IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

AMENDED DEMAND LETTER
CERTIFIED
Complaint Intake #: 37367-C

March 20, 2013

Ms. Karen Beck, Administrator
Prairie Hills Assisted Living
5815 S.E. 27th Street
Des Moines, IA 50320

RE: NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INVESTIGATION REPORT – PRAIRIE HILLS ASSISTED LIVING

Dear Ms. Beck:

I. Final Complaint/Incident Investigation Report – Prairie Hills Assisted Living, Des Moines, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued 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, following a complaint investigation by DIA on January 5-6, 2012. The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights, Evaluation, Medications, Staffing, Service Plans and Nurse Review.

Prairie Hills Assisted Living ("Program") is being assessed a $2,500 civil penalty pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rules 67.12(3)(a)(2).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.12(3)(a)(2), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The program previously received regulatory insufficiencies in the areas of Staffing, Tenant Rights, Medications and Service Plans.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

In this case, the determination of a $2,500 civil penalty is based upon repeated regulatory insufficiencies in the areas of Staffing, Tenant Rights, Medications and Service Plans. As the enclosed report details, Program staff failed to coordinate with hospice staff to provide appropriate care for a tenant receiving hospice care. Service plans were not representative of the care needs of two tenants receiving hospice care. Program staff did not know what cares, including hospice-related cares, to provide a tenant. Nor did the staff know what services hospice provided to the tenant. Medications were not recorded as given, oxygen saturation levels were not recorded, wound care treatments were not recorded, and a tenant's physician was not contacted related to the tenant's aspiration or for an order to restrict fluid intake to thickened liquids.

II. Reduction of Civil Penalty

If, within 30 days of the receipt of this demand letter, you withdraw your previous request for formal hearing, and 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 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 one thousand six hundred twenty-five dollars ($1,625) within 30 days after the receipt of this demand letter.

III. Conclusion

The Program is being assessed a $2,500 civil penalty pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Plan of Correction (POC) submitted on February 7, 2012, has been reviewed and will constitute the final POC related to the on-site visit of January 5 & 6, 2012.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures.

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: **Complaint/Incident Intake #:** 37367-C

Kit Steiber, Administrator
Prairie Hills Assisted Living
5815 S.E. 27th Street
Des Moines, IA 50320

Date of Complaint/Incident Investigation:

January 5 & 6, 2012

Monitor(s):

Hal L. Chase, RN BSN MPH

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

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

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

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

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

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

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers 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:	30
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	37

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	6
TOTAL census of Assisted Living Program	43

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: Rights, Medications, Staffing and Service Plan.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged a tenant, who was actively dying, was receiving hospice services, and was not receiving good skilled care. The tenant was placed in memory care with six other tenants in memory care.

- Monitoring Observation: Two tenant files were reviewed. Tenant #2's file was reviewed and indicated no issues of concern related to tenant rights.

  Tenant #1 and Tenant #2 received hospice care. Tenant #1, an 84 year old was admitted on 10-29-11 and had diagnoses of: Chronic Obstructive Pulmonary Disease (COPD), Skin Cancer and Profound Hearing Loss. Tenant #1 was admitted to hospice on 12-27-11, with an admitting diagnosis of Failure to Thrive. A Global Deterioration Scale (GDS) was completed on 12-28-11 and staged Tenant #1 at three, which indicated mild cognitive decline. Tenant #1 resided in the general population until his/her return on 12-29-11 from a skilled nursing facility, when he/she was placed in the dementia unit.

  Nurse's notes of 12-6-11 indicated staff entered Tenant #1's apartment after being called by Tenant #1 for assistance. When staff arrived, Tenant #1 was lying across the bed. Tenant #1's face was red and his/her skin and body was hot to touch.

Tenant #1 was responsive; however, the words were slurred and hard to understand. Vital signs were taken and indicated blood pressure was difficult to read, lung sounds were "wet" and Tenant #1 was gasping for breath. Tenant #1 was transported to a hospital emergency room for evaluation and was later admitted for aspiration pneumonia.

Nurse's notes of 12-29-11, indicated Tenant #1 returned to the program. Discharge instructions from a skilled nursing facility, included physician orders for oral medications, assistance with activities of daily living (ADLs,) wound care for skin tears and open wounds, an ace wrap for ankle support, an order for a mechanical soft diet, difficulty with swallowing and hospice care.

Wound care included the following: cleanse right arm with wound cleanser, apply Vaseline gauze to open area, cover with telfa and wrap with gauze daily and as needed (prn). Apply an ace wrap to ankle daily for support, cleanse left head wound and apply Bacitracin twice daily. Cleanse left elbow with wound cleaner, apply Bacitracin, cover with telfa and wrap with kling daily at bedtime. Apply Vaseline jelly to right shoulder and left lower leg – scales/lesions twice daily. Cleanse buttock with normal saline (NS) and apply Casmoseptine twice daily. Medication Administration Records (MARs) for 12-29-11 through 1-4-12 did not record wound care treatments. The service plan of 12-29-11 did not establish interventions related to wound care. No other documentation was found which documented wound care was given.

A hospice care plan of 12-29-11 established interventions to monitor and control pain, provide assistance with hygiene, safety, fall risk, difficulty swallowing and risk for aspiration. A diet order on 12-29-11, a hospice order indicated Tenant #1's diet ordered changed to mechanical soft. Additional interventions included; assess nutrition, provide nutritional supplements and fluid intake. Monitor for skin breakdown and bowel status. A hospice aide plan of care included interventions which included the use of side rails, bed bath or shower weekly, peri-care, grooming, assist with transfer and ambulation, assist with light feeding and skin care.

Functional, cognitive and health evaluations were completed on 12-28-11 and indicated Tenant #1 was weak and needed staff assistance with ambulation and a gait belt was to be used at all times. Tenant #1 had trouble with swallowing at times, had three skin tears and had open areas on the head and scalp. Tenant #1 complained of pain to the left ankle and had an ace wrap for ankle support. Tenant #1 had previously fallen at the Program on 12-4-11 and had fallen at the skilled nursing facility on 12-19-11 and sustained two new skin tears.

A nurse review, completed on 12-29-11, indicated hospice would be providing care for Tenant #1 through the end of life. Tenant #1 would be returning to the Program and needed the assistance of one staff on all ADLs, including ambulation. Tenant #1 had a skin tear to the left upper arm and Tenant #1's weight had decreased from 140 pounds on 11-29-11 to (N/A was written) on 1-4-12. Tenant #1's level of care increased from one to three and the cognitive score increased from four to eleven and a GDS from zero to three.

Tenant #1's service plan of 12-29-11 indicated Tenant #1 needed assistance with ADLs, including bathing, dressing and one staff assist with ambulation, transfer, and toileting. Tenant #1 was independent with meals. (An order for a mechanical soft diet dated 12-29-11 was not identified on the service plan.) The Program administered all medications. The service plan identified hospice as an outside provider but did not establish interventions as identified by hospice that Tenant #1 needed, specifically, interventions related to pain management, fall and safety prevention, to assess nutrition, provide nutritional supplements and fluid intake. Monitor for skin breakdown, bowel status, the use of side rails, bathing, peri-care assist with light feeding and skin care.

The service plan of 12-29-11 did not include interventions identified from the evaluations completed on 12-28-11, from the discharge orders from the skilled nursing facility and from the hospice care plan of 12-29-11.

Nurse's notes of 1-1-12 indicated the hospice registered nurse (RN) was to see Tenant #1 related to decreased intake and increase in body temperature, as Tenant #1 had a fever of 103 degrees Fahrenheit (F). Tylenol 650mg suppository – one rectally every four hours prn was ordered for pain and fever. No additional entries were made in the nurse's notes and no other entries were found in the nurse's notes indicating any additional action taken by the Program nurse.

A hospice assessment, completed on 1-3-12, indicated the Program nurse reported Tenant #1 fell on 1-1-12. The hospice assessment indicated Tenant #1 had an increase in lethargy, increase in weakness and a decrease in appetite since the fall. The Program nurse had reported Tenant #1 was in bed and was difficult to arouse. Nurse's notes and incident reports were reviewed and no entries were made related to Tenant #1's fall. The Program did not assess and document the health status of Tenant #1 when changes occurred.

Hospice clinical notes of 1-4-12 indicated the Program nurse notified the hospice nurse Tenant #1 had aspirated when taking medications and had continued to decline. Tenant #1 had increased respirations and coarse lung sounds. Hospice clinical notes indicated saturation percentage of oxygen (SPO2) was at 70 %, on three liters of oxygen per minute by nasal canula. A physician's order of 1-4-12 at 11:30 a.m. ordered oxygen to keep (SPO2) greater than 90%. Program documentation indicated SPO2 levels were not documented until 1-6-12 at 2:00 a.m. The Program nurse did not clarify the order for oxygen therapy to include the rate of three liters per minute and how Tenant #1 was to receive oxygen therapy. A physician's order was obtained on 1-5-12 at 6:30 p.m. for oxygen at three liters to keep SPO2 greater than 90%.

Hospice clinical notes of the same date indicated Tenant #1 was difficult to arouse and had a body temperature of 103.5 F. Tylenol was given and Tenant #1's temperature was 99.4 F.

A physician's order of 1-4-12, at 11:30 a.m., indicated oral medications were to be crushed. The order to crush medications was not added to the MARs until 1-5-12. A nurse review of 1-5-12 at 9:00 a.m. and indicated Tenant #1 was unable to swallow thin liquids, aspirated when taking oral medications and tolerated thick liquids as it was easier to swallow without aspirating. Tenant #1's physician had not been

contacted related to Tenant #1's aspiration or for an order to restrict fluid intake to thickened liquids.

A physician's order of 1-5-12 at 6:30 p.m. discontinued all oral medications except comfort medications and nebulizer treatments. A physician's order of 1-6-12 discontinued all nebulizer treatments. Tenant #1's medication orders of 12-29-11 through 1-4-11 indicated the following errors:

Potassium Chloride 20meq	One tablet daily a.m.	Not recorded as given 1-3-12, 1-4-12 and 1-5-12
Tamsulosin HCL 0.4mg (Flomax)	One tablet daily a.m.	Not recorded as given 1-3-12, 1-4-12 and 1-5-12
Calcium 600mg/Vitamin D 400mg	One tablet daily a.m.	Not recorded as given 1-3-12, 1-4-12 and 1-5-12
Coumadin 3mg	One tablet daily except Fridays	Not recorded as given 1-3-12 and 1-4-12
Lasix 20 mg	One tablet daily a.m.	Not recorded as given 1-3-12, 1-4-12 and 1-5-12
Mirlazapine 15 mg	One tablet at bedtime	Not recorded as given 1-3-12 and 1-4-12

On 1-5-12, at approximately 1:30 p.m., a monitor and a hospice aide observed Tenant #1. Tenant #1 was in bed and in a semi-conscious state. Tenant #1 was dependent for all personal and health related cares. The hospice aide re-positioned Tenant #1. When doing so Tenant #1 demonstrated facial grimacing, which appeared to be pain to his/her left shoulder and arm when moved. MARs for 1-5-12 indicated the Program nurse recorded Tenant #1 refused comfort medications, which included pain medications at 10:10 a.m. Another entry of the same date, but without a time noted, indicated a Tylenol 650mg suppository was given.

The hospice RN was interviewed on 1-5-12 at approximately 3:30 p.m. She stated interventions established in the hospice care plan and hospice aide care plan were supplemental and expected the Program to implement these interventions routinely as outlined in the both hospice and hospice aide care plans.

A service plan was updated on 1-5-12 and indicated Tenant #1 required complete cares with bathing, hygiene, dressing, transfer and required turning every two hours. Tenant #1 needed encouragement to eat, needed assistance with toileting and was alert and oriented but was lethargic and sleeping. Interventions for pain management from hospice were not listed except to assist with dressing and administering medications. The Program did not complete a functional, cognitive and health evaluation to determine Tenant #1's current status and to support the service plan of 1-5-12.

The Program nurse was interviewed on 1-5-12 at 4:10 p.m. and stated Tenant #1 had a significant decline in health status on 1-4-12, between 12:00 p.m. and 7:00 p.m. The Program nurse stated she had updated the service plan, but not until the morning of 1-5-12 and had not completed evaluations.

A review of Tenant #1's file revealed a task sheet had not been used to document cares related to re-positioning, fluid intake, nutritional supplements, changing of undergarments and pain management. Physical inspection of Tenant #1's room during the on-site of 1-5-12, at approximately 2:00 p.m. revealed Tenant #1 was lying bed in a prone position, in a semi-conscious state. A container was half full with a warm thickened liquid substance was sitting on a counter/table on the other side of the room. It appeared to have been sitting there for awhile as a skim coating over the top of the liquid was present. No documentation was found indicating what cares, including re-positioning, fluid intake and when staff had been in to check on Tenant #1.

Program documentation indicated staffing patterns included two direct care staff were assigned to the general population for the day shift - 6:00 a.m. until 2:00 p.m., two direct care staff for the evening shift – 2:00 p.m. until 10:00 p.m. and one direct care staff on nights – 10:00 p.m. until 6:00 a.m. Only one direct care staff was assigned to the dementia unit for each of the three shifts, as noted above.

Staffs #1, #2 and #3 were interviewed on 1-5-12 approximately between 1:45 p.m. and 4:10 p.m. Staff #1, who worked in the dementia unit, identified Tenant #1 needed routine two-staff assist with transfer, was non weight bearing, was bed-bound, was incontinent and did not participate in any way with his/her toileting. Tenant #1 required total care for all ADLs. Staff #1 stated the hospice RN and a hospice aide came daily or every other day, but wasn't sure what hospice did for Tenant #1. Staff #1 stated the Program nurse or Staff #5; the Licensed Practical Nurse (LPN) completed Tenant #1's cares. For the last few days it took two staff to re-position Tenant #1 in bed. Staff #1 stated after breakfast on 1-4-12, the Program nurse told her to not give any food or water to Tenant #1. Staff #1 stated she hadn't given Tenant #1 any fluids or food since that time. Staff #1 stated Tenant #1 was to be re-positioned every two-hours but she wasn't doing any of the cares for Tenant #1 as the Program nurse and care staff from the general population were doing the cares. Staff #1 stated Tenant #1's lips were cracked and was asked by the Program nurse to find "swabs" to help with giving fluids, but none could be found. Staff #1 stated she assumed she was to check on Tenant #1, but she hadn't received any instructions from the Program nurse to do so.

Staff #2, who worked in the general population of the program, identified Tenant #1 needed two-staff to routinely transfer Tenant #1. Tenant #1 needed maximal assistance with all ADLs and needed to be re-positioned every two hours since he/she returned on 12-29-11. Staff #2 stated a task sheet or recording of cares wasn't used but an end of shift report was given to the on-coming shift. Staff #2 stated staff was to change Tenant #1's undergarments every two hours with re-positioning, but she hadn't helped with cares since 12-29-11, except for repositioning Tenant #1.

Staff #3 was assigned in the dementia unit from 2:00 p.m. until 10:00 p.m. during this investigation. Staff #3 stated the Program nurse told her what cares needed to be done for Tenant #1, but didn't remember when she was told by the Program nurse. Staff #3 stated if Tenant #1 needed to be changed she was to call additional staff to assist her. She was to check on Tenant #1 every hour to see if Tenant #1 was wet or soiled. Staff #3 stated she was to administer medications to Tenant #1 by placing the

oral medications in a cup and hand the cup to Tenant #1 to take, along with water or orange juice. Staff #3 stated she was to give Tenant #1 breathing treatments and described the process of doing this by "turning on the machine" and Tenant #1 "would hold the nebulizer." Staff #3 stated these were the only cares she gave Tenant #1.

On 1-5-12 at 5:30 p.m., a monitor directed the Program nurse to work with the hospice nurse to establish and document coordinated care between the hospice and the Program through the Program's service plan, educate staff on the immediate care needs of Tenant #1, to use a task sheet representing cares given to Tenant #1, including re-positioning, changing of undergarments, when fluids and nutrition supplements were to be given, wound care and pain management.

On 1-6-11 at approximately 10:05 a.m., Staff #3 was interviewed for a second time. She had been assigned to the dementia unit where Tenant #1 resided. Staff #3 stated she was given directions from the Program nurse regarding Tenant #1's care needs. She was to check on Tenant #1 hourly, take vital signs, check Tenant #1's undergarments and bedding, check Tenant #1's breathing pattern, turn Tenant #1 every two-hours and report to the Program nurse when Tenant #1 was in pain. Staff #3 stated she was given a "cheat sheet" to use when doing vital signs. Staff #3 stated she was not aware of any task sheets or to record cares that were done.

Tenant #1's service plans of 12-29-11 and 1-5-12 were not representative of Tenant #1 needs when he/she returned from skilled care on 12-29-11 and subsequent changes in care needs as identified above through 1-5-12. Hospice interventions, including pain management, fluid hydration and comfort measures, in both the hospice care plan and the hospice aide care plan were not represented in either service plan. Neither the service plan of 12-29-11 or 1-5-12, nor the MARs for 12-29-11 through 1-5-12 identified wound care, as ordered by Tenant #1's physician on 12-29-11 was performed. MARs of 12-29-11 through 1-4-12 indicated oral medications were not given as ordered by Tenant #1's physician. A mechanical soft diet had been ordered on 12-29-11, but wasn't given to Tenant #1 until a monitor requested the order be implemented on 1-5-12. Task sheets were not used to document cares and needs of a tenant who was actively dying and not able to advocate for himself/herself. Staff #1, #2 and #3 was interviewed and couldn't identify the care needs of Tenant #1.

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

B. Evaluation

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

Monitoring Observation: Nurse's notes of 1-1-12 indicated the hospice RN was to see Tenant #1 related to decreased intake and increase in body temperature, as Tenant #1 had a fever of 103 degrees F. Tylenol 650mg suppository – one rectally every four hours prn was ordered for pain and fever. No additional entries were made in the nurse's notes. No other entries in the nurse's notes indicated any additional action taken by the Program nurse.

A hospice assessment, completed on 1-3-12, indicated the Program nurse reported Tenant #1 fell on 1-1-12. The hospice assessment indicated Tenant #1 had an increase in lethargy, increase in weakness and a decrease in appetite since the fall. The Program nurse had reported Tenant #1 was in bed and was difficult to arouse. Nurse's notes and incident reports were reviewed and no entries were made related to Tenant #1's fall. The Program did not assess and document the health status of Tenant #1 when changes occurred.

Hospice clinical notes of 1-4-12 indicated the Program nurse notified the hospice nurse Tenant #1 had aspirated when taking medications and had continued to decline. Tenant #1 had increased respirations and coarse lung sounds. Hospice clinical notes indicated saturation percentage of oxygen (SPO2) was at 70 %, on three liters of oxygen per minute by nasal canula. A physician's order of 1-4-12 at 11:30 a.m. ordered oxygen to keep (SPO2) greater than 90%. Program documentation indicated SPO2 levels were not documented until 1-6-12 at 2:00 a.m. The Program nurse did not clarify the order for oxygen therapy to include the rate of three liters per minute and how Tenant #1 was to receive oxygen therapy. A physician's order was obtained on 1-5-12 at 6:30 p.m. for oxygen at three liters to keep SPO2 greater than 90%.

Hospice clinical notes of the same date indicated Tenant #1 was difficult to arouse and had a body temperature of 103.5 F. Tylenol was given and Tenant #1's temperature was 99.4 F.

The Program completed a nurse review on 1-5-12 at 9:00 a.m. and indicated Tenant #1 was unable to swallow thin liquids and aspirated when taking oral medications. The Program nurse documented Tenant #1 tolerated thick liquids and it was easier for Tenant #1 to swallow without aspirating. Tenant #1's physician had not been contacted related to Tenant #1's aspiration or for an order to restrict fluid intake to thickened liquids.

A service plan of 1-5-12 indicated Tenant #1 required complete cares with bathing, hygiene, dressing, transfer and required turning every two hours. Tenant #1 needed encouragement to eat, needed assistance with toileting and was alert and oriented but was lethargic and sleeping. Interventions from hospice were not listed except to assist with dressing and administering medications. The Program nurse stated she hadn't completed the evaluations. The Program did not complete a functional, cognitive and health evaluation with a change in health status.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30-days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service profession. 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. Medications

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

Monitoring Observation: Two tenant files were reviewed. Tenant #2's MARs were reviewed and indicated no errors were made.

Tenant #1's medication orders from 12-29-11 through 1-4-11 indicated the following errors:

Potassium Chloride 20meq	One tablet daily	Not recorded as given 1-3-12 and 1-4-12
Tamsulosin HCL 0.4mg (Flomax)	One tablet daily	Not recorded as given 1-3-12 and 1-4-12
Calcium 600mg/Vitamin D 400mg	One tablet daily	Not recorded as given 1-3-12 and 1-4-12
Coumadin 3mg	One tablet daily except Fridays	Not recorded as given 1-3-12 and 1-4-12
Lasix 20 mg	One tablet daily	Not recorded as given 1-3-12 and 1-4-12
Mirlazapine 15 mg	One tablet at bedtime	Not recorded as given 1-3-12 and 1-4-12

On 1-5-12, a physician order was obtained to discontinue all oral medications. A treatment order of 1-4-12 indicated the Program was to keep Tenant #1's oxygen saturation levels greater than 90%. On 1-5-11, a physician ordered oxygen at three liters and to keep oxygen saturation levels at greater than 90%. Program data indicated SPO2 records were not initiated until 1-5-11 at 2:00 a.m.

Discharge orders of 12-29-11 indicated wound care was to be given to the following areas: Cleanse right arm with wound cleanser, apply Vaseline gauze to open area, cover with telfa and wrap with gauze daily and prn. Apply an ace wrap to ankle daily for support, cleanse left head wound and apply Bacitracin twice daily. Cleanse left elbow with wound cleaner, apply Bacitracin, cover with telfa and wrap with kling daily at bedtime. Apply Vaseline jelly to right shoulder and left lower leg – scales/lesions twice daily. Cleanse buttocks with NS and apply Casmoseptine twice daily. MARs for December, 2011 and January, 2012 were reviewed and did not record wound care treatments. An order of 1-5-11discontinued wound care to the right arm and shoulder, left elbow and left lower leg. Medication Administration Records for 12-29-11 through 1-4-12 did not record wound care treatments.

The Program completed a nurse review on 1-5-12 at 9:00 a.m. and indicated Tenant #1 was unable to swallow thin liquids and aspirated when taking oral medications. The Program nurse documented Tenant #1 tolerated thick liquids and it was easier for Tenant #1 to swallow without aspirating. Tenant #1's physician had not been contacted related to Tenant #1's aspiration or for an order to restrict fluid intake to thickened liquids.

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

D. Service Plans

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

Monitoring Observation: Functional, cognitive and health evaluations were completed on 12-28-11 and indicated Tenant #1 was weak and needed staff assistance with ambulation and a gait belt was to be used at all times. Tenant #1 had trouble with swallowing at times, had three skin tears and had open areas on the head and scalp. Tenant #1 complained of pain to the left ankle and had an ace wrap for ankle support. Tenant #1 had previously fallen at the Program on 12-4-11 and had fallen at the skilled nursing facility on 12-19-11 and sustained two new skin tears.

Tenant #1's service plan of 12-29-11 indicated Tenant #1 needed assistance with ADLs, including bathing, dressing and one staff assist with ambulation, transfer, and toileting. Tenant #1 was independent with meals. (An order for a mechanical soft diet dated 12-29-11 was not identified on the service plan.) The Program administered all medications. The service plan identified hospice as an outside provider but did not establish interventions as identified by hospice that Tenant #1 needed, specifically, interventions related to pain management, fall and safety prevention, to assess nutrition, provide nutritional supplements and fluid intake. Monitor for skin breakdown, bowel status, the use of side rails, bathing, peri-care assist with light feeding and skin care.

The service plan of 12-29-11 did not include interventions identified from the evaluations completed on 12-28-11, from the discharge orders from the skilled nursing facility and from the hospice care plan of 12-29-11.

Nurse's notes of 1-1-12 indicated the hospice registered nurse (RN) was to see Tenant #1 related to decreased intake and increase in body temperature, as Tenant #1 had a fever of 103 degrees Fahrenheit (F). Tylenol 650mg suppository – one rectally every four hours prn was ordered for pain and fever. No additional entries were made in the nurse's notes and no other entries were found in the nurse's notes indicating any additional action taken by the Program nurse.

A hospice assessment, completed on 1-3-12, indicated the Program nurse reported Tenant #1 fell on 1-1-12. The hospice assessment indicated Tenant #1 had an increase in lethargy, increase in weakness and a decrease in appetite since the fall. The Program nurse had reported Tenant #1 was in bed and was difficult to arouse. Nurse's notes and incident reports were reviewed and no entries were made related to Tenant #1's fall. The Program did not assess and document the health status of Tenant #1 when changes occurred.

Hospice clinical notes of 1-4-12 indicated the Program nurse notified the hospice nurse Tenant #1 had aspirated when taking medications and had continued to decline.

Tenant #1 had increased respirations and coarse lung sounds. Hospice clinical notes indicated saturation percentage of oxygen (SPO2) was at 70 %, on three liters of oxygen per minute by nasal canula. A physician's order of 1-4-12 at 11:30 a.m. ordered oxygen to keep (SPO2) greater than 90%. Program documentation indicated SPO2 levels were not documented until 1-6-12 at 2:00 a.m. The Program nurse did not clarify the order for oxygen therapy to include the rate of three liters per minute and how Tenant #1 was to receive oxygen therapy. A physician's order was obtained on 1-5-12 at 6:30 p.m. for oxygen at three liters to keep SPO2 greater than 90%.

The Program completed a nurse review on 1-5-12 at 9:00 a.m. and indicated Tenant #1 was unable to swallow thin liquids and aspirated when taking oral medications. The Program nurse documented Tenant #1 tolerated thick liquids and it was easier for Tenant #1 to swallow without aspirating. Tenant #1's physician had not been contacted related to Tenant #1's aspiration or for an order to restrict fluid intake to thickened liquids.

A service plan of 1-5-12 indicated Tenant #1 required complete cares with bathing, hygiene, dressing, transfer and required turning every two hours. Tenant #1 needed encouragement to eat, needed assistance with toileting and was alert and oriented but was lethargic and sleeping. Interventions from hospice were not listed except to assist with dressing and administering medications.

A nurse review of 1-5-11 indicated Tenant #1 had become unable to swallow thin liquids and aspirated when taking oral medications. Thick liquids had been tolerated and easier without aspiration. The Program nurse was interviewed on 1-5-12 at 4:10 p.m. and stated Tenant #1 had a significant decline in health status on 1-4-12, between 12:00 p.m. and 7:00 p.m. The nurse review of 1-5-12 was later amended that evening, which included notifying the hospice nurse Tenant #1 was actively dying and change in ADLs were delegated to staff. Tenant #1 was to be turned and changed every two hours, vital signs every two hours and Tenant #1 was to only be given thickened liquids and toothettes to mouth for hydration.

Nurse's notes of 1-1-12 indicated Tylenol 650mg suppository – one rectally every four hours prn. Hospice RN was to see Tenant #1 related to decreased intake and increase in body temperature, as Tenant #1 had a fever of 103 degrees F.

Tenant #1's service plans of 12-29-11 and 1-5-12 were not representative of Tenant #1 needs when he/she returned from skilled care on 12-29-11 and subsequent changes in care needs as identified above through 1-5-12. Hospice interventions, including pain management, fluid hydration and comfort measures, from the hospice care plan and the hospice aide care plan were not represented in either service plan. Neither the service plan of 12-29-11 or 1-5-12, nor the MARs for 12-29-11 through 1-5-12 identified wound care, as ordered by Tenant #1's physician on 12-29-11 was performed. MARs of 12-29-11 through 1-4-12 indicated oral medications were not given as ordered by Tenant #1's physician. A mechanical soft diet had been ordered on 12-29-11, but wasn't given to Tenant #1 until a monitor requested the order be implemented on 1-5-12. Task sheets were not used to document cares and needs of a tenant who was actively dying and not able to advocate for himself/herself, until a monitor directed the program to implement the use of task sheets. Staff #1, #2 and #3 was interviewed and couldn't identify the care needs of Tenant #1.

Tenant #2, an 80 year old, was admitted on 1-4-12 and had diagnoses of: Pyloric Stenosis and Dementia. A cognitive ability assessment was completed on 1-3-12, which scored Tenant #2 at 28 out of 28, indicating high risk for cognitive decline. Tenant #2 resided in the dementia unit. Tenant #2 had been admitted to hospice on 8-4-12, prior to being admitted to the Program. The hospice care plan of 12-21-11 indicated Tenant #2 had an admitting diagnosis of Acquired Pyloric Stenosis. Hospice interventions included pain assessment and monitoring, provide comfort, safety and hygiene, assess nutritional status, assess physical factors causing nausea and vomiting and control diarrhea. A hospice aide care plan of 11-21-11 included assisting Tenant #2 with bathing, grooming, stand by assist with transfer and assisting with meals. A service plan of 1-4-12 indicated assistance with ADLs but did not include interventions identified in the hospice care plan of 12-21-11 and the hospice aide care plan of 11-21-11.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.221(1) and 69.22 (2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r.481-69.26(1))

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30-days of the tenant's occupancy and as needed with significant change, but no less than annually. (IAC r. 481-69.26 (3))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum a. The tenant's identified needs and preferences for assistance. c. The service provider(s), of other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy. (IAC r.481-69.26(4)(a)(c))

E. Staffing

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

Monitoring Observation: Staff #1, #2 and #3 were interviewed on 1-5-12 approximately between 1:45 p.m. and 4:10 p.m. Staff #1, who worked in the dementia unit, identified Tenant #1 as needing routine two-staff assist with transfer, was non weight bearing, was bed-bound, was incontinent and did not participate in any level of his/her toileting. Tenant #1 required total care for all ADLs. Staff #1 stated the hospice RN and a hospice health aide came daily or every other day, but wasn't sure what hospice did for Tenant #1. Staff #1 stated the Program nurse or Staff #5 LPN completed Tenant #1's cares. For the last few days it took two staff to re-position Tenant #1 in bed. Staff #1 stated after breakfast on 1-4-12, the Program nurse told her not to give any food or water to Tenant #1. Staff #1 stated she hadn't given Tenant #1 any fluids or food since that time. Staff #1 stated Tenant #1 was to be re-positioned every two-hours but she wasn't doing any of the cares for Tenant #1 as the Program nurse and care staff from the general population were doing the cares. Staff #1 stated Tenant #1's lips were cracked and was asked by the Program nurse to

find "swabs" to help with giving fluids, but none could be found. Staff #1 stated she assumed she was to check on Tenant #1, but she hadn't received any instructions from the Program nurse to do so.

Staff #2, who worked in the general population of the program, identified Tenant #1 needed two-staff to routinely transfer Tenant #1. Tenant #1 needed maximal assistance with all ADLs and needed to be re-positioned every two hours since his/her return 12-29-11. Staff #2 stated a task sheet or recording of cares wasn't used but an end of shift report was given to the on-coming shift. Staff #2 stated staff was to change Tenant #1's undergarments every two-hours with repositioning, but she hadn't helped with cares since 12-29-11, except for repositioning Tenant #1.

Staff #3 was assigned in the dementia unit from 2:00 p.m. until 10:00 p.m. during this investigation. Staff #3 stated the Program nurse told her what cares needed to be done for Tenant #1, but didn't remember when she was told by the Program nurse. Staff #3 stated if Tenant #1 needed to be changed she was to call additional staff to assist her. She was to check on Tenant #1 every hour to see if Tenant #1 was wet or soiled. Staff #3 stated she was to administer medications to Tenant #1 by placing the oral medications in a cup and hand the cup to Tenant #1 to take, along with water or orange juice. Staff #3 stated she was to give Tenant #1 breathing treatments and described the process of doing this by "turning on the machine" and Tenant #1 "would hold the nebulizer." Staff #3 stated these were the only cares she gave Tenant #1.

On 1-5-12 at 5:30 p.m., a monitor directed the Program nurse to work with the hospice nurse to establish and document coordinated care between the hospice and the Program through the Program's service plan, educate staff on the immediate care needs of Tenant #1, to use a task sheet representing cares given to Tenant #1, including re-positioning, changing of undergarments, when fluids and nutrition supplements were to be given, wound care and pain management.

On 1-6-11 at approximately 10:05 a.m., Staff #3 was interviewed for a second time. She had been assigned to the dementia unit where Tenant #1 resided. Staff #3 stated she was given directions from the Program nurse of what cares Tenant #1 needed. She was to check on Tenant #1 hourly, take vital signs, check Tenant #1's undergarments and bedding. Check Tenant #1's breathing pattern, turn Tenant #1 every two-hours and report to the Program nurse when Tenant #1 was in pain. Staff #3 stated she was given a "cheat sheet" to use when doing vital signs. Staff #3 stated she was not aware of any task sheets or to record cares that were done.

Program staff, when interviewed, did not know what cares, including hospice related cares, to provide Tenant #1. Staff #1, #2 and #3 did not know what services hospice provided Tenant #1.

- 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))

F. Nurse Review

Complaint/Incident Allegation: It was alleged a nurse refused to come in over New Years Day and a tenant had "a real bad skin tear." The next day the skin tear was worse when the bandage was changed.

Monitoring Observation: Nurse's notes of 1-1-12 indicated the hospice registered nurse (RN) was to see Tenant #1 related to decreased intake and increase in body temperature, as Tenant #1 had a fever of 103 degrees Fahrenheit (F). Tylenol 650mg suppository – one rectally every four hours prn was ordered for pain and fever. No additional entries were made in the nurse's notes and no other entries were found in the nurse's notes indicating any additional action taken by the Program nurse.

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- 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 registered nurse or a licensed practical nurse via nurse delegation (3.) 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))