IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 43504-C

June 19, 2013

Ms. Amy Pagel, Director
Traditions of West Union
609 Hwy 150 North
West Union, IA 52175-1057

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – AMENDED FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - TRADITIONS OF WEST UNION
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Pagel:

I. Amended Final Complaint/Incident Investigation Report – Traditions of West Union, West Union, IA

Enclosed is the **Amended Final Complaint/Incident Investigation Report ("Report")** issued by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **May 14 - 16, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Criteria for Admission and Retention and Medications.

Traditions of West Union ("Program") is being assessed a **$1500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.12(3)(a)(1), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

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 determination of a **$1500 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, the RN failed to follow physician orders, failed to obtain orders to hold medications and to change dosage prior to directing staff to do so. The RN directed staff to administer medications against physician orders, directed staff to lie regarding witnessing the destruction of narcotics. The RN used medications meant for others, signed another employee's initials on MARs. She stockpiled medications instead of returning them to the pharmacy, repackaged medications and did not assure medications were locked per program policy.

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 **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of **nine hundred seventy five dollars ($975)** 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 **$1500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1). The Plan of Correction (POC) submitted on June 11, 2013, has been reviewed and will constitute the final POC related to the on-site visit of May 14 -16, 2013. The Request for Reconsideration has been accepted in the area of Criteria for Admission and Retention for Tenant #10; however, the regulatory insufficiency remains. The **Amended Final Complaint/Incident Investigation Report** is enclosed.

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, Rose Boccella, at 515/281-7039.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Amended Final Complaint/Incident Investigation Report

Assisted Living Program:

Amy Pagel, Director
Traditions of West Union
609 Highway 150 North
West Union, Iowa 52175-1057

Complaint/Incident Intake #:

43504-C

Date of Complaint/Incident Investigation:

May 14, 15 and 16, 2013

Monitor(s):

Maribeth Freland RN
Joyce Kix RN

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

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

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

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

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

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

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	23
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	27
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	10
Total Population of Program at time of on-site	10
TOTAL census of Assisted Living Program	37

Program History – The program received a regulatory insufficiency in the area of Dementia Specific Education during the September 2011 Recertification on-site.

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

A. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged multiple tenants residing at the program exceeded the level of care approved for an assisted living.

- Monitoring Observation: The monitors reviewed the records of Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14 and #15. Tenants #1, #4, #5, #6, #7, #9, #11, #13, #14 and #15 currently reside at the program and, after record review and staff member interview, do not exceed the level of care. Tenants #2 and #3 no longer resided at the program, but a review of the records and staff member interview indicated neither exceeded level of care.

  Tenant #8, a 95 year old, was admitted 11-28-07 and currently resided in the memory care unit. Tenant #8 had diagnoses of: Vascular Dementia, Hypertension (HTN), and Coronary Artery Disease (CAD). Tenant #8 scored 6 on the Global Deterioration Scale (GDS) completed 5-1-13 which indicated severe cognitive decline. Tenant #8 was admitted to Hospice on 3-26-13. The program did not apply for a waiver with the Department of Inspections and Appeals to allow Tenant #8 to remain living at the program. Nurse Notes, dated 4-11-13, documented Tenant #8 required two persons for assisting with transfers.

During interview, Staff #1, #2, #3, #6, and #7, all universal workers (UW) stated that Tenant #8 required two people to transfer. Staff #8, UW, stated that Tenant #8 was totally dependent for bathing, dressing and toileting and had needed a two-person transfer for the past 3 to 6 months.

Tenant #8 required two people to assist with transferring, thereby exceeding the criteria for assisted living level of care.

Tenant #12, a 97 year old, was admitted to the program on 12-25-07 and died on 4-30-13. Tenant #12 had diagnoses of: Adult Failure to Thrive, Dementia, CAD and Upper Respiratory Infection at the time of death. Tenant #12 had a history of stroke and falls. Tenant #12 scored a 6 on the GDS completed on 3-28-13, indicating severe cognitive decline and scored a 7 on the GDS completed on 4-25-13, indicating very severe cognitive decline. Tenant #12 was admitted to hospice on 3-29-13. (The program had never applied for a waiver with the Department of Inspections and Appeals to allow Tenant #12 to remain living at the program.)

Tenant #12's service plans, dated 3-19-13 and 3-28-13, directed staff to assist with feeding, transfer, using 1 to 2 person assistance, to and from bed to wheelchair, and to assist Tenant #12 with grooming, dressing (staff members to dress and undress as he/she either not willing or resisting during the process), bathing and toileting (check and change incontinence products as he/she no longer recognized the need to toilet). The service plan indicated Tenant #12 used a wheelchair for all mobility. Tenant #12 exhibited frequent episodes of agitation, either threatening to hit, spit or strike out at staff members when trying to provide necessary assistance.

Hospice Interdisciplinary Group note, dated 4-2-13, documented Tenant #12 was having breakfast fed to him/her. Hospice Interdisciplinary Group Meeting Note, dated 4-4-13, indicated Tenant #12 required staff members to feed him/her.

During interview, Staff #1, UW, reported Tenant #12 required two to three persons to transfer for approximately two months before his/her death on 4-30-13. Staff #1 reported Tenant #12 was dependent with all activities of daily living (ADLs) for approximately two months before his/her death, required staff members to feed him/her and could not self propel his/her wheelchair for mobility once staff members assisted Tenant #12 into it.

During interview, Staff #2, UW, reported Tenant #12 required two staff members to transfer during the entire two months Staff #2 worked at the program. Tenant #12 began hitting, biting and kicking staff members when assisting a few days before Staff #2 resigned from the program.

During interview, Staff #3, UW, reported Tenant #12 required total assistance of two staff members for all transfers.

During interview, Staff #6, UW, reported Tenant #12 required two staff members to transfer 75 percent of the time for the last three months of Tenant #12's life. Staff #6 reported Tenant #12 did not bear weight at all for those three months, was checked for incontinence and changed during those three months and fed by staff members for

the last three weeks of his/her life. Staff #6 reported Tenant #12 hit out at staff frequently.

The resident advocate (Ombudsman) associated with the program indicated she observed Tenant #12 on 4-5-13 during an on-site investigation. The Ombudsman observed two staff members transfer Tenant #12 from the wheelchair to a recliner. The Ombudsman indicated Tenant #12 also required the assistance of two staff members with toileting and dressing during the on-site visit. The Ombudsman indicated, during interview, Staff #11, UW, told the Ombudsman Tenant #12 consumed a lot of staff member time, at times requiring the assistance of three staff members. Staff #11 reported Tenant #12 was incontinent of bladder and bowel and was completely dependent upon staff members to meet his/her toileting needs.

Tenant #12 required two people to assist with transferring, was dependent with toileting, dressing, mobility and eating for greater than 21 days, thereby exceeding the criteria for assisted living.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: a. Is bed-bound; or b. Requires routine, two-person assistance with standing, transfer or evacuation; or c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk; or d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or e. Is under the age of 18; or f. Requires more than part-time intermittent health related care; or g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or h. Is medically unstable; or i. Requires maximal assistance with activities of daily living. (IAC r. 481-69.23(1))

B. Medications

Complaint/Incident Allegation: It was alleged the program registered nurse (RN) was repackaging tenant medications. It was alleged the RN was stockpiling tenant medications when a tenant died and re-dispensing the stockpiled medications to other tenants when needed. It was alleged the RN was administering a tenant medication which had been prescribed to the tenant's family member. It was alleged the program RN made changes to physician's orders without first calling the physician for approval.

- Monitoring Observation:

The policy for Medication Storage directed medications and treatments stored by the program are to be stored in a designated location such as room, cabinet or medication cart that must be locked. The policy for Medications and Treatments directed staff to check all medications for expiration dates and if the medication is expired contact the pharmacy and do not give the medication. The policy for Unused Medications directed that unused controlled substances should be returned to the legally responsible party or disposed at the program within 30 days by the nurse and another professional in the presence of each other.

Tenant #1, a 75 year old, was admitted to the program on 11-25-09 and resided in the secured memory care unit. Tenant #1 had diagnoses of: Parkinson's Disease, Depression with Psychotic Features, Neuropathic Pain, HTN, CAD, Atrial Fibrillation and Restless Leg Syndrome. Tenant #1 scored a 4 on the GDS completed on 3-4-13, indicating moderate cognitive decline.

According to the service plan, dated 3-4-13, the program administered all medications for Tenant #1. During interview, Tenant #1's physician reported he prescribed Xanax (anti-anxiety medication) 0.25 milligrams (mg) every 6 hours as needed on 12-6-12. On 1-10-13, the physician added Xanax 0.25 mg twice daily on a routine basis to Tenant #1's medication regimen due to the tenant's report of increased anxiety.

The January 2013 Medication Administration Record (MAR) included the transcription of the routine Xanax order on 1-11-13. Staff members administered the Xanax twice daily from 1-11-13 to 1-31-13, documenting when Tenant #1 either refused or was unavailable to take the Xanax.

The February 2013 MAR contained notations documenting the Xanax at 3:00 p.m. was being held per RN instruction beginning on 2-2-13 and continuing through the entire month. The February 2013 MARs documented use of the as needed dosage of Xanax seven times.

During interview, Tenant #1's physician reported he received a note from the program RN which included reporting the need to hold Tenant #1's afternoon dose of Xanax due to the tenant's excessive sleepiness. The physician indicated he was not aware of how long the RN had been holding the afternoon dose. The physician indicated this process was unusual to him, reporting most facilities contact him via facsimile to request a medication dosage change, he signs for approval and sends back via facsimile. On 2-28-13, the pharmacy sent the physician a request to reorder the Xanax 0.25 mg twice daily and every six hours as needed. The physician approved the reorder, assuming the program had reinitiated the twice daily routine dose.

The March 2013 MAR contained a notation by the RN instructing staff members to hold all routine Xanax dosages, using only the Xanax as needed dosage if Tenant #1 requested it. The March 2013 MAR documented use of the as needed dosage of Xanax 25 times.

According to the Communication Notebook, kept in the memory care staff office, the program RN wrote directions to the staff members on 3-15-13, instructing them to administer only one dose of the as needed Xanax order to Tenant #1 in the daytime and then again in late evening if Tenant #1 requested.

During interview, Tenant #1's physician denied discontinuing the Xanax routine twice daily dosage for Tenant #1. The physician reported the program RN sent him a current list of medications taken by Tenant #1 on 3-26-13, which included the twice daily dosage of Xanax and the as needed every 6 hours dosage of Xanax; therefore, the physician assumed Tenant #1 was still taking both dosages. On 4-11-13, Tenant #1 visited the physician, reporting continued anxiety. The physician increased the Xanax dosage to 0.25 mg three times daily and removed the as needed dosage due to

the physician's belief that the twice daily dosing was not sufficient to relieve Tenant #1's anxiousness.

The April 2013 MAR contained a notation by the RN instructing staff members to hold all routine twice daily Xanax dosages, using only the Xanax as needed dosage if Tenant #1 requested it. The April 2013 MAR documented use of the as needed dosage of Xanax one time. The three times daily dosage was initiated on the MAR on 4-12-13.

According to the Communication Notebook, the program RN wrote directions to the staff members on 4-12-13, instructing staff members to ask Tenant #1 first if he/she needed the Xanax before giving the routine dosage and document as refused if he/she didn't think it necessary. (The April 2013 MAR documented Tenant #1 refused one of the three times daily dosages eight times between April 12 and April 30. The May 2013 MAR documented Tenant #1 refused one of the three times daily dosages eight times between May 1 and 14.)

The program RN did not obtain physician's orders to hold the routine dosage of Xanax prior to doing so in February 2013. The RN continued to direct staff members to administer the Xanax to Tenant #1 against physician's orders in March, April and May 2013.

According to the Communication Notebook, the program RN directed staff members to give Tenant #1 three Tylenol at one time if needed for better control of knee pain. The March, April and May 2013 MARs included physician orders for Tylenol 500 mg two tabs one time daily as needed.

The program RN did not obtain physician's orders to change the dosage of Tylenol prior to instructing staff members to do so.

Tenant #2, a 90 year old, was admitted to the program on 3-6-08, resided in the memory care unit and died on 3-2-13. Tenant #2 had diagnoses of: Adult Failure to Thrive, Dementia and Depression. Tenant #2 scored a 6 on the GDS completed on 12-7-12, indicating severe cognitive decline. According to the service plan, dated 12-7-12, the program administered all medications to Tenant #2.

Tenant #2's MARs included a physician's order for Lorazepam 0.5 mg one time daily as needed. Documentation indicated staff members gave the Lorazepam twice in one day on 12-15-12, 2-10-13 and 2-15-13.

Tenant #2's physician ordered liquid Lorazepam and liquid Morphine on 3-1-13. After Tenant #2 died, the program RN documented destroying the liquid Lorazepam and the liquid Morphine with Staff #3, UW, witnessing the destruction. The RN reported sending all tablet Lorazepam back to the prescribing pharmacy.

During interview, Staff #3, UW, denied witnessing the destruction of the liquid Morphine and Lorazepam. Staff #3 reported the RN called her into the office in the memory care unit and told her to sign the destruction form. Staff #3 indicated observation of a container of wet sand but could not ascertain what the fluid was as she had not observed the RN placing the fluid into the sand. Staff #3 told the RN she

didn't feel comfortable signing the form as she had not witnessed the destruction; however, the RN again told her to sign the form, so Staff #3 did.

During reconciliation of the Lorazepam tablets, the monitor identified 88 tablets were delivered by the pharmacy, 33 tablets were documented as administered to Tenant #2 and zero tablets were returned to the pharmacy, leaving 55 tablets of Lorazepam unaccounted for.

The program RN did not follow the program's policy on destruction of medications and did not return the Lorazepam tablets left after Tenant #2 died to the pharmacy per program policy, leaving 55 tablets unaccounted for. Tenant #2's as needed Lorazepam tablet order was not administered according to physician's orders.

Tenant #3, an 88 year old, was admitted to the program on 8-4-09, resided in the memory care unit and died on 2-8-13. Tenant #3 had diagnoses of: Dementia, Seizure Disorder and CAD. Tenant #3 scored a 6 on the GDS completed on 2-2-13, indicating severe cognitive decline. According to the service plan, dated 2-2-13, the program administered all medications to Tenant #3.

Tenant #3's clinical record contained a physician's order, dated 12-31-12, ordering Tramadol 50 mg to be taken four times daily. According to the December 2012 and January 2013 MARs, staff administered 13 tablets of Tramadol between 12-31-12 and 1-3-13.

According to pharmacy dispensing documentation, the pharmacy did not deliver the Tramadol prescribed for Tenant #3 until 1-4-13. During interview, the program RN admitted that Tenant #3's family member brought in a bottle of Tramadol (prescribed to the family member) and the RN directed staff members to administer the medication prescribed to the family member to Tenant #3.

The RN dispensed medication to Tenant #3 that was prescribed and filled by a pharmacy to a person other than the tenant.

During interview, Staff #3, UW, reported the RN told her to give Tenant #3 left over liquid morphine that had been prescribed to Tenant #2 after he/she died. (Tenant #3 died on 2-8-13 and Tenant #2 did not die until 3-2-13; therefore, Tenant #2 would not have had left over liquid morphine.)

Tenant #4, an 89 year old, was admitted to the program on 4-10-10 and resided in the general population area of the program. Tenant #4 had diagnoses of: Recent Intermittent Confusion, Depression, Anxiety, Spinal Stenosis and Renal Insufficiency. Tenant #4 scored a 5 on the GDS completed on 3-5-13, indicating moderately severe cognitive decline.

The clinical record contained a physician's order, dated 2-28-13, to initiate Melatonin (used to promote sleep) 3 grams (gm) at bedtime. The clinical record also contained a facsimile to the physician, notifying the physician that the RN had never started administering the Melatonin to Tenant #4. The RN requested to discontinue the Melatonin at that time and the physician agreed to discontinue.

The nurse failed to follow physician's orders.

During tour of the memory care unit, the monitors noted large baskets containing bottles of tenant medications. The program RN told the monitors the medications were left over after the pharmacies delivered too many bottles of the same medications. After reconciliation of the medications for Tenant #4, the monitors noted Tenant #4 was to be given Methotrexate 2.5 mg three tablets weekly. The bottles remaining in the basket were filled by the pharmacy on 2-21-12, 6-30-12 and 3-20-13. The bottle filled on 2-21-12 expired on 2-20-13. The RN was unable to explain the discrepancy between the number of tablets filled by the pharmacy, the number of tablets documented as given and the number of tablets remaining.

The monitor observed a bottle of Methotrexate 2.5 mg in Tenant #4's medication box located in his/her apartment. The bottle was filled by the pharmacy on 12-10-11 and expired on 12-9-12. Staff members had been dispensing medications from the expired bottle during May 2013.

The clinical record also contained a physician's order, dated 5-14-13, for Nystatin powder to be applied to Tenant #4's irritated groin twice daily for 7 days. The May 2013 MAR contained initials of Staff #1 as administering the powder in the morning of 5-14-13.

During interview, Staff #1 reported she was told by the program RN on the morning of 5-14-13 to apply the Nystatin as the tenant was planning to go out with family. Staff #1 indicated Tenant #4 had not yet received the bottle of Nystatin from the pharmacy so the RN gave Staff #6 a bottle of Nystatin containing a pharmacy label with Tenant #16's name on it and told Staff #1 and Staff #6 to use it on Tenant #4. Staff #1 reported she applied the other tenant's Nystatin powder to Tenant #4 groins but did not initial the MAR.

During interview, Staff #6 reported she was told by the program RN on the morning of 5-14-13 to apply the Nystatin as the tenant was planning to go out with family. Staff #6 indicated Tenant #4 had not yet received the bottle of Nystatin from the pharmacy so the RN gave her a white bottle (about the size of a small aspirin bottle) of Nystatin containing a pharmacy label with Tenant #16's name on it and told Staff #1 and Staff #6 to use it on Tenant #4.

During interview, the Director reported the pharmacy used by Tenant #4 only delivers to the program between 3:00 p.m. and 5:00 p.m. The tenant/family sign out sheet indicated Tenant #4 left the program with family members at 2:30 p.m.

During interview, the program RN denied giving Staff #1 and #6 another tenants Nystatin powder but admitted to initialing the MAR with Staff #1's initials in the 5-14-13 slot.

The nurse used medication meant for other tenants and the nurse signed another employee's initials on the MARs.

Tenant #5, an 86 year old, was admitted to the program on 4-29-09 and currently resided in the general population area. Tenant #5 had diagnoses of: Senile Dementia

with Delusions and Behavior Disturbances. Tenant #5 scored a 6 on the GDS completed on 3-2013, indicating severe cognitive decline.

During tour of the memory care unit, the monitors noted large baskets containing bottles of tenant medications. The program RN told the monitors the medications were left over after the pharmacies delivered too many bottles of the same medications. After reconciliation of the medications for Tenant #5, the monitors noted Tenant #5 was to be given Seroquel 25 mg daily. The bottles remaining in the basket were filled by the pharmacy on 7-10-12, 10-4-12, 11-12-12, 12-14-12,and 12-31-12. The RN was unable to explain the discrepancy between the number of tablets filled by the pharmacy, the number of tablets documented as given and the number of tablets remaining.

The RN stock piled medications instead of returning them to the pharmacy.

Tenant #7, a 90 year old, was admitted to the program on 4-5-12 and resided in the general population area. Tenant #7 had diagnoses of: Atrial Fibrillation; HTN and Hyperlipidemia. Tenant #7 scored a 3 on the GDS completed on 5-2-13, indicating mild cognitive decline.

During tour of the memory care unit, the monitors noted large baskets containing bottles of tenant medications. The program RN told the monitors the medications were left over after the pharmacies delivered too many bottles of the same medications. After reconciliation of the medications for Tenant #7, the monitors noted Tenant #7 was to be given Coumadin routinely. The bottle of Coumadin remaining in the basket was filled with 61- 5 mg tablets, 30 being oval in shape and 31 being oblong in shape. The RN reported she had mixed three bottles of Coumadin together, making the 61 tablets.

The RN repackaged tenant medications.

Tenant #9, a 93 year old, was admitted to the program on 7-17-08 and currently resided in the secured memory care unit. Tenant #9 had diagnoses of: Dementia; HTN; and Osteoporosis. Tenant #9 scored a 6 on the GDS completed on 3-14-13, indicating severe cognitive decline. Tenant #9's service plan indicated staff members administered all medications to Tenant #9.

According to the Communication Notebook, kept in the memory care staff office, the program RN wrote directions to the staff members on 3-22-13, directing them to give Tenant #9 cough syrup until the bottle was gone. The directions indicated "it's not on the MARs and I don't want it there". The same note directed staff members to give Tenant #9 Tylenol 500 mg two tablets four times daily at 8:00 a.m., 12:00 noon, 4:00 p.m. and 8:00 p.m. while taking the cough syrup.

Tenant #9's clinical record lacked an order for the cough syrup. The RN reported she had obtained an order from Tenant #9's physician but could not produce an order with Tenant #9's name on it. The MARS for March 2013 lacked any indication staff members had given the cough syrup. During interview with Staff #1, Staff #6 and Staff #8 reported there was a community bottle of Robitussin in the memory care office that had instructions to give to tenants with cough or cold as needed. The

instructions were to document on a plain sheet of paper not on the MAR. Staff #8 reported she had given cough syrup to Tenant #9 as instructed by the RN.

During interview, the RN initially indicated that she had obtained physician orders for Tenant #9 to take the Robitussin and she had transcribed the order onto the MAR for staff members to initial. Upon further questioning, the RN thought she may not have placed the order on the MAR, having staff members document on a separate sheet of paper which she now believed she may have thrown away.

Tenant #9's clinical record contained a physician's order for Tylenol 500 mg two tabs as needed, not to exceed 3000 mg in a 24 hour period. The RN directed staff members to give the Tylenol outside the physician ordered parameters.

Tenant #12's service plan indicated staff members administered his/her medications. According to the Communication Notebook, kept in the memory care staff office, the program RN wrote directions to the staff members on 3-22-13, directing them to give Tenant #12 cough syrup until the bottle was gone. The directions indicated "it's not on the MARs and I don't want it there".

Tenant #12's clinical record lacked an order for the cough syrup. The RN reported she had obtained an order from Tenant #12's physician but could not produce an order with Tenant #12's name on it. The MARS for March 2013 lacked any indication staff members had given the cough syrup. During interview with Staff #1, Staff #6 and Staff #8 reported there was a community bottle of Robitussin in the memory care office that had instructions to give to tenants with cough or cold as needed. The instructions were to document on a plain sheet of paper not on the MAR. Staff #8 reported she had given cough syrup to Tenant #12 as instructed by the RN.

During interview, the RN initially indicated that she had obtained physician orders for Tenant #12 to take the Robitussin and she had transcribed the order onto the MAR for staff members to initial. Upon further questioning, the RN thought she may not have placed the order on the MAR, having staff members document on a separate sheet of paper which she now believed she may have thrown away.

Tenant #12's MARs included a physicians order for Lorazepam 0.5 mg up to three times daily (a.m., p.m. and bedtime) as needed. The RN reported sending all tablets Lorazepam back to the prescribing pharmacy after Tenant #12 died on 4-30-13.

The February 2013 MAR documented staff members held Tenant #12's Lorazepam per RN instruction from 2-20-13 to 2-27-13. Tenant #12's clinical record lacked a physician's order to hold the Lorazepam. The clinical record did not identify the reason the RN held the medication and lacked physician communication related to the change.

During reconciliation of the Lorazepam tablets, the monitor identified 183 tablets were delivered by the pharmacy, 150 tablets were documented as administered to Tenant #12 and 57 tablets were returned to the pharmacy. After reconciliation, the monitors found the RN returned 24 tablets more tablets to the pharmacy than could be accounted for based on the number originally delivered and the number administered.

During interview, Staff #3, UW, reported she found a bubble pack filled with Lorazepam 0.5 mg containing a label with Tenant #2's (a tenant who had died in March and took Lorazepam 0.5 mg) name on it in Tenant #12's medication basket. Staff #3 believed the program RN placed the bubble pack in Tenant #12's basket with the plan to have staff administer Tenant #2's medications to Tenant #12. Staff #3 indicated she took the bubble pack to the Director.

During interview, the program Director reported sometime in March 2013 a staff member brought Tenant #2's Lorazepam bubble pack to her office, indicating the bubble pack had been in Tenant #12's medication basket. The bubble pack had one tablet missing and 29 remaining. Tenant #2 died on 3-2-13 and according to policy, the medication should have been sent back to the pharmacy. The Director reported she completed an investigation and the RN told her the staff member must have pulled the medication bubble pack from the wrong place so the Director gave the bubble pack back to the RN and assumed the bubble pack went back to the pharmacy. (The pharmacy did not get the bubble pack returned to them.)

During interview, Staff #1 reported the RN kept deceased tenant medications in her office or in the memory care cupboard and had given staff members instruction to take medications out of these left over medications if needed for other tenants use. Staff #1 reported at the end of the month staff members gather the bubble packs and throw empty ones away and give those that still contain medications to the RN. She was unsure of what the RN did with the left over medications.

During interview, Staff #2 reported she had heard the RN kept deceased tenant medications and had given instruction to other staff members to give deceased tenant medications to other tenants. Staff #2 reported at the end of the month staff members gather the bubble packs and throw empty ones away and give those that still contain medications to the RN. She was unsure of what the RN did with the left over medications.

During interview, Staff #3 reported the RN stockpiled deceased medications in her office in a bag and in the memory care office and had instructed her to give deceased tenant medications to other tenants. Staff #3 reported at the end of the month, the RN had Staff #3 punch out remaining medications for all tenants and place in bottles before destroying the bubble packs.

During interview, Staff #6 reported the RN kept deceased tenant medications in her office or in the memory care cupboard and had given staff members instruction to take medications out of these left over medications if needed for other tenants use. Staff #6 reported at the end of the month staff members gather the bubble packs and throw empty ones away and give those that still contain medications to the RN. She was unsure of what the RN did with the left over medications.

During interview, Staff #8 reported the RN kept deceased tenant medications in her office or in the memory care cupboard and had given staff members instruction to take medications out of these left over medications if needed for other tenants use. Staff #8 reported at the end of the month staff members gather the bubble packs and

throw empty ones away and give those that still contain medications to the RN. She was unsure of what the RN did with the left over medications.

Tenant #2 had Lorazepam tablets which were never returned to the pharmacy. Staff members indicated the RN had given instruction to use other tenant medications as needed. The RN returned more of Tenant #12's Lorazepam tablets to the pharmacy than should have been left over at the time of Tenant #12's death.

Tenant #15, an 85 year old, was admitted to the program on 4-13-12 and currently resided in the general population area. Tenant #15 had diagnoses of: Parkinson's Disease and Arthritis. Tenant #15 scored a 4 on the GDS completed on 3-28-13, indicating moderate cognitive decline. According to the service plan, dated 3-28-13, Tenant #15's family member sets up all routine medications in a weekly medication planner and staff members administer the daily medications from the planner. Tenant #15's family member does not set up as needed medications.

During observation while accompanying staff members to Tenant #15's apartment, the monitor observed two bottles of Nitroglycerin, one bottle of Tums, one bottle of Aleve pain reliever, one tube of Triamcinolone Cream and one jar of C/Dermazinc liquid setting on a shelf surrounding the microwave.

The program did not assure all medications that were administered by the program were locked as per policy.

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

- Regulatory Insufficiency: When medications are administered traditionally by the program, medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. (IAC r. 481-67.5(6) b)

C. Tenant Rights

Complaint/Incident Allegation: It was alleged the program did not allow a tenant who resided in the secured memory care unit to go out of the unit to participate in activities being held in the general population area.

- Monitoring Observation: The monitors reviewed the clinical records of five tenants who resided in the memory care unit, Tenants #1, #6, #8, #9 and #14. All tenants received diversional activities within the secured unit. Tenants in the memory care unit have dementia and have been assessed to need a secure place to live. The program chose not to allow the memory care unit tenants outside the unit to attend activities in the general population area as that area's exit doors are not secured. In order to assure cognitively impaired tenants safety, staff would be required to provide constant supervision while outside of the unit.

- Regulatory Insufficiency: None noted.

D. Evaluation

Complaint/Incident Allegation: It was alleged the program RN did not readily respond to tenant changes in condition. It was alleged a tenant fell, resulting in an injury, and staff involved and the program RN did not follow up on the injury appropriately.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14 and #15. The monitors identified no significant changes in condition for the time period evaluated for Tenants #1, #4, #5, #6, #7, #8, #10, #11, #13, #14 and #15.

  Tenant #2 resided in the memory care unit and had diagnoses of Osteoporosis and Spinal Neuropathy, resulting in chronic back pain. Tenant #2 used Tylenol on an as needed basis to relieve the back pain. Tenant #2 began experiencing a decline in health status in November 2012. The program RN initiated hospice services for Tenant #2. The hospice took over responsibility of Tenant #2's pain medications upon admission on 11-20-12. Tenant #2 continued to take Tylenol for the back pain throughout December 2012, January 2013 and February 2013. The hospice ordered Roxanol (liquid morphine) for pain to be used on an as needed basis on 1-7-13 and Lorazepam for anxiety on 1-7-13 to be used on an as needed basis. On 2-19-13, Tenant #2 again began to decline, presenting increased confusion. The program RN accompanied Tenant #2 to the physician for an evaluation. Tenant #2's clinical record lacked documentation of unaddressed pain. Tenant #2 used both the Lorazepam and Roxanol throughout February 2013. Tenant #2 died on 3-2-13.

  Tenant #3 resided in the memory care unit and had diagnoses of Dementia. Tenant #3 began experiencing a decline in his/her health status in December 2012. The program RN initiated hospice services for Tenant #3. The hospice took over responsibility of Tenant #3's pain medications upon admission on 12-29-12. The hospice ordered Tramadol on a routine basis to be given to Tenant #3 for pain and ordered Roxanol (liquid morphine) for pain to be used on an as needed basis on 1-11-13 and Lorazepam for anxiety on 1-11-13 to be used on an as needed basis. Tenant #3's clinical record lacked documentation of unaddressed pain. Tenant #3 used Tramadol, Lorazepam and Roxanol throughout January 2013. Tenant #3 died on 2-8-13.

  Tenant #9 resided in the memory care unit. Tenant #9's clinical record indicated in February 2013, Tenant #9 began experiencing pain in the right great toe. Tenant #9 was seen by the physician and had x-rays done on the right foot with no fractures noted. The physician diagnosed Tenant #9's pain in the toe as an arthritic joint.

  In March 2013 Tenant #9 experienced constipation. Tenant #9 used Milk of Magnesia to relieve the constipation during the month of March. During March 2013 Tenant #9 went to the emergency room and was diagnosed as having excessive feces

in his/her colon. The physician did not diagnose an impacted bowel. The Milk of Magnesia dosage was increased to illicit a bowel movement.

During interview, Tenant #9's family member reported Tenant #9 was seen in the emergency room for the constipation as described above and saw the physician for the toe pain. The family member reported the program RN accompanied Tenant #9 to the emergency room to evaluate Tenant #9's constipation.

The monitors reviewed the program's incident reports for March, April and May 2013. Incident reports documented Tenants #4, #6, #7, #8, #13, #14 and #15 experienced fall, none resulting in injury. The monitors reviewed the clinical records of Tenants #4, #6, #7, #8, #13, #14 and #15, finding no documented injuries.

The monitors interviewed staff members related to tenant injuries, noting the following information:

During interview, Staff #1, UW, reported she knew of no recent tenant injuries.

During interview, Staff #2, UW, reported that a few days before she resigned she entered Tenant #12's apartment to find Tenant #12 lying on the ground with Staff #12 and Staff #13 at Tenant #12's side. Staff #12 and #13 reported Tenant #12 had been lowered to the floor during a transfer. Staff #2 reported she noted Tenant #12 to have no injuries related to the incident.

During interview, Staff #3, UW, reported on 3-18-13 Staff #4, UW, told her that Tenant #12 injured his/her knee, causing the knee to "gush blood" during transferring to the wheelchair with the assistance of Staff #8, UW, and Staff #11, UW.

During interview, Staff #4, UW, reported she observed Staff #11, UW, and Staff #14, UW, transfer Tenant #12 into a wheelchair a couple months ago. Staff #4 observed Tenant #12 hitting and fighting with the staff members. During the transfer, Tenant #12 bit Staff #14 in the hand. Tenant #12 was sat onto the edge of the wheelchair but did not get completely seated. Tenant #12's knee rested on the floor before the two staff members could lift him/her up enough to be completely seated. Staff #4 denied seeing any injury at the time of the incident. Staff #4 denied seeing any "gushing of blood". Staff #4 reported a couple days after the incident Staff #3 asked if Tenant #12 had an incident in the previous few days as Tenant #12's knee was bruised. Staff #4 told Staff #3 about the incident as described above. Staff #4 reported she went to look at Tenant #12's knee, noting only bruising but no cut. Staff #4 reported Tenant #12's knee appeared to have a "rug burn".

Tenant #12's clinical record contained a nurse note, dated 3-20-13 and signed by the program RN. The RN documented noting a bruise and scratch on Tenant #12's left knee that appeared to be healing.

During interview, the program RN confirmed she had written the documentation as described above but could not remember how she came to look at Tenant #12's knee to discover the old bruising and scratch. The RN did not know the etiology of the injury and did not complete an incident report upon finding the injury. The RN reported the injury to Tenant #12's legal representative.

- Regulatory Insufficiency: None noted.

E. Service Plans

Complaint/Incident Allegation: It was alleged the program staff members did not follow the service plan when caring for tenants residing in the secured memory care unit.

- Monitoring Observation: The monitors reviewed 12 current tenant's clinical records, Tenant #1, #4, #5, #6, #7, #8, #9, #10, #11, #13, #14 and #15. No discrepancies were identified between identified needs and service plan documentation.

  Tenant #5 resided in the general population with his/her spouse. In March 2013, the RN determined Tenant #5 had a GDS of 6 which indicated severe cognitive decline. The service plan for Tenant #5 included directions for Tenant #5 to be "day guested" into the secured memory care unit after breakfast until 11:30 when he/she could join his/her spouse. This visit to the secured memory unit was to occur when the spouse requested a break. During the on-site visit, Tenant #5's spouse did not request the tenant go to the secure unit.

  The resident advocate (Ombudsman) associated with the program indicated she observed Tenant #5 on 4-5-13 during an on-site investigation. The Ombudsman observed Tenant #5 in the secured memory care unit after 11:30 a.m. The program did not document the exact times Tenant #5 was "day guesting" in the unit, therefore, the monitors could not determine if there was a pattern of not following the service plan for Tenant #5.

- Regulatory Insufficiency: None noted.

F. Staffing

Complaint/Incident Allegation: It was alleged staff members were not trained adequately to care for tenants with dementia. It was alleged the program did not have enough staff members working at one time in the secured memory care unit. It was alleged one staff members had a medical condition which prevented lifting but the staff member was assigned to work in the memory care unit.

- Monitoring Observation: The monitors reviewed the personnel files of Staff #1, #2, #3, #4, #5 and #8, all UW who work in the secured memory care unit. All six personnel files contained documentation of eight hours of dementia education within 30 days of employment and annually thereafter if applicable.

  According to the January, February, March, April and May 2013 schedule, the program routinely staffed one person in the secured memory care unit each shift, staffed two persons in the general population area on the day and evening shift, staffed one person as a float between the memory care unit and the general population on the day and evening shift and staffed one person in the general population area on the night shift.

The monitors interviewed Staff #1, #6 and #8, all UWs who work in the memory care unit, about the staffing patterns. All three UWs reported feeling rushed and at times overwhelmed with only one person covering the memory care unit, but indicated the float and staff in the general population unit were always available to assist when needed. All three UWs reported they were always able to complete personal care tasks and meet the individual needs of the tenants each day.

The program did have a current employee, Staff #10, UW, who was on a temporary lifting restriction due to a medical condition. Staff #10 worked the day shift. When Staff #10 was working, three other staff members were available to assist with tenant transfers as needed.

The regulations do not determine what staff to tenant ratio is acceptable. The regulations require an adequate amount of trained staff members to be available in the immediate proximity to care for tenants in both the memory care unit and the general population unit. The program routinely scheduled staff members in an adequate amount to meet the tenants' needs.

- Regulatory Insufficiency: None noted.

G. Activities

Complaint/Incident Allegation: It was alleged the program did not provide activities for tenants residing in the secured memory care unit.

- Monitoring Observation: The program Director provided schedules for Memory Care Weekly Activities. The schedule indicated one primary activity for each day of the week and also included documentation that a schedule of multiple times and daily events was not a realistic expectation for tenants with dementia. Staff members were directed to choose activities throughout the day that fit the tenant's needs and provided one on one or small group activities. The program also provided a suggested list of appropriate activities including exercise, art, baking, games, music, puzzles and reminiscing or story reading.

  The monitors reviewed the clinical records Tenants #1, #6, #8, #9 and #10, all tenants currently residing in the program's secured memory care unit. Each individual tenant's service plans directed specific activities which interested each tenant. The program tracked individual tenant's participation in activities.

  The Resident Activity Participation Records for March 2013 indicated Tenant #1 had participated in 31 activities, Tenant #6 had taken part in 25 activities, Tenant #8 (a hospice tenant) had taken part in four activities, Tenant #9 had participated in 32 activities and Tenant #10 had participated in 20 activities. The monitors observed multiple one on one activities occurring throughout the on-site survey.

  The Resident Activity Participation Records for April 2013 indicated Tenant #1 had participated in 54 activities, Tenant #6 had taken part in 52 activities, Tenant #8 (a hospice tenant) had taken part in two activities, Tenant #9 had participated in 34

activities and Tenant #10 had participated in 61 activities. The monitors observed multiple one on one activities occurring throughout the on-site survey.

The Resident Activity Participation Records for May 2013 indicated Tenant #1 had participated in 36 activities, Tenant #6 had taken part in 27 activities, Tenant #8 (a hospice tenant) had taken part in two activities and Tenant #9 had participated in 37 activities. The monitors observed multiple one on one activities occurring throughout the on-site survey.

- Regulatory Insufficiency: None noted.

I. Other

Complaint/Incident Allegation: It was alleged the program did not provide toiletries and personal hygiene items for tenants.

- Monitoring Observation: An assisted living program is based on a tenant/landlord agreement. Tenants residing in an assisted living are responsible to provide their own toiletries and personal hygiene products.

- Regulatory Insufficiency: None noted.