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

July 1, 2013

Ms. Randee Blietz, Executive Director
Garden View Senior Community
800 Darby Drive
Monona, IA 52159

RE: Final Recertification Monitoring Evaluation Report – Garden View Senior Community, Monona, IA

Dear Ms. Blietz:

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 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 **S0215** with effective dates of **July 15, 2013** through **July 14, 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:

Randee Blietz, Executive Director
Garden View Senior Community
800 Darby Drive
Monona, IA 52159

Date of Monitoring Visit:

May 29, 2013

Monitor(s):

Stephanie Cummins, MA

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:	17
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	17

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	21

Tenant/Family Satisfaction Results – A community meeting with seven tenants was held. Housekeeping services were provided to their satisfaction and the building and grounds were safe, clean and sanitary. The tenants appreciated having their clothes washed separately. Nursing services were available and there was a quick response from staff when tenants requested assistance. The tenants were getting what was expected when they signed the occupancy agreement. Staff treated the tenants with respect and knew what services to provide. The tenants said the majority of staff was trained to provide the services; however, one staff needed to be more thorough regarding cares. They liked the food and said there were a variety of meats, vegetables and desserts offered. Staff served the tenants appropriately and hot foods were served hot and cold foods were served cold. The meat was tough, especially the pork chops which were thin. They requested more tender meats, more fresh salads, fresh fruit and less starches. There were enough activities offered; however, more activities could be provided on Tuesdays and Thursdays per one tenant. The tenants did not provide any suggestions for additional activities and enjoyed the bus trips, Bingo and going out to eat. They received an activity calendar. The tenants felt safe and made their own decisions. The tenants were satisfied with the Program and would recommend it to others. The tenants enjoyed having other people to visit with and appreciated the care provided.

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: Four tenant files were reviewed.

Tenant #2, an 88 year old, was admitted on 3-14-13 and diagnoses included: Hypertension (HTN), Osteoarthritis and Chronic Obstructive Pulmonary Disease. Progress Notes dated 4-1-13 indicated Citalopram 5 milligrams (mg) for 6 days and then 10 mg daily was ordered for Depression. Tenant #2 had been feeling down and stated just wanting to die. Progress Notes dated 4-8-13 indicated Tenant #2 wished Tenant #2 would just die and wanted to commit suicide. When asked if Tenant #2 had a plan, Tenant #2 replied "I think about it often." Evaluations were completed on 4-11-13, within 30 days of occupancy; however, were not completed as needed. According to a Program document dated 5-8-13, Tenant #2 had the left leg swollen from the knee through the foot. There was bruising down the leg and around the ankle. Tenant #2 had been in pain. An order was received for an ACE wrap on the left ankle and lower leg to give added support and reduce swelling. On 5-13-13 Tenant #2 was given an ankle support to be used as needed. According to a Program document dated 5-17-13, Tenant #2's lower leg had been painful for the last month and bruising and swelling were noted. Tenant #2 had been wearing the ankle brace to help with stability. Sometimes symptoms of left leg included: pain, tingling and numbness. Evaluations were not completed as needed.

Tenant #3, an 89 year old, was admitted on 7-16-05 and diagnoses included: Melanoma, HTN, Benign Prostate Hypertrophy, Hypothyroidism and History of Cellulitis. According to a Program document dated 5-13-13, Tenant #3 had a worsening cough, sore throat and was achy all over. Over the past weeks there had been increased edema in the legs and abdomen. Tenant #3 also had a weight gain of three pounds in one week. Staff observed out of character behavior with confusion and outbursts. Progress Notes dated 5-14-13 indicated Tenant #3's lung sounds were coarse and crackly. The doctor was notified and stated Tenant #3 had a stroke, signs of heart failure and the Melanoma had spread to the chest. The doctor stated Tenant #3 could go back on Hospice if that's what the family wanted. On 5-17-13 Tenant #3 was re-admitted to Hospice, according to Progress Notes. Evaluations were not completed as needed.

Tenant #4, a 96 year old, was admitted on 12-30-10 and diagnoses included: Diabetes, Dementia, Hearing Loss, Poor Eye Sight and Knee and Shoulder Replacement. Tenant #4 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #4 resided in the dementia unit. Progress Notes dated 5-8-13 indicated Tenant #4 had been having increased agitation and aggression towards staff and other tenants and threatened to hit another tenant. The doctor was notified and ordered a Urine Analysis (UA) and Cefdinir 300 milligrams (mg) one tablet twice daily for five days. The Nurse Review completed on 5-14-13 indicated Tenant #4 had been on an antibiotic for a Urinary Tract Infection (UTI). Evaluations were not completed as needed.

Review of tenant files indicated evaluations were not completed as needed with significant change.

- 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: Four tenant files were reviewed.

Tenant #1, a 94 year old, was admitted on 7-25-08 and diagnoses included: Confusion, HTN, Hard of Hearing, Pacemaker, History of Cerebral Vascular Accident and Post Traumatic Stress Disorder. Tenant #1 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit. According to a Program document dated 5-24-13, Tenant #1 had more trouble sleeping through the night and had increased falls. The service plan did not reflect the increased falls and troubles sleeping through the night. Staff #1 said Tenant #1 visited Tenant #1's spouse and knew the code for the dementia unit. Staff #1 said most frequently Tenant #1 set off the alarms when leaving or staff observed Tenant #1 leaving. Tenant #1's spouse also visited Tenant #1 in the dementia unit. Staff #2 said Tenant #1 knew the code to the dementia unit and came out to the general population. Tenant #1 did not have any exit seeking or wandering behavior, however, would ask staff how to get to Tenant #1's spouse apartment in the general population. Staff #2 did not have any concerns regarding Tenant #1 wandering when outside the unit. The service plan did not reflect Tenant #1 leaving the secured dementia unit and staffing interventions to ensure safety while out of the unit. The service plan did not reflect the identified needs of Tenant #1.

Tenant #2's file was reviewed. Progress Notes dated 4-1-13 indicated Citalopram 5 mg for 6 days and then 10 mg daily was ordered for Depression. Tenant #2 had been feeling down and stated just wanting to die. Progress Notes dated 4-8-13 indicated Tenant #2 wished Tenant #2 would just die and wanted to commit suicide. When asked if Tenant #2 had a plan, Tenant #2 replied "I think about it often." The service plan was updated within 30 days of occupancy on 4-11-13; however, was not updated as needed. The service plan indicated staff would contact the nurse with any suicidal ideations. The service plan did not provide any other interventions related to feeling down and wanting to die. The service plans did not reflect the identified needs of Tenant #2. According to a Program document dated 5-8-13, Tenant #2 had the left leg swollen from the knee through the foot. There was bruising down the leg and around the ankle. Tenant #2 had been in pain. An order was received for an ACE wrap on the left ankle and lower leg to give added support and reduce swelling. On 5-13-13 Tenant #2 was given an ankle support to be used as needed. According to a Program document dated 5-17-13, Tenant #2's lower leg had been painful for the last month and bruising and swelling were noted. Tenant #2 had been wearing the ankle brace to help with stability. Sometimes symptoms of left leg included: pain, tingling and numbness. The service plan did not reflect the swelling, bruising and pain to the left leg.

The service plan did not reflect the use of the ACE wrap or ankle support. The service plan was not updated as needed and did not reflect the identified needs of Tenant #2.

Tenant #3's file was reviewed. According to a Program document dated 5-13-13, Tenant #3 had a worsening cough, sore throat and was achy all over. Over the past weeks there had been increased edema in the legs and abdomen. Tenant #3 also had a weight gain of three pounds in one week. Staff observed out of character behavior with confusion and outbursts. Progress Notes dated 5-14-13 indicated Tenant #3's lung sounds were coarse and crackly. The doctor was notified and stated Tenant #3 had a stroke, signs of heart failure and the Melanoma had spread to the chest. Tenant #3 had been discharged from Hospice on 4-8-13. The doctor stated Tenant #3 could go back on Hospice if that's what the family wanted. On 5-17-13 Tenant #3 was re-admitted to Hospice, according to Progress Notes. The service plan reflected Hospice dated 5-17-13; however, did not reflect any services Hospice provided. According to the Medication Sheet, staff applied Jojoba oil topically to left arm prior to compression wrap at bedtime. The service plan did not reflect the Jojoba Oil and compression wrap at bedtime. The service plan was not updated as needed and did not reflect the identified needs of Tenant #3.

Tenant #4's file was reviewed. Progress Notes dated 5-8-13 indicated Tenant #4 had been having increased agitation and aggression towards staff and other tenants and threatened to hit another tenant. The doctor was notified and ordered a UA and Cefdinir 300 mg one tablet twice daily for five days. The Nurse Review completed on 5-14-13 indicated Tenant #4 had been on an antibiotic for a UTI. The service plan was not updated as needed and did not reflect the UTI and antibiotic therapy. According to a Program document dated 2-15-13, Tenant #4 had been on Viibryd 20 mg daily and had increased hostility towards staff, suicidal ideations, and increased falls due to insomnia. Viibryd and Region were discontinued on 2-7-13. Tenant #4 was started on Sertraline 75 mg daily, Risperdone was increased to 0.5 mg and Trazodone 100 mg at bedtime. Since the new medication change Tenant #4 had a decrease in violent behavior, was still agitated but much less than before. Staff #1 said Tenant #4 did not have any physical behaviors; however, Tenant #4 called out, was confrontational to tenants and staff and staff redirected Tenant #4. Staff #1 said the behaviors varied depending on the day. Staff #2 said Tenant #4 had rude behavior and had spit on a staff and smacked a staff. Staff #2 said staff provided interventions including: find something to eat, have Tenant #4 walk away or take Tenant #4 to the toilet. The service plan reflected Tenant #4 had mood swings, staff to be aware of up and down moods and staff attempted to redirect Tenant #4 when Tenant #4 became frustrated. The service plan did not provide interventions related to Tenant #4's behaviors. The service plan was not updated as needed and did not reflect the identified needs of Tenant #4.

Review of tenant files indicated service plans were not updated as needed and did not reflect the identified needs of the tenants.

- 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: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

C. Medications

Monitoring Observation: Four tenant files were reviewed. According to the Program's Medication Documentation on Medication Administration Record (MAR) policy, staff was to initial the box on the MAR form to identify the medication appropriate for that time and date. According to the Assisting with Self-Administration/ Administration of Pro Re Nata (PRN) Medications policy, any PRN (as needed) medication given was documented on the MAR and a notation was made on the reverse side or where indicated on the front of the MAR with time, reason given, and the follow-up of the results.

The table below represents lack of documented results for as needed medications and medications and treatments not documented as administered and completed.

TENANT	MEDICATION	DOCUMENTATION ON MEDICATION SHEET
Tenant #2	Arthricream 10 % apply topically three times daily as needed for pain for arthritic pain	On 4-27-13 was documented as administered three times, am, pm, and night on the Medication Sheet. It was not documented as administered on the Medication Notes and the effectiveness of the medication was not documented
Tenant #2	Oxycodone HCl 5 mg take one tablet every four hours as needed for pain	On 3-25-13 and 3-28-13 was documented as administered on the Medication Sheet. It was not documented as administered on the Medication Notes and the effectiveness of the medication was not documented
Tenant #2	Oxycodone HCl 5 mg take one tablet every four hours as needed for pain	On 3-20-13 and 3-22-13 documented as administered on the Medication Sheet and Medication Notes; the effectiveness of the medication was not documented
Tenant #3	Weekly weight at 10:00 a.m.	4-3-13 and 4-11-13 not documented as completed on the Medication Sheet
Tenant #3	Jojoba Oil, apply topically to left arm prior to compression wrap at bedtime	3-15-13 not documented as completed on the Medication Sheet
Tenant #4	Acetaminophen 325 mg/5	On 4-2-13 documented as

	milliliters (ML): 325 mg by mouth every four hours as needed for pain or fever	given on the Medication Sheet. On the Medication Notes the effectiveness of the medication was not documented
Tenant #4	Acetaminophen 325 mg/5 ML: 325 mg by mouth every four hours as needed for pain or fever	Documented on the Medication Notes as administered on 4-3-13 at 7:40 a.m.; not documented on the Medication Sheet as administered and the effectiveness of the medication was not documented
Tenant #4	Acetaminophen 325 mg/5 ML: 325 mg by mouth every four hours as needed for pain or fever	Documented as administered twice on 4-13-13 on the Medication Notes; only one dose was documented as administered on the Medication Sheet
Tenant #4	Acetaminophen 325 mg/5 ML: 325 mg by mouth every four as needed for pain or fever	On 4-30-13 documented as given on the Medication Sheet. On the Medication Notes the effectiveness of the medication was not documented

Review of tenant files indicated medications and treatments were not documented as administered or completed and the effectiveness of as needed medication was not documented.

- Regulatory Insufficiency: When medications are administered traditionally by the program: 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))