IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

May 13, 2013

Mr. Alan Bruinsma, Administrator
Fountain View Assisted Living
5503 Gordon Drive East
Sioux City, IA 51106

RE: Final Recertification Monitoring Evaluation Report – Fountain View Assisted Living, Sioux City, IA

Dear Mr. Bruinsma:

Enclosed is the **Final Recertification Monitoring Evaluation 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.

DIA has completed the review of your Plan of Correction (POC) in response to the **Preliminary Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Request for Reconsideration has been denied. This decision is based on two severely cognitively impaired tenants exited the program without staff knowledge. This constitutes elopement and needed to be reported to the Department. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0172** with effective dates of **April 22, 2013** through **April 21, 2015**.

If you have any questions in regard to this certification, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Recertification Monitoring Evaluation Report

Assisted Living Program:

Alan Bruinsma, Administrator
Fountain View Assisted Living
5503 Gordon Drive East
Sioux City, IA 51106

Date of Monitoring Visit:

April 2nd and 3rd, 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 were provided by the Program at the time of the on-site.

General Population Program	
Number of tenants without cognitive disorder:	33
Number of tenants with cognitive disorder:	4
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:	3
Total Population of Program at time of on-site	4
TOTAL census of Assisted Living Program	41

Tenant/Family Satisfaction Results – A meeting was held with nine tenants. The best thing about the program was the food, the kind people, and the availability of church programs. Housekeeping was completed to the tenants' satisfaction in apartments and common areas. The tenants reported using a call button to request assistance. Staff responded in less than five minutes. Staff members were reported to give very good care, and were kind and respectful. The food was described as mostly good with choices available. There were enough activities offered. The tenants reported feeling safe at the program and would recommend it to others.

Program History – The program did not receive any regulatory insufficiencies during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

A. Evaluation of Tenant

Monitoring Observation: Tenant #9, an 81 year-old, was admitted on 2-15-13 and had diagnoses of: Diabetes Mellitus Type II, Hypothyroidism, and Hypertension (HTN). On 2-19-13, Tenant #9 was staged at four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. A physician's note from a visit dated 1-8-13 indicated Tenant #9 was very quiet and passive. Tenant #9 was described as monotone. Tenant #9 resided in the general population on the third floor with a spouse, Tenant #10. A form labeled Functional/Health/Safety Assessment Pre-Admission was completed on 2-11-13. The functional portion of the assessment dated 2-11-13 indicated Tenant #9 had not exhibited any behaviors. A Short Portable Mental Status Questionnaire (SPMSQ), a cognitive screening tool was completed on 2-11-13. Tenant #9 had nine errors, which indicated severe impairment. The SPMSQ was not signed so it could not be determined if

the initial cognitive evaluation was completed by a health care professional or a human service professional as required.

Daily Notes of 2-15-13 at 12:30 p.m. indicated Tenant #9 was admitted to the program from an independent living apartment on campus. The notes times at 11:00 p.m.also documented Tenant #9 left the building at 4:30 p.m. and 6:00 p.m. and was found wandering to the old apartment on the facility campus. Tenant #9 was wandering and was confused. The notes indicated the Executive Director was notified and ordered room checks every 30 minutes to one hour throughout the night. The notes documented a family member was notified and would be at the program the next day "to assist in keeping residents in facility." There was no documentation Tenant #9 was evaluated after leaving the program.

An email from the Executive Director dated 2-22-13 outlined six approaches staff were to use to help Tenant #9 and #10 stay in the building and adjust as much as possible.

Notes dated 2-27-13 and timed 7:30 a.m. indicated around midnight Tenant #9 was walking towards the business office with cookies and juice in hand. Tenant #9 was informed of the time, and replied "I do not know it's that late." Tenant #9 and Tenant #10 were escorted to the apartment where they locked themselves in the bedroom.

Notes dated 3-1-13 and timed 7:10 a.m. indicated Tenant #9 and Tenant #10 were in bed when checked shortly after 4:00 a.m. At 4:45 a.m. staff received a call from another portion of the building that Tenant #9 was there. Tenant #9 was assisted back to the apartment. At 5:15 a.m., a staff member heard the elevator and went to check on Tenant #9. Tenant #9 was not in the apartment, but was found in the dining room, which was located on the first floor.

Notes dated 3-5-13 timed 2:00 p.m. refer the reader to Tenant #10's clinical record. The notes for Tenant #10 on 3-5-13 timed 1:50 p.m. documented Tenant #9 and Tenant #10 were on the first floor when a staff member asked where they were going. Tenant #10 indicated they were going to The Point, another building on campus where Tenant #9 and Tenant #10 resided prior to admission, to visit. The staff member stated it was snowing and windy and Tenant #9 and #10 agreed to not to go.

Notes dated 3-9-13 and timed 10:00 p.m. indicated Tenant #9 was redirected from wandering from the second to third floor.

Notes dated 3-10-13 and times 10:00 p.m. indicated Tenant #9 was more confused and was redirected from leaving the program three times. Tenant #9 was also reoriented to time after attempting to go to supper two hours after eating.

A 30-day nurse review was completed on 3-15-13 by the registered nurse (RN). The RN indicated Tenant #9 was not oriented to time and Tenant #9 required redirection. Reminders were given frequently for meal times and activities. Tenant #9 and #10 were redirected to wear coats if going outside to the old apartment. Tenant #9 also needed reminders to use a walker with ambulation. Evaluations of function and health were completed on 3-15-13. The evaluation indicated Tenant #9 did not exhibit any behaviors, including wandering. Tenant #9 was staged at four on the GDS on 2-19-13.

Notes in Tenant #10's clinical record on 3-17-13 and timed at 5:00 p.m. indicated Tenant #9 and #10 were in the beauty salon with the hair dryers on sitting in the dark.

Notes dated 3-17-13 timed 10:30 p.m. indicated Tenant #9 was "extremely confused" the entire shift and was directed from going to the old apartment, redirected from the stairwell, and redirected from another tenant's apartment. The notes indicated an administrator was called and 30 minute checks were instituted.

Notes dated 3-24-13 timed 9:30 p.m. indicated Tenant #9 and #10 were wandering on the third floor most of the shift and required redirection several times.

Notes dated 3-29-13 times 10:00 p.m. indicated Tenant #9 was redirected from the stairs. Tenant #9 was also instructed not to use the call light for no reason. Tenant #9 was on the first floor and was redirected to not play with the juice machine.

Evaluations indicated Tenant #9 exhibited no behaviors. Documentation in the Daily notes showed Tenant #9 wandered. Evaluations were not completed within 30 days of admission and with a change of condition.

Tenant #10, an 83 year-old, was admitted on 2-15-13 and had diagnoses of: Diabetes Type II, Hyperlipidemia, and Dementia. On 2-19-13 Tenant #10 was staged at four on the GDS which indicated moderate cognitive decline. Tenant #10 resided on the third floor of the general population with a spouse, Tenant #9. A form labeled Functional/Health/Safety Assessment Pre-Admission was completed on 2-11-13. The functional portion of the assessment dated 2-11-13 indicated Tenant #10 had not exhibited any behaviors. An SPMSQ, a cognitive screening tool was completed on 2-11-13. Tenant #10 had eight errors, which indicated severe impairment. The SPMSQ was not signed so it could not be determined if the initial cognitive evaluation was completed by a health care professional or a human service professional as required.

On 2-15-13, Daily Notes timed 12:30 p.m. indicated Tenant #10 was admitted to the program from an independent living apartment on campus. The notes documented Tenant #10 became agitated with the admission process.

On 2-15-13, Daily Notes times at 11:00 p.m. documented Tenant #10 was confused. The notes documented Tenant #10 left the building at 4:30 p.m. and 6:00 p.m. and was found wandering to the old apartment on the facility campus. The notes indicated the Executive Director was notified and ordered room checks every 30 minutes to one hour throughout the night. The notes documented a family member was notified and would be at the program the next day "to help keep residents on floor." There was no documentation Tenant #10 was evaluated after leaving the program.

On 2-16-13, notes timed 11:50 a.m. indicated Tenant #10 was confused as to place and redirected with some success.

On 2-19-13 notes timed 9:33 p.m. indicated Tenant #10 was wandering the hallway on the third floor with a coat on "looking for home." Notes indicated Tenant #10 was unable to identify the apartment on the third floor, and pointed out the old apartment building on campus as home.

On 2-13-13 notes timed for the day shift indicated Tenant #10 was confused and wandering the hallway. Notes times at 7:00 p.m. indicated a nurse from another part of the building called the assisted living staff to verify where Tenant #10 resided. Tenant #10 had been looking for the spouse, and was escorted to the apartment.

An email from the Executive Director dated 2-22-13 outlined six approaches all staff were to use to help Tenant #9 and #10 stay in the building and adjust as much as possible.

On 2-24-13 notes timed for the day shift documented a conversation between Tenant #9 and #10 in which the husband asked the wife if she was pregnant. The wife replied she might be. The staff member indicated Tenants #9 and #10 were not joking.

On 2-24-13, notes timed at 1900 indicated Tenant #10 was more confused and had non-sensical sentence structure and was unable to make needs known.

Notes dated 2-27-13 and timed 7:30 a.m. indicated around midnight Tenant #9 was walking towards the business office with cookies and juice in hand. Tenant #9 was informed of the time, and replied he/she was unaware of the time. Tenant #9 and Tenant #10 were escorted to the apartment where they locked themselves in the bedroom.

On 3-1-13, notes timed 6:25 p.m. indicated Tenant #10 was redirected twice for wandering.

The notes for Tenant #10 on 3-5-13 timed 1:50 p.m. documented Tenant #9 and Tenant #10 were on the first floor when a staff member asked where they were going. Tenant #10 indicated they were going to The Point, another building on campus where Tenant #9 and Tenant #10 resided prior to admission, to visit. The staff member stated it was snowing and windy and Tenant #9 and #10 agreed to not to go.

On 3-5-13 notes timed 9:37 p.m. indicated Tenant #10 was in the laundry room and looking for the bathroom. Tenant #10 was directed across the hall to the apartment.

On 3-6-13 notes timed 9:25 p.m. indicated the first floor front office called the staff after supper to report Tenant #10 left the building to go to the old apartment on campus and left Tenant #9. Tenant #10 returned before staff reached the first floor.

On 3-9-13 notes indicated a late entry for the night shift of 3-8-13 at 2:15 a.m. indicated Tenant #10 and #9 were walking down the third floor hallway fully dressed. Tenant #10 stated they always got up early. Tenant #10 indicated they were on their way to breakfast.

On 3-10-13 notes timed for the day shift indicated both tenants were confused about meals during the shift.

On 3-10-13 notes timed 10:00 p.m. indicated Tenant #10 was redirected from going outside three times.

On 3-12-13 notes timed 9:25 p.m. indicated Tenant #10 was wandering the third floor asking the same questions over and over. Tenant #10 had on a coat and wanted to go to

the old apartment building to visit. Documentation indicated Tenant #10 needed much redirection.

A 30-day nurse review was completed by the RN on 3-15-13. The RN indicated Tenant #10 was not oriented to time, and needed reminders for meal times and activities. Tenant #10 also required redirection when Tenant #10 was found downstairs before breakfast. Tenant #10 needed reminders to wear a coat when the weather was bad. Evaluations of function and health were completed on 3-15-13. The evaluation indicated Tenant #10 did not exhibit any behaviors including wandering. Tenant #10 was staged at four on the GDS on 2-19-13.

On 3-15-13 notes timed at 8:00 p.m. indicated Tenant #10 was more confused, came up the medication cart, grabbed the water pitcher, and poured water onto the top of the cart.

On 3-17-13, notes timed 10:30 p.m. indicated Tenant #10 was extremely confused for the whole shift. Tenant #10 was redirected from leaving the program at 6:30 p.m., from the third floor stairwell, and another tenant's apartment. Another note timed at 5:00 p.m. indicated Tenant #9 and #10 were in the beauty salon with the hair dryers on sitting in the dark.

On 3-18-13 notes timed 9:35 p.m. indicated Tenant#10 was getting onto the third floor elevator without socks, shoes, or coat. Tenant #10 was going to the old apartment on campus. Tenant #10 was redirected and a staff member checked on Tenant #10 later. Tenant #10 was observed wandering in and out of the laundry room.

On 3-21-12 notes timed 1:00 p.m. Tenant #10 was noted to have "inappropriate behavior." Tenant #10 answered the apartment door with no clothes on. Tenant #10 also referenced sexual activity between Tenant #10 and Tenant #9. After dressing, the staff member administered medications. Tenant #10 stated the pills would make Tenant #9 want to take clothes off.

On 3-22-13 notes timed 8:30 p.m. documented Tenant #10 was wandering on the first floor. Tenant #10 continued to make "inappropriate" comments to staff regarding sexual relations with Tenant #9.

On 3-23-13 notes timed 8:30 p.m. indicated a staff member stopped Tenant #10 from reaching into a sharps container.

On 3-24-13 notes timed 9:30 p.m. indicated Tenant #10 was wandering on the third floor and was looking for someone, but could not say who.

On 3-25-13 notes timed 9:50 p.m. indicated Tenant #10 was wandering on the third floor attempting to follow a staff member into other tenant's apartments.

On 3-28-13 notes timed 9:43 p.m. indicated Tenant #10 thought staff members were cooking in the laundry room.

On 3-29-13, notes timed for the day shift indicated when medications were passed, Tenant #10 came out of the bedroom without clothes on, and had happened "several" mornings. The documentation indicated Tenant #10 exhibited "inappropriate" behavior

about sexual relations with Tenant #9, and Tenant #10 talked about sexual relations and having children when spoken to by staff.

On 3-29-13 notes timed 9:00 p.m. indicated tenant #10 was redirected from the stairwell.

On 3-31-12 notes timed 7:00 p.m. indicated Tenant #10 was more confused. Tenant #10 reported the apartment was cold. A staff member found the air conditioning on and the temperature set to 40 degrees.

On 4-1-13 notes timed 9:53 p.m. indicated Tenant #10 wandered the third floor throughout the shift.

Evaluations indicated Tenant #10 had no behaviors. Documentation in the Daily Notes showed Tenant #10 wandered and exhibited sexual behavior.

Tenants #9 and #10 were initially scored on the SPMSQ, a cognitive screening tool, which indicated severe impairment. Four days after admission, Tenants #9 and #10 were staged on the GDS, however, functional and health evaluations were not completed, even after each tenant exhibited changes in behavior within the first four days of admission, including an elopement. At 30 days, evaluations of function and health were completed, but no cognitive evaluation was completed at that time. The evaluations at 30 days indicated Tenants #9 and #10 exhibited no behaviors, including wandering. Tenants #9 and #10 continued to exhibit wandering and/or sexual behavior after the 30-day evaluations. Evaluations were not completed with the continued wandering.

Tenant #1, a 79 year-old, was admitted on 9-28-12 and had diagnoses of: Parkinson's Disease, HTN, and Plasma Cell Dyscrasia. An SPMSQ was completed prior to admission. The SPMSQ was not signed so it could not be determined if the initial cognitive evaluation was completed by a health care professional or a human service professional as required.

Tenant #12 was admitted on 10-22-12 and had diagnoses of: Dementia, Hypothyroidism, HTN, Hyperlipidemia, Depression, and Osteoporosis. Tenant #12 failed the SPMSQ completed prior to admission. The SPMSQ was not signed; it was not clear the initial cognitive evaluation was completed by a health care professional or a human service professional. Evaluations of function and health were completed on 11-18-12; however the documents were not signed. It was not clear who completed the 30-day evaluations.

Initial cognitive evaluations were not signed by a health care or human service professional. Evaluations were not completed within 30 days of admission and with changes of condition.

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))

B. Service Plan

Monitoring Observation: Tenant #9 was admitted on 2-15-13. The initial service plan did not identify any behaviors and indicated Tenant #9 did not use assistive devices with ambulation. The initial service plan did not document interventions for wandering. Daily notes 2-15-13 through 3-15-13 indicated Tenant #9 was confused and wandering, and included an elopement on the first day of admission. The initial service plan was not updated with a change of condition to include interventions for elopement or wandering. The nurse review of 3-15-13 indicated Tenant #9 needed reminders to use a walker with ambulation. The service plan was not updated with a change of condition.

Evaluations of function, cognition, and health were completed prior to admission, and a service plan was developed all dated 2-11-13. Tenant #9 failed the SPMSQ and Tenant #9 was staged at four on the GDS on 2-15-13. A functional and health assessment was completed on 3-15-13. The service plan of 3-15-13 was not based on a cognitive evaluation. The evaluations of 3-15-13 indicated Tenant #9 did not exhibit wandering or other behaviors.

The service plan dated 3-15-13 indicated Tenant #9 managed to get to the dining room for meals and find the apartment after meals with the spouse. The service plan indicated staff members checked on Tenant #9 because Tenant #9 had been going to the old apartment on campus for meals. Tenant #9 and #10 were to be encouraged to eat in the program's dining room. Tenant #9 and #10 needed redirection in the middle of the night thinking it was breakfast time. Staff members were to redirect the Tenant's back to their apartment. The service plan identified Tenant #9 refused to wear a call pendant. The service plan indicated Tenant #9 was safe to be alone in the apartment. After the service plan was updated on 3-15-13, Tenant #9 continued to exhibit wandering behavior and was found on the first floor "playing" with the juice machine, was attempting to enter other tenant's apartments, and was trying to go down a stairwell when a walker was needed for ambulation. The service plan did not identify frequent checks, or specific interventions for redirection. The service plan did not meet the identified needs of Tenant #9. The service plan did not identify activity needs. The service plan did not identify a nursing facility preference.

Tenant #10 was admitted on 2-15-13. The initial service plan did not identify any behaviors. Daily Notes 2-15-13 through 3-15-13 indicated Tenant #10 was confused and wandering, including an elopement on the first day of admission. The initial service plan

was not updated with a change of condition to include interventions for elopement or wandering. The service plan was not updated with a change of condition.

Evaluations of function, cognition, and health were completed prior to admission, and a service plan was developed all dated 2-11-13. Tenant #10 failed the SPMSQ and Tenant #10 was staged at four on the GDS on 2-15-13. A functional and health assessment was completed on 3-15-13. The service plan of 3-15-13 was not based on a cognitive evaluation. The evaluations of 3-15-13 indicated Tenant #10 did not exhibit wandering or other behaviors.

The service plan dated 3-15-13 indicated Tenant #10 managed to get to the dining room for meals and find the apartment after meals with the spouse. The service plan indicated Tenant #10 was independent with ambulation and liked to walk to the old apartment to visit friends. Staff members were to redirect Tenant #10 if the weather was bad. The service plan indicated Tenant #10 had difficulty understanding when staff indicated Tenant #10 could not go to the old apartment and visit. Tenant #10 was to be reminded to wear the call pendant. Tenant #10 was identified as safe to be in the apartment. After the service plan was updated on 3-15-13, Tenant #10 continued to exhibit wandering behavior and thought staff members were cooking in the laundry room, was attempting to enter other tenant's apartments, and was trying to go down a stairwell. The service plan did not identify frequent checks, or specific interventions for redirection. The service plan did not identify interventions for "inappropriate" sexual behavior. The service plan did not meet the identified needs of Tenant #10. The service plan did not identify activity needs. The service plan did not identify a nursing facility preference.

Tenant #1 was admitted on 9-22-12. The program did not provide documentation of a service plan completed prior to admission. Tenant #1 was admitted to hospice on 10-3-12 for Paralysis Agitans. The current service plan dated 2-11-13 did not identify a nursing facility preference.

Tenant #12 was admitted on 10-22-12. Tenant #12 failed the SPMSQ completed prior to admission. Tenant #12 was staged at six on the GDS on 11-17-12. Tenant #12 resided in the general population. The program did not provide documentation of a service plan completed prior to admission. The current service plan dated 2-13-13 did not identify a nursing facility preference.

Service plans were not based on evaluations, were not completed prior to admission, were not updated with a change of condition, and did not meet identified tenant needs, did not identify activity needs in persons exhibiting dementia, or 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: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant

and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

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 not 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; (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,d,e))

C. Other –Program Notification to the Department

Monitoring Observation: Tenants #9 and #10 were admitted to the general population of the program on 2-15-13. Tenants #9 and #10 had been living in independent housing on the same campus as the assisted living program. Each failed the SPMSQ, and the scoring indicated Tenant #9 and #10 had severe intellectual impairment.

Daily Notes for Tenant #9 dated 2-15-13 and timed as 11:00 p.m. indicated Tenant #9 was "very confused" on the evening shift. Tenant #9 was found and brought back by staff from the old apartment building on the facility campus, once at 4:30 p.m. and again at 6:00 p.m. The kitchen staff of the assisted living program called the assisted living staff asking if Tenant #9 was coming down to supper. Tenant #9 was located at the old apartment dining room eating supper. The Executive Director was contacted and ordered room checks every 30 minutes then hourly checks throughout the night. A family member was contacted and would be at the program the next day "to assist in keeping residents in facility."

Daily Notes for Tenant #10 dated 2-15-13 and timed as 11:00 p.m. indicated Tenant #10 was "very confused" on the evening shift. Tenant #10 was found to have wandered over to the old apartment twice, at 4:30 p.m. and 6:00 p.m. The kitchen staff of the assisted living program called the assisted living staff asking if Tenant #10 coming down for supper. Tenant #10 was found at the old apartment dining room eating supper. The Executive Director was contacted and ordered room checks every 30 minutes then hourly checks throughout the night. A family member was contacted and would be at the program the next day "to help keep resident's on floor."

Evaluations were not completed and service plans were not updated to include interventions for wandering or elopement. The service plans were not updated to include the frequent checks. No interventions were in place for wandering and elopement immediately following the event.

Elopement means a tenant who has impaired decision-making ability leaves the program without the knowledge or authorization of staff.

Two cognitively impaired persons left the assisted living program without staff knowledge. The program's response to Tenants #9 and #10 leaving the building was to institute frequent checks, however, the tenants were not evaluated and service plans were not updated. Tenants #9 and #10 eloped from the program. The department was not notified of the elopements.

Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: When a tenant elopes from a program. (IAC r. 481-67.4(4))

D. Medications

Monitoring Observation: Staff #3 was observed passing medications to Tenant #1 at 8:45 a.m. on 4-2-13. The Medication Administration Record (MAR) indicated Senna, four tablets, was to be given twice a day. Staff #3 administered three tablets because the pill bottle indicated three were to be given. The medication list signed by the physician on 2-10-13 indicated four tablets were to be given.

Staff #3 was observed passing medications to Tenant #3 at 9:25 a.m. on 4-2-13. The MAR indicated 30 milliliters (ml) of Milk of Magnesia was to be given. Staff #3 set a medication cup on the counter and poured Milk of Magnesia in the cup, but did not raise the cup to visualize the level of the medication in the cup to see if the desired 30 ml was present. The monitor raised the cup and observed 20 ml in the medication cup. Staff #3 added more medication to make 30 ml after the monitor asked Staff #3 to check the amount of medication in the cup.

Staff #4 was observed passing medications to Tenant #9 at 8:30 a.m. on 4-3-13. The MAR indicated 81 milligrams (mg) of chewable children's aspirin was to be given daily. Staff #4 took a bottle of enteric coated low dose aspirin, 81mg, from the tenant's medication cupboard. Staff #4 went to place the medication in a separate cup so that Tenant #9 could chew the pill. Staff #4 was set to have Tenant #9 chew the enteric coated tablet until the monitor showed the label on the bottle indicating the pill was enteric coated.

Staff #4 was observed passing medications to Tenant #4 at 9:08 a.m. on 4-3-13. The MAR indicated a Bisacodyl suppository was to be given daily for constipation. A review of the physician's order indicated the Bisacodyl was to be given "as needed."

Tenant #4 was to receive Ammonium Lactate 12% lotion applied to the feet twice a day according to the MAR. Upon entry to the apartment by Staff #4 and the monitor, another staff member was observed applying compression stockings. Tenant #4 stated the lotion had not been applied, but the stockings had already been applied. Tenant #4 did not receive the morning application of lotion on 4-3-12. Tenant #4 stated the lotion had not been applied in the morning for several days. Tenant #4 stated the lotion was applied when the compression stockings were removed in the evening. The MAR documented the morning application of lotion on 4-1 and 4-2-13.

The MAR for Tenant #9 indicated Oxybutinin, for urinary frequency, was to be given twice daily. The MAR however, was not highlighted to indicate a morning dose was due. Oxybutinin was not documented as given in the morning on 4-1 and 4-2-13

The MAR indicated Tenant #10 was to receive Donepezil, a dementia medication, one tablet daily. The Donepezil was listed on the MAR twice and each MAR entry was signed as given on 4-1 and 4-2-13, which indicated Tenant #10 received twice the daily dosage prescribed.

The MAR indicated Tenant #11 was to receive 17 grams of Polyethylene Glycol, a laxative, in water every other day. The entry was type-written. The medication was documented as given on 4-1-13. The MAR also indicated Tenant #11 was to receive 17 grams of Miralax for constipation every other day. The entry was handwritten. The medication was documented as given on 4-1-13. Polyethylene Glycol is the generic name for Miralax. The MAR documented Tenant #11 received twice the daily dosage prescribed.

Medications were not given as prescribed. MAR's were not correct.

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))

E. Staffing

Monitoring Observation: The service plan for Tenant #1, dated 2-11-13, indicated Tenant #1 had an indwelling catheter in place and staff members were to provide catheter care every shift and as needed. The current program nurse (RN) was hired into the assisted living program on 9-12-12. Staff #1, a Certified Medication Assistant (CMA) was hired 4-11-11. Staff #2, CMA, was hired 4-27-07. Staff #3, CMA, was hired 5-9-96. Training files lacked documentation of training by the RN related to catheter care.

An 8:00 a.m. medication pass was observed on 4-2-13. Staff #3 was passing medications and reported she was the only person passing medications. 8:00 a.m. medications were not given to Tenant #2 until 9:15 a.m. The medications included Lisinopril, a medication for blood pressure.

8:00 a.m. medications were not given to Tenant #3 until 9:25 a.m. The medications included Omeprazole for Gastroesophageal Reflux Disease (GERD), and Metoprolol for blood pressure ordered twice daily.

An 8:00 a.m. medication pass was observed on 4-3-13. Staff #4 was passing medications and reported she was the only person passing medications. 8:00 a.m. medications were not given to Tenant #4 until 9:08 a.m. The medications included Spironolactone, a diuretic; Citalopram, an antidepressant; Carvedilol for blood pressure; Furosemide, a diuretic, Isosorbide, a vasodilator; Lisinopril for blood pressure; Oxybutinin for overactive bladder; and Pantoprazole for GERD.

8:00 a.m. medications were not given to Tenant #5 until 9:16 a.m. The medications included Amlodipine for blood pressure; and Benazepril, an angiotensin converting enzyme inhibitor, usually given for blood pressure.

8:00 a.m. medications were not given to Tenant #6 until 9:28 a.m. The medications included Losartan for blood pressure, Furosemide, a diuretic; and Carvedilol for blood pressure.

8:00 a.m. medications were not given to Tenant #7 until 9:52 a.m. The medications included Cetirizine, an antihistamine; Omeprazole for GERD; Dicyclomine, an anticholinergic that was ordered three times a day; Donezipil, used in dementia; Diovan for blood pressure; Metoprolol for blood pressure, Venlafaxine for depression; Quetiapine for depression; and Amlodipine for blood pressure. Tenant #7 also received artificial tears eye drops. The dosage of eye drops was scheduled four times a day with the next dose due at 11:00 a.m. according to the MAR.

At 10:10 a.m. Staff #4 reported she still had 3-4 tenants who had not received 8:00 a.m. medications. The monitor notified administration that the 8:00 a.m. medication pass had not been completed.

The standard for the administration of medications, one hour before to one hour after medications are due, was not followed.

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. Other: Policies and Procedures.

Monitoring Observation: A medication pass was observed on 4-2-13. The monitor came into the apartment as Staff #3 was observed administering eye drops to Tenant #8 at 8:37 a.m. The medications were already documented as given. Staff #3 documented the eye drops prior to giving them. According to the Medication Administration Policy, medications were not to be documented prior to being given.

Staff #3 had already applied gloves to administer eye drops to Tenant #8. Staff #3 removed the gloves and left the apartment without washing hands or using hand sanitizer. According to the Eye Drop Installation procedure, hands were to be washed after the removal of gloves.

Staff #3 was observed passing medications to Tenant #1 at 8:45 a.m. Staff #3 did not wash hands prior to leaving the room. The Medication Administration Policy indicated hands were to be washed between tenant contacts.

Staff #3 was observed passing medications to Tenant #6 at 8:55 a.m. The medications were not documented as given as indicated in the Medication Administration Policy.

Staff #3 was observed passing medications to Tenant #8 at 9:00 a.m. The medications were already documented as given. Staff #3 stated she had seen Tenant #8 earlier, documented the medications as given, but did not give the medications at that time.

Staff #3 was observed passing medications to Tenant #2 at 9:15 a.m. Staff #3 was observed using bare hands to handle the pills. The Medication Administration Policy indicated pills were not to be touched.

The program's policies on medication administration were not followed.

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)