IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 41148-CR2
Recertification R2

July 18, 2013

Ms. Cathy Johnson, Administrator
Golden Horizons Assisted Living
800 Byron Godberson Drive
Ida Grove, IA 51445

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

Dear Ms. Johnson:

I. Final Complaint/Incident Investigation Report – Golden Horizons Assisted Living, Ida Grove, 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 **Jun 18 and 19, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Occupancy Agreement, Compliance with POC and Tenant Documents.

Golden Horizons ("Program") is being assessed a **$500 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 Occupancy Agreements and Compliance with POC.

The determination of a **$500 civil penalty** is based upon repeated in the area(s) of: Occupancy Agreements and Compliance with POC . As the enclosed Report details, the Program failed to have occupancy agreements completed properly for Tenants 1, 3, 9, 10, 12 and 16 and the Program failed to follow the previously submitted Plan of Correction.

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 **three hundred and twenty five dollars ($325)** 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 **$500 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 16, 2013, has been reviewed and will constitute the final POC related to the on-site visit of June 18 and 19, 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 Revisit to Recertification and Complaint Investigation Report

Assisted Living Program:

Cathy Johnson, Administrator
Golden Horizons Assisted Living
800 Byron Godberson Drive
Ida Grove, IA 51445

Complaint/Incident Intake #: 41148-CR2
Recertification R2

Date of Revisit to Recertification and Complaint/Incident Investigation

June 18th and 19th, 2013

Monitor(s):

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:	0
Total Population of Program at time of on-site	20
TOTAL census of Assisted Living Program	20

Program History – The program received regulatory insufficiencies in the areas of Evaluations, Service Plans, Nurse Review, Staffing, Medications, Occupancy Agreement, Policy and Procedures, Record Checks, and Compliance with the Plan of Corrections, during this certification period.

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

A. Evaluation

No regulatory insufficiencies were noted during the first revisit.

B. Occupancy Agreement

During the first revisit, Tenants #9 and #10 did not have occupancy agreements signed prior to occupancy, and the occupancy agreement did not reference tenant-landlord and Iowa law.

Monitoring Observation: The Program provided a blank copy of the Tenant Agreement (occupancy agreement). The agreement was updated April 2013 and referenced tenant-landlord law as well as Iowa law.

The Tenant Agreement was reviewed for Tenants #9 and #10. Both tenants signed a new agreement on 5-6-13; however, pages three and six of the agreement, were not completed. Blanks were provided for a tenant's name, apartment number, level of care and monthly fees. None of the information was provided in the blank spaces. The Tenant Agreements (occupancy agreements) were not complete. The blank Tenant Agreements were signed by Tenants #9 and #10 and Registered Nurse (RN) 2 who was the administrator at the time of signing.

RN 2 stated she had been the administrator at the program, and had stepped down from the position a few weeks ago. RN 2 stated she was continuing at the Program as a part-time nurse. At the time the blanks were discovered in the Tenant Agreements, RN 2 was informed by the monitor the agreements were not complete. RN 2 was present for the first day of the onsite visit.

RN 1 was present during the second day of the onsite visit. An unsigned note was left for RN 2 which indicated the blank spaces in the Tenant Agreements needed to be filled in, and "I ran out of time to fill it out."

During the course of the second revisit, the following was noted:

According to the plan of correction (POC) all tenants were to sign an updated Tenant Agreement. Agreements were also reviewed for Tenants#1, #3 and #12 and all had blanks on pages three and six. Tenant #16 was admitted for respite care on 5-15-13 and was admitted to the program on 6-3-13. The Tenant Agreement for Tenant #16 was signed on 5-14-13; however, there were blank spaces on pages three and six. The occupancy agreements were not complete.

The occupancy agreements had blank spaces and information on tenant name, apartment, and fees was not completed. Occupancy agreements were not complete at the time of signing.

- Regulatory Insufficiency: An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made. (235C.5(1))

- Regulatory Insufficiency: The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements. (IAC r. 481-69.21(3))

C. Service Plans

The Program received regulatory insufficiencies related to failure to base service plans on evaluations, failure to meet identified needs, and failure to indicate nursing facility preference. Tenants #1, #2, #3, #7, and #8 were cited during the March 4 and 5, 2013 first revisit to the recertification and complaint investigation, #41148-C.

- Monitoring Observation: Tenants #2 and #8 were discharged from the Program prior to the date listed in the POC.

  Clinical records were reviewed for Tenants #1, #3, #7, #12, and #16. The service plans were based on evaluations, met the needs of the tenants, and indicated nursing facility preference.

- Regulatory Insufficiency: None noted.

D. Nurse Review

The Program received regulatory insufficiencies related to failure to complete a nurse review every 90 days or with change of condition for Tenants #2, #3, and #8 during the March 4 and 5, 2013 first revisit to the recertification and complaint investigation, #41148-C.

- Monitoring Observation: Tenants #2 and #8 were discharged from the Program prior to the date listed in the POC.

  Clinical records were reviewed for Tenants #1, #3, #7, #10, and #12. Nurse reviews were completed at 90-days and with changes in condition.

- Regulatory Insufficiency: None noted.

E. Staffing

The Program received regulatory insufficiencies related to staff failure to demonstrate an understanding of a new medication system and lack of documented staff training to determine competency on medications, hand washing, or medical and personal cares for Staff #2 and #3. None of the staff members had documented training on compression stockings during the March 4 and 5, 2013 first revisit to the recertification and complaint investigation, #41148-C.

- Monitoring Observation: Staff training records were reviewed including Staff #2 and #3. Training was documented for medications, hand washing, medical and personal cares and compression stockings.

  Staff #2, #4, #8, and #9 were interviewed. All stated they had received training on the administration of medications, hand washing, medical and personal cares, and compression stockings. All stated they had been observed by RN 1 when performing the tasks.

- Regulatory Insufficiency: None noted.

F. Medications

The Program received a regulatory insufficiency related to staff failure to demonstrate accepted professional standards for medication administration and failure to maintain a list of tenant medications during the March 4 and 5, 2013 first revisit to the recertification and complaint investigation, #41148-C.

- Monitoring Observation: A medication pass was observed on 6-18-13. Staff #5 was observed administering medications to five tenants. Hands were washed upon entering and exiting the apartments. Gloves were applied to administer eye drops to Tenant #15. Hands were washed prior to applying gloves and immediately after removing gloves.

  Staff #5 was observed administering medications to Tenant #15. Staff #5 checked the label on the bottle of eye drops against the medication list and noted the two matched.

  At no time did Staff #5 use bare hands to count pills. A spoon was used to separate pills for easier counting. The pill counts were observed to match the medication lists during medication passes to five tenants.

  The Program provided documentation of training on medications and hand washing for Staff #3.

  The procedure for medication administration was followed.

- Regulatory Insufficiency: None noted.

G. Policies and Procedures

The Program received a regulatory insufficiency related to staff failure to follow policies and procedures related to medications, hand washing, and the use of gloves during the March 4 and 5, 2013 first revisit to the recertification and complaint investigation, #41148-C

- Monitoring Observation: The Program provided incident reports for the last two months. RN 2 reported there were no medication errors. Two incident reports were provided. One was signed by RN 1 and one by RN 2. RN 2 was also the administrator. One incident report lacked documentation of signatures of an RN and an administrator as indicated in the POC.

  The procedure for medication administration, hand washing, and use of gloves was followed during the observed medication pass on 6-18-13.

- Regulatory Insufficiency: None noted.

H. Record Checks

No regulatory insufficiencies were noted during the first revisit.

I. Compliance with Plan of Correction

The Program failed to follow the POC following the March 4 and 5, 2013 first revisit to the recertification and complaint investigation, #41148-C.

- Monitoring Observation: The Program was noted to have completed the following since the last visit:
  - RN 1 provided documentation of a completed chart audit.
  - Service plans were updated for clinical records reviewed.
  - Functional, cognitive, and health evaluations were used to update the service plans.
  - RN 1 provided a calendar to document a schedule for scheduled assessments and nurse reviews.
  - The Program continued to use the Cognitive Ability Assessment as a cognitive screening tool.
  - Nursing facility preferences were listed on service plans.
  - Nurse reviews were completed appropriately in the clinical records reviewed.
  - Staff received training on medication administration, hand washing, medical and personal cares. Staff indicated they had been observed performing the tasks by a nurse.

  The following had not been completed at the time of the onsite visit:
  - One incident report lacked the signature of an administrator.
  - The occupancy agreements had blank spaces and information on tenant name, apartment, and fees was not completed. Occupancy agreements were not complete at the time of signing.

  The Program did not follow its plan of correction in the area of Occupancy Agreements and Policies and Procedures.

- Regulatory Insufficiency: The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. (IAC r. 481-67.10(8))

J. Tenant Documents

During the course of the second revisit, the following was noted:

- Monitoring Observation: A medication pass was observed on 6-18-13. Staff #5 was observed administering medications to five tenants. After observing a tenant taking the medication, Staff #5 documented the medications as given on the staff worksheet. The worksheet listed the tasks/duties to be completed for all tenants during the shift. According to the medication administration procedure, staff members were to document on the worksheet, which was carried by the staff member during the shift. After passing medications to most of the tenants, Staff #5 then went to the office to document the medications as given on the Resident Weekly Care Logs, as indicated in the procedure.

  Tenant #1 was to receive pills in the evening. The Program utilized a planner system. The planner was filled by a pharmacy, and staff members were to compare the number of pills in the planner against the number of pills listed on the medication list kept in the tenant's apartment. Tenant #1 had Systane eye drops ordered to be given four times a day as noted on the medication list. Staff #5 asked Tenant #1 if he/she wanted the eye drops. Tenant #1 refused the eye drops. On the staff worksheet, Staff #5 documented the pills were given, but the eye drops were refused. The staff worksheet listed all tenants and did not become part of the permanent record.

  After completing a blood sugar check with another tenant, Staff #5 went to the office to document on the Resident Weekly Care Logs (Care Log) as indicated in the procedure. There was a delay in charting on the Care Log, the form which became part of a tenant's permanent record. At that time, Staff #5 documented on the five tenants who received medications, and the one tenant that had a blood sugar check. On Tenant #1's Care Log, Staff #5 documented the 5:00 p.m. medications were given. Staff #5 did not document the eye drops were refused.

  The Resident Weekly Care Logs documented for each tenant tasks to be completed such as housekeeping, laundry, bathing assistance, compression stockings, and blood sugar checks. The Resident Weekly Care Log documented preferences of the tenant such as housekeeping and laundry as well as nurse-directed tasks such as meal reminders, and physician-directed orders for medication administration and tasks such as blood sugar checks. The Program did not utilize a Medication Administration Record for the documentation of medications or physician-ordered tasks.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: (q) When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs). (IAC r. 481-69.25(1)(q))