IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint/Incident Intake #: 40267-C

November 20, 2012

Christina Bricker, Administrator
Summit Pointe Senior Living
3505 English Glen Avenue
Marion, IA 52632

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

Dear Ms. Bricker:

I. Final Recertification Monitoring Evaluation & Complaint/Incident Investigation Report – Summit Pointe Senior Living (Program), Marion, IA

Enclosed is the **Final Recertification Monitoring Evaluation & 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) chapter 481—67 and 481—69. The Report notes the Regulatory Insufficiencies in the area(s) of: Food Service, Staffing, Tenant Rights, Program Reporting to Department and Transportation.

Summit Pointe Senior Living is being assessed a $5,000 civil penalty pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1). The Program failed to comply with regulatory requirements. The non-compliance resulted in imminent danger or a substantial probability of resultant death or physical harm to a tenant. Program failed to train

staff appropriately regarding preparing a therapeutic diet and failed to assure a tenant received a therapeutic diet. A tenant did not receive emergent care as needed prior to his/her death. The RN did not summon emergency services as described by the Program's policy.

DIA is accepting the Plan of Correction (POC) following the Program's submission of information. DIA is denying the Request for Reconsideration in reference to Food Service. The Dietician was not involved in any aspect of the situation. Oversight was inadequate. DIA is denying the Request for Reconsideration in reference to Staffing . It is correct that the RN does not require delegation; however, multiple staff were not delegated appropriately. There was no oversight by the Dietician. DIA is denying the Request for Reconsideration in reference to Tenant Rights. The tenant did not receive emergent care as needed. The RN did not summon emergency services per program policy and tenant's family. DIA is denying the Request for Reconsideration in reference to Program Reporting to Department. The program should have reported at the time of the accident. It wasn't determined until later that the tenant died of natural causes.

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 **Rose Boccella** and remit the penalty assessed by check or money order to the State of Iowa in the amount of three thousand two hundred and fifty dollars($3,250) 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 **S0248** with effective dates of **December 15, 2012** through **December 14, 2014**.

V. Conclusion

The Program is being assessed a $5.000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The POC submitted on October 31, 2012, has been reviewed and will constitute the final POC related to the on-site visit of October 2 and 3, 2012. DIA is denying the program's Requests for Reconsideration in reference to Food Service, Staffing, Tenant Rights and Program Reporting to Department.

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. Rose Boccella, at 515/281-7039 or **Rose.Boccella@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:

Christina Bricker, Administrator
Summit Pointe Senior Living
3505 English Glen Ave.
Marion, Iowa 52632

Complaint/Incident Intake #:

40267-C

Date of Complaint/Incident Investigation:

October 2 and 3, 2012

Monitor(s):

Maribeth Freland RN
Joyce Kix RN

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

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

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

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

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	94
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	101

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	12
Total Population of Program at time of on-site	13
TOTAL census of Assisted Living Program	114

Program History – The program had no regulatory insufficiencies this certification period.

Tenant/Family Satisfaction Results – A community meeting was held with 28 tenants in attendance. The tenants reported general satisfaction with the program. They reported respectful staff interaction and timely response to calls made using emergency pendants. The tenants reported the food served by the program was palatable and the provision of scheduled activities plentiful. They reported the program's environment to be clean and safe, acknowledging they would recommend the program to others.

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

A. Food Service

- Monitoring Observation: During the on-site visit, the program reported no tenants received a physician ordered therapeutic diet. During interview, Staff #1, certified nursing assistant (CNA), reported Tenant #4, a tenant who had previously resided in the program's secured memory care unit, was fed a pureed diet with honey thickened liquids. Staff #1 reported Tenant #4 aspirated while being fed an ice cream/thickened milk mixture by Staff #2, registered nurse (RN) and died.

  Tenant #4, a 95 year old, was admitted to the program on 2-14-08 with diagnoses of: Hypertension, Anxiety, Paranoia, Dementia and History of Pneumonia. Tenant #4 had a history of swallowing difficulties resulting in aspiration. Tenant #4 scored a 6 on the Global Deterioration Scale, completed on 7-17-12, indicating severe cognitive decline. Tenant #4 resided in the secured memory care unit until his/her death on 7-20-12. Tenant #4's service plan indicated the RN determined Tenant #4 to be at risk of choking on 3-1-09. On 8-2-10, the RN determined Tenant #4 required frequent

staff member cuing to eat slowly and supervision during meals to monitor for increased coughing and choking with direction to notify the RN if Tenant #4 was unable to stop choking. On 12-16-09, the registered nurse included the following instructions to help prevent choking to Tenant #4's service plan: tuck chin when swallowing, small sips of liquid with no straw or continuous cup drinking, frequent dry swallows, small bite, sit up at 90 degrees for all oral intake and supervision at all times when eating. The interventions as stated above continued to remain on the 6-27-12 service plan.

Tenant #4's clinical record contained multiple physician orders changing Tenant #4's diet, beginning with a pureed diet order on 12-12-09, which continued until his/her death on 7-20-12. The most current physician order, dated 1-13-12, ordered liquids to be thickened to a honey consistency (honey-thickened liquids), which continued until Tenant #4's death on 7-20-12.

During review of the program's menus, the monitors noted no menu written for a pureed diet with changes in liquid consistency. During interview with Staff #3, Chef, the program had never had a specified menu for Tenant #4. Staff #3 reported the program's consulting dietician had never written and approved a therapeutic menu or reviewed any procedures for food preparation and service for therapeutic diets. Staff #3 reported purchasing pre-formed pureed products and pre-thickened liquids from a licensed vendor to be served to Tenant #4. Staff #3 indicated other items, such as desserts and fruit slurries were prepared at the program to supplement the purchased items.

During interview with the program's consulting dietician, she reported having no knowledge that Tenant #4 had been on a therapeutic diet of pureed with honey-thickened liquids. The dietician indicated that menu planning for Tenant #4 would have required review of Tenant #4's height, weight and co-morbidities to determine a nutritionally sound menu.

- Regulatory Insufficiency: Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician assistant, or advanced registered nurse practitioner. A current copy of the Iowa Simplified Diet Manual published by the Iowa Dietetic Association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing the procedures for food preparation and service for therapeutic diets. (IAC r. 481-69.28(4))

B. Staffing

- Monitoring Observation: Tenant #4's service plan indicated the RN determined Tenant #4 to be at risk of choking on 3-1-09. On 8-2-10, the RN determined Tenant #4 required frequent staff member cuing to eat slowly and supervision during meals to monitor for increased coughing and choking with direction to notify the RN if Tenant #4 was unable to stop choking. On 12-16-09, the registered nurse included the following instructions to help prevent choking to Tenant #4's service plan: tuck chin when swallowing, small sips of liquid with no straw or continuous cup drinking,

frequent dry swallows, small bites, sit up at 90 degrees for all oral intake and supervision at all times when eating. The interventions as stated above continued to remain on the 6-27-12 service plan.

Tenant #4's clinical record contained multiple physician orders changing Tenant #4's diet, beginning with a pureed diet order on 12-12-09, which continued until his/her death on 7-20-12. The most current physician order, dated 1-13-12, ordered liquids to be thickened to a honey consistency (honey-thickened liquids), which continued until Tenant #4's death on 7-20-12. The clinical record also contained a physician's order, dated 3-28-11, allowing Tenant #4 to have ice cream per his/her request. With subsequent diet order changes, the service plan was not clear whether the ice cream consumption could be continued. (On 10-3-12 the program obtained a letter from Tenant #4's physician which indicated the physician did not believe the continuation of ice cream would have had a significant impact on Tenant #4's health.)

Staff #3, the Chef, reported the program had never had a specific menu for Tenant #4. Staff #3 reported the program's consulting dietician had never written and approved a therapeutic menu or reviewed any procedures for food preparation and service for therapeutic diets. Staff #3 reported purchasing pre-formed pureed products and pre-thickened liquids from a licensed vendor to be served to Tenant #4. Staff #3 indicated other items, such as desserts and fruit slurries were prepared at the program to supplement the purchased items. Staff #3 indicated ice cream and applesauce would not be appropriate consistency for a honey thickened liquid diet. Staff #3 reported he stored bulk containers of applesauce and pudding in the memory care unit; however, he reported these were not to be used for Tenant #4. Staff #3 indicated individual servings of frozen ice cream were stored in the memory care unit but were not to be used for Tenant #4.

The consulting dietician reported having no knowledge that Tenant #4 had been on a therapeutic diet of pureed with honey thickened liquids. The dietician indicated that menu planning for Tenant #4 would have required review of Tenant #4's height, weight and co-morbidities to determine a nutritionally sound menu. The dietician indicated ice cream and applesauce would not be appropriate consistency for a honey thickened liquid diet. She indicated ice cream melted to quickly once in the mouth, which would have made the consistency too thin for Tenant #4.

Staff #1, #4, #5, #6 and #7, reported staff members had a pump bottle of liquid thickener in the memory care unit to use to thicken items when pre-thickened liquids were not available. Staff members also reported supplementing the pre-formed pureed meals with dessert items which they soaked with pre-thickened milk product. The staff members would mix the items up with a fork once softened.

Staff #1, CNA, reported, at times, she supplemented Tenant #4's meals sent from the kitchen with applesauce and pudding. Staff #1 reported she had never served Tenant #4 ice cream; however, she had seen other staff members serve Tenant #4 soft serve ice cream. Staff #1 reported Tenant #4 fed him/herself most of the time but required staff member assistance with feeding at times. Tenant #4 required one half teaspoon sized bites and needed to eat slowly. Tenant #4 often had coughing spells during meals.

Staff #4, CNA, reported, at times, she supplemented Tenant #4's meals sent from the kitchen with pudding and gelatin kept on the unit in bulk. Staff #4 reported she never fed Tenant #4 ice cream but had observed other staff serving it to Tenant #4. Staff #4 reported Tenant #4 would feed him/herself most of the time with occasional requirement for staff assistance. Tenant #4 would attempt to take "huge bite" so he often had to be reminded to take a smaller bites.

Staff #5, CNA, reported, at times she supplemented Tenant #4's meals sent from the kitchen with applesauce and pudding kept on the unit in bulk. Staff #5 reported Tenant #4 used to eat ice cream but soft serve ice cream was too runny. Staff #5 no longer gave ice cream to Tenant #4. Staff #5 reported over the few weeks prior to Tenant #4's death, Tenant #4 required staff members to feed a few bites of each meal before Tenant #4 would take over feeding him/herself. Tenant #4 had coughing episodes often when drinking continuously but never saw coughing or choking with the pureed items.

Staff #6, CNA, reported she would moisten desserts, such as cake and cookies, with Tenant #4's pre-thickened milk product and mix with a fork. Staff #6 reported having no specific instructions on how to make the dessert items into the appropriate pureed consistency but based this on observation of the other items sent from the kitchen. Staff #6 reported Tenant #4 would generally feed him/herself but occasionally required staff member assistance.

Staff #7, CNA, reported he would moisten desserts, such as cake and cookies, with Tenant #4's pre-thickened milk product and mix with a fork. Staff #7 reported Tenant #4 would generally feed him/herself but occasionally required staff member assistance. Staff #7 reported he never fed Tenant #4 ice cream but did observe others giving ice cream on a non-routine basis.

The program had written documentation of a Staff Communication Log, dated 1-13-12, with written instructions on how much of the liquid thickener to add to a small and a large glass of liquid; however, the program did not maintain any documentation of RN delegation following a return demonstration by each direct care worker documenting each staff members' competency with the thickening of Tenant #4's liquids or how to puree food items to make them the appropriate consistency for Tenant #4.

The program did not obtain direction from its consulting dietician on which foods would be the appropriate consistency for Tenant #4. Staff members served Tenant #4 different items to supplement Tenant #4's meals sent from the kitchen without having permission to do so. Some staff members were altering the consistency of dessert items served on the general diet without having knowledge of the proper consistency required. The monitors found no documentation of RN delegation in the above stated staff members' personnel files showing competency with creating a pureed food item or thickening liquid items to the appropriate consistency when using the liquid pump thickener.

- 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))

C. Tenant Rights

Complaint/Incident Allegation: It was alleged a staff member fed a tenant too quickly, causing the tenant to aspirate. The tenant had respiratory difficulty and staff members did not follow up appropriately, resulting in death of the tenant.

- Monitoring Observation: During the on-site visit, the program reported no tenants received a physician ordered therapeutic diet. During interview, Staff #1, CNA, reported Tenant #4, a tenant who had previously resided in the program's secured memory care unit, was fed a pureed diet with honey thickened liquids. Staff #1 reported Tenant #4 aspirated while being fed ice cream by Staff #2, RN and died.

  Tenant #4's service plan indicated the RN determined Tenant #4 to be at risk of choking on 3-1-09. On 8-2-10, the RN determined Tenant #4 required frequent staff member cuing to eat slowly and supervision during meals to monitor for increased coughing and choking with direction to notify the RN if Tenant #4 was unable to stop choking. On 12-16-09, the registered nurse included the following instructions to help prevent choking to Tenant #4's service plan: tuck chin when swallowing, small sips of liquid with no straw or continuous cup drinking, frequent dry swallows, small bites, sit up at 90 degrees for all oral intake and supervision at all times when eating. The interventions continued to remain on the 6-27-12 service plan.

  The 6-27-12 service plan indicated Tenant #4 was able to ambulate with stand by assistance and a gait belt or if weak, to use a wheelchair.

  Tenant #4's clinical record contained multiple physician orders changing Tenant #4's diet, beginning with a pureed diet order on 12-12-09, which continued until his/her death on 7-20-12. The most current physician order, dated 1-13-12, ordered liquids to be thickened to a honey consistency, which continued until Tenant #4's death on 7-20-12. The clinical record also contained a physician's order, dated 3-28-11, allowing Tenant #4 to have ice cream per his/her request. With subsequent diet order changes, the service plan was not clear whether the ice cream consumption could be continued.

  During interview with Staff #3, Chef, the program had never had a specified menu for Tenant #4. Staff #3 reported the program's consulting dietician had never written and approved a therapeutic menu or reviewed any procedures for food preparation and service for therapeutic diets. Staff #3 reported purchasing pre-formed pureed products and pre-thickened liquids from a licensed vendor to be served to Tenant #4. Staff #3 indicated other items, such as desserts and fruit slurries were prepared at the program to supplement the purchased items. Staff #3 indicated ice cream and applesauce would not be appropriate consistency for a honey thickened liquid diet. Staff #3 reported he stored bulk containers of applesauce and pudding in the memory care unit; however, he reported these were not to be used for Tenant #4. Staff #3 indicated individual servings of frozen ice cream were stored in the memory care unit but were not to be used for Tenant #4.

  During interview with the program's consulting dietician, she reported having no knowledge that Tenant #4 had been on a therapeutic diet of pureed with honey thickened liquids. The dietician indicated that menu planning for Tenant #4 would

have required review of Tenant #4's height, weight and co-morbidities to determine a nutritionally sound menu. The dietician indicated ice cream and applesauce would not be appropriate consistency for a honey thickened liquid diet. She indicated ice cream melted to quickly once in the mouth, making the consistency too thin for Tenant #4.

During interview multiple direct care staff members, Staff #1, #4, #5, #6 and #7, reported staff members had a pump bottle of liquid thickener in the memory care unit to use to thicken items when pre-thickened liquids were not available. Staff members also reported supplementing the pre-formed pureed meals with dessert items which they soaked with pre-thickened milk product. The staff members would mix the items up with a fork once softened.

According to a Physician's Progress Report, dated 8-10-10, Tenant #4's family members completed an Iowa Physician's Order for Scope of Treatment. Tenant #4's family reported Tenant #4 had always been clear that he/she would not have wanted to have cardiopulmonary resuscitation or mechanical ventilation with endotracheal intubation; however, Tenant #4 was accepting of receiving non-invasive ventilatory support and unit transfer if necessary. The family made the choice to have no feeding tube initiation and would be accepting of interventions that may return Tenant #4 to the hospital. The family understood that the situation may eventually change in such a way to make comfort care focus more appropriate but, for the time being, chose to remain with the above stated interventions. The program did not present the monitors with any changes in the family's choices for the Scope of Treatment.

According to an incident report, dated 7-20-12 and completed by Staff #2, RN. Tenant #4 experienced respiratory difficulties after finishing the noon meal. Tenant #4 continued to experience respiratory difficulties, resulting in Tenant #4's death.

During interview, Staff #2 reported she mixed up an eight ounce glass that was two thirds full of honey thickened milk with two spoons of soft serve ice cream mixed in and fed Tenant #4 two to three spoonfuls on 7-20-12 at 1:45 p.m. Tenant #4 began to cough, sounded raspy and expectorated a small amount of thick phlegm. The RN stopped feeding Tenant #4 and reported believing the episode would subside on its own. The RN reported she thought Tenant #4 was cold, so she moved the tenant's wheelchair away from the window. The RN left Tenant #4 where he/she was seated and went to her office to answer a phone call. Tenant #4 was supervised by Staff #8, licensed practical nurse (LPN) and a resident assistant. She reported this took approximately eight to ten minutes. When the RN returned to the area, she noted Tenant #4 was in the medication room with the LPN. Tenant #4 was receiving a nebulizer treatment. Tenant #4's skin color "looked better" although the RN did not report what she was comparing Tenant #4's skin color to. The RN noted audible expiratory wheezing. The RN reported at approximately 2:00 p.m. she and the LPN took Tenant #4 to his/her room and placed Tenant #4 into bed with the head of the bed elevated. The RN reported the LPN left the room and the RN stayed at Tenant #4's bedside for ten minutes. The RN reported leaving Tenant #4's room after ten minutes and returned every five minutes to check on Tenant #4. The RN reported making the five minute checks two to three times, with the last check revealing Tenant #4 rested quietly with continued audible expiratory wheezing. The RN

indicated she followed up in the manner as described above as Tenant #4 was DNR and had requested no hospitalizations.

The program administration conducted an internal investigation on 7-23-12. Staff #2, RN, reported on 7-20-12 at 1:40 p.m., Tenant #4 had been slipping down in his/her wheelchair multiple times during lunch. Staff members repositioned Tenant #4 and encouraged him/her to cough. The RN reported she heard Tenant #4 having audible expiratory wheezing. She went to Tenant #4's side, noting Tenant #4 as having eyes open with pale, warm and dry skin and audible expiratory wheezing. Tenant #4 expectorated a small amount of thick phlegm. The RN reported she told the LPN and resident assistant to monitor Tenant #4 and keep him/her upright in the wheelchair. The RN reported the LPN gave Tenant #4 a nebulizer treatment in the medication room. At this time, the RN noted Tenant #4's eyes were closed and the audible expiratory wheezing had lessened. The RN reported she and the LPN took Tenant #4 to his/her room at 1:45 p.m. and placed Tenant #4 in bed with the head of bed elevated. The RN reported she stayed in the room until 2:05 p.m. then checked on Tenant #4 every five minutes until she entered the room at 2:20 p.m. with the Health Services Director and found Tenant #4 without respirations. The original written statement did not indicate the RN had been feeding Tenant #4, as described in her interview with monitors, prior to Tenant #4's respiratory difficulties.

The program administration clarified details with Staff #2 during the internal investigation noting the additional information: The RN clarified she had been feeding Tenant #4 a half full glass of thickened soft serve ice cream prior to Tenant #4's respiratory difficulties; she fed two spoonfuls which took approximately one to one and a half minutes with the second bite causing Tenant #4 to cough and Tenant #4 began shaking his/her head "no"; she stopped feeding Tenant #4 and moved him/her away from the air conditioner; and she clarified Tenant #4 did not bear any weight when assisted to bed by herself and the LPN and Tenant #4's eyes remained closed.

After review of the program's internal investigation of the incident involving Tenant #4 and interviews conducted with staff members involved, the monitors noted the following information:

a. Staff #6, CNA, reported she worked in the memory care unit on 7-20-12 dayshift float position. Staff #6 served the lunch meal to Tenant #4 at approximately 12:30 p.m. The meal consisted of pre-formed pureed items sent from the kitchen but did not include dessert. At around 1:00 p.m., she noted Tenant #4 ate all of the pureed items and a piece of cake that had been soaked in thickened milk and stirred up. Staff #6 reported Tenant #4 did not have any trouble swallowing and had no coughing during the meal. At 1:15 p.m. Staff #6 noted Staff #2, RN, was feeding Tenant #4 ice cream from an eight ounce glass that appeared to be full. Staff #6 told the RN that Tenant #4 had just finished eating a whole meal with dessert at lunch 15 minutes prior. The RN replied "he deserves a treat too." Staff #6 observed Staff #2 feed the entire glass of ice cream to Tenant #4 in less than ten minutes, which Staff #6 believed was much too quickly. Within a few minutes, at approximately 1:30 p.m. the RN yelled for help. Staff #6 responded, noting Tenant #4 had vomited approximately one half cup of white ice cream like material onto a clothing protector. Staff #6 noticed the fluid coming out of Tenant #4's nose and noticed a loud gurgling in the back of the tenant's throat.

Tenant #4 appeared to be trying to take breaths in and Staff #6 heard a rattling noise when Tenant #4 breathed in. The RN said "get rid of the evidence" so Staff #6 took the empty glass and soiled clothing protector away. When returning to the table, the RN said Tenant #4 "will be okay". Staff #6 went to a nearby table to work on charting when she looked up and noted Tenant #4 struggling to breathe. She immediately responded, moving the wheelchair closer to where she was sitting. She asked for help from Staff #1 who observed the situation and noted the LPN in the medication room so Staff #1 yelled for help from the LPN. The LPN told the staff to take Tenant #4 to the medication room and sent Staff #1 to obtain the nebulizer machine from Tenant #4's room. Staff #6 yelled for Staff #2, the RN, to come as she had gone back to her office in the memory care unit. The RN and LPN assessed Tenant #4 in the medication room. Staff #6 heard someone say "his color doesn't look right". The RN told the LPN to attempt to sweep out Tenant #4's mouth and the LPN complied. Staff #6 began caring for other tenants and left work at shift end at 2:00 p.m. noting Tenant #4, the LPN and the RN were still in the medication room.

b. Staff #8, LPN, reported on 7-20-12 early afternoon was in the memory care unit medication room completing filing. Staff #1, CNA, summoned her reporting Tenant #4 was "not doing well". Staff #8 noted Tenant #4 coughing, having difficulty breathing and noted rapid wheezing and gurgling noises. The LPN attempted to pat Tenant #4 on the back and chest unsuccessfully. Tenant #4 was not responding verbally. Staff #1 took Tenant #4 to the medication room and the LPN began administering a nebulizer treatment. The LPN sent Staff #1 to get Staff #2, RN. The RN could not get Tenant #4 to respond but said "don't worry, will be okay. Color is coming back." The LPN did not document noting Tenant #4's color to be improving. The LPN noted a rapid pulse rate and reported this to the RN who indicated this was normal. The LPN donned a glove and attempted to sweep Tenant #4's mouth out, with nothing removed. Staff #8 attempted to sweep the mouth with a sponge swab, getting very little mucus removed. Tenant #4's eyes were closed and Tenant #4 became very limp. The LPN asked the RN if 911 should be called and the RN replied "No he will come out of it." The RN left the medication room and went back to her office, saying Tenant #4 would be fine. The LPN remained with Tenant #4 in the medication room. She attempted to obtain a blood pressure reading but was unable to obtain a reading. After the nebulizer treatment was complete, the RN returned to the medication room. Tenant #4 was leaning in the wheelchair. The RN directed the LPN to take Tenant #4 to his/her room to lie down. The RN and LPN struggled to get Tenant #4 into bed as Tenant #4 could not bear weight, remained limp and eyes closed. After getting Tenant #4 into bed and in a comfortable position with the head of the bed elevated, the LPN left the room while the RN remained in the room with Tenant #4. The LPN immediately left the memory care unit and went to the receptionist's desk to seek out the Health Services Director. At 2:15 p.m., after locating the Health Services Director, the LPN went to care for another tenant at the direction of the Director and the Director went to the memory care unit. The LPN reported feeling uncomfortable with the situation.

c. On 7-20-12 at 2:15 p.m., the Health Services Director was approached by Staff #8, LPN, who appeared to be frantic. The LPN reported Tenant #4 was having problems after being fed ice cream by Staff #2, RN. Tenant #4 began coughing, gurgling and vomiting. The LPN did not believe Tenant #4 was getting enough air exchange. The Health Services Director arrived in the unit, noting Staff #2,

RN, was in her office. The Health Services Director was joined by Staff #2. On the way down the hall, Staff #2 told the Health Services Director that Tenant #4 had aspirated on some ice cream and vomited. Staff #2 indicated Tenant #4 had been given a nebulizer treatment and had "perked up a little." Both arrived at Tenant #4's room together at 2:20 p.m. noting Tenant #2 lying in bed with the head of the bed elevated. Tenant #4's skin color was ashen and was no longer breathing. The Health Services Director called 911. The police department and fire department paramedics were summoned to respond at 2:22 p.m. Both departments were on scene at 2:26 p.m.

According to the fire department paramedic's report, dated 7-20-12, the responders arrived at 2:26 p.m. to be met by program employees outside waving to the door that should be entered. The attending nurse advised the paramedics that Tenant #4 had a Do Not Resuscitate order. The paramedics assessed Tenant #4 to have no pulse and no respirations. Tenant #4's skin was pale, warm and dry. They noted Tenant #4 was dressed in a shirt, pants and socks and lying in a supine (lying on the back) position on the bed. Tenant #4's shirt front at the sternum region was wet. The nurse (Staff #2) reported she had been with Tenant #4 for the past hour. Tenant #4 had been eating when the nurse heard him gasp for air and she believed he had aspirated. The nurse reported Tenant #4 had not complained of anything prior to the incident. At 2:30 p.m. the medical examiner pronounced Tenant #4 deceased.

The program's policy, titled Resident Conditions and When to Call, directed staff members to notify the RN with coughing involving food or fluids and to call 911 and the family with any cough involving severe breathing problems.

Staff #6's, Staff #8's and the Health Services Director's recollection of events corroborated each others' reports. The monitors noted discrepancies between Staff #2's written statement, interview and response to the emergency paramedics. The monitors determined Staff #2, RN, was feeding Tenant #4 a snack when Tenant #4 had just completed eating a full meal with dessert approximately fifteen to thirty minutes prior. The RN reported adding a small amount of ice cream to a glass of honey thickened milk, which would have changed the consistency of the mixture to be thinner than honey thickened. According to staff member reports, the RN fed the entire glass of ice cream/milk mixture when Tenant #4 began to vomit with some fluid coming out of the tenant's nose. Tenant #4 began coughing and having difficulty breathing. The RN did not summon emergency services as described by the program's policy and per Tenant #4's family instruction. Instead, the RN took Tenant #4 to his/her room and left Tenant #4 unsupervised for an undetermined amount of time. Fifteen to twenty minutes later, Tenant #4 was found deceased. Tenant #4 did not receive emergent care as needed.

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

D. Program Reporting to the Department

- Monitoring Observation: On 7-20-12, Tenant #4, a tenant who had a history of swallowing difficulties resulting in a requirement for use of a pureed diet with honey thickened liquids, exhibited coughing, choking and respiratory difficulties after being fed a diluted ice cream/pre-thickened milk mixture by staff. Tenant #4 did not respond to staff attempts to open his/her airway. The program completed an incident report, dated 7-20-12, documenting Tenant #4's breathing difficulties. Tenant #4 subsequently died. The program did not report the incident resulting in death to the Department of Inspections and Appeals as required by regulation.

- 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 of any accident causing major injury resulting in (1) death; or (2) admission to a higher level of care for treatment; or (3) requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the tenant, and the tenant's prognosis. (IAC r. 481-67.4(1)a.(1)(2)(3))

E. Transportation

- Monitoring Observation: The program administration reported the program provided transportation to tenants. One of the vehicles used for transportation was a sports utility vehicle. The Administrator indicated the program used the five passenger seat vehicle for activities, physician appointments and individual tenant shopping trips. The Administrator reported Staff #9, #10 and #11 transported tenants in the sports utility vehicle while in paid status.

  Staff #9, the program marketer, drove the van when tenant transportation was required. Staff #9's driver license indicated she had been issued a Class C driver license by the State of Iowa, indicating approval to drive a non-commercial vehicle. The State of Iowa requires persons to have a class D (Chauffeur's) driver's license with endorsement 3, allowing non-commercial use of a vehicle when transporting less than 16 passengers for hire.

  Staff #10, an activity assistant, drove the van when tenant transportation was required. Staff #10's driver license indicated she had been issued a Class C driver license by the State of Iowa, indicating approval to drive a non-commercial vehicle. The State of Iowa requires persons to have a class D (Chauffeur's) driver's license with endorsement 3, allowing non-commercial use of a vehicle when transporting less than 16 passengers for hire.

  Staff #11, an activity assistant, drove the van when tenant transportation was required. Staff #11's driver license indicated she had been issued a Class C driver license by the State of Iowa, indicating approval to drive a non-commercial vehicle. The State of Iowa requires persons to have a class D (Chauffeur's) driver's license with endorsement 3, allowing non-commercial use of a vehicle when transporting less than 16 passengers for hire.

- Regulatory Insufficiency: When transportation services are provided directly or under contract with the program, the driver shall have a valid and appropriate driver's license or commercial driver's license as required by law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated. (IAC r. 481-69.33(6))