IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
43880-C
44124-C

July 18, 2013

Ms. Michelle Van Dolah, Manager
Rosebush Gardens
4925 West Avenue
Burlington, IA 52601

RE: Final Complaint/Incident Investigation Report, Rosebush Gardens, Burlington, Iowa

Dear Ms. Van Dolah:

Enclosed is the **Final Complaint/Incident Investigation 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 reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Michelle Van Dolah, Manager
Rosebush Gardens
4925 West Avenue
Burlington, IA 52601

Complaint/Incident Intake #: 43880-C
44124-C

Date of Complaint/Incident Investigation:

June 5, 12 and July 3, 2013

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS
James Berkley, RN BS

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:	31
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	32
TOTAL census of Assisted Living Program	32

Program History – The program received regulatory insufficiencies in the area of Food Service during this certification period.

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

A. Policies and Procedures

Complaint/Incident Allegation #43880-C: It was alleged there were concerns regarding a tenant's death and tenant checks.

- Monitoring Observation: Five tenant files were reviewed. Tenants #1, #2 and #5 were discharged in the past three months. Tenant #1 was discharged. Tenant #2 and Tenant #5 expired.

  The Program's Death Policy indicated in the event a tenant was found expired: if the Administrator or registered nurse (RN) was not in the building they were to be called and they would give instructions on what to do. If they were not in the building and received a call that a tenant was found expired, one or both would go into the building. Staff would complete a report on facilities staff incident report that included what time the tenant was found, where the tenant was at, the last time the tenant was seen and what they were doing. The Administrator and/or RN would make all notifications and staff would not make notifications unless directed by the Administrator and/or RN. The nurse would ask the contact person if they wanted the mortuary called or if they wanted to come in first and if they wanted anyone else called. The Nurse or Administrator would stay until the body was released to the mortuary. The mortuary would provide a release to the Program.

  According to the Night Time Well Being Checks Policy and Procedure with a review date of 5-13-11, with tenant agreement or per request staff would check in on the tenant every two hours and as needed from bedtime until wake up time. Staff entered the room and performed a well-being check making every effort not to disturb the tenant. If a tenant had been ill, the check could be done more often, for a shorter period of time. The Nurse would notify staff when and if that was needed.

The tenant would be informed of the two hour check and if they wanted an interval of checks done staff would be informed and it would also be on the service plan.

Tenant #2, a 92 year old, was admitted on 9-16-10 and diagnoses included: Diabetes. Atrial Fibrillation, Renal Mass, History of Cerebral Vascular Accident (CVA) and History of Gastrointestinal Bleed. Tenant #2's resuscitation status was Do Not Resuscitate (DNR). Tenant #2 died on 5-16-13. Tenant #2 scored an 11/11 on the cognitive tool, which indicated no or mild impairment. The service plan indicated staff provided safety checks at night per tenant request. The times of those checks were not specified on the service plan or when the first or last check was to be completed. The Program's Service Log for May 2013 indicated there was an "x" for safety checks on 5-15-13. The Service Log indicated there was an as needed medication administered on third shift. The Medication Administration Record (MAR) indicated Tramadol HCL 50 milligrams (mg) one tablet by mouth every four to six hours as needed was administered at 2:40 a.m. for complaints of foot and leg pain. The effectiveness of the as needed medication was noted at 4:00 a.m. and indicated there was some relief.

According to Nurse's Notes, the Nurse received a call from staff and reported Tenant #2 was found unresponsive in bed. At 8:10 a.m. the Nurse arrived at the Program, vital signs were absent and Tenant #2 was unresponsive. At 8:15 a.m. a call was placed to Tenant #2's family. At 8:20 a.m. a call was placed to the doctor and it was reported Tenant #2 was found unresponsive with vital signs absent. At 8:25 a.m. Tenant #2's family was at the Program and requested the Nurse contact the funeral home. The Nurse called the funeral home and support was given to the family. At 9:00 a.m. the body was released to the funeral home.

Staff #2 said at approximately 8:00 a.m. she was in with another tenant and Staff #3 asked her to go to Tenant #2's apartment as Staff #3 did not think Tenant #2 was breathing. Staff #2 went into the apartment with Staff #3. Tenant #2 was in bed, had a sunken face and Tenant #2's arm was cool to touch. Tenant #2 was in bedtime clothes and the C-PAP machine was on and running. Tenant #2 was covered up. Staff #2 called the Nurse and the Nurse arrived within 5 to 10 minutes. Staff #2 said Tenant #2 was probably not supposed to be up before that time and Staff #3 had gone in the apartment to administer medications.

Staff #3 said she arrived at work, got report from the previous shift and started the medication pass. There was nothing unusual relayed from third shift. At 7:15 a.m. she went to Tenant #2's apartment and the living room light was still off. Tenant #2 had not been feeling good, it was typical to sleep in and she did not think much of it. At 8:00 a.m. Staff #3 went back to Tenant #2's apartment to administer medication, the light was still off and Staff #3 rounded the corner and noticed Tenant #2 wasn't breathing. Staff #3 got Staff #2 and there was no response from Tenant #2. Staff #2 touched Tenant #2 to make sure Tenant #2 was not breathing. The Nurse was called and the Nurse called family. She said third shift did two hour checks and the last check was at 5:00 a.m. and there were no scheduled checks on her shift. Medications were administered one hour before and one hour after the prescribed time.

The Nurse said she was on her way to the Program and received a call regarding Tenant #2. Tenant #2 did not have any vital signs, was non-responsive, was lying in bed with the C-PAP on, a rosary in hand, knees on a pillow, wearing pajamas and was covered by a sheet, blanket and bedspread. The family, doctor and funeral home were notified. An incident report was not completed. Tenant #2 had nighttime checks and newspapers were delivered at 4:30 a.m. While asking questions about Tenant #2, Staff #5 got mad and quit, according to the Nurse. Staff #3 went in at the start of the medication pass about 7:05 a.m. or 7:10 a.m. and Tenant #2 was in bed and Staff #3 left. Staff #3 came back at approximately 8:00 or 8:30 a.m.

The Manager said she got a call from the Nurse that Tenant #2 was unresponsive and the Nurse was near the building. The Manager said newspapers were delivered around 4:30 a.m. The Manager said the check was a visual check (unless ill), staff checked to make sure the tenant was in bed and not on the floor. Staff was to check as quietly as possible. The Manager contacted staff regarding Tenant #2 and Staff #5 said it was not her hall but it was Staff #5's hall, according to the Manager.

At the time of Tenant #2's death the Program's policy did not require documentation of each check and there was no documentation of checks at each interval the checks were completed. The service plan did not specify the times of the checks including the first and last check and indicated safety checks at night. There were no safety checks for Tenant #2 on first shift according to the service plan and staff interview. It could not be determined when the exact time of the last check as it was not documented; however, safety checks were documented with an "x" on the Service Log, the effectiveness of the as needed medication was documented at 4:00 a.m. and newspapers were delivered at 4:30 a.m. An incident report was not completed that provided information including the time Tenant #2 was last seen, what Tenant #2 was doing, where Tenant #2 was found and at what time Tenant #2 was found. The policy and procedure regarding death of a tenant was not followed regarding Tenant #2.

A Policy and Procedure regarding Well Being Checks was dated 6-11-13. The policy indicated the safety checks would be on the service plan for those tenants that requested safety checks. Staff would check on the tenant every two hours with a 30 minute grace time. Staff would enter the apartment quietly making effort to not disturb the tenant. If tenant had been ill or any other reason the RN would notify staff and add it to the communication board. Checks and times would be logged on the Safety Check Flow sheet and if needed a comment would be added.

Tenant #5, an 83 year old, was admitted on 5-22-12 and diagnoses included: Ataxia, Confusion, Hypertension (HTN), Left Side Lower Extremity Weakness and Renal Failure (Acute). Tenant #5 resuscitation status was indicated as DNR. Tenant #5 received Hospice services. Tenant #5 died on 6-11-13. The service plan was completed on 6-11-13 and indicated staff provided safety checks every hour on all three shifts and initialed on the MAR. The service plan indicated staff was to notify the Nurse with changes in breathing patterns, periods when breathing seemed to stop and changes of color around the mouth to bluish color.

According to Nurse's Notes dated 6-11-13 at 6:05 p.m. the Nurse received a call from staff who stated Tenant #5 was unresponsive, there was no noted respiration and requested the Nurse return to the Program.

The Nurse returned to the Program, vital signs were absent and Tenant #5 was pronounced by the Nurse. Comfort was provided and the doctor was notified. The Hospice nurse was notified and the body was released to the funeral home.

According to a Staff Incident Report for Residents, on 6-11-13 at 6:00 p.m. staff went in to do the hourly check on Tenant #5 and Tenant #5 was moving the tongue around and was breathing. Staff told Tenant #5's legal representative that she would be back in to give Tenant #5's scheduled medications. When staff came right back in the legal representative told staff the Hospice volunteer thought that Tenant #5 was deceased because the volunteer checked for a pulse. Staff got a co-worker and the Nurse was called at 6:05 p.m. The report indicated the date and time Tenant #5 was found. The report indicated the last time seen Tenant #5 was moving the tongue around and was breathing. The report indicated it was an hourly check but did not indicate what time the check occurred. The report did not indicate where Tenant #5 was found.

The MAR indicated checks were consistently documented as completed including the check documented as completed at 5:00 p.m. for Tenant #5. Documentation of checks was provided as indicated on the service plan.

At the time of Tenant #5's death hourly checks were to be completed and the hourly checks were documented on the MAR. The MAR reflected checks were consistently completed every hour. An incident report was completed; however, did not include what time Tenant #5 was last seen and where Tenant #5 was found.

Review of the policy, review of tenant files and interviews indicated the policy was not followed as it related to filling out a report for Tenant #2's death and for not completing the report with details required per policy for Tenant #5's death.

- 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))

B. Evaluation

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

- Monitoring Observation: Five tenant files were reviewed.

Tenant #1, a 100 year old, was admitted on 4-27-07 and diagnoses included: Non-Insulin Dependent Diabetes Mellitus, HTN, Coronary Artery Disease, Reflux, Osteoporosis and Macular Degeneration. Tenant #1 was discharged on 5-29-13. Nurse's Notes dated 4-30-13 indicated Tenant #1 had Risperdal 0.5 mg twice daily ordered and a diagnosis of delusional behavior. Nurse's Notes dated 5-13-13 indicated Tenant #1 had complaints of not being able to catch Tenant #1's breath and had a tight feeling pointing to the left chest.

Tenant #1 was transported to the Emergency Department (ED) and returned with a diagnosis of acute chest pain and sinus bradycardia. A new order was received to discontinue Metoprolol. Nurse's Notes dated 5-13-13 and 5-14-13 indicated Tenant #1 complained of labored breathing, had complaints of being unable to catch Tenant #1's breath and a complaint of it hurting to breathe. According to a Hospice record, Tenant #1 started on Hospice on 5-16-13. Nurse's Notes dated 5-22-13 indicated Tenant #1 slept most of the day and ate only a small amount for breakfast and lunch. Hospice notes dated 5-16-13 indicated oxygen was ordered. Hospice notes dated 5-21-13 indicated Tenant #1 slept most of the day, was too tired to go to the dining room for meals over the weekend and Tenant #1 took longer to complete Activities of Daily Living (ADLs) due to fatigue and dyspnea. Hospice notes dated 5-29-13, indicated Tenant #1 ate breakfast that morning but had not eaten a meal in almost a week (unsure if Tenant #1was eating or drinking while in room due to confusion). Hospice Notes indicated Tenant #1 had increased confusion to the point where Tenant #1 was no longer safe in an assisted living program, Tenant #1 did not remember Tenant #1 had oxygen or how to use it, did not remember how to call staff and Tenant #1 was not eating or drinking much. Evaluations were not completed as needed with significant change.

Tenant #2's file was reviewed. According to a document dated 4-29-13, Tenant #2 had 3+ edema in the right ankle, there was an 8 x 8 blister on the right toe and the fluid looked clear. There was 2+ edema in the left ankle. Tenant #2 was being treated for Methicillin-Resistant Staphylococcus Aureus (MRSA) in 2nd toe on the right foot. Lasix 20 mg daily times four days was ordered. On 5-2-13 Nurse's Notes indicated Tenant #2 presented with blister on opposite great toe and still had 3+ edema in ankles. Tenant #2 was taken to the ED and was diagnosed with bilateral lower extremity edema, bilateral great toe blisters and treatment was to cover blisters lightly and elevate feet as much as possible. Nurse's Notes dated 5-3-13 indicated Tenant #2 had a new order for Silvadene to right great toe, cover with Telfa and wrap with gauze daily. Nurse's Notes dated 5-6-13 indicated Tenant #2 felt tired and had low blood pressure. Tenant #2 was taken to the hospital and was admitted for dehydration. Tenant #2 returned to the Program on 5-9-13 and had a new order for a treatment on bilateral feet. According to the Discharge Medication List, Santyl apply external daily, mix with equal parts of Mupirocin and apply to wounds on toes and cover with Mepilex daily was ordered. Nurse's Notes dated 5-13-13 indicated Tenant #2 complained of a headache and malaise. The doctor ordered to increase Losartan to 100 mg daily and report blood pressure in two days. Evaluations were completed on 3-20-13; however, were not completed as needed with significant change.

Tenant #3, a 68 year old, was admitted on 12-13-12 and diagnoses included: Diabetes, HTN, Seizure Disorder, Dementia (early onset) and History of CVAs. Nurse's Notes from 1-23-13 to 4-25-13 indicated Tenant #3 had feelings of sadness and depression and had inappropriate behavior and conversations. Tenant #3 had high blood glucose readings including readings that indicated high and were not registered numbers. Notes indicated blood sugar readings were at times over 500 and as low as 31. The notes indicated Tenant #3 was non-compliant with a diabetic diet, had a managed risk related to the high blood sugars, had hypoglycemic symptoms and took glucose tablets and glucose gel. The notes indicated Tenant #3 had additional orders for doses of insulin with high blood sugar readings.

On 2-14-13 Tenant #3 complained of not feeling well, reported vomiting and was sent to the hospital by ambulance. Tenant #3 was admitted to the intensive care unit at the hospital with a diagnosis of Diabetic Ketoacidosis. On 4-25-13 staff heard a banging noise and Tenant #3 was found on the kitchen floor. Tenant #3 thought Tenant #3 was hypoglycemic and complained of right hip pain. A snack was given for low blood sugar (31) and the Nurse was notified. The Nurse instructed staff to call 911 due to right hip pain and increased pain with attempt to move right lower extremity. Tenant #3 was admitted for right hip fracture and went to skilled care after hospital discharge. Tenant #3 returned to the Program on 5-16-13. Evaluations were completed within 30 days of taking occupancy and with significant change post right hip fracture, skilled nursing stay and return to the Program. Evaluations were not completed as needed with hypoglycemic symptoms, repeated high blood sugar readings, behaviors and non-compliance with diet. Evaluations were not completed as needed with significant change.

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))

C. Service Plans

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

- Monitoring Observation: Five tenant files were reviewed.

Tenant #1's file was reviewed. According to a Hospice record, Tenant #1 started on Hospice on 5-16-13. Nurse's Notes dated 5-22-13 indicated Tenant #1 slept most of the day and ate only a small amount for breakfast and lunch. Hospice notes dated 5-16-13 indicated oxygen was ordered. Hospice notes dated 5-21-13 indicated Tenant #1 slept most of the day, was too tired to go to the dining room for meals over the weekend and Tenant #1 took longer to complete ADLs due to fatigue and dyspnea. Hospice notes dated 5-29-13, indicated Tenant #1 ate breakfast that morning but had not eaten a meal in almost a week (unsure if Tenant #1was eating or drinking while in room due to confusion). Hospice Notes indicated Tenant #1 had increased confusion to the point where Tenant #1 was no longer safe in an assisted living program, Tenant #1 did not remember Tenant #1 had oxygen or how to use it, did not remember how to call staff and Tenant #1 was not eating or drinking much. According to Physician's Orders, Tenant #1 had an order for Nitrostat 0.4 mg tablet sublingual, place one tablet under tongue every five minutes up to three doses as needed for chest pain. Nitrostat was not reflected on the service plan.

The service plan was updated on 5-16-13 and reflected Hospice. The service plan was not updated after 5-16-13 to reflect increased confusion and sleeping, the use of oxygen, not eating or drinking as much and taking longer to complete ADLs. The service plan was not updated as needed and did not reflect the identified needs of Tenant #1.

Tenant #2's file was reviewed. According to a document dated 4-29-13, Tenant #2 had 3+ edema in the right ankle, there was an 8 x 8 blister on the right toe and the fluid looked clear. There was 2+ edema in the left ankle. Tenant #2 was being treated for MRSA in 2nd toe on the right foot. Lasix 20 mg daily times four days was ordered. On 5-2-13 Nurse's Notes indicated Tenant #2 presented with blister on opposite great toe and still had 3+ edema in ankles. Tenant #2 was taken to the ED and was diagnosed with bilateral lower extremity edema, bilateral great toe blisters and treatment was to cover blisters lightly and elevate feet as much as possible. Nurse's Notes dated 5-3-13 indicated Tenant #2 had a new order for Silvadene to right great toe, cover with Telfa and wrap with gauze daily. Nurse's Notes dated 5-6-13 indicated Tenant #2 felt tired and had low blood pressure. Tenant #2 was taken to the hospital and was admitted for dehydration. Tenant #2 returned to the Program on 5-9-13 and had a new order for a treatment on bilateral feet. According to the Discharge Medication List, Santyl apply external daily, mix with equal parts of Mupirocin and apply to wounds on toes and cover with Mepilex daily was ordered. Nurse's Notes dated 5-13-13 indicated Tenant #2 complained of a headache and malaise. The doctor ordered to increase Losartan to 100 mg daily and report blood pressure in two days. The service plan was completed on 3-21-13 and updated on 3-22-13 and 3-26-13 with changes. The service plan was not updated as needed and did not reflect the identified needs of Tenant #2.

Tenant #3's file was reviewed. Nurse's Notes from 1-23-13 to 4-25-13 indicated Tenant #3 had feelings of sadness and depression and had inappropriate behavior and conversations. Tenant #3 had high blood glucose readings including readings that indicated high and were not registered numbers. Notes indicated blood sugar readings were at times over 500 and as low as 31. The notes indicated Tenant #3 was non-compliant with a diabetic diet, had a managed risk related to the high blood sugars, had hypoglycemic symptoms and took glucose tablets and glucose gel. The notes indicated Tenant #3 had additional orders for doses of insulin with high blood sugar readings. On 2-14-13 Tenant #3 complained of not feeling well, reported vomiting and was sent to the hospital by ambulance. Tenant #3 was admitted to the intensive care unit at the hospital with a diagnosis of Diabetic Ketoacidosis. On 4-25-13 staff heard a banging noise and Tenant #3 was found on the kitchen floor. Tenant #3 thought Tenant #3 was hypoglycemic and complained of right hip pain. A snack was given for low blood sugar (31) and the Nurse was notified. The Nurse instructed staff to call 911 due to right hip pain and increased pain with attempt to move right lower extremity. Tenant #3 was admitted for right hip fracture and went to skilled care after hospital discharge. Tenant #3 returned to the Program on 5-16-13. Service plans were completed within 30 days of taking occupancy and with significant change post right hip fracture, skilled nursing stay and return to the Program on 5-16-13. The service plan was not updated as needed were not completed as needed with hypoglycemic symptoms, repeated high blood sugar readings, behaviors and non-compliance with diet.

The service plan did not reflect those issues and interventions. The service plan was not updated as needed and did not reflect the identified needs of Tenant #3.

Tenant #4, a 97 year old, was admitted on 8-2-08 and diagnoses included: Hypercholestermia, Hyperlipidemia, Gastro Esophageal Reflux Disease, HTN, Degenerative Joint Disease and Anxiety. Tenant #4 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Nurse's Notes dated 3-15-13 indicated staff reported being bitten in the upper arm by Tenant #4. Tenant #4 stated Tenant #4 would have bitten staff's nose off if Tenant #4 could. Staff reported Tenant #4 attempted to punch staff while attempting to place Tenant #4 in bed on 3-14-13. According to Nurse's Notes dated 4-22-13 it was reported on 4-19-13 that Tenant #4 was in the wrong room, sitting in another tenant's chair and refused to leave. Staff got a wheelchair and asked Tenant #4 to sit in it and Tenant #4 started swinging. Tenant #4 dug fingernails into staff's hand and acted out at dinner yelling. The service plan reflected Tenant #4 became very upset and anxious if not in a familiar surrounding or if the routine was broke. The service plan did not reflect Tenant #4's behaviors and interventions related to the behaviors. According to a Discharge Summary Homecare note, Tenant #4 was discharged from home health services on 3-22-13 and physical therapy (PT) services on 3-14-13. The service plan did not reflect the home health services and PT and the discontinuation of the services. The service plan did not reflect the identified needs of Tenant #4.

Tenant #5's file was reviewed. Physician's Orders indicated Tenant #5 had an order for oxygen at two Liters (L) continuous and oxygen at two to four L per comfort. The service plan did not reflect the use of oxygen. The service plan did not reflect the identified needs of Tenant #5.

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: (a)The tenant's identified needs and preferences for assistance; (c) The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy and physical therapy. (IAC r. 481-69.26(4)(a,c))

D. Medications

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

- Monitoring Observation: Five tenant files were reviewed.

Tenant #3's file was reviewed. Nurse's Notes indicated blood sugar readings were at times over 500 and as low as 31.

The notes indicated Tenant #3 was non-compliant with a diabetic diet, had a managed risk related to the high blood sugars and had hypoglycemic symptoms.

According to the May 2013 MARs Humalog 100/ML inject subcutaneously per sliding scale was ordered. The sliding scale: 175-225= 2 units, 226-275= 4 units, 276-325= 6 units, 326-375= 8 units, 376-425= 10 units and to notify the doctor of anything greater than 425. According to the blood glucose monitoring flow sheets on 5-23-13 (evening) Tenant #3's blood glucose was 484 and on 5-26-13 at bedtime the blood glucose was 446. There was a late entry dated 5-22-13 at 4:20 p.m. regarding a call to the doctor regarding a blood glucose reading of 484. There was no documentation regarding a call to the doctor on 5-26-13 with a blood glucose reading of 446 and the documentation on 5-23-13 regarding the notification to the doctor was charted as a late entry. The doctor was not notified of blood glucose readings outside the parameters as ordered.

- 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))

E. Tenant Rights

Complaint/Incident Allegation #44124-C: It was alleged the Manager was short tempered with most tenants and on occasions had been heard yelling at tenants in the hallways.

- Monitoring Observation: Four tenants were interviewed and Staff #1, #2, #3, the Nurse and the Manager was interviewed. There was not preponderance of the evidence to support the allegation.

- Regulatory Insufficiency: None noted.

F. Structural Requirements

Complaint/Incident Allegation #44124-C: It was alleged the roof had leaked for years and there was mold in the attic from the leaks.

- Monitoring Observation: According to a Program document, on 5-30-13 there was a wind storm, there were severe weather and tornado warnings issued and the tenants and building was secured per policy and procedure. The building lost partial power and the fire alarm went off. The Fire Department was called and a check of the building was done. There were no signs of a fire. Hourly checks were started. Extra staff was called in to work and all arrived within 20 minutes. An electrician was called and Staff #4 (maintenance staff) was also called. Staff #4 was sent to buy extra flashlights for tenant apartments. The electrician indicated the loss of power was from the city power. The fire alarm company was called and reset the alarm. The insurance company was also notified to report the damage.

The damage from the storm included lost shingles, siding that was blown off, the flag pole was bent over and marketing signs were blown away. Roofing companies were called for estimates. Staff #4 tacked down loose shingles and also checked the whole building for leaks; none were noted. The Program provided copies of invoices, receipts, pictures of damage and staff hours worked.

Staff #4 (maintenance staff) was interviewed. He said the roof was bad and the skylights leaked every once in a while. He said the storm tore off a lot of shingles but the roof was bad before. At the time of the investigation, there were no leaking skylights. He said there had been one in the lounge/dining room, one in the A hall (lounge) and one in the B hall (lounge). He said the leaks were months ago. The biggest share of the leaks was the skylights and he had tarred around the skylights. He said there were no issues with mold and he had been in the attic about one to two months ago. There was no health issues related to moisture.

In the dining room, there was a patched area near the skylight. There was an area in the A hall lounge on the ceiling/lower peak area to the wall that appeared to be patched/painted. There was an area in the B hall lounge on the wall where the ceiling met the wall that appeared to be patched with what appeared to be a streak down the wall. The areas did not appear to be leaking at the time of the investigation.

Maintenance logs were reviewed. There was an entry on 2-7-13 that indicated in the dining room there was a leak by the skylight. This was the only entry in the time period reviewed that indicated there was a leak around the skylights.

Staff #1 said maintenance issues were addressed appropriately and there were no maintenance issues neglected.

Staff #2 said there were no maintenance issues and there were no complaints from tenants. Staff #2 said Staff #4 (maintenance staff) responded quickly to maintenance issues.

The Nurse said the maintenance issues Staff #4 (maintenance staff) could fix on his own were resolved quickly. She said there were leaks from the rain in public areas (not tenant apartments) and Staff #4 fixed the leaks.

The Manager said Staff #4 did a fantastic job. She said there were no issues with mold related to the roof. The Manager said she was working on getting estimates for the roof.

Four tenants were interviewed and did not have any concerns regarding maintenance issues or lack of a response to maintenance issues.

Per staff interviews, tenant interviews, observations and review of Program documents the Program had a leaking skylight in February 2013. There was a storm on 5-30-13 and the building sustained damage including damage to the roof. There were no leaks at the time of the investigation and the Program was in the process of obtaining estimates for the repairs. There were no concerns with mold identified by the Program.

- Regulatory Insufficiency: None noted.

G. Program Notification to the Department

During the course of report review the following was identified: The program failed to notify the Department of damage sustained to the building during a storm on 5-30-13 as confirmed by the Complaint/Incident Unit on 7-3-13.

- Monitoring information: According to a Program document, on 5-30-13 there was a wind storm, there were severe weather and tornado warnings. The damage from the storm included lost shingles, siding that was blown off, the flag pole was bent over and marketing signs were blown away.

  On 7-3-13 at 11:10 a.m. an interview was performed via telephone with the Program Manager questioning why the program had failed to report damage to the building that occurred during the storm on 5-30-13 as required by Chapter 67.4(2). According to the Program Manager the Insurance Company was notified of the damage to the roof including missing shingles, damaged and missing siding, the bent flag pole and the missing marketing signs but she just didn't believe the damage was severe enough to report to the Department. This monitor informed the Program Manager the rule doesn't specify the amount of damage done to a program before it needs to be reported just that damage occurred to a program by natural or other disaster. The Program Manager confirmed and stated they failed to contact the Complaint/Incident Unit after 5-30-13 to report the damage to the program as required.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available, when damage to the program is caused by a natural or other disaster. (IAC r. 481-67.4(2)