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 17, 2013

Ms. Sue Hyde, Executive Director
Keelson Harbour Assisted Living
2810 Aurora Avenue
Spirit Lake, IA 51360

RE: Final Recertification Monitoring Evaluation Report – Keelson Harbour Assisted Living, Spirit Lake, IA

Dear Ms. Hyde:

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 is denied. Evaluations remained an issue with two additional individuals not mentioned in the request. 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 **S0258** with effective dates of **June 14, 2013** through **June 13, 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:

Sue Hyde, Executive Director
Keelson Harbour Assisted Living
2810 Aurora Avenue
Spirit Lake, IA 51360

Date of Monitoring Visit:

April 24, 2013

Monitor(s):

Joyce Kix, RN
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:	45
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	47
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	4
Number of tenants with cognitive disorder:	20
Total Population of Program at time of on-site	24
TOTAL census of Assisted Living Program	71

Tenant/Family Satisfaction Results – A community meeting was held with 29 tenants and one family member. They reported the program staff members were friendly and respectful. The nursing services were great with quick response to calls but there were times when requests for pain medication were delayed when staff members were busy. There were isolated concerns mentioned regarding the menu but most felt the food was generally good. The tenants enjoyed activities but felt there were plenty offered. They felt 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 monitors made observations detailed in the following areas.

A. Evaluation of Tenant

Monitoring Observation: Tenant #1, a 91 year old, was admitted to the dementia unit on 1-25-13 with diagnoses of: Alzheimer's and Chronic Anemia. The cognitive assessment completed on 2-25-13 included the Global Deterioration Scale (GDS) with the number five circled. The form lacked indication of which categories the nurse felt pertained to Tenant #1.

Tenant #2, a 78 year old, was admitted to the dementia unit on 4-29-10 with diagnoses of: Dementia, Cerebral Vascular Accident and Gastro-Intestinal Bleed. The annual health and functional evaluations were completed 4-27-12. The clinical record lacked inclusion of a GDS evaluation which is required annually.

Tenant #3, an 89 year-old, was admitted on 3-27-09 and had diagnoses of: Hypertension (HTN), Cerebral Degenerative Ataxia, and Depressive Disorder. Tenant #3 had no errors on a cognitive screening on 3-27-13. Tenant #3 resided in the general population. A physician's order dated 3-26-13 indicated Tenant #3 was prescribed an antibiotic for a urinary infection. Tenant #3 was to be observed for a change in mental status. An order noted on 4-1-13 discontinued the antibiotic, fluids were to be forced, and urinalysis repeated in five days. In an interview with the Registered Nurse (RN) she stated Tenant #3 became sick when taking the antibiotic, and indicated staff members were unable to obtain a urine specimen for the repeat urinalysis. An order dated 4-11-13 and noted 4-12-12, Tenant #3 was prescribed a different antibiotic for a urinary infection. A note to the physician dated 4-17-13 indicated Tenant #3 continued to yell at staff and the RN was requesting something to calm Tenant #3. Ativan was prescribed as needed. A nurse's note dated 4-23-13 indicated Tenant #3 was looking for grandchildren under the couch. Evaluations were not completed for changes in behavior that continued after the use of antibiotics for a urinary infection. Evaluations were not completed with a change in condition.

Tenant #4, an 89 year-old, was admitted on 11-30-12 and had diagnoses of: Diabetes, Chronic Constipation, and HTN. Tenant #4 had no errors on a cognitive screening tool on 2-28-13 and resided in the general population. Evaluations were completed on 11-19-12 prior to admission, on 12-27-12 within 30 days of admission, and on 2-28-13 as part of a 90-day assessment. All evaluations indicated Tenant #4's skin was in good condition. A physician's order dated 3-8-13 requested a referral to an Enterostomal Therapist (ET), someone who specializes in the care of skin and wounds. The referral was for skin breakdown in the superior gluteal cleft. Notes from an ET visit dated 3-18-13 indicated the reason for the visit was a pressure ulcer at the base of the spine. Tenant #3 was noted to have a full thickness ulcer which appeared infected. A culture of the area showed heavy growth of E. Coli and Klebsiella Pneumoniae, both infecting organisms. Evaluations of the condition of Tenant #3's skin were not completed with a change of condition.

Tenant #6, an 84 year old, was admitted to the dementia unit on 8-1-12 with diagnoses of: HTN, Gout, Hyperlipidemia and Prostate Cancer. The cognitive assessment completed on 2-1-13 included GDS with the number four circled. The form lacked indication of which categories the nurse felt pertained to Tenant #6.

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: The program's policy for Service Plans dated 2011 directed the tenant's service plan was to be designed to meet the specific needs of each individual... the service plan would include any services from outside sources...The service plan would indicated any preference for nursing home care should the need present itself.

The clinical record for Tenant #1 included a nurse's note dated 4-22-13 that documented that a chair and bed alarm had been initiated due to anxiety. The service plan lacked inclusion of the interventions of the alarms. The service plan did not indicate Tenant #1's preference for a nursing home.

Tenant #3 had evaluations of function, cognition, and health completed on 3-27-13. A service plan was completed. A fall risk assessment was also completed which indicated Tenant #3 was at high risk for falls. Nurse's notes dated 3-27-13 indicated Tenant #3 needed reminders to ask for help when feeling weak or needing extra help. The functional assessment indicated Tenant #3 had balance problems while standing and walking. The health assessment indicated Tenant #3 was visually impaired, described as partial to total blindness. Tenant #3 was also identified as having a history of urinary infections. The service plan identified balance problems but did not include reminders for assistance. The service plan identified visual impairment, and history of urinary infection, but did not identify specific interventions to direct staff members in the care of Tenant #3. The service plan was not based on the evaluations and did not meet the identified needs of Tenant #3.

Tenant #3 began antibiotic treatment for a urinary infection on 3-26-13, was taken off the antibiotic on 4-1-13 after becoming sick, had physician orders to observe for mental status changes and to force fluids, and exhibited behaviors for which the RN sought medication. Tenant #3 continued to exhibit behaviors on 4-23-13. The service plan did not direct staff to report changes in behavior or to force fluids. The service plan did not identify staff interventions when Tenant #3 yelled at them. The service plan was not updated as Tenant #3's condition changed and did not meet the identified needs of Tenant #3. The service plan did not identify Tenant #3's preference for a nursing facility.

Tenant #4 was admitted on 11-30-12. An initial service plan was completed on 11-19-12, prior to admission. The service plan was not updated or reviewed within 30 days of admission.

Tenant #4's physician requested an ET consult for a pressure ulcer at the base of the spine. The ET recommended cushions to all seats Tenant #4 sat in, frequent position changes, and recommended Tenant #4 not slouch in the chair. Propping of feet was suggested as a way to avoid slouching. The service plan was not updated with the recommendations of the ET. The service plan did not identify Tenant #4 had a skin wound. The service plan did not meet the identified needs of Tenant #4. The service plan

did not identify Tenant #4 was receiving services from the ET, an outside service provider. The service plan did not identify a nursing facility preference.

Tenant #5, an 88 year old, was admitted to the dementia unit on 11-16-12 with diagnoses of Parkinsonism and Prostate Cancer. The clinical record contained a physician's order dated 3-6-13 for physical therapy for evaluation and treatment. The service plan lacked evidence of physical therapy treatments. The RN reported the physical therapist did not leave documentation of their visits so she was not aware if a therapist had completed an evaluation or if therapist had continued treatment. At the request of the monitor, the RN requested documentation from the therapy service for evidence of visits and physician's orders. The physician ordered physical therapy on 3-11-12 for two to three visits a week for eight weeks for strengthening and gait training. The service plan did not identify Tenant #5's preference for a nursing facility.

The clinical record for Tenant #6 lacked evidence of completion of service plan after 30 days of occupancy. The RN stated she was unaware of the requirement to complete and sign a service plan at the 30 day time-period. The service plan did not identify Tenant #6's preference for a nursing facility.

Tenant #7, a 79 year-old, was admitted on 5-1-10 and had diagnoses of: Mental Disorder, Hypothyroidism, Obsessive-Compulsive Disorder, and Schizoaffective Disorder. Tenant #4 had no errors on a cognitive screening tool dated 11-1-12. Tenant #7 resided in the general population. According to evaluations completed on 11-1-12, Tenant #7 had no behaviors that required intervention. Nurse's notes dated 1-24-13 indicated Tenant #7 was having increased behaviors. It was noted Tenant #7 had refused medications the day before. In an interview, the RN stated when Tenant #7 refused medications, behavior changed and Tenant #7 required admissions to the hospital. Tenant #7 was taken to the hospital via ambulance and admitted on 1-24-13. Nurse's notes dated 2-28-13 indicated Tenant #7 refused to go to the hospital for lab work. Tenant #7 was taken to the hospital via ambulance and admitted.

The most current service plan for Tenant #7 was dated 3-30-12. A service plan was not completed annually. Tenant #7 had a history of mental illness. The RN stated when Tenant #7 refused medication, mental changes were noted and Tenant #7 required hospitalization. The service plan did not identify interventions to direct staff to notify the nurse if medications were refused. The service plan did not identify behaviors exhibited or strategies for staff members to use when Tenant #7 exhibited behaviors. The service plan did not meet the identified needs of Tenant #7. The service plan did not identify 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; (c) The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy; and (e)

Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. (IAC r. 481-69.26(4)(a,c,e))

C. Medications

Monitoring Observation: The clinical record for Tenant #3 included an order electronically signed on 4-11-12 by a physician for Macrobid 100 mg twice a day. 20 capsules were prescribed, indicating the medication was to be given for 10 days. A review of the medication administration record (MAR) indicated the medication was to be given twice a day for seven days. The order was incorrectly transcribed to the MAR.

There were two entries, one for a morning dose and one for an evening dose, both indicating the medication was to be given for seven days. The physician's order indicated the medication was to be given for 10 days. The MAR documented a dose was given in the morning on 12 consecutive days. The MAR documented a dose was given in the evening on nine consecutive days. The medication was not administered according to the physician's orders.

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. Nurse Review

Monitoring Observation: The nurse's notes for Tenant #2 dated 3-22-13 documented the tenant was found sitting in a chair with a blank stare and not responding to verbal or physical stimuli. Tenant #2 was sent to the emergency room for evaluation and returned with physician's orders for an antibiotic. The clinic record lacked evidence of completion of a nurse review regarding Tenant #1's condition upon return from the hospital. Three days later Tenant #2 fell and fractured a hip.

Tenant #3 was prescribed an antibiotic for a urinary infection on 3-26-13. In an interview, the RN stated the antibiotic was discontinued because the medication made Tenant #3 sick. The program had difficulty in obtaining a specimen for a repeat urinalysis. Another antibiotic was prescribed on 4-11-13. Nurse's notes dated 4-23-13 revealed Tenant #3 was exhibiting behaviors and it was suspected the urinary infection was not resolved. A nurse review was not completed and the clinical record lacked a clear documentation of the events and changes with Tenant #3, changes in condition, which occurred with urinary infections.

Nurse's notes for Tenant #5 dated 4-15-13 documented Tenant #5 was unresponsive, grey and drooling with a blood pressure of 96/54. Tenant #5 was not responding to stimuli and was sent to the emergency room. The tenant returned with new orders. The clinic record lacked evidence of completion of a nurse review upon return from the hospital. Tenant #5 fell the next day and sustained no injury.

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 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

Monitoring Observation: Staff #2 was hired 10-11-12 as a shift leader. Staff #3 was hired 1-3-13 as a resident assistant. Staff #4 was hired on 3-5-12 as a memory care manager. Staff #5 was hired 5-10-12 as a resident assistant. Staff #6 was hired 9-12-12 as a resident assistant. According to the Registered Nurse (RN), shift leaders and managers were Certified Nursing Assistants (CNA), and resident assistants were universal workers. Training records were reviewed.

Staff #2 had documentation the RN had completed delegations for vital signs and medications. The RN had verbally reviewed personal cares such as bathing, hygiene, and toileting, but had not observed Staff #2 performing the cares. Staff #2's training file contained documentation Staff #7, a lead care manager but not an RN, had trained Staff #2 on showers and compression stockings.

Staff #3 had documentation the RN had completed delegations for vital signs. The RN had verbally reviewed personal cares such as bathing, hygiene, and toileting but had not observed Staff #3, resident assistant, performing the cares. Staff #3's training file contained documentation Staff #8, lead care manager but not an RN, had trained Staff #3 on showers and compression stockings.

Staff #4 had documentation the RN had completed delegations for medications and vital signs. The RN had verbally reviewed personal cares such as bathing, hygiene, and toileting, but had not observed Staff #4 performing the cares.

Staff #5, resident assistant, had documentation the RN had completed delegations for vital signs and medications, but had only verbally reviewed personal cares such as bathing, hygiene, and toileting and had not observed Staff #5 performing the cares.

Staff #6, resident assistant, had documentation the RN had completed delegations for vital signs, but had only verbally reviewed personal cares such as bathing, hygiene, and toileting and had not observed Staff #6 performing the cares.

In an interview with Staff #9, resident assistant, she stated she had not been observed by the RN performing cares such as compression stockings and personal cares such as bathing.

Staff training files lacked documentation of nurse-delegated training of personal and medical cares.

During observation of medication administration, Staff #1 placed the medications for a tenant from the container filled by the pharmacy into a plastic medication cup. The

tenant declined to take the medication until after she/he had eaten breakfast. Staff #1 left the room with the medication but was unsure how to maintain the medications until such time as the tenant wanted them because she did not want to destroy them and incur extra expense to the tenant. Although Staff #1 had been delegated to pass medications, She was unsure of all aspects of handling medications in the event the tenant was unable to take the medications immediately.

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))