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

DEMAND LETTER
CERTIFIED
Complaint Intake #: 43579-C
43796-C

July 10, 2013

Ms. Kim Meredith, Interim Administrator
Eiler House Assisted Living
920 W. Garfield
Clarinda, IA 51632

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - EILER HOUSE ASSISTED LIVING
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Meredith:

I. Final Complaint/Incident Investigation Report – Eiler House Assisted Living, Clarinda, IA

Enclosed is the **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 22, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights, Tenant Documents, Evaluation, Service Plans, Criteria for Admission and Retention, Medications, Nurse Review, Policies and Procedures, Staffing, Food Service and Mandatory Reporter Training for Dependent Adult Abuse.

Eiler House Assisted Living ("Program") is being assessed a **$1500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.12(3)(a)(2), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of Evaluation, Service Plan, Medications, Nurse Review, DAA Training and Staffing.

The determination of a **$1500 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plan, Medications, Nurse Review, DAA Training and Staffing . As the enclosed Report details, the Program failed to complete service plans based on the evaluations and failed to complete evaluations and service plans with change of condition. The Program failed to document medications accurately. The Program failed to provide adequate training and documentation of staff training.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Jim Berkley** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of **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)(b) and 481 IAC 67.12(3)(a)(2). The Plan of Correction (POC) submitted on July 2, 2013, has been reviewed and will constitute the final POC related to the on-site visit of May 22, 2013.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of notice or service of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Jim Berkley, at 515/281-4116.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Kim Meredith, Interim Administrator
Eiler House Assisted Living
920 W. Garfield
Clarinda, IA 51632

Complaint/Incident Intake #: 43579-C
43796-C

Date of Complaint/Incident Investigation:

May 22, 2013

Monitor(s):

Hal Chase, RN BSN MPH
Lori Miner, RN BSN

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

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

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

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

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	20
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	21
TOTAL census of Assisted Living Program	21

Program History – During the recertification visit on January 8, 2013, the program received a regulatory insufficiency related to record checks.

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

A. Tenant Rights

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

- Monitoring Observation: Tenant #1, an 80 year old, was admitted on 1-21-13 and had diagnoses of: Lewy Body Dementia, Nutritional Deficiency, Neurogenic Bladder, Constipation, Dysphagia, Anxiety and a History of Falls. A Global Deterioration Scale (GDS) was completed on 1-21-13 and staged Tenant #1 at seven, which indicated severe dementia.

  A service plan of 2-13-13 indicated Tenant #1 required a mechanical soft diet with nectar thickened liquids. Staff #3 and #4 were interviewed and reported Tenant #1 was not allowed to dine with other tenants in the dining room, as the previous Administrator directed staff to serve all meals in his/her apartment because other tenants had complained of how Tenant #1 ate his/her food.

  Staff members #3 and #4 were interviewed. Both stated Tenant #1 had a tendency to fall forward. Both stated Tenant #1 was placed in the recliner with the chair tilted back or the feet up to keep Tenant #1 in the recliner. Staff #4 stated Tenant #1 was checked every two hours, and that Tenant #1 did not know how to use the call light. The recliner was used to restrain Tenant #1.

- Regulatory Insufficiency: All tenants have the following rights. 1. To be treated with consideration, respect and full recognition of personal dignity and autonomy. 4. To be free from mental and physical abuse. (IAC r. 481-67.3 (1)(4))

B. Tenant Documents

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

- Monitoring Observation: During the onsite investigation, monitors requested eight tenant files. Program census indicated Tenants #1, #2, and #3 resided at the Program. Tenants #4, #5, #6, #7 and #8 were discharged. Tenants #4 through #8's files lacked documentation related to evaluations, service plans, 90-day nurse reviews, nurse's notes, physician orders and medication administration records. Monitors were unable to determine each of tenant's cognitive and functional status and need for assistance during their residency at the Program and why they were discharged.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: c. the initial evaluations and update; e. the initial individual service plan and updates; i. when any personal or health-related care is delegated to the program, the medication information sheets; documentation of health professionals' orders, such as those for treatment, therapy and medication; and nurses' notes written by exception. (IAC r. 481-69.25(1)(c,e,i))

C. Evaluation

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

- Monitoring Observation: Eight tenant files were reviewed. No issues were found with Tenants #3, #7 and #8

  Tenant #1's file indicated the initial cognitive evaluation of 1-21-13 was a GDS and not a scored cognitive evaluation. A cognitive evaluation was not completed within 30 days of admission.

  Tenant #1 was admitted to home health care in November, 2012. Home health care plans of 1-7-13 and 3-8-13 indicated Tenant was to receive the following cares: proper positioning during meals, the use of side bed rails, fall precautions, and a gait belt with all transfers. Tenant #1's diet consisted of a mechanical soft diet with nectar thickened liquids and monitoring of oral intake. Tenant #1 was to receive wound care for a stage one pressure ulcer, repositioning every two hours, perineum care and monitoring for exacerbation of pulmonary dysfunction and checking pulse oximetry as needed and assessing for pain management.

  A monitor interviewed the home health nurse who provided direct care for Tenant #1 and had developed the care plans. She stated Tenant #1 became a client in November 2012, prior to the tenant being admitted to the assisted living program. She stated Tenant #1 had always needed two-staff assist with all transfers, as Tenant #1 had a history of falls and Lewy Body Dementia.

  Functional and health evaluations of 1-21-13 and 2-13-13 did not include evaluations related to care needs identified by the home health agency's care plans of 1-7-13 and 3-8-13.

Tenant #2, a 71 year old, was admitted on 3-29-13 and had diagnoses of: Diabetes Mellitus Type II, Hypothyroidism, Coronary Artery Disease, Hypertension (HTN), Chronic Rash, Insomnia, and Anxiety. A cognitive evaluation of 3-29-13 indicated Tenant #2 scored 29 out of 30, which indicated normal cognition. Evaluations were not completed within 30 days of admission.

Tenant #4, an 84 year old, was admitted on 9-7-12 and had a diagnosis of Dementia. A GDS was completed on 11-15-12 and staged Tenant #4 at four, which indicated moderate cognitive decline.

Resident notes of 1-10-13 through 1-24-13 indicated Tenant #4 was weak, lethargic, had increased confusion and sustained at least four suspected falls. A fall on 1-19-13 resulted in a hospital emergency room evaluation for arm, leg, back and head pain. Tenant #4 sustained significant bruising related to this fall.

Functional and health evaluations were last completed on 10-15-12. The Program did not complete functional, cognitive and health evaluations with a significant change of condition as documented between 1-10-13 through 1-24-13.

Tenant #5, a 97 year old, was admitted on 7-31-06 and had diagnoses of: Congestive Heart Failure, HTN, Osteoarthritis, Macular Degeneration, Depressive Disorder, Anxiety, GERD, Peripheral Neuropathy and Osteoporosis. A cognitive evaluation of 2-2-13 indicated Tenant #5 scored 21 out of 30, which indicated mild cognitive decline.

Evaluations indicated Tenant #5 was independent with mobility and used a walker for ambulation. Tenant #5's resident service notes indicated at least eight suspected falls between 12-10-12 through 3-30-13. A service plan of 2-2-13 indicated Tenant #5 had two falls in the last week and was on antibiotic (ATB) therapy for a urinary tract infection (UTI). Tenant #5's physician was notified of Tenant #5's falls and edema in both legs and feet. No other follow-up was noted.

Functional and health evaluations of 2-2-13 did not indicate Tenant #5 was evaluated related to eight suspected falls of 12-10-12 through 3-30-13.

Tenant #6, an 84 year old, was admitted on 3-20-13 and had diagnoses of: HTN, GERD and Dementia with Agitation. A scored cognitive evaluation of 7 out 30 was completed on 3-14-13 which indicated moderately severe cognitive decline.

Tenant #6 was admitted to home health service on 3-27-13, following a prior hospitalization of 2-28-13 through 3-20-13. The home health care plan of 3-27-13 established interventions of: assessing respiratory status, using a pulse-oximetry if short of breath and notifying the physician if oxygen saturation is less than 89%. Staff was to avoid positioning Tenant #6 directly on the Trochanter when lying Tenant #6 on his/her side. Pressure reducing surfaces and raising heels were to be utilized when in bed. The perineum was to be cleansed as needed and assessed for fungal/yeast infection.

Resident service notes of 3-29-13 indicated Tenant #6 was sent to a hospital emergency room for heavy breathing. Tenant #6 returned the same day and was

diagnosed with a UTI and prescribed ATB therapy twice daily for seven days. Tenant #6 had a Foley catheter and staff was to encourage Tenant #6 to drink fluids.

Resident service notes of the same date but separate entry indicated Tenant #6 had an "area" (possibly a sore) on the buttocks. Tenant #6's right foot was swollen. Notes indicated staff was to float Tenant #6's heels to reduce skin breakdown. Resident service notes of 3-30-13 indicated Tenant #6 had two sores on the peri-area caused from the Foley catheter rubbing against the skin. Tenant #6's temperature was 100 degrees Fahrenheit at 8:00 a.m.

Resident service notes of 3-31-13 indicated Tenant #6 refused to eat, but would drink fluids. Resident service notes of 4-2-13 indicated Tenant #6 was seen by a physician and was admitted to the hospital.

A letter from Tenant #6's family member and a notice of voluntary termination of residency of 4-9-12 indicated Tenant #6 was discharged from the Program.

The Program did not evaluate Tenant #6's functional, cognitive health status when Tenant #6 was admitted to home health and when a change of the tenant's condition existed as documented in resident service notes of 3-29-13 through 4-2-13.

- 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 services 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))

D. Service Plans

Complaint/Incident Allegation: It was alleged tenants had several falls which resulted in significant injuries, including fracture and head trauma. It was alleged interventions were not established to address the prevention or mitigation of future falls. (43579-C)

- Monitoring Observation: Eight tenant files were reviewed. No issues were found with Tenants #1, #2, #3, #6, and #8 related to the complaint. A review of Tenants #4, #5 and #7s' file indicated a history of falls. No issues were found with Tenant #7 related to falls.

  Tenant #4's resident service notes of 1-10-13 through 1-24-13 indicated Tenant #4 was weak, lethargic, had increased confusion and sustained at least four suspected falls. A fall on 1-19-13 resulted in a hospital emergency room evaluation for arm, leg, back and head pain. Tenant #4 sustained significant bruising related to this fall.

Tenant #4's service plan of 10-15-12 indicated Tenant #4 needed assistance with activities of daily living (ADLs), including bathing, grooming and dressing. Tenant #6 was independent with ambulation and needed staff assistance when dizzy.

The service plan of 10-15-12 was not updated with a change of condition related to the suspected falls. A service plan of 2-1-13, signed by RN 1 and Tenant #4's legal representative, was not complete. Interventions related to ADLs were left blank. The service plan of 2-1-13 was not supported by evaluations.

Tenant #5's resident service notes indicated at least eight suspected falls between 12-10-12 through 3-30-13. A service plan of 2-2-13 indicated Tenant #5 had two falls in the last week, and was on ATB therapy for a UTI. Fall protocols were established on 2-28-13 and 3-24-13, but the service plan did not establish interventions related to falls, ATB therapy and a history of UTI's.

During the course of the investigation, the following information was obtained.

Tenant #1's service plan of 1-21-13 was not supported by an appropriate cognitive evaluation. A GDS was completed when a scored objective tool was to be used. The service plan of 2-13-13 was not supported by a cognitive evaluation. The service plan of 3-14-13 was not supported by functional, cognitive and health evaluations.

Service plans of 2-13-13 and 3-14-13 did not include interventions established in the home health care plan of 1-7-13 and 3-8-13. The home health care plans indicated Tenant was to receive the following cares: proper positioning during meals, the use of side bed rails, fall precautions, and a gait belt with all transfers. Tenant #1's diet consisted of a mechanical soft diet with nectar thickened liquids and monitoring of oral intake. Tenant #1 was to receive wound care for a stage one pressure ulcer, repositioning every two hours, perineum care and monitoring for exacerbation of pulmonary dysfunction and checking pulse oximetry as needed and assessing for pain management.

Tenant #2's initial service plan of 3-29-13 did not have the required signatures of the nurse, tenant or the tenant's legal representative. The service plan of 3-29-13 was not updated within 30 days of admission.

Resident service notes of 4-8-13 through 4-28-13 indicated at least three incidents of suspected falls. Notes of 4-28-13 indicated a change in health status and a need to update the service plan to reflect an increase in level of care. A service plan was updated on 5-3-13, but was not supported by evaluations.

Tenant #6's service plan of 3-20-13 was not updated when Tenant #6 was admitted to home health on 3-27-13. A home health care plan established additional care needs and resident service notes of 3-29-13 through 3-31-13 indicated catheter placement, skin breakdown and refusal to eat and to encourage Tenant #6 to drink more fluids.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluation 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: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26 (3))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (a) The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

E. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged tenants exceeded criteria for admission to the program (43796-C). It was alleged a tenant exceeded criteria for admission and retention (43579-C).

- Monitoring Observation: Eight tenant files were reviewed and no issues were found related to exceeding criteria for admission and retention with Tenants #2 through #8.

  Tenant #1's initial functional and health evaluation of 1-21-13 indicated Tenant #1 required routine two staff to assist with all transfers. Staff #3 and #4 each reported Tenant #1 needed routine two-staff to assist with all transfers.

  A monitor interviewed the home health nurse who provided direct care and developed the care plans. She stated Tenant #1 became a client in November, 2012, prior to being admitted to the assisted living program. She stated Tenant #1 had always needed two-staff assist with all transfers, as Tenant #1 had a history of falls and Lewy Body Dementia.

  Tenant #1 exceeded admission and retention criteria at time of admission. Monitors observed staff transfer Tenant #1. Two staff were needed to transfer Tenant #1 from a recliner to the toilet.

  The Program gave a 30-day written notice of discharge on 4-30-13, citing medical reasons for discharge; however, Tenant #1 continues to reside at the Program.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: c. is dangerous to self or other tenants or staff, including but not limited to a tenant who, despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression. (IAC r. 481-69.23(1)(c)(1))

F. Medications

Complaint/Incident Allegation: It was alleged narcotics were kept without inventory. It was alleged medications have been accepted for tenants who no longer lived at the program. It was alleged medications belonging to tenants who no longer live at the

program were given to a free clinic by a previous nurse. It was alleged medications were left in the medication room in a sack unsecured. (43579-C)

- Monitoring Observation: The Medication Administration Records (MARs) were reviewed including narcotic count sheets tenants currently residing in the program, including Tenants #1, #3, and #9. Narcotics were inventoried on sheets listing the individual tenant and specific medication. The Program also documented narcotic counts at the beginning and end of each shift. The Program provided prescription ordering records which documented the date a medication was ordered and the date the medication was received from the pharmacy as well as the name of the staff member receiving the medications. According to IAC r. 481-67.5(6) the Program is required to keep a list of tenants' medication when the Program administers medications. Narcotics protocol is determined by the Program's nurse. The Program had a list of tenants' medications and had a narcotics protocol.

  RN 1 left the Program on 3-29-13, approximately two months prior to the onsite visit. Staff #3, #4, and the RN 2 were interviewed. Medications were sent with the tenant and/or family when a tenant left the program, including Tenants #4 and #8. When medications arrived for tenants who no longer resided at the program, the medications were returned to the pharmacy. If the pharmacy would not accept the medications for return, the medications were destroyed per Program policy. A tour of the Program's medication room revealed no extra medications and no medications for tenants that no longer resided at the program.

  The RN 2 stated she was aware of an unmarked box of syringes being given to the free clinic. Staff members #3 and #4 were not aware of any medications prescribed to one tenant being given to another or given to an outside agency. There was no evidence the Program currently was using medications prescribed for one tenant and giving them to someone else.

  Staff #4 reported Tenant #3 had self-administered medications, and then had the Program administer medications. At the time of the changeover, medications for Tenant #3 were in a sack in the medication room. No other tenants had medications in grocery sacks. Staff #4 reported the medication room door was locked. Upon a tour of the program, the monitor observed the medication room door to be locked. The medication room was toured and there were no medications observed to be sitting on the counter. The locked medication room door maintained security of the medications. No regulatory insufficiencies were noted.

Complaint/Incident Allegation: It was alleged medications were signed off as given when the medications were not actually given. It was alleged medications were left on the counter and not given, but were signed off as given. (43579-C)

- Monitoring Observation: The monitors arrived onsite at approximately 8:45 a.m. The MARs were reviewed shortly after 9:00 a.m. Staff members were not observed passing medications at that time. The MAR for Tenant #10 indicated the Sertraline due at 8:00 a.m. had not been given. Staff #4 was interviewed as she signed all other 8:00 a.m. medications as given. Staff #4 stated she gave the Sertraline but did not document it, a medication error.

Staffs #3 and #4 were interviewed and stated medications were set up at the time of administration, and medications were documented as given only after the medication was actually given. Staff #4 was observed during a medication pass at 11:30 a.m. Staff #4 was observed setting up medications, administering them, and then documenting the medications as given after doing so.

The Program was asked to provide incident reports for the last three months. The incident report log for February and March 2013 did not document any medication errors. An incident report dated 4-5-13 documented that the communication book indicated Tenant # 11 was not given 10:00 p.m. medications and staff did not remember the medication until 4:00 a.m. The incident report documented the incident occurred on 4-1-13, and noted the incident report was not completed at the time of the occurrence. An incident report dated 4-9-13 documented a medication was missed for Tenant #12 because of a label change. The incident occurred on 4-8-13. An incident report dated 4-11-13 documented a medication was still in the bubble pack for Tenant #10, but was documented as given. No other incident reports given to the monitor documented medication errors.

Staff #4 and RN 2 stated Staff #4 had left a cup of pills for Tenant #1on the kitchen counter and had not administered the pills. After questioning, RN 2 sent by email a copy of an incident report dated 4-6-13 that documented the incident timed at 5:00 p.m. The previous administrator used the incident report to document a cup of pills, identified as Oxycontin, Namenda, and Vytorin, was found in the kitchen. The incident report documented the medications were documented as given but had not been given. The April MAR was reviewed and the medications listed above were documented as given. The narcotic inventory sheet also documented the administration of Oxycodone. Medications were documented as given when they were not.

Staff #4 and RN 2 reported a narcotic count error for Tenant #3 The bubble-pack card of Oxycodone was empty and new supply had been received in several cards. A dose had been administered and rather than placing the used card on top, the card had been placed underneath an unused card. The staff member counting did not look at the bubble pack and assumed no pills had been taken. The count appeared to be off, with one more pill present than on the count sheet. The staff member took a pill out of the bubble pack and placed it in the sharps container to make the count correct by destroying one pill. When the next shift came in, the bubble packs were all counted and observed, and now the count was one less than on the narcotic count sheet. Upon questioning, RN 2 provided written statements of the event which occurred on 4-25-13. The narcotic inventory sheet did not document the destruction of the Oxycodone.

Complaint/Incident Allegation: It was alleged a tenant's medication was to be held for one day, but due to lack of communication medication was held for a week, which caused a tenant to be hospitalized. (43579-C)

- Monitoring Observation: Twelve tenant files were reviewed related to the administration of medications by staff. No issues were found related to the allegation with Tenants #1 through #5 and #7 through #12.

Tenant #6 had been hospitalized prior to admission beginning 2-28-13 through 3-12-13 with an admitting diagnosis of Dementia with Agitation. There was no record of a physician's order for medications upon admission.

MARs indicated the following medications were to be administered. Ditropan 5mg – one tab three times daily, Depakote 125mg – one tablet three times daily, Haldol 5mg – one tablet three times daily, Zestril 10mg – one tablet twice daily, Ambien 10mg – one tablet at night. Tylenol 325mg – one to two tablets every six hours as needed. Milk of Magnesia – 30cc every six hours as needed, Tenormin 25mg – one tablet daily, K-Dur 10 meq – one tablet daily, Macrodantin 50mg – two tablets at night, Ativan .5mg – one tablet every four hours as needed

On 3-28-13 Tenant #6's physician was notified by staff that Tenant #6's medications were held on 3-27-13 as Tenant #6 was "highly lethargic." Tenant #6 had an evening dose of Haldol. Medications were also held on 3-28-13 due to similar lethargy. On the same date, the physician ordered to continue the same dosages for Zestril, Tenormin, Macrodantin and K-Dur Potassium. Ditropan was changed from three times daily to twice daily. Ambien was to have been discontinued, but no date of discontinuation was noted.

MARs for March, 2013 indicated two separate sets of MARs were made for the medications listed below. The first set of MARs had a start date of 3-20-13 through 3-27-13. A second set for the same medications started 3-28-13. The second set indicated the Program nurse noted to start using the second set of MARs on 3-28-13. A review of both sets of MARs for the combined period of 3-21-13 through 3-29-13 indicated the following:

Zestril 10mg was held at 8:00 p.m. on 3-25-27-13 and no record of giving Zestril at 8:00 p.m. on 3-28-29-13, Tenormin 25mg was held 3-27-28-13, Macrodantin 50mg was held 3-25-27-13, K-Dur Potassium 10meq was held 3-27-28-13 and Ditropan 5mg was not given at 12:00 p.m. and 5:00 p.m. on 3-26 & 27-13 and at 8:00 a.m. on 3-27-29-13. MARs for 3-29-13 indicated morning medications listed above were held due to swallowing issues. Tenant #6 was sent to a hospital emergency room on 3-29-13, but returned the same day at 3:30 p.m.

A review of Tenant #6's physician orders did not indicate a physician had ordered medications held for the periods of 3-25-13 through 3-29-13.

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

G. Nurse Review

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

Monitoring Observation: Tenant #4's resident notes of 1-10-13 through 1-24-13 indicated Tenant #4 was weak, lethargic, had increased confusion, and sustained at least four suspected falls. Nurse reviews were not completed with a change of condition.

Tenant #5's resident service notes indicated at least eight suspected falls between 12-10-12 through 3-30-13. A service plan of 2-2-13 indicated Tenant #5 had two falls in the last week and was on ATB therapy for a UTI. Tenant #5's physician was notified of Tenant #5's falls and edema in both legs and feet. Nurse reviews were completed on 12-10-12. A nurse review was completed on 3-4-13 related to a fall Tenant #5 sustained on 2-28-13. Resident service notes of 4-2-13 indicated RN 2 completed a nurse review of fall Tenant #5 had on 3-25-13. Nurse reviews were not completed with a change of condition.

Tenant #6 was admitted to home health service on 3-27-13, following a prior hospitalization of 2-28-13 through 3-20-13. The home health care plan of 3-27-13 established interventions of: assessing respiratory status, using a pulse-oximetry if short of breath and notifying the physician if oxygen saturation is less than 89%. Staff was to avoid positioning Tenant #6 directly on the Trochanter when lying Tenant #6 on his/her side. Pressure reducing surfaces and raising heels were to be utilized when in bed. The perineum was to be cleansed as needed and assessed for fungal/yeast infection.

Resident service notes of 3-29-13 indicated Tenant #6 was sent to a hospital emergency room for heavy breathing. Tenant #6 returned the same day and was diagnosed with a UTI and ATB therapy was prescribed twice daily for seven days. Tenant #6 had a Foley catheter and staff was to encourage Tenant #6 to drink fluids.

Resident service notes of the same date but separate entry indicated Tenant #6 had an "area" (possibly a sore) on the buttocks. Tenant #6's right foot was swollen. Notes indicated staff was to float Tenant #6's heels to reduce skin breakdown. Resident service notes of 3-30-13 indicated Tenant #6 had two sores on the peri-area caused from the Foley catheter rubbing against the skin. Tenant #6's temperature was 100 degrees Fahrenheit at 8:00 a.m. Resident service notes of 3-31-13 indicated Tenant #6 refused to eat, but would drink fluids. The Program did not complete nurse reviews related to significant changes in the tenant's condition

- Regulatory Insufficiency: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r.481-69.27(1))

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: to monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r.481-69.27(1))

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r.481-69.27(3)

- Regulatory Insufficiency: To provide the program with written documentation of the activities under the service plan, as set forth in rule 481—69.26(231C), showing the time, date and signature. (IAC r.481-69.27(4)

H. Policies and Procedures

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

- Monitoring Observation: Staff training records were reviewed for five staff members (#2 through #6). All were employed as Personal Service Assistants (PSA) and assisted with the serving of food. Staff #2 had a certificate dated 3-19-12 which indicated a self-study course had been completed on food service sanitation. Staff #3, hired 3-18-13, had a certificate dated 7-6-12 that was not signed by a presenter and was not identified as a self-study course. Staff #4 completed a self-study course on food safety on 7-6-12. Staff #5 had no documented food safety training. Staff #6 completed a self-study course on 9-11-12.

  According to the Program's Dining and Nutrition Services Orientation Record, all training was to be instructor-led. The training was to involve the food manager or dietitian, and the new employee was not to be given the handbook to read.

  Staff #2, #4, and #6 completed a self-study course. Staff #3 had a training certificate that did not identify the training was instructor-led. The Program did not follow its procedure for training of food safety to employees.

  Staff #4 and RN 2 reported a narcotic count error for Tenant #3. The bubble-pack card of Oxycodone was empty and new supply had been received in several cards. A dose had been administered and rather than placing the used card on top, the card had been placed underneath an unused card. The staff member counting did not look at the bubble pack and assumed no pills had been taken. The count appeared to be off, with one more pill present than on the count sheet. The staff member took a pill out of the bubble pack and placed it in the sharps container to make the count correct by

destroying one pill. The Program's procedure for the destruction of narcotics was not followed.

When the next shift came in, the bubble packs were all counted and observed, and now the count was one less than on the narcotic count sheet. Upon questioning, RN 2 provided written statements of the event which occurred on 4-25-13. RN 2 stated an incident report had not been completed and there was no incident report provided to the monitors when asked to provide them. An incident report was not used to document an incident involving Tenant #3's medications.

Staff #4 and RN 2 stated Staff #4 had left a cup of pills for Tenant #1 on the kitchen counter. After questioning, RN 2 sent by e-mail a copy of an incident report dated 4-6-13 that documented the incident. The incident report was not on the premises at the time of the onsite visit, and was provided to the monitor electronically.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The Program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)
- Regulatory Insufficiency: The program's policies and procedures on incident reports, at a minimum, shall include the following: (e) All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. (f) A copy of the completed incident report shall be kept on file on the program's premises for a minimum of three years. (IAC r. 481-67.2(1)(e,f))

I. Staffing

Complaint/Incident Allegation: It was alleged staff training was not completed and training certificates were for "show." (43579-C)

- Monitoring Observation: The RN 1 left employment with the Program on 3-29-13. The training record for Staff #2, a PSA was reviewed. A nurse had last documented training in 2009. There was no documentation in the training record by any other nurse, including RN 1 or RN 2.

The training record for Staff #3, PSA was reviewed. Staff #3 stated she had not taken a formal CNA class. The training record documented the RN 1 completed training on health-related cares on 9-6-12. The column used to document the demonstration of competency for vital signs was blank. The columns on the orientation form contained June 2012 dates and the documented trainer was Staff # 7, PSA. RN 1 signed the form and dated it 9-6-12. Staff #3 did not sign the form to indicate she had received the training. There was no documentation the RN 1 observed Staff #3 performing ADLs. Staff #3 was interviewed and stated she passed medications. The medication assistance training form documented Staff #3 passed a written exam, but did not document Staff #3 successfully completed observed medication passes. There was no documentation by any other nurse other than RN1.

The training record for Staff #4 PSA was reviewed. Staff #4 reported she was a CNA. The training record documented the RN 1 completed training on health-

related cares and staff orientation on 9-6-12. The column used to document the demonstration of competency for vital signs was blank. The columns on the orientation training form for ADLs and medication assistance procedures had a line drawn with a notation the items were discussed at in-service. There was no documentation to suggest Staff #4 was observed by a nurse prior to performing the tasks. There was no documentation in the training record by any nurse other than the RN 1.

The training record for Staff #5 PSA was reviewed. The medication competency checklist was signed by the RN 1; however, Staff #5 did not sign the form as indicated to document training had been received.

The training record for Staff #6 PSA was reviewed. The health-related cares form dated 9-6-12 documented the RN 1 trained Staff #6 on vital signs and personal cares; however, Staff #6 did not sign the form to indicate she had received and understood the training. The staff orientation from dated 9-8-12 documented the RN 1 had provided training however, Staff #6 did not sign the form to indicate she received training on ADL's. The medication assistance training form documented Staff #6 passed a written exam, but did not document Staff #6 successfully completed observed medication passes. There was no documentation by any other nurse other than RN 1.

Staff training records lacked documentation of completed training on vital signs, ADL's, and medications. In one instance, training was received from another PSA. Training forms lacked a signature by the employee as indicated to document training was received.

- 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))

J. Food Service

Complaint/Incident Allegation: It was alleged staff training was not completed related to food handling. (43579-C)

- Monitoring Observation: Staff training records were reviewed for five staff members (#2 through #6). All were employed as PSA and assisted with the serving of food. Staff #2 had a certificate dated 3-19-12 indicated a self-study course had been completed on food service sanitation. There was no documentation of an annual food safety course completed in 2013. Staff #3, hired 3-18-13, had a certificate dated 7-6-12 that was not signed by a presenter and was not identified as a self-study course. Staff #4 completed a self-study course on food safety on 7-6-12. There was no documentation Staff #5, hired 11-20-12, had completed food safety training. Staff #6 completed a self-study course on 9-11-12. There was no documentation a food protection manager was involved in the training.

  The Program provided documentation the Dining Services Coordinator had completed a two-and-a-half hour course Safe Food course presented by Iowa State

University Extension. The Safe Food course did not meet the requirements under the Food Code for a food protection program.

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

Tenant #1 had a physician's order for a therapeutic diet, mechanical soft with nectar thickened liquids. Staff #1, who was working in the kitchen at the time of the interview, stated the main dish for the evening meal was chili. Staff #1 stated Tenant #1 did not tolerate chili well. Staff #1 substituted pureed meatloaf and mashed potatoes for the chili. Staff #1 stated she took it upon herself to replace the chili with the pureed meatloaf and mashed potatoes. Staff #1 was unable to provide documentation from a dietitian for the meals provided to Tenant #1. In a fax dated 5-31-13, the Program sent the cover page to the Iowa Simplified Diet Manual to the department with a note the manual was located in the kitchen. Staff #1 was unable to locate a copy of the Iowa Simplified Diet Manual during the onsite visit.

- Regulatory Insufficiency: Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician assistant, or advanced registered nurse practitioner. A current copy of the Iowa Simplified Diet Manual published by the Iowa Dietetic Association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets.
(IAC r. 481-69.28(4))

- Regulatory Insufficiency: Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (a) In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by: (3) Successfully completing a course meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another course may be substituted if the course's curriculum includes substantially similar competencies to a course that meets the requirements of the Food Code and the provider of the course files with the department a statement indicating that the course provides substantially similar instruction as it relates to sanitation and safe food handling.
(IAC r. 481-69.28(5)(a)(3))

K. Mandatory Reporter Training for Dependent Adult Abuse.

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

- Monitoring Observation: Staff #2 was hired 8-18-08, Staff #3 was hired 3-18-13, Staff #4 was hired 11-1-12, and Staff #6 was hired 8-22-12. Staff training files lacked documentation of training on dependent adult abuse at the time of the onsite visit. The Program faxed certificates dated 5-29-13, after the monitoring visit, which

documented Staff #2, #3, and #4's completion of Dependent Adult Abuse training. The Program did not fax documentation for Staff #6.

- Regulatory Insufficiency: A person required to report cases of dependent adult abuse pursuant to section 235B.3, other than a physician whose professional practice does not regularly involve providing primary health care to adults, shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment or self-employment which involves the examination, attending, counseling, or treatment of adults on a regular basis. Within one month of initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person's employer or, if self-employed, from the department. The person shall complete at least two hours of additional dependent adult abuse identification and reporting training every five years. (235B.16 (5)(b))