conditional Certificate is lifted by the Department. Proof of nurse delegation completed within 30 days for all staff to be submitted to the Department.

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:

Prairie Hills at Des Moines
Kit Steiber, Administrator
2680 East Payton Ave.
Des Moines, IA 50320

Complaint/Incident Intake #:

39911-C
39952-I

Date of Complaint/Incident Investigation:

July 30, 31 and August 6, 2012

Monitor(s):
Ann Martin, RN
Rose Bocella, MA
Maribeth Freland, RN
Joyce Kix, RN

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

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

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

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

Current Program Census

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

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	37
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	46
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	54

Program History – – The program received a regulatory insufficiency in the area of Record Checks during the Sept. 14, 2011 Recertification on-site. During the Complaint Investigation (#36136-C) of Oct. 5, 2011, the program received regulatory insufficiencies in the areas of Staffing and Food service. During the December 12-15, 2011 Complaint Investigation (36937-C, 37112-A), the program received regulatory insufficiencies in the areas of: Tenant Rights, Medications, Staffing and Service Plan. The program received regulatory insufficiencies in the areas of : Tenant Rights, Evaluations, Medications, Service Plan and Staffing during the Complaint Investigation (937367-C) of January 5 and 6, 2012. The program received a regulatory insufficiency in the area of medications during the Feb. 17, 2012 Complaint Investigation (37904-C). During the Complaint Investigation (38113-C, 37367-CR) of March 20 & 21, 2012, the program received regulatory insufficiencies in the areas of: Medications, Evaluation and Service Plan.

Complaint/Incident Investigation – The Complaint/Incident investigators made the observations detailed in the following areas:

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

A. Nurse Review

- Monitoring Observation: Tenant #1, an 86 year old, was admitted to the general population on 5-26-10 with diagnoses of: Depression, Dementia, Anxiety Disorder, Coronary Artery Disease, Diabetes, Hypertension (HTN), and Hyperlipidemia. The service plan of 7-10-12 documented the tenant required staff assistance with laying

out clothing, bathing and medication administration. Tenant #1 was independent with ambulation, transfers, eating, and toileting. Tenant #1 scored 5 on the Global Deterioration Scale (GDS) completed 7-10-12 which indicated moderately severe cognitive decline. The clinical record contained incident reports documenting Tenant #1 either fell or was found on the floor on 5-6-12, 6-1, 7 and 12-12, and 7-10-12. During interview, Staff #4, #5, #6, #8, reported that it took two people to get Tenant #1 up from the floor. The clinical record lacked evidence of a nurse review completed for a change in condition including falls which would require two people to assist to transfer. After the monitors identified the need, the RN completed a nurse review for a significant change in condition.

Tenant #5, an 82 year old, was admitted to the general population on 1-13-12 with diagnoses of: Dementia, Depression with Anxiety, HTN, Coronary Artery Disease, Osteoarthritis and Osteoporosis with Chronic Pain. The nurse's note of 6-5-12 documented Tenant #5 fell and reported pain in the lower back and bilateral hips. The Medication Administration Record (MAR) documented a physician's order 6-8-12 for Lidoderm (medication for pain) 5% patch. Apply topically in the a.m. and remove in p.m. The MAR documented the patch had not been applied from 7-7 through 8-6-12 due to unavailability. A facsimile to the physician dated 7-11-12 advised the physician that the patch had not been applied since 7-7-12 because the pharmacy had not delivered it because they were waiting for prior authorization from the physician for insurance purposes. The pharmacist replied that the request for authorization had been sent to the physician on 7-11-12 at 9:14 a.m. The clinical record contained no other documentation of communication with the physician until 8-6-12 when the registered nurse placed a call to the physician. The clinical record contained a nurse review dated 8-2-12 which failed to address Tenant #5's pain level and the continued unavailability of the pain patch. The nurse failed to identify and complete a nurse review to evaluate the unavailability and necessity of the pain medication.

- Regulatory Insufficiency: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions and referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r. 481-69.27 (1))

B. Evaluation

- Monitoring Observation: The service plan for Tenant #1, dated 7-10-12, documented the tenant required staff assistance with laying out clothing, bathing and medication administration. Tenant #1 was independent with ambulation, transfers, eating, and toileting. Tenant #1 scored 5 on the Global Deterioration Scale (GDS), completed 7-10-12, which indicated moderately severe cognitive decline. The clinical record contained incident reports documenting Tenant #1 either fell or was found on the floor on 5-6-12, 6-1, 7 and 12-12, and 7-10-12. During interview, Staff #4, #5, #6,

#8, reported that it took two people to get Tenant #1 up from the floor. Tenant #1 had been issued a 30-day notice for involuntary discharge on 7-26-12 stating that Tenant #1 exceeded the level of care for assisted living. The clinical record lacked evidence of completion of health, cognitive or functional evaluations to determine that change in level of care. During interview, the Manager, Registered Nurse (RN) and Licensed Practical Nurse (LPN) stated that the current service plan was not adequate to care for Tenant #1 and evaluations should have been completed. After the monitors identified the need, the RN completed evaluations which identified a change in condition with resistance to cares and difficulty finding his/her apartment and an increase in the score of the GDS to 6 (severe cognitive decline).

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall 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 with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

C. Service Plans

- Monitoring Observation: The service plan for Tenant #1, dated 7-10-12, documented the tenant required staff assistance with laying out clothing, bathing and medication administration. Tenant #1 was independent with ambulation, transfers, eating, and toileting. Tenant #1 scored 5 on the Global Deterioration Scale (GDS) completed 7-10-12 which indicated moderately severe cognitive decline. The clinical record contained incident reports documenting Tenant #1 either fell or was found on the floor on 5-6-12, 6-1, 7 and 12-12, and 7-10-12. During interview, Staff #4, #5, #6, #8, reported that it took two people to get Tenant #1 up from the floor. The service plan did not identify interventions for falls or instructions to transfer Tenant #1 after a fall. During interview, the Manager, RN and LPN stated that the current service plan was not adequate to care for Tenant #1 and evaluations should have been completed with service plan up-dates. After the monitors identified the need on the RN completed a new service plan which included interventions for resistance to cares.

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

D. Tenant Rights

- Monitoring Observation: The service plan for Tenant #1, dated 7-10-12, documented the tenant required staff assistance with laying out clothing, bathing and medication administration. Tenant #1 was independent with ambulation, transfers, eating, and toileting. Tenant #1 scored 5 on the GDS completed 7-10-12 which indicated

moderately severe cognitive decline. The clinical record contained incident reports documenting Tenant #1 either fell or was found on the floor on 5-6-12, 6-1, 7 and 12-12, and 7-10-12. The incident report dated 7-10-12 indicated Tenant #1 was found on the floor at 12:30 am. While attempting to assist Tenant #1 off of the floor, the staff member reported an injury which disabled her from assisting Tenant #1 back to bed. During interview, Staff #4, certified nursing assistant (CNA), Staff #5, universal worker (UW), Staff #6, CNA, Staff #8, UW, reported that it took two people to get Tenant #1 up from the floor. The program reported that normal staffing for the night shift included one person in general population and one person in the memory care unit. Per interview with multiple staff members and the Manager, the staff member in the memory care unit was not allowed to leave unless a replacement was present. Staff #6 called the RN and was told to call other staff members from other shifts to come in to help. Staff #6 reportedly made Tenant #1 a nest on the floor with pillows and a blanket. Because Staff #6 could not find anyone to come in and help, she called the RN back again. During interview on 7-31-12 the RN said she told Staff #6 to call 911; however, the RN had provided a written statement dated 7-10-12 which documented the RN asked Staff #6 if an ambulance needed to be called and was told by Staff #6 that Tenant #1 was not in distress. The statement indicated the RN told Staff #6 to summon the ambulance should Tenant #1 exhibit any distress. The written document stated that the RN told Staff #6 to have the memory care staff member help with the transfer but Staff #6 told her that Staff #8 could not lift Tenant #1 off of the floor by herself. The RN did not call back to ascertain the resolution of the incident and the result was Tenant #1 laid on the floor from 12:30 a.m. to approximately 6:00 a.m. when day staff arrived at the program and assisted the tenant off of the floor with two staff members.

- Regulatory Insufficiency: All tenants have the following rights: To receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

E. Medications

- Monitoring Observation: The following medication errors and/or discrepancies in documentation were identified:

  1. The Medication Administration Record (MAR) for Tenant #7 included an order for Furosemide (a diuretic) 30 milligrams (mg) if weight increases by three to five pounds and to notify the nurse before giving. Documentation of weight indicated a weight of 105 on 7-16-12 and 112 on 7-23-12 or a weight gain of seven pounds. The MAR lacked documentation that Tenant #7 received the medication on 7-23-12. The Nurse's Notes lacked documentation of communication with the nurse regarding the increase in weight.
  2. The MAR for Tenant #8 included an order for Furosemide 40 mg is weight is 115 or more. The MAR indicated Tenant #8's weight as 115 on 7-6 and 7-13-12. The MAR lacked documentation that the medication was administered on either day.
  3. The MAR for Tenant #5 documented an order for Lidoderm (a pain medication) 5% patch topically every day. The MAR documented the medication was not applied from 7-7-12 through 8-6-12 due to unavailability. A facsimile to the physician dated 7-11-12 advised the physician that the patch had not been applied

since 7-7-12 because the pharmacy had not delivered since they were waiting for prior authorization from the physician for insurance purposes. The pharmacist replied that the request for authorization had been sent to the physician on 7-11-12 at 9:14 a.m. The clinical record contained no other documentation of communication with the physician until 8-6-12 when the registered nurse placed a call to the physician. The medication had not been applied to Tenant #5 for 31 days.

4. The MAR for Tenant #9 documented an order for Furosemide 40 mg daily for weight above 150. The MAR documented Tenant #9's weight as 154 on 7-1-12. The MAR lacked documentation that the medication was administered.

- Regulatory Insufficiency: The administration of medications shall be provided by a registered nurse, a licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6) a.)

F. Staffing

Complaint/Incident Allegation: 39952-I The program reported a staff member was unable to assist a tenant off the floor when the tenant fell and failed to contact other staff members for assistance.
39911-C It was alleged that an on-call staff member was under the influence and/or unavailable and unable to attend to responsibilities when called on.
39911-C It was alleged staff members were unable to reach the on-call nurse, the Director of Nursing and the Manager when a tenant became ill during the night, requiring transport to the emergency room for medical evaluation.

- Monitoring Observation: During interview, RN reported all staff members were instructed to call the nurse on-call with all tenant falls, tenant health concerns, medication questions and procedural questions.

  On 6-22-12 Staff #16, CNA, did not report for duty as scheduled, leaving only one direct care worker for the 10:00 p.m. to 6:00 a.m. shift. Staff #12, UW, and Staff #15, CNA, worked on the evening shift with a planned ending to the shift at 10:00 PM. Upon discovering Staff #16 had not come to work, Staff #12 attempted to contact the RN to report the scheduling concern. Staff #12 called the RN multiple times with no answer. At approximately 10:30 p.m., Tenant #3 was observed to be short of breath and with bluish colored lips. Tenant #3's pulse oxygen level was 78 percent on room air and had a blood pressure of 199/100. According to interview, Staff #12 and Staff #15 reported the LPN was on call on the night of 6-22-12. Both Staff #12 and Staff #15 reported making multiple attempts to call the LPN. After receiving no return call from the LPN, both staff members attempted to call the RN multiple times without making contact. After receiving no return call from the RN, both staff members attempted to call the Manager of the program without successfully making contact. At approximately 11:00 p.m. Staff #12 was able to contact the Staff #1, the administrative assistant, (who had no medical training.) According to interview, Staff #1 told Staff #12 and Staff #15 to call 911 for transport of Tenant #3 to the emergency room for medical evaluation. Staff #1 voluntarily

came into the program to assist the staff members with Tenant #3's transfer paperwork and the scheduling issues previously noted. Staff #1 indicated she also attempted to contact the LPN, the RN and the Manager while at the program with no immediate answers or response. Staff #1 went back home at approximately 1:00 a.m. on 6-23-12. The LPN returned the administrative assistant's telephone call at approximately 2:00 a.m. The Manager called back at approximately 5:00 a.m. and the RN returned the administrative assistant's call later in the afternoon of 6-23-12. The tenant required hospitalization and was eventually transferred to a higher level of care without returning to the program.

The LPN reported her cellular phone battery died without her knowledge during the night; therefore, she did not receive any calls prior to 2:00 a.m. when she looked at her phone and discovered the dead battery. The Manager reported she was sleeping and did not hear her phone ringing. The RN reported she had taken a sleeping pill and gone to bed, not waking to hear the phone.

On 7-10-12 at approximately 12:30 a.m. Staff #6, CNA, found Tenant #1 lying on his/her apartment floor. The aide did not identify any apparent injury and then attempted to assist Tenant #1 off of the floor. During the process, Staff #6 injured herself and was unable to further assist Tenant #1 off of the floor. Staff #8, UW, was the only other staff member working in the program at the time of the fall. Staff #8 refused to assist Tenant #1 off of the floor without assistance of another staff member and Staff #6 could not help. At 1:51 a.m. Staff #6 called the RN, who was on-call for the night, and reported the situation. The RN instructed Staff #6 to make Tenant #1 comfortable with pillows and blankets and try to locate another staff member via telephone to come into the program to assist Tenant #1 off of the floor. Staff #6 attempted to reach other staff members, finding no one. At approximately 2:50 a.m., Staff #6 again called the RN, and reported she was unable to find another staff member to assist; therefore, Tenant #1 remained on the floor. Tenant #1 did not report pain and appeared comfortable. The RN told Staff #6 to have Staff #8 do the laundry and Staff #6 should curl up on the couch and wait for the morning staff members to arrive, leaving Tenant #1 on the floor.

During interview, Staff #4, CNA, Staff #5, UW, Staff #6, CNA, Staff #8, UW, reported that it routinely took two people to get Tenant #1 up from the floor. Tenant #1 had a history of five falls between 6-6-12 and 7-10-12. Four of the falls occurred on the night shift. The program reported the normal staffing for the night shift included one person in general population and one person in the memory care unit. Multiple direct care staff members and the Manager reported the staff person in the memory care unit was not allowed to leave unless a replacement was present. The program regularly scheduled only one staff person in the general population at night when at least one tenant required two persons to assist with a transfer after a fall.

The program failed to ensure adequate staffing was available to meet the identified needs of the tenants. The direct care workers followed the program identified chain of command when changes in tenant health issues and/or falls were found; however, the LPN, RN and Manager were not available or did not respond to the reports.

On Friday 7-13-12, Staff #12, UW, Staff #13, UW and Staff #15, CNA, were working in the general population on the 2 to 10 shift. Staff #10, UW, was working in the

memory care unit. At about 9:45 p.m. Staff #8 came in to work the night shift and said she was replacing another staff member who was on the schedule. Staff #12, #13 and #15 realized that the schedule was wrong and there was only one person coming for the night shift. The program reported that minimum staffing for the program on night shift is two people- one person in general population and one in memory care. Program policy voiced by the Administrator and multiple staff directed the staff person in the memory care unit could not leave the unit unattended at any time. Staff #12, Staff #13 and Staff #15 called the RN five times and the RN advised them to handle it themselves by calling in other staff or else stay themselves. They were advised if they did not stay it would be considered abandonment. They called four or five people and could not find anyone to come in until 1:30 a.m. when Staff #5 could come. Staff #10 also called the RN and she indicated that the lack of staffing was their problem and the RN would not come in to rectify the situation or fill the position. Staff #10 reported that she felt the conversations were not threatening or screaming but several staff as well and the RN hung up on each other. The RN did not go to the program to assure enough staff was present to care for the tenants adequately.

The RN was on call the week of 7-23-12. Staff #10 reported that on 7-28-12 she tried to call the RN five to six times regarding a staffing issue and got no answer. Staff #10 called the LPN who then gave instructions. The LPN reported she received nine calls prior to 11:30 p.m. on 7-28-12. The RN reported she had not realized she was on-call therefore had missed six calls from employees of the program prior to 11:30 p.m. at which time she was made aware that she was on-call. Between 11:30 p.m. and 7:47 a.m. the RN received 14 telephone calls to discuss scheduling issues. The RN reported staff members were arguing about who could leave early. The RN did not go to the program to attempt to get the situation under control.

Staff members were required to find their own replacement but had no way of knowing if the staff member replacing them had been delegated in all essential tasks. The program reported that five of the current staff members had not been delegated to pass medications and other staff members were still in orientation at the time of the on-site visit. On two separate occasions, staff members had scheduling issues and were requesting the assistance of the RN in solving the problem. The RN failed to assist in the resolution of the problem on both occasions.

The monitors interviewed the delegating RN, who reported she understood she should observe all tasks being demonstrated by each direct care worker before she signs the delegation papers allowing each staff member to perform the task independently. The RN was hired by the program on 5-1-12 and was responsible for the delegating of new staff members and re-delegation of prior staff members.

The monitors reviewed multiple direct care staff personnel files for documentation of delegation and performed interviews as applicable, finding the following:

Staff #3, CNA, had a hire date of 5-9-12. Staff #3's personnel file contained documentation of the RN's delegation of personal care tasks and medication administration. During interview, Staff #3 reported the RN did not watch her perform any tasks prior to having her sign the program's documentation of delegation. Staff

#3 currently provides independent care of program tenants. During interview, the RN reported Staff #3 was correct in her report of how delegation occurred.

Staff #4, CNA, had a hire date of 2-14-11. Staff #4 reported that during re-delegation, the RN did not watch her demonstrate medication administration. Staff #4 reported the RN brought delegation papers to her and had her sign the papers as if delegated.

Staff #6, CNA, had a hire date of 5-8-12. Staff #6 had not worked in a program setting for greater than one year. Staff #6's personnel file contained documentation of the RN's delegation of personal care tasks and medication administration. During interview, Staff #6 reported she watched films and then the RN brought a stack of delegation papers to her to sign. The RN did not watch her demonstrate medication administration or any other task. Staff #6 stated that the first time she was assigned to work in the general population for the 10:00 p.m. to 6:00 a.m. shift, she was not aware of where the tenant's medications were stored until a tenant told her that medications were kept in the apartment and the aide had the key. Staff #6 performed independent care of program tenants following the signing of the delegation documents until her termination from employment on 7-25-12.

Staff #10, CNA, had a hire date of 3-29-12. Staff #10 reported that during re-delegation, the RN did not watch her demonstrate medication administration. Staff #4 reported the RN brought delegation papers to her and had her sign the papers as if delegated, as long as she felt comfortable with the task.

Staff #11, UW, had a hire date of 5-30-12. Staff #11 reported she shadowed other direct care workers for four days, learning to care for tenants and then was informed she could perform tasks independently. The RN did not observe return demonstration of personal care tasks. The RN verbally reviewed how to administer medications but did not observe Staff #11 actually administering the medications. Staff #11 reported she attempted to administer medications alone on the first night assigned; however, she had questions and needed to seek assistance from the RN. Then, at that time, the RN would have observed her administering the medications.

The RN did not routinely observe return demonstration of personal care tasks and medication administration during delegation and re-delegation of staff members prior to allowing the staff members to care for program tenants independently.

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

During the investigation, the following information was identified:

G. Other

- Monitoring Observation: During interview, Staff #12 and Staff #15 alleged the program terminated the employment of each without just cause and reported a belief that the termination was a direct result from reporting grievances with the program RN to the Department of Inspections and Appeals. Staff #12, UW, Staff #13, UW, and Staff #15, CNA, worked in the general population on the 2 to 10 shift on Friday

7-13-12. Staff #10 was working in the memory care unit. At about 9:45 p.m. Staff #8 came in to work the night shift and said she was replacing another staff member who was on the schedule. Staff #12, #13 and #15 realized that the schedule was wrong and there was only one person coming in for the night shift. The program reported that minimum staffing for the program on night shift is two people- one person in general population and one in memory care. Staff #12, #13 and #15 called the RN multiple times and was advised to handle it themselves by calling in other staff or else stay themselves. They were advised if they did not stay it would be considered abandonment. They called four or five people and could not find anyone to come in until 1:30 a.m. when Staff #5 could come. Staff #10 also called the RN and was told that the lack of staffing was their problem and the RN would not come in to rectify the situation or fill the position. Staff #10 reported that she felt the conversations were not threatening or screaming but several staff as well and the RN hung up on each other.

On 7-15-12 an e-mail was sent to the owner of the program and the Manager to express the concerns over the RN not helping with the staffing situation. Staff #12, #13 and #15 signed the e-mail. On 7-16-12 at 9:00 a.m. the Manager, the RN and the LPN discussed the e-mail.

On 7-16-12 at 1:00 p.m. Staff #12, #13 and #15 came to the program to discuss concerns with the Manager. Staff #10 reported she did not attend the meeting as this was her scheduled day off. Staff #15 reported that the Administrator directly asked if they had turned in a complaint to DIA and Staff #12 said "yes". Staff #12 and #13 confirmed this. The Manager reported she did not ask if the employees had sent the email to DIA but reported that she had assumed the e-mail had been sent to the DIA because the staff members involved had a history of calling the state with concerns. Following the 7-16-12 meeting, the Manager talked with the RN, telling her of the plan to meet at 1:00 p.m. on 7-17-12. The Manager said "the RN stated they may call the state but I want to let them go".

The Manager reported that they were all decent employees and she had told them she was not going to fire them. The three staff members continued to be upset but did not want to confront the RN at that time. A meeting was set up for the 7-17-12 at 1:00 p.m. to talk with the RN. Even though all three staff were scheduled to work the 2 to 10 shift that day they went home because they were upset.

On 7-17-12 at about 10:30 a.m., the RN called Staff #12 and terminated her with the reason, "Not a good fit". Directly after that the RN called Staff #15 and left a message to call her. Staff #15 returned the call and was terminated by the RN with the reason, "Not a good fit". Staff #13 was going to be terminated for the same reason but called and quit before the RN fired her.

On 7-17-12 sometime before 11:18 a.m., the Manager called DIA and advised that they were going to fire some employees and they felt the employees would call in a complaint.

On 7-17-12 at 1:00 p.m., Staff #10 came to the program for the meeting with the RN. Staff #10 reported she had already received calls from Staff #12 and Staff #15 telling her they had been fired so she came to work with the full expectation that she would

also be terminated as she was involved on the night of 7-13-12 when the discord with the RN initiated. She was advised by the RN that she was not being fired because her name was not on the e-mail that was sent to the owner and the Administrator.

Review of the personnel files for Staff #10, #12, #13 and #15 revealed no evidence of insubordination or discipline during their employment. All four employees reported receiving no verbal discipline during their employment.

According to the program policy, titled Employee Grievances and Suggestions, all employees may report concerns with the program or express grievances without discrimination against or toward anyone for his or her part in presenting the grievances or suggestions.

According to the program policy, titled Staff Evaluations, employees would receive three month evaluations only if deemed necessary. During interview, the Manager reported she does all nursing staff members evaluations. She does not routinely perform three month evaluations unless there is a concern with the employee. The Manager reported she did not complete any three month evaluations for Staff #10, #12, #13 or #15 as they did not exhibit performance concerns.

- Regulatory Insufficiency: None noted.