

TERRY E. BRANSTAD  
GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

KIM REYNOLDS  
LT. GOVERNOR

**DEMAND LETTER  
CERTIFIED  
Complaint Intake #: 41148-CR1  
Recertification R1**

April 18, 2013

Ms. Katie Clausen, Administrator  
Golden Horizons Assisted Living  
800 Byron Godberson Drive  
Ida Grove, IA 51445

- RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL REVISIT TO  
RECERTIFICATION AND COMPLAINT/INCIDENT INVESTIGATION  
REPORT - GOLDEN HORIZONS ASSISTED LIVING**
- II. Reduction of Civil Penalty**
- III. Appeals/Hearings**
- IV. Conclusion**

Dear Ms. Clausen:

**I. Final Revisit to Recertification and Complaint/Incident Investigation Report –  
Golden Horizons Assisted Living, Ida Grove, IA**

Enclosed is the **Final Revisit to Recertification and 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 an investigation by DIA on **March 4 and 5, 2013**. The Report notes Regulatory Insufficiencies in the area(s) of: Occupancy Agreement, Service Plan, Nurse Review, Staffing, Medications, Policies and Procedures and Compliance with POC.

**Golden Horizons Assisted Living** (“Program”) is being assessed a **\$3,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 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 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.

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 Service Plan, Nurse Review, Staffing, Policies and Procedures and Medications.

The determination of a **\$3,000 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Service Plan, Nurse Review, Staffing, Policies and Procedures and Medications. As the enclosed Report details, the Program failed to individualize service plans and updates were not based on evaluations for several tenants, nurse reviews were incomplete and were not completed with significant change in condition, program failed to provide staff with necessary training and document all training received, and program failed to follow its policy regarding medication administration as well as accepted professional standards for medication administration.

## **II. Reduction of Civil Penalty**

If, within 30 days of the notice or service 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 **one thousand nine hundred and fifty dollars (\$1950)** within 30 days after the notice or service of this demand letter.

## **III. Appeals/Hearings**

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written 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 the notice or service of this demand letter.

#### IV. Conclusion

The Program is being assessed a \$3,000 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 April 17, 2013, has been reviewed and will constitute the final POC related to the on-site visit of March 4 and 5, 2013.

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 notice or service 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 Revisit to Recertification and Complaint Investigation Report**

**Assisted Living Program:**

**Complaint/Incident Intake #:** 41148-CR1  
Recertification R1

Katie Clausen, Administrator  
Golden Horizons Assisted Living  
800 Byron Godberson Drive  
Ida Grove, IA 51445

**Date of Complaint/Incident Investigation:**

March 4<sup>th</sup> and 5<sup>th</sup>, 2013

**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.

<b>General Population Program</b>	
Number of tenants without cognitive disorder:	<u>22</u>
Number of tenants with cognitive disorder:	<u>0</u>
Total Population of Program at time of on-site	<u>22</u>
<b>TOTAL census of Assisted Living Program</b>	<u>22</u>

**Program History** – The program received regulatory insufficiencies in the areas of Evaluations, Service Plans, Nurse Review, Staffing, Medications, Policy and Procedures and Record Checks during this certification period.

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

**A. Evaluation**

The program received regulatory insufficiencies related to a Licensed Practical Nurse performing initial assessments and failure to complete evaluations within 30 days of admission for Tenants #1 and #3 during the October 17 and 18, 2012 recertification and complaint investigation, #41148-C.

- **Monitoring Observation:** The program identified two new tenants in 2013, #9 and #10.

Tenant #9, a 64 year-old, was admitted on 12-28-12 and had diagnoses of: History of Fractured Tibia, Generalized Muscle Weakness, Hypertension (HTN), Chronic Kidney Disease, Hyperlipidemia, Esophageal Stricture, Irritable Bowel Syndrome, Asthma, and History of Fall. Functional, cognitive, and health evaluations were completed on 12-26-12 and 1-22-13 by a registered nurse. The program utilized the Cognitive Ability Assessment as the screening tool.

Tenant #10, an 83 year-old, was admitted on 1-19-13 and had diagnoses of: Fracture of Humerus following a fall, HTN, Atrial Fibrillation, Hyperlipidemia, and Osteoarthritis. Functional, cognitive, and health evaluations were completed on 1-18-13 and 2-14-13 by a registered nurse. The program utilized the Cognitive Ability Assessment as the screening tool.

Functional, cognitive, and health evaluations were completed by a registered nurse prior to admission and within 30 days of admission.

- **Regulatory Insufficiency:** None noted.

## B. Occupancy Agreement

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

- Monitoring Observation: Tenant #9 was admitted to the program on 12-28-12. Tenant #9 signed the Resident Agreement (occupancy agreement) on 1-4-13, after Tenant #9 moved into the program.

Tenant #10 was admitted to the program on 1-19-13. The Resident Agreement (occupancy agreement) contained the signature of Tenant #10, but was not dated. The signature page did not indicate the document was signed prior to occupancy.

Occupancy agreements were not signed prior to admission to the program.

According to the Administrator, the occupancy agreements were new. The occupancy agreement and supporting documents were reviewed. A statement to indicate tenant-landlord law applied was not found. The occupancy agreement referenced Minnesota law and indicated the program was licensed and governed by the State of Minnesota but did not reference Iowa law and certification. The occupancy agreement was not updated with changes.

- Regulatory Insufficiency: An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made. (235C.5(1))
- Regulatory Insufficiency: In addition to the requirements of Iowa Code section 231C.5, the written occupancy agreement shall include, but not be limited to, the following information in the body of the agreement or in the supporting documents and attachments: (e) A statement that the tenant landlord law applies to assisted living programs. (IAC r. 481-69.21(2)(e))
- Regulatory Insufficiency: The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements. (IAC r. 481-69.21(3))

### C. Service Plans

The program received regulatory insufficiencies related to failure to base service plans on evaluations, failure to meet identified needs, and failure to indicate nursing facility preference for Tenants #1, #3, #7, and #8 during the October 17 and 18, 2012 recertification and complaint investigation, #41148-C.

- Monitoring Observation: Tenant #1, an 83 year-old, was admitted on 10-23-11 and had diagnoses of: Anemia, Atrial Fibrillations, Benign Prostatic Hypertrophy, Bilateral Leg Weakness, Cardiomyopathy, Diabetes Mellitus, HTN, and Peripheral Vascular Disease. The 90-day assessment was completed on 12-6-12 and included functional, cognitive, and health evaluations completed by a registered nurse (RN). The program utilized a Cognitive Ability Assessment as the cognitive screening tool. A fall risk assessment was also completed which indicated Tenant #1 was a moderate fall risk. The health assessment indicated Tenant #1 used two liters of oxygen at night for sleep apnea, and staff members placed water in the oxygen concentrator daily. The functional assessment identified Tenant #1 as independent with ambulation with the use of a walker. A review of the service plan dated 12-6-12 did not identify Tenant #1 was independent with ambulation with a walker. The service plan identified the oxygen concentrator was filled daily, but did not indicate what was to be used to fill the concentrator. The service plan did not identify the use of oxygen at night for sleep apnea. A nursing home preference was selected.

The service plan was not based on evaluations, and did not meet the identified needs of Tenant #1.

Tenant #2, a 103 year-old, was admitted on 1-24-11 and had diagnoses of: Atrial Fibrillation, Congestive Heart Failure, Gastroesophageal Reflux Disease (GERD), and History of Anemia. Cognitive and health evaluations were completed on 10-16-12 completed by an RN. The forms used were the "old" forms. A service plan was dated 10-16-12. The service plan did not identify nursing facility preference. The program utilized a Cognitive Ability Assessment as the cognitive screening tool. The program did not complete functional, cognitive and health evaluations with service plan updates including nursing home preference by 1-7-13 as indicated in the Plan of Correction.

Tenant #3, an 82 year-old, was admitted on 5-1-12 and had diagnoses of: Osteoarthritis, Chronic Urinary Tract Infections, Hyperlipidemia, HTN, Coronary Artery Disease, GERD, Mild Dementia, Type II Diabetes, and Lower Extremity Venous Insufficiency. The program utilized a Cognitive Ability Assessment as the cognitive screening tool. Functional, cognitive, and health evaluations were completed by an RN on 2-11-13 for "hospitalization." The health evaluation references "insertion sites from catheterization" and "heart catheterization" and according to the Program Nurse, Tenant #3 had stents placed.

The health evaluation also noted catheterization sites were to be monitored for signs of infection, and extremities were to be monitored for cold, numbness, or pain. Documentation also included a steady gait with assistance of a walker. The service plan did not identify Tenant #3 was independent with ambulation with the use of a walker as identified in the evaluations. The service plan did not identify a nursing home preference.

The service plan was not based on evaluations and did not meet the identified needs of Tenant #3. The service plan did not identify a nursing home preference.

Tenant #7, an 86 year-old, was admitted on 2-11-11 and had diagnoses of: Gout, HTN, Macular Degeneration, Alzheimer's Dementia, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Type II Diabetes, and History of Breast Cancer. Tenant #7 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive impairment. Functional, cognitive, and health evaluations were completed on 12-28-12 and the service plan was updated, prior to 1-7-13.

Tenant #7 was admitted to the hospital on 2-8-13 and returned to the program on 2-13-13 with a diagnosis of Transient Ischemic Attack and Weakness according to the nursing progress notes. Functional, cognitive, and health evaluations were completed by an RN on 2-13-13. The health evaluation indicated Tenant #7 complained of feeling weak and needed stand-by assistance for ambulation with a walker until Tenant #7 regained his/her strength. The service plan dated 2-13-13 indicated assistance with ambulation was "as needed" only and did not identify a walker. The service plan did identify a nursing home preference.

The service plan was not based on evaluations and did not meet the identified needs of Tenant #7.

Tenant #8, an 85 year-old, was admitted on 2-3-11 and had diagnoses of: Interstitial Lung Disease, Protein-Calorie Malnutrition, Osteoporosis, and HTN. Tenant #8 had eight errors on the Cognitive Ability Assessment and was staged at two on the GDS which indicated very mild cognitive decline. Tenant #8 was admitted into hospice care on 3-3-13 with a diagnosis of Pulmonary Fibrosis. Annual functional, cognitive, and health evaluations were completed on 12-28-12. The health evaluation indicated Tenant #8 was on oxygen at all times. The service plan did not identify Tenant #8's use of oxygen. The service plan was not based on evaluations and did not meet the identified needs of Tenant #8. The service plan did identify a nursing facility preference. The service plan was not based on evaluations and did not meet the identified needs of Tenant #8.

The clinical record was reviewed for Tenant #12. Annual functional, cognitive, and health evaluations were completed on 1-3-13 and a service plan was created based on evaluations. The Cognitive Ability Assessment was the cognitive screening tool. The service plan documented a nursing facility preference.

- 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; 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,e))

#### **D. Nurse Review**

The program received regulatory insufficiencies related to failure to complete a nurse review every 90 day for Tenants #1, #3, #7, and #8 during the October 17 and 18, 2012 recertification and complaint investigation, #41148-C.

- Monitoring Observation: Tenant #1 had a 90-day nurse review completed on 12-6-12.

Tenant #2 had health and cognitive evaluations completed 10-16-12. According to the service plan, the program provided bathing assistance, assistance with compression stockings, and administered medications. The chart lacked documentation of a 90-day nurse review. The program reported Tenant #2 was out of the building for hospitalization and follow-up care. The clinical record lacked documentation from a nurse as to why Tenant #2 was out of the building.

Nursing progress notes dated 1-12-13 indicated Tenant #3 was recovering from an upper respiratory infection. Notes dated 1-13-13 indicated Tenant #3 was taken to the hospital for chest pain and returned with an order for an antibiotic. The progress notes did not specify a reason for the antibiotic but an entry dated 1-15-13 indicated lungs were clear. Notes beginning 1-16-13 documented Tenant #3 was nauseated and vomiting and thought to be related to the antibiotic. An anti-nausea drug was ordered. Notes dated 1-24-13 indicated Tenant #3 had been experiencing loose stools since 1-17-13. A physician's order was received on 2-13-13 for the medication Flagyl, with a notation it was to be used for loose stools. A nurse review was not completed due to loose stools beginning 1-17-13 and the medication order of 2-13-13 for continued loose stools. A nurse review was not completed with a change of condition.

Tenant #3 was hospitalized for a cardiac catheterization resulting in the placement of stents according to the health evaluation completed on 2-11-13 following hospitalization. The health evaluation also noted catheterization sites were to be monitored for signs of infection, and extremities were to be monitored for cold, numbness, or pain. There was no documentation in the nursing progress notes after 2-19-13 and no documentation of the condition of the insertion sites or extremities. A nurse review was not completed with a change of condition.

The clinical record for Tenant #7 was reviewed. No issues with nurse review were identified.

The clinical record for Tenant #8 contained a physician's order dated 2-1-13 for a wound gel to be applied to an open wound on the coccyx. A nurse review was not completed for an open wound on the coccyx, a change of condition.

- 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; and (IAC r. 481-69.27(1))
- 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))

## **E. Staffing**

The program received regulatory insufficiencies related to staff failure to demonstrate an understanding of a new medication system and lack of documented staff training to determine competency on medications or medical and personal cares for Staff #1, #2, #3, and #5 during the October 17 and 18, 2012 recertification and complaint investigation, #41148-C.

- Monitoring Observation: The program provided documentation of one medication error since 1-7-13. An incident report was completed, the physician was notified, and the employee was given a written warning. The incident involved Tenant #11 who was given evening medications in the morning on 2-25-13.

The program instituted a new medication administration system. According to the program, the pharmacy pre-filled a caddie, and medications requiring a pulse check prior to administration were placed in individually labeled "sleeves" separate from the caddie. The medication administration record (MAR) documented the pills that were to be in the caddie, and also identified pills that were in the separate sleeves. Staff members were to count the pills in the caddie and compare to the number of pills listed on the MAR. Pills in the sleeves were in addition to pills in the caddie. The new written medication administration procedure did not address the use of separate sleeves for drugs such as Digoxin or Metoprolol.

Staff #2 was observed during a medication pass with Tenant #1. According to the MAR for Tenant #1, Metoprolol was in a separate sleeve and if the pulse rate was less than 50, the medication was to be held. The MAR also indicated Tenant #1 was on Digoxin and it too was in a separate sleeve. The Digoxin was to be held if the pulse rate was less than 60. Staff #2 was also noted to be carrying a clipboard which contained the new Medication Administration Policy. Staff #2 was observed taking one pill out of the sleeve labeled Digoxin and placing it in an unmarked cup. Then Staff #2 took one pill out of the sleeve labeled Metoprolol and placed in another cup which was also unmarked. Staff #2 then counted the number of pills listed on the MAR, and poured the pills from the caddie into a third cup and counted them. The number of pills matched the number of pills listed on the MAR. Staff #2 proceeded to check Tenant #1's pulse. Staff #2 was asked to identify which of the unlabeled cups held the Digoxin (hold for pulse less than 60), and which held the Metoprolol (hold for pulse less than 50). Staff #2 incorrectly identified the pills. Staff #2 checked Tenant #1's pulse and identified the rate was above 60 and placed both pills from the unmarked cup into the cup with the multiple pills from the caddies and administered the pills. Staff #2 did not demonstrate an understanding of the purpose of the separate medication sleeves when she put those pills into unlabeled cups.

At no time did Staff #2 use bare hands to count pills. A spoon was used to separate pills for easier counting.

The Nurse identified Tenant #2 as out of the building during the onsite visit; viewing of a medication pass was not possible.

Staff #2 was observed passing medications to Tenant #3. Staff #2 identified nine pills on the MAR and counted nine pills in the caddie. There were no extra sleeves documented on the MAR.

Staff #1 left employment on 12-6-12. Staff #2, #4, and #5 was trained on the new medication procedure on 11-28-12. Staff #8, a new employee, was trained on 2-19-13 and Staff #9 was trained on 11-28-12. There was no documentation that Staff #3 was trained on the new procedure. The Nurse was unable to provide documentation she had observed staff members demonstrating the new medication procedure.

The Nurse provided documentation of hand washing training which was signed by Staff # 2, #4, #5, and #9; however, the entries were not dated. Staff #8 signed the documentation on 2-19-13. The documentation was not signed by Staff #3. The Nurse was unable to provide documentation she had observed staff members demonstrating the hand washing procedure.

The Nurse provided documentation of training on activities of daily living in an in-service dated 1-10-13. The documentation was signed by Staff #4, #5, #8, and #9. The documentation was not signed by Staff #2 or #3. The Nurse was unable to provide documentation she had observed staff members demonstrating cares related to activities of daily living.

Clinical records for Tenants #2 and #12 were reviewed. The service plan for Tenant #2, dated 10-16-12 indicated staff members were to apply compression stockings daily. The service plan for Tenant #12, dated 1-3-13, indicated staff members were to assist with compression stockings. The Nurse was unable to provide documentation of staff training on compression stockings. There was no documentation the Nurse had observed staff members applying compression stockings.

Staff did not demonstrate an understanding of the new medication procedure. The medication procedure did not give direction as to the use of medication "sleeves" separate from the caddy. The program did not provide documentation of staff training and observation of the administration of medications, medical and personal cares. Staff training files lacked documentation of training to determine competency to provide cares and treatments for the tenants of the program.

The MAR for Tenant #1 was reviewed on 12-7-12 and 3-4-13. The MAR for Tenant #3 had a review date of 3-5-13 at 7:40 a.m. The MAR for Tenant #7 had a review date of 2-25-13 and 3-4-13. The MAR for Tenant #13 had a review date of 1-28-13 and 3-4-13. MAR's were not reviewed monthly.

- 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))

## **F. Medications**

The program received a regulatory insufficiency related to staff failure to demonstrate accepted professional standards for medication administration and failure to maintain a list of tenant medications during the October 17 and 18, 2012 recertification and complaint investigation, #41148-C.

- Monitoring Observation: A medication pass was observed on 3-5-13. Staff #2 was observed administering medications to four tenants. Hands were washed upon entering the apartments. Hands were not washed prior to leaving the apartments. Gloves were applied to administer eye drops to Tenant #13. Hands were not washed immediately after removing gloves and Staff #2 proceeded to get out the pill caddy with gloves still on. Gloves were also applied in order to assist Tenant #13 with hearing aids. Gloves were removed and hands were not washed.

Staff #2 was observed administering medications to Tenant #7. Tenant #7 had a physician's order dated 12-7-12 for NaCl 5%/Muro 128 eye drops. Staff #2 checked the bottle of eye drops against the MAR and noted the Muro 128. Staff #2 proceeded to administer the eye drops after applying gloves. Closer inspection of the bottle revealed the bottle was NaCl 2%/Muro 128. Staff #2 did not closely check the bottle of eye drops against the MAR and the incorrect medication was given. The Administrator phoned the pharmacy and it was reported the pharmacy had an order for NaCl 2%/Muro 128 and not the 5% NaCl.

At no time did Staff #2 use bare hands to count pills. A spoon was used to separate pills for easier counting. The pill counts were observed to match the MAR's during all four medication passes.

The MAR was reviewed for Tenant #6. The MAR indicated a multivitamin twice a day. The MAR was reviewed for Tenant #4. Hydrocodone was identified as 5/325 milligrams, one tablet scheduled daily in the morning, and 1-2 tablets every four hours as needed. MAR's included dosages.

Staff #1 left employment on 12-6-12. Staff #2, #4, and #5 was trained on the new medication procedure on 11-28-12. Staff #8, a new employee, was trained on 2-19-13 and Staff #9 was trained on 11-28-12. There was no documentation that Staff #3 was trained on the new procedure. The Nurse was unable to provide documentation she had observed staff members demonstrating the new medication procedure.

The Nurse provided documentation of hand washing training which was signed by Staff # 2, #4, #5, and #9, however the entries were not dated. Staff #8 signed the documentation on 2-19-13. The documentation was not signed by Staff #3. The Nurse was unable to provide documentation she had observed staff members demonstrating the hand washing procedure.

The program failed to follow procedures set forth by the program as well as accepted professional standards for medication administration.

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

## G. Policies and Procedures

The program received a regulatory insufficiency related to staff failure to follow policies and procedures related to medications, hand washing, and the use of gloves during the October 17 and 18, 2012 recertification and complaint investigation, #41148-C.

- Monitoring Observation: The program provided documentation of one medication error since 1-7-13. An incident report was completed, the physician was notified, and the employee was given a written warning. The incident involved Tenant #11 who was given evening medications in the morning on 2-25-13. The medication error report was not signed by the administrator.

The Nurse provided documentation of hand washing training which was signed by Staff # 2, #4, #5, and #9, however the entries were not dated. Staff #8 signed the documentation on 2-19-13. The documentation was not signed by Staff #3. The Nurse was unable to provide documentation she had observed staff members demonstrating the hand washing procedure.

The hand washing training indicated hands must be washed upon entering and before leaving each tenant's apartment, as well as before and after the use of gloves. Staff #2 did not follow the procedure when observed during a medication pass.

The program provided copies of three incident reports written since 1-7-13. One for Tenant #1 dated 1-21-13, one for Tenant #14 dated 2-1-13, and one for Tenant #15 dated 2-23-13. The incident reports were signed by the Nurse, but not by the Administrator.

- 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)

## H. Record Checks

The program received a regulatory insufficiency related to failure to complete background checks for criminal history, child abuse and dependent adult abuse prior to hire during the October 17 and 18, 2012 recertification and complaint investigation, #41148-C.

- Monitoring Observation: The original report identified Staff #1, #2, and #3 as having background checks completed, but not prior to hire. The program identified two staff members hired in 2013.

Staff #7, housekeeper, was hired 1-28-13. A criminal background check was completed on 1-8-13. Child abuse and dependent adult abuse registry checks were completed on 1-10-13. Staff #7 did not have a criminal history and was not listed on either registry.

Staff #8, caregiver, was hired 2-6-13. A criminal background check was completed on 1-30-13. Child abuse and dependent adult abuse registry checks were completed on 2-1-13. Staff #8 did not have a criminal history and was not listed on either registry.

- Regulatory Insufficiency: None noted.

## **I. Compliance with Plan of Correction**

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

- Monitoring Observation:
  1. The Administrator was interviewed and stated no chart audits had been completed. By the end of the monitoring visit, the Administrator provided an audit form. The RN stated she had looked through charts but did not provide documentation of audits.
  2. Not all clinical records were updated with functional, cognitive, and health evaluations using new forms, and service plans were not updated by 1-7-13.
  3. Not all 90-day nurse reviews were completed on time as indicated in the Plan of Correction (POC).
  4. The clinical records for Tenants #1, #2, #3, #7, #8, #9, #10 and #12 included a Cognitive Ability Assessment as a cognitive screening tool. The clinical records did not contain an SPMSQ (Short Portable Mental Status Questionnaire) as indicated in the POC.
  5. Tenant #1, evaluations were completed prior to 1-7-13, but the service plan was not updated as indicated in the POC.
  6. Tenant #2 and #3 did not have a nursing facility preference identified on the service plan.
  7. Tenant #3 had evaluations completed on 2-11-13, but were not completed by 1-7-13 as indicated in the POC.
  8. Not all staff received training as indicated in the POC.
  9. The Nurse was unable to provide documentation which indicated the Nurse followed staff to observe staff technique in order to verify staff correctly followed policies and procedures.
  10. MAR's were not reviewed monthly to ensure compliance.
  11. Incident reports were not signed by the Administrator as indicated in the POC.

The program did not follow its plan of correction.

- 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))