IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED

Complaint Intake #: 41630-C

January 23, 2013

Mr. Darin Severson, Administrator
Linnwood Estates
700 North Linn
Glenwood, IA 51534

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

Dear Mr. Severson:

I. Final Complaint/Incident Investigation Report – Linnwood Estates, Glenwood, 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: Staffing, Evaluation, Tenant Documents, Service Plan, Nurse Review, Transportation, Policies and Procedures, Dependent Adult Abuse Training, Managed Risk and Compliance with POC.

Linnwood Estates is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program's continued failure (or refusal) to comply with regulatory requirements within the prescribed time frame established has a direct relationship in the health, safety, or security of tenants. Program failed to complete dependent adult abuse training as required.

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 **Jim Berkley** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of three hundred twenty five dollars ($325) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

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

IV. Conclusion

The Program is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on January 22, 2013, has been reviewed and will constitute the final POC related to the on-site visit of December 5 & 6, 2012.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Jim Berkley, at 515/281-4116.

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:

Darin Severson, Administrator
Linnwood Estates
700 North Linn
Glenwood, IA 51534

Complaint/Incident Intake #: 41630-C

Date of Complaint/Incident Investigation:

December 5th and 6th, 2012

Monitor(s):

Lori Miner, RN BSN

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:	20
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	21
TOTAL census of Assisted Living Program	21

Program History – There were regulatory insufficiencies cited in the area of Other (Dependent Adult Abuse Training) during this recertification period

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

A. Staffing

Complaint/Incident Allegation: It was alleged a registered nurse (RN) only works a few hours a week at the program and is not on-call consistently.

- Monitoring Observation: The current RN was hired 8-20-12. The program also employs a licensed practical nurse (LPN) as Director of Nursing (DON). In an interview with the program RN, she stated she had another full-time job and came to the program in the evening. Staff members have contacted her after work hours. In an interview with the LPN, she stated staff members called her and she would contact the RN. The LPN stated an RN was also available from the nearby nursing facility. In an interview with the Administrator he stated the RN was hired with the understanding of an on-call status and an RN was available from the nearby nursing facility

  During interview, Staff #3 stated she had access to the phone numbers for the LPN and RN to call if needed. Staff #3, #6, #7 stated a nurse was available and had no issues with the availability of the RN.

  Handwritten nurse's notes for Tenant #1 dated 8-10-12 revealed a nurse from the nearby nursing facility attended to Tenant #1's catheter.

  The program employed an LPN, an RN, and had the availability of an RN from the nearby nursing facility.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged the RN had not completed nurse-delegated training.

- Monitoring Observation: The current RN employed at the program was hired 8-20-12. Staff #1 Certified Nursing Assistant (CNA) was hired 1-17-11. Staff #2 CNA was hired 8-23-10. Staff #3 Personal Care Attendant was hired 4-12-10. Staff #4 CNA was hired 8-3-05. Staff #5 Medication Manager was hired 2-25-10. Staff training records lacked documentation of the delegation of personal and health cares, catheter care, and medication administration by the current program RN or LPN.

  Staff #3 was interviewed and stated training for bathing, dressing, grooming and support stockings was completed by the previous DON.

  Staff #6 was interviewed and stated she provided assistance with bathing, dressing, toileting, catheter care, support stockings and medications. Staff #6 stated she had not received training from either the current LPN or RN.

  Staff #7 stated she administered medications, assisted with support stockings and catheter, and provided personal cares. Staff #7 stated she had not received training from either the current LPN or RN.

  A review of Tenant #1's file revealed staff members had done a daily dressing change to a supra-pubic catheter site 11-14-12 through 11-18-12. Staff training records lacked documentation of delegation of the dressing change.

  The LPN and RN were interviewed and stated nurse-delegated training had not been completed.

  Nurse's notes written by staff members including Staff #1, #3, and #4, and dated 8-11-12 through 11-29-12 contained several entries by the unlicensed staff which indicated the unlicensed staff found Tenant #1 had " no adverse reactions" to antibiotics, an assessment, as well documentation that unlicensed staff were "monitoring" Tenant #1's condition. It is not within the scope of practice of an unlicensed staff member to perform assessments.

  Nurse-delegated training was not completed. Assessments were completed by unlicensed staff members.

- 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))

- Regulatory Insufficiency: Any nursing services shall be provided in accordance with Iowa Code chapter 152 and 655—Chapter 6. (IAC r. 481-67.9(5))

B. Evaluation

Complaint/Incident Allegation: It was alleged evaluations were not completed with change of condition. It was alleged evaluations for change of condition were not completed by a registered nurse.

While reviewing clinical records, the following regulations were considered: After the initial evaluation is completed by a healthcare or human service professional, an LPN can complete an evaluation when the tenant has not exhibited significant change. (IAC r. 481-69.22(1,2))

During review, clinical records contained computerized documentation from the LPN and handwritten nurse's notes containing documentation completed mostly by unlicensed staff members with an occasional handwritten note by the RN. Documentation reflected the writer's involvement with a tenant at the time of the occurrence.

- Monitoring Observation: Tenant #1, an 84 year-old, was admitted on 2-10-12 and had diagnoses of: Hypothyroidism, Hyperlipidemia, Anxiety, Depression, Hypertension (HTN), Esophageal Reflux, Osteoarthrosis, and Neurogenic Bladder. A physician progress note dated 9-24-12 documented Tenant #1 had an indwelling Foley catheter and was leaking around the catheter. A home health nurse changed the Foley catheter. Tenant #1 was having bladder spasms. Tenant #1 was reported to be considering the placement of a supra-pubic catheter. On 10-16-12 an order was received for an antibiotic for a urinary infection. On 11-6-12 Tenant #1 saw a physician to prepare for placement of a supra-pubic catheter. An antibiotic was ordered for 10 days. On 11-12-12 Tenant #1 went through an outpatient procedure for the insertion of a supra-pubic catheter. Tenant #1 returned to the program with orders for daily dressing changes around the supra-pubic site, activity restrictions, and signs to report to the physician. The discharge instruction sheet indicated Tenant #1 received anesthesia for the procedure. Staff documentation in the nurse's notes dated 11-16-12 revealed Tenant #1 was dizzy and did not feel well. On 11-17-12 staff documented Tenant #1 had a temperature of 100.1 degrees and wasn't feeling well. On 11-21-12 staff documented Tenant #1 complained of bloating and slight pain in the abdomen. Progress notes written by the LPN on 11-21-12 documented Tenant #1 had seen the physician for suture removal at the supra-pubic catheter site.

  The clinical record for Tenant #1 contained documentation of functional and health evaluations on 5-8-12. The clinical record lacked evaluations after return to the program following placement of a supra-pubic catheter on 11-12-12 which resulted in daily dressing changes. The clinical record lacked documentation of the condition of the surgical site, how the supra-pubic catheter was functioning, whether or not Tenant #1 had any reportable signs, and Tenant #1's functional ability following activity restrictions. Evaluations of function, cognition, and health were not completed with a change of condition.

  Tenant #2, an 85 year-old, was admitted on 8-7-12 and had diagnoses of: Late –Effect Intracranial Injury, Esophageal Reflux, HTN, Alzheimer's Disease, Atrial Fibrillation, and Diabetes. A legal representative for Tenant #2 signed the occupancy agreement on 8-7-12. Nurse's notes dated 8-7-12 signed by an RN from the nursing facility revealed Tenant #2 was admitted on 8-7-12. The cognitive screening tool dated 8-10-12 was not signed, so it was not clear who completed the evaluation. The cognitive screening tool was not completed prior to Tenant #2's admission to the program. Tenant #2 had eight errors on the cognitive screening tool which indicated severe intellectual function.

A completed functional and health form was in the clinical record, but the form was not dated, so it was unclear that the form was completed prior to admission. The clinical record lacked documentation of a functional, cognitive, and health evaluation completed within 30 days of admission.

Tenant #2 was admitted to the program on 8-7-12 from an acute rehabilitation program. On 5-2-12, Tenant #2 underwent a procedure for placement of a subdural drain after a fall which resulted in an acute subdural hematoma with mass effect and midline shift. The transfer sheet from acute rehab indicated Tenant #2 was at risk for falls. An incident report dated 8-31-12 documented Tenant #2 stood up from the lunch table, lost balance, fell backwards onto the floor and bumped his/her head. Tenant #2 was transferred to the hospital for evaluation. The LPN stated Tenant #2 had a big knot on the back of the head. Tenant #2 returned to the program on the same date with instructions for home care following a concussion. Discharge instructions indicated Tenant #2 was to be observed for 24 hours for signs of neurological change. The discharge instructions were not noted by the LPN until 9-4-12 this was four days after return to the program. There was no documentation of assessment for neurological change. An RN did not evaluate Tenant #2 upon return to the program following a fall, which resulted in a concussion. Evaluations were not completed with a change in condition.

An undated functional assessment indicated Tenant #2 required cues to perform activities of daily living (ADLs). A handwritten nurse's note completed by unlicensed staff dated 8-9-12 indicated Tenant #2 was started on a bowel and bladder program. The functional assessment dated 9-12-12 indicated Tenant #2 required total assistance with bathing and hygiene, and minor assistance such as cues for toileting. Handwritten nurse's notes by unlicensed staff members dated 9-6-12 through 10-10-12 revealed decline in Tenant #2's physical functioning. Tenant #2 displayed frequent incontinence requiring staff assistance. Nurse's notes dated 9-17-12 stated Tenant #2 required "total assistance" with morning care. Nurse's notes dated 10-10-12 stated Tenant #2 was a total assist with all ADLs. Evaluations were not completed with a change of condition.

Tenant #3, an 81 year-old, was admitted on 12-30-12 and had diagnoses of: Glaucoma, Hyperplasia of the Prostate, Dementia, and Parkinson's Disease. Functional, cognitive, and health evaluations were completed on 7-25-12 for a change of condition, a gradual increase in confusion. Tenant #3 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive decline. The GDS form did not indicate which statements best described Tenant #3, only the number three was circled. Tenant #3 had physician's orders dated 9-26-12 for physical therapy (PT) for balance and gait training, and speech therapy (ST) to strengthen a weak voice. At the time of the onsite visit, documentation of PT and ST visits and completion of therapies was not part of the clinical record. The LPN contacted PT and ST during the onsite visit to obtain documentation to be included as part of the clinical record. ST was completed on 10-22-12 and PT on 11-5-12. The PT discharge summary indicated Tenant #3 did not meet established goals. Due to fall risk and shuffle gait, assist of one for ambulation was recommended as well as cues for safe transfers and mobility throughout the apartment.

A functional evaluation completed 9-18-12 indicated Tenant #3 was not reliable with mobility, but did not specify staff assist or the use of a walker. Evaluations were not completed following the completion of PT and ST to determine Tenant #3's ability to ambulate safely.

Handwritten nurse's notes 8-6-12 to 12-5-12 completed by unlicensed staff detailed Tenant #3 was unable to turn self over in bed, was incontinent of urine and did not know what to do next, was repeatedly asking "what do I do now?" and required step-by-step cueing for toileting. Several entries documented Tenant #3 required total assistance with ADLs. Documentation in the nurse's notes indicated decline in cognitive ability and a decline in functional ability since the 9-18-12 functional assessment. Evaluations were not completed with a change of condition.

Tenant #4, an 88 year-old, was admitted on 12-17-10 and had diagnoses of: Hyperlipidemia, HTN, and Vincent's Angina. Tenant #4 was staged at two on the GDS, dated 12-5-11, which indicated very mild cognitive decline. An incident report dated 8-3-12 indicated Tenant #4 was found on the floor after tripping and hitting head on a nightstand. Tenant #4 had a one and one-half inch cut and bump on the head as well as a scrape on the right shoulder and cut on a finger. Tenant #4 also complained of a "stretched feeling" in the left ribs. Tenant #4 was transported to the hospital, and according to computerized nurse's notes, Tenant #4 received seven staples to the head. The clinical record lacked documentation by licensed staff until 8-8-12, which only indicated Tenant #4 sustained a fall and received staples to the head. Documentation dated 8-11-12 indicated staples were removed and the wound was well approximated. Evaluations of Tenant #4 following a head injury were not completed.

Tenant #5, a 90 year-old, was admitted on 4-26-12 and had diagnoses of: Osteoarthrosis, Senile Dementia, Urinary Incontinence, Anxiety, and Hyperlipidemia. On 3-13-12, the most recent GDS, Tenant #5 was staged at three which indicated mild cognitive decline. The GDS form did not indicate which statements best described Tenant #5, only the number three was circled. One functional assessment dated 9-17-12 by the LPN and 9-18-12 by the RN documented Tenant #5 had "heavy impairment in all areas" requiring constant reorientation, prone to wandering and unable to remember personal information. The functional assessment indicated a decline in cognitive ability. Tenant #5's GDS staging was not re-evaluated. Handwritten nurse's notes written by unlicensed staff documented the following for Tenant #5:

Date	Notation
8-7-12	Found Tenant #5 going into another tenant's room, Tenant #5 was asking what happened to spouse. The program information sheet identified Tenant #5 as a widow(er).
8-9-12	11:00 p.m. - Asking about spouse, and indicated he/she was leaving. Staff unsuccessful at redirection. Getting agitated. 11:50 p.m. – getting ready to leave, second attempt at redirection unsuccessful
8-28-12	Tenant #5 knocking on doors, asking to come in, does not know where room is.
8-30-12	Tenant #5 very agitated when staff pulled laundry for night shift

	washing because clothes were wet with urine. Tenant #5 denied incontinence. Tenant #5 paged staff, but became angry when staff arrived and grabbed staff who attempted to turn off call light. Unsuccessful at calming Tenant #5
9-1-12	Asking about spouse, agitated at staff who would not let Tenant #5 call family at 9:45 p.m.
9-3-12	Wants to leave, redirection unsuccessful
9-5-12	Wants to leave, asking about spouse, "seems to forget" what staff says "within two minutes"
9-8-12, 3:45 a.m.	Tenant #5 in commons area from 9 p.m. to midnight wanting to call family. Family does not want Tenant to have phone in evening as Tenant #5 calls continuously. Agitated about spouse.
9-8-12, 6:00 p.m.	Very angry towards other tenants and staff when another tenant was sitting in Tenant #5's usual seat for supper
9-9-12	Tenant #5 was wearing same shirt for over three days and refused to change clothes
9-28-12	Wanting to leave, attempts at redirection unsuccessful
10-5-12	At 7:30 a.m. staff attempted to enter apartment but the door was blocked with an end table and garbage can
10-24-12	Tenant #5 upset and keeps saying he/she "just wants to die"
10-27-12, 1:30 a.m.	Back and forth between common area and room four times, looking for spouse. Has been blocking door so people can't get in.
10-29-12	Tenant #5 stated he/she should just die during sleep
11-7-12	Staff went to give medications, apartment door was blocked with a chair
11-16-12	At exit door looking out, wandering
11-25-12	Tenant #5 alternating between anger and sadness

Evaluations were not completed with Tenant #5's significant change of condition.

Evaluations were not completed prior to admission, within 30 days of admission, and with significant change.

- Regulatory Insufficiency: A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. (IAC r. 481-69.22(1))

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

C. Tenant Documents

Complaint/Incident Allegation: It was alleged activities of daily living (ADLs) provided to tenants was not documented.

- Monitoring Observation: Iowa Administrative Code 481-69.25(1)(q) states when the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs).

  The program identified 21 tenants, one of which was staged at four on the GDS and would indicate cognitive decline. The program had no tenants in hospice receiving end-of-life care. While documentation of routine personal care or health-related care may be beneficial, documentation of ADL's was not required by rule in this instance.

- Regulatory Insufficiency: None noted.

During the course of the investigation the following was noted:

- Monitoring Observation: Tenant #2 was admitted to the program on 8-7-12. Tenant #2 was discharged on 10-10-12 according to the notation on list of recently discharged tenants. According to a handwritten note in the nurse's notes dated 10-10-12 and written by an unlicensed staff member, Tenant #2 was a "total assist with all ADLs this morning." The last computerized documentation by the LPN was 9-5-12. In an interview with the LPN, she stated the Administrator handled the discharge of Tenant #2. The chart lacked documentation to indicate Tenant #2 was discharged, the reason for discharge, any communication with the tenant and/or legal representative related to discharge, whether the discharge was voluntary or involuntary, and Tenant #2's place of residence after discharge. Nurse's notes were not complete.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: (i) When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception. (IAC r. 481-69.25(1)(i))

D. Service Plans

Complaint/Incident Allegation: It was alleged a tenant was at risk for falls and the tenant's needs were not being met.

- Monitoring Observation: Tenant #1's current service plan was dated 9-4-12. A functional assessment was completed on 8-31-12. Cognitive and health evaluations were not completed. The service plan was not based on evaluations.

  Tenant #1 had an indwelling Foley catheter and had services from home health as documented in the LPN's note of 10-16-12. Tenant #1 had a supra-pubic catheter placed on 11-12-12 and required daily dressing changes and activity restrictions following the procedure. The current service plan dated 9-4-12 did not indicate the services of home health, and was not updated following the placement of the supra-pubic catheter to include dressing changes, activity limitations, signs Tenant #1 would exhibit that would be reportable to the nurse, or identify staff member's responsibility in the care of the catheter and leg bag. The service plan did not meet the needs of Tenant #1. The service plan did not identify Tenant #1's preference for nursing facility care.

  Tenant #2's current service plan was dated 9-12-12. A functional assessment was completed at that time. The clinical record lacked documentation of a health or cognitive assessment. The service plan was not based on evaluations.

  Tenant #2 was admitted to the program with a history of falls and incident reports documented at least three falls while at the program. The service plan did not identify interventions to prevent falls. Tenant #2 was diabetic and the program was checking Tenant #2's blood sugar levels. The service plan did not identify Tenant #2 as diabetic and interventions related to potential hypoglycemia. The service plan did not identify the use of a walker as indicated in a PT note dated 9-20-12. The service plan did not identify a bowel and bladder program or any other interventions for incontinence. A handwritten nurse's note dated 8-29-12 by unlicensed staff indicated Tenant #2 had a rash on the buttocks and legs, with scratch marks and scabs. The service plan did not identify skin breakdown intervention in relation to incontinence. The service plan did not meet the identified needs of Tenant #2. The service plan did not indicate Tenant #2's preference for nursing facility care.

  The current service plan for Tenant #3 was dated 9-26-12 and a functional assessment was completed at that time. The functional assessment indicated Tenant #3 required completed supervision and administration of all medications. The service plan indicated staff stored and prepared medications, and Tenant #3 self-administered medications. The clinical record lacked documentation of a health or cognitive assessment. The service plan was not based on evaluations.

  Tenant #3 fell on 10-9, 10-12, and 10-27-12. Handwritten nurse's notes dated 10-28-12 documented family requested Tenant #3 use the walker all the time. PT was completed on 11-5-12 with goals unmet. PT recommended assist of one for ambulation due to fall risk and shuffle gait, and cues for safe transfers and mobility throughout the apartment.

The service plan did not identify interventions related to the history or risk of falls and the service plan did not identify the outside services of PT and ST.

Beginning 10-12-12 handwritten nurse's notes by unlicensed staff members documented Tenant #3 required total assistance intermittently with ADLs. The current service plan dated 9-26-12 indicated Tenant #3 was independent with bathing and grooming. The service plan did not meet the identified needs of Tenant #3. The service plan did not indicate Tenant #3's preference for nursing facility care.

Tenant #4 had a history of Vincent's Angina. Handwritten nurse's notes by unlicensed staff members dated 8-22 and 9-7-12 indicated Tenant #4 had chest pain and nitroglycerin was given. The service plan did not identify staff interventions for chest pain. The service plan did not meet the identified needs of Tenant #4. The current service plan was dated 10-18-12 and a functional assessment was completed at that time. The clinical record lacked documentation of a health or cognitive assessment. The service plan was not based on evaluations. The service plan did not indicate Tenant #4's preference for nursing facility care.

Tenant #5's current service plan was dated 9-24-12. One functional assessment dated 9-17-12 by the LPN and 9-18-12 by the RN was completed. The clinical record lacked documentation of a health or cognitive assessment. The service plan was not based on evaluations. Handwritten nurse's notes 8-1-12 to 11-29-12 documented several episodes of wandering, wanting to leave, paranoia as evidenced by blocking the apartment door, seeking a deceased spouse, and expressions of wanting to die. The notes documented Tenant #5 was not easily redirected. The notes also documented Tenant #5's refusal to change clothes and shower. The service plan did not identify interventions for Tenant #5's behaviors.

Handwritten nurse's notes dated 9-3, 9-16, 9-17, and 9-20-12 indicated Tenant #5 complained of a "nervous stomach" and vomiting. Tenant #5 had an "as needed" order for an anti-anxiety medication, Xanax. The service plan did not provide direction to staff as to when to administer the Xanax. Nurse's notes documented Tenant #5 was not to use the phone in the evening. The service plan did not identify interventions for phone use. A functional assessment completed 9-17-12 indicated Tenant #5 was incontinent. A task sheet dated August 2012 indicated Tenant #5 was on a two-hour bowel and bladder schedule. The service plan dated 9-24-12 indicated Tenant #5 was continent, and would not allow staff to provide cares. The service plan did not identify interventions for incontinence and was not based on the functional evaluation. The service plan did not meet identified needs of Tenant #5. The service plan did not identify Tenant #5's preference for nursing facility care.

Service plans were not based on evaluations, were not updated with change in condition, did not identify outside service providers, did not meet identified tenant needs, and did not identify tenant preference for nursing facility care.

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

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (a) The tenant's identified needs and preferences for assistance; (c) The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy; (d) For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests; and (e) Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. (IAC r. 481-69.26(4)(a,c,e))

E. Nurse Review

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

While reviewing clinical records, the following regulation was considered: An RN or LPN with supervision shall complete a nurse review at least every 90 days when a tenant receives personal or health related care, or with significant change in tenant condition. (IAC r. 481-69.27(1))

- Monitoring Observation: Tenant #1 had a neurogenic bladder and was diagnosed with a urinary tract infection. Nurse's notes written by staff members and dated 8-11-12 through 11-29-12 contained several entries by unlicensed staff which indicated the unlicensed staff found Tenant #1 had " no adverse reactions" to antibiotics, an assessment, as well documentation that unlicensed staff were "monitoring" Tenant #1's condition. Licensed staff did not complete a nurse review following antibiotic administration to determine the effectiveness of the antibiotic or any adverse reactions.

  Tenant #1 had a supra-pubic catheter placed on 11-12-12. Staff documentation in the nurse's notes dated 11-16-12 revealed Tenant #1 was dizzy and did not feel well. On 11-17-12 staff documented Tenant #1 had a temperature of 100.1 degrees and wasn't feeling well. On 11-21-12 staff documented Tenant #1 complained of bloating and slight pain in the abdomen. The clinical record lacked documentation by any nurse after Tenant #1 was reported to experience dizziness and fever four to five days postoperatively. A nurse review was not completed with a change of condition.

  Tenant #1 received personal and health care, including medication administration, from program staff members. The clinical record contained documentation of a 90-day review on 5-8-12. A functional assessment dated 8-31-12 contained a notation of "90-day." An assessment of health and a medication review was not completed on 8-31-12. The clinical record lacked documentation of a nurse review completed 90 days later, which was the end of November 2012. The clinical record lacked documentation of the discontinuation of dressing changes following the placement of the supra-pubic catheter. Physician's orders were not current. 90-day nurse reviews were not completed for Tenant #1.

Tenant #2 had an order for PT from 8-8-12 to 10-6-12. Tenant #2 fell on 8-31-12 which resulted in a concussion. Tenant #2 fell again on 9-2-12 at 9:15 a.m. When turning a corner, Tenant #2 lost balance and fell over with the walker landing on top. An incident report was completed. Handwritten nurse's notes completed by unlicensed staff dated 9-2-12 and timed 4:45 p.m. indicated Tenant #2 was weak and unstable when walking. Nurse's notes dated 9-3-12 revealed Tenant #2 thought he/she was doing well until the fall. Computerized notes completed by the LPN dated 9-5-12 revealed Tenant #2 had a swollen and bruised right hand and wrist with complaints of pain with use. Tenant #2 was seen by a physician who indicated there were no fractures. A nurse review was not completed following the fall to determine functional ability, including the ability to safely use a walker following injury. Tenant #2 was discharged from PT on 9-20-12. Not all of the PT goals were met, and Tenant #2 still needed cues to transfer safely. A nurse review was not done at the completion of PT to determine Tenant #2's functional ability. A handwritten nurse's note by unlicensed staff indicated Tenant #2 had a rash on the buttocks and legs, with scratch marks and scabs. A nurse review was not completed with a change in skin condition in a tenant who exhibited incontinence.

Tenant #3 had a 90-day review completed 6-1-12. A 90-day review was not completed after 6-1-12. The service plan dated 9-26-12 indicated Tenant #3 required staff assistance to prepare medications and Tenant #3 self-administered medications. Computerized progress notes completed by the LPN dated 9-26-12 indicated Tenant #3 had physician's orders to increase the dose of Sinemet, a Parkinson's medication. The clinical record lacked a signed physician's order for the medication increase. During the onsite visit, the LPN obtained an order for the increased Sinemet for the clinical record. A review of Tenant #3's health, medications, and current physician's orders was not completed every 90 days.

On 10-27-12, Tenant #3 lost balance and fell resulting in an abrasion to the left knee. Handwritten nurse's notes dated 10-28-12 and 10-29-12 documented a reddish discoloration near the left eye. A nurse review was not completed after the fall.

Tenant #4 had a 90-day review completed on 6-4-12. A 90-day review was not completed after 6-4-12. The service plan dated 10-18-12 indicated Tenant #4 required staff assistance with bathing, grooming, dressing and medications. Computerized notes dated 9-17-12 to 11-17-12 documented changes to the following medications: Coreg, an antihypertensive; Lasix, a diuretic, Iron; Levothyroxine, a thyroid hormone; and Vitamin B. The physician's order dated 10-9-12 that made changes to the Coreg and Lasix documented Tenant #4 had a slow heart rate and not enough perfusion. A review of Tenant #4's health, medications, and current physician's orders was not completed every 90 days.

Handwritten nurse's notes dated 9-21-12 indicated Tenant #4 complained of foot pain and did not want to walk very far. 9-23-12 notes indicated Tenant #4 had toe pain and thought something was under the toenail. Notes dated 9-23-12 at 8:00 p.m. indicated Tenant #4 was wobbly and had to grab onto a chair. Tenant #4 indicated pain in the toe. Computerized notes dated 9-26-12 indicated Tenant #4 saw a podiatrist on 9-24-12 and returned with no new orders. A nurse review was not completed after Tenant #4 complained of toe pain and exhibited a change in functional ability.

Tenant #5 had a 90-day nurse review completed on 6-12-12. 90-day reviews were not completed after 6-12-12. The service plan dated 9-24-12 indicated Tenant #5 required assistance with bathing, grooming, dressing, and medications. A review of Tenant #5's health, medications, and current physician's orders was not completed every 90 days.

An incident report dated 11-23-12 documented Tenant #5 got up from the dining room table, and fell. Tenant #5 stated a toe was stubbed, and "my knee went away." Tenant #5 was also observed to have a scrape on the right elbow and hit the right shoulder on the wall. Handwritten nurse's notes written by unlicensed staff indicated Tenant #5 complained of knee pain on 11-24-12. On 11-25-12, Tenant #5 received medication for knee pain. On 11-29-12, the LPN documented Tenant #5 was noted to be complaining of increasing right knee pain and requesting pain medication frequently with little effectiveness. A nurse review was not completed with a change of condition following a fall to determine Tenant #5's ability to ambulate independently.

A review of health, medications, and physician's orders was not completed every 90 days and with significant change for tenants receiving personal or health care from the program.

- 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 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 or 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))

- Regulatory Insufficiency: To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program. (IAC r. 481-69.27(2))

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

F. Transportation

Complaint/Incident Allegation: It was alleged the program had a van that was not outfitted for use.

- Monitoring Observation: The Director of Nursing stated the program used a van for outings. The van did not contain a first aid kit, safety triangles, or a fire extinguisher.

  The Activity Director stated she drove the van for outings in her position as Activity Director. The Activity Director had a Class C non-commercial Iowa driver's license. 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: The driver shall have a valid and appropriate Iowa 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))

- Regulatory Insufficiency: Each vehicle shall have a first-aid kit, fire extinguisher, safety triangles and a device for two-way communication. (IAC r. 481-69.33(7))

G. Activities

Complaint/Incident Allegation: It was alleged activities were not being held.

- Monitoring Observation: The program provided activity calendars for October-December 2012. Activities were listed for all days of the week. The Activity Director stated staff members provided Saturday activities. The Activity Director stated there were activities 10-20 hours per week. The activity calendar for 12-5-12 listed three activities and all three of those activities were observed to be held.

- Regulatory Insufficiency: None noted.

H. Policies and Procedures

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

- Monitoring Observation: Tenant #2 was admitted to the program on 8-7-12 after an acute rehabilitation stay following a fall which resulted in a subdural hematoma. A shared risk agreement dated 8-7-12 was signed by a social worker and the power of attorney for Tenant #2. According to the occupancy agreement section 12.8, the agreement was to be signed by the tenant, a tenant representative, and the nurse manager for the program. The tenant and the nurse manager did not sign the shared risk agreement. The program did not follow its procedure for shared risk statements outlined in the signed occupancy agreement.

  Handwritten nurse's notes dated 10-9-12 revealed Tenant #3 had fallen in the room as reported to staff by a relative. The program did not provide documentation of completion of an incident report. Nurse's notes dated 10-12-12 documented Tenant #3 reported a fall to staff.

Tenant #3 was observed by a staff member to have a rug burn on the left knee. The program did not provide documentation of completion of an incident report. According to the incident report policy, all accidents or unusual occurrences within the building that affect tenants shall be reported as incidents with incident report forms available. The program did not follow its policy on incident reports.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)

I. Dependent Adult Abuse Training

Complaint/Incident Allegation: It was alleged staff members had not completed mandatory reporter training for dependent adult abuse.

- Monitoring Observation: Staff #1 CNA was hired 1-17-11. Staff #2 CNA was hired 8-23-10. Staff #3 Personal Care Attendant was hired 4-12-10. Staff #4 CNA was hired 8-3-05. Staff #5 Medication Manager was hired 2-25-10. Staff #4 had a certificate for completion of dependent adult abuse which expired 10-6-12. None of the other training records contained any documentation of the completion of dependent adult abuse training.

- Regulatory Insufficiency: A person required to report cases of dependent adult abuse pursuant to section 235B.3, other than a physician whose professional practice does not regularly involve providing primary health care to adults, shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment or self-employment which involves the examination, attending, counseling, or treatment of adults on a regular basis. Within one month of initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person's employer or, if self-employed, from the department. The person shall complete at least two hours of additional dependent adult abuse identification and reporting training every five years. ((235B.16(5)(b))

J. Managed Risk Statement

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

- Monitoring Observation: Tenant #2 was admitted to the program on 8-7-12 from an acute rehabilitation program. On 5-2-12, Tenant #2 underwent a procedure for placement of a subdural drain after a fall, which resulted in an acute subdural hematoma with mass effect and midline shift. The transfer sheet from acute rehab indicated Tenant #2 was at risk for falls. The occupancy paperwork contained a shared risk agreement dated 8-7-12 which stated Tenant #2 needed to call for assistance for transfers to prevent falls. The risk agreement was not signed by Tenant #2 but was signed by a power of attorney for Tenant #2. A cognitive screening tool dated 8-10-12 indicated Tenant #2 had eight errors which indicated severe intellectual function.

After failing the cognitive screening tool, Tenant #2 was not staged on the GDS within 30 days of admission. The program did not assess Tenant #2's cognitive function prior to completion of the shared risk agreement.
Tenant #2 was not cognitively able to participate in the managed risk process. Tenant #2 did not sign the shared risk agreement.

- Regulatory Insufficiency: The program shall have a managed risk policy. The managed risk policy shall be provided to the tenant along with the occupancy agreement. The managed risk policy shall include the following: A consensus-based process to address specific risk situations. Program staff and the tenant shall participate in the process. The result of the consensus-based process may be a managed risk consensus agreement. The managed risk consensus agreement shall include the signature of the tenant and the signatures of all others who participated in the process. The managed risk consensus agreement shall be included in the tenant's file. (IAC r. 481-69.31(2))

K. Compliance with Plan of Correction

- Monitoring Observation: The program's Plan of Correction, submitted to the Department on 4-6-12, included a plan of correction indicating a plan to correct the cited insufficiencies related to staff training on Dependent Adult Abuse Education and requirements.

  During the monitoring complaint visit conducted 12-5 & 12-6-12, the monitor continued to find discrepancies related to Dependent Adult Abuse training for staff in the program.

- Regulatory Insufficiency: The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. (IAC r. 481-67.10(8))