IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 41630-CR2
44323-C

July 31, 2013

Ms. Amber Bell, RN Administrator
Linnwood Estates
700 North Linn
Glenwood, IA 51534

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION AND COMPLAINT SECOND REVISIT REPORT - LINNWOOD ESTATES
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Bell:

I. Final Complaint/Incident Investigation and Complaint Second Revisit Report – Linnwood Estates, Glenwood, IA

Enclosed is the **Final Complaint/Incident Investigation and Complaint Second Revisit 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 **July 8 & 9, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plan and Compliance with Plan of Correction.

Linnwood Estates ("Program") is being assessed a **$2,000 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 and Compliance with Plan of Correction.

The determination of a **$2,000 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plan and Compliance with Plan of Correction. As the enclosed Report details, the Program failed to have an RN complete evaluations with significant changes in condition for Tenants 1,3 and 10. The Program failed to individualize or update service plans with significant changes in condition for Tenants 1, 3, 9 and 10.

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 **one thousand three hundred dollars ($1,300)** 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 **$2,000 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 June 30, 2013, has been reviewed and will constitute the final POC related to the on-site visit of July 8 & 9, 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 Investigation and Complaint Second Revisit Report

Assisted Living Program:

Amber Bell, RN Administrator
Linnwood Estates
700 North Linn
Glenwood, IA 51534

Complaint/Incident Intake #: 41630-CR-2
 # 44323-C

Date of Complaint/Incident Investigation:

July 8th and 9th, 2013

Monitor(s):

Lori Miner, RN BSN
Maribeth Freland, RN

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

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

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

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

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	15
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	17
TOTAL census of Assisted Living Program	17

Program History – There were regulatory insufficiencies cited in the area of Other (Dependent Adult Abuse Training), Staffing, Evaluations, Tenant Documents, Service Plans, Nurse Review, Transportation, Policy and Procedure and Managed Risk during this recertification period

A. Staffing

The program received regulatory insufficiency at the time of the onsite complaint investigation in December 2012 and was recited at the first onsite revisit completed on May 15 and 16, 2013 related to lack of documented nurse-delegated training for unlicensed personnel.

Monitoring Observation: The May 2013 revisit to the program revealed staff records lacked documented training on support stockings and the administration of medication through a nebulizer.

Staff training records for Staff #1, #2, #3, #4, and #5 documented training on support stockings and use of a nebulizer on May 30 and 31, 2013.

No new staff members were hired since the last Plan of Correction date.

The program provided documentation of staff competency audits.

- Regulatory Insufficiency: None noted.

B. Evaluation

The program received regulatory insufficiency at the time of the onsite complaint investigation in December 2012 and was recited at the first onsite revisit completed on May 15 and 16, 2013 related to evaluations not being completed within 30 days of admission and with significant change related to Tenants #1, #3, and #6.

- Monitoring Observation: There were no new admissions after the Plan of Correction date. The program provided documentation of audits of the clinical record. The monitors reviewed the clinical records of Tenants #1, #3, #6, #9, #10, #11 and #12. The monitors did not identify any concerns related to evaluation for Tenants #6, #9, #11 and #12.

  Tenant #1, an 85 year-old, was admitted on 2-10-12 and had diagnoses of: Hypertension (HTN), Osteoarthrosis, Anxiety, Chronic Venous Stasis Ulcers, Coronary Artery Occlusion and Neurogenic Bladder resulting in Chronic Urinary Tract Infections. Tenant #1 answered all questions correctly when taking the Short Portable Mental Questionnaire (SPMSQ) on 6-21-13, indicating intact intellectual functioning. Tenant #1 received skilled nurse and physical therapy services from a home health agency while residing at the assisted living program.

  The home health agency's nurse notes documented Tenant #1 had a pressure sore to the buttocks that was being assessed and treated by a home health agency during the month of June 2013. The assisted living program's nurse notes documented Tenant #1's pressure sore to the buttocks was healed on 6-19-13.

  The assisted living nursing notes documented staff members noted a 2 centimeter red/purple cyst located between Tenant #1's right great toe and right second toe on 6-11-13. Staff members documented the area between Tenant#1's toes appeared to be getting larger on 6-27-13.

  According to the functional assessment completed by a licensed practical nurse on 6-17-13, Tenant #1 fell on 5-15-13 and 5-27-13 after losing his/her balance. Tenant #1 did not experience injury with either fall. Tenant #1's clinical record included a physician's order, dated 6-21-13, which ordered physical therapy and occupational therapy to evaluate Tenant #1 for needs and provide services as necessary.

  Tenant #1's clinical record included a health evaluation completed by the assisted living registered nurse/director of nursing (RN/DON) on 5-13-13. The clinical record lacked any further health evaluations.

  Tenant #1's clinical record included a cognitive evaluation completed by Staff #8, licensed practical nurse (LPN) on 6-21-13 and a functional evaluation completed by Staff #8, LPN, on 6-17-13.

  Tenant #1 experienced two falls in May 2013 due to poor balance which required a referral for physical therapy evaluation and treatment. Tenant #1 exhibited a pressure area on the buttocks that was being treated by the home health agency in June 2013 and healed on 6-19-13. Tenant #1 had a cyst between his/her toes which was documented as worsening in June 2013. Tenant #1's clinical record lacked a health evaluation completed by a registered nurse addressing the above stated changes in condition. Tenant #1's clinical record included a cognitive and functional evaluation addressing Tenant #1's changes in condition; however, both evaluations were completed by an LPN rather than an RN as required by regulation.

Tenant #3, an 82 year-old, was admitted on 12-30-10 and had diagnoses of: Glaucoma, Hyperplasia of the Prostate, Dementia, and Parkinson's disease. Functional and cognitive evaluations were completed on 1-10-13. A cognitive screening tool dated 7-4-13 indicated Tenant #3 had mild cognitive impairment.

A fax to the physician dated 6-14-13 indicated Tenant #3 had fallen on 6-10-13 but sustained no injury. Nurse's notes dated 6-11-13 documented a drop in Tenant #3's blood pressure when going from a sitting to standing position. Notes of 6-11-13 indicated Tenant #3 was encouraged to drink more liquids because of the low blood pressure. On 6-14-13 Tenant #3 continued to exhibit a drop in blood pressure when going from a sitting to standing position. Tenant #3 also reported feeling dizzy. The physician was notified via fax on 6-14-13. Tenant #3 had an appointment with the physician on 6-19-13 and was prescribed a medication for the blood pressure. Nurse's notes dated 6-21-13 revealed Tenant #3 was unsteady on the feet and required assistance to return to the apartment. Tenant #3 also indicated a feeling of dizziness during the morning.

Nurse's notes dated 6-24-13 indicated Tenant #3 had an adverse reaction to the medication prescribed on 6-19-13. Tenant #3 was described as unsteady on the feet and confused. Staff had held the medication until the physician could be reached, at which time the medication was discontinued. Notes of 6-24-13 also indicated Tenant #3 was encouraged to drink more liquids. On 6-25-13, the program requested and received an order from the physician for Physical Therapy (PT) to evaluate Tenant #3. On 6-27-13, according to the nurse's notes, Tenant #3 was started on another medication for low blood pressure.

Tenant #3 exhibited a significant change of condition between 6-10-13 and 6-27-13. The clinical record lacked documentation of the completion of functional, cognitive, and health evaluations with the change of condition.

Tenant #10, a 91 year-old, was admitted on 12-1-08 and had diagnoses of: Parkinson's Disease, Chronic Duodenal Ulcers, Diabetes, Osteoarthritis, Pressure Sore on the Coccyx and Neurogenic Bladder. Tenant #10 answered all questions but two correctly when taking the SPMSQ on 6-24-13, indicating intact intellectual functioning. Tenant #1 received skilled nurse and physical therapy services from a home health agency while residing at the assisted living program.

Tenant #10's clinical record included a physician's order, dated 5-8-13, which documented Tenant #10 had a pressure area on the coccyx which required treatment.

Tenant #10's Medication Administration Record (MAR) documented Tenant #10's pressure area on the coccyx was being cleansed with normal saline and covered with a Mepilex patch every 3 days and as needed. The MAR indicated the coccyx wound was healed on 6-24-13.

Tenant #10's clinical record did not document any falls during May or June of 2013; however, the clinical record contained a physician's order, dated 6-21-13, ordering a physical therapy and occupational therapy evaluation. The occupational therapy evaluation occurred on 7-1-13 and the physical therapy evaluation occurred on 7-3-13. Both therapies planned to continue service provision.

During the onsite visit on 7-9-13 the monitor observed the physical therapist providing care to Tenant #10.

Tenant #10's clinical record included a health evaluation completed by the assisted living RN/DON on 3-18-13. The clinical record lacked any further health evaluations.

Tenant #10's clinical record included a cognitive evaluation completed by Staff #8, LPN on 6-24-13 and a functional evaluation completed by Staff #8, LPN, on 6-20-13.

Tenant #10 exhibited a pressure area on the coccyx that was being treated by the home health agency in June 2013 and healed on 6-24-13. Tenant #10 required a physical therapy evaluation and follow up treatment beginning on 7-3-13. Tenant #10's clinical record lacked a health evaluation completed by a registered nurse addressing the above stated changes in condition. Tenant #10's clinical record included a cognitive and functional evaluation addressing Tenant #10's changes in condition; however, both evaluations were completed by an LPN rather than an RN as required by regulation.

- 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. Tenant Documents

The program received regulatory insufficiency at the time of the onsite complaint investigation in December 2012 and was recited at the first onsite revisit completed on May 15 and 16, 2013 related to physician-ordered tasks not being listed on the Medication Administration Record (MAR) for Tenants #7 and #8.

- Monitoring Observation: Tenants #1, #7, #8 and #10 were identified as tenants who received assistance with support stockings. The clinical records were reviewed for Tenants #7 and #8 which confirmed staff members were applying and removing physician-ordered support stockings.

June and July 2013 MARs for Tenants #1, #7, #8 and #10 contained a listing for physician-ordered support stockings. The support stockings were no longer listed on the task sheet.

The program provided documentation of audits of clinical records.

- Regulatory Insufficiency: None noted.

D. Service Plans

The program received regulatory insufficiency at the time of the onsite complaint investigation in December 2012 and was recited at the first onsite revisit completed on May 15 and 16, 2013 related to service plans not based on evaluations, not completed within 30-days of admission, not updated with change in condition, not identifying outside service providers, not meeting identified tenant needs, and not identifying tenant preference for nursing facility care, and did not identify activities for a person with dementia as related to Tenants #1, #3, #6, and #9.

Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #3, #6, #9, #10, #11 and #12. The nursing facility preference was identified on the service plans for Tenants #1, #3, #9, #10, #11 and #12. The program provided documentation of audits of clinical records.

The monitors identified no concerns related to service plans for Tenants #6, #11 and #12 after review of the clinical records.

Tenant #1 fell on 5-15-13 and 5-27-13 after losing his/her balance. Tenant #1 did not experience injury with either fall. Tenant #1's clinical record included a physician's order, dated 6-21-13, which ordered physical therapy and occupational therapy to evaluate Tenant #1 for needs and provide services as necessary.

The service plan, dated as last updated on 6-24-13, did not include any new interventions following the two falls in May 2013 and lacked identification of Tenant #1's physical and occupational therapy services as required by regulation.

Nurse's notes for Tenant #3 dated 6-11, 6-14, and 6-24-13 encouraged Tenant #3 to drink more fluids for low blood pressure. The service plan, dated 4-4-12, did not identify Tenant #3 was to be encouraged to drink fluids. The service plan did not identify interventions related to a change in blood pressure when Tenant #3 went from sitting to standing. The service plan was not updated with a change of condition and did not meet the identified needs of Tenant #3.

Tenant #9, an 87 year-old, was admitted on 6-4-04 and had diagnoses of: Depressive Disorder, Diabetic Retinopathy, HTN, Osteoarthrosis, Diabetes, and Dementia. On 4-10-13, Tenant #9 was staged at six on the Global Deterioration Scale (GDS) which indicated severe cognitive decline.

The service plan identified activities for a person with dementia and the clinical record contained a more extensive list of one-to-one activities. The service plan directed staff to use activities to redirect Tenant #9 when wandering. The service plan identified a two-hour toileting schedule and a review of the nurse's notes did not indicate incontinence was unmanageable. A task sheet documented personal cares. A fax dated 7-5-13 indicated Tenant #9 had loose stools and an order was received from the physician for medication to add bulk to the stools. Tenant #9 did not exceed level of care at this visit; however, the program provided documentation of a meeting with family to discuss a decline in Tenant #9's condition and the initiation of discharge planning.

Tenant #9's service plan was dated 6-14-13. Functional, cognitive, and health evaluations were not completed at that time. The service plan was not based on evaluations.

Tenant #10's clinical record did not document any falls during May or June of 2013; however, the clinical record contained a physician's order, dated 6-21-13, ordering a physical therapy and occupational therapy evaluation. The occupational therapy evaluation occurred on 7-1-13 and the physical therapy evaluation occurred on 7-3-13. Both therapies planned to continue service provision.

During the onsite visit on 7-9-13 the monitor observed the physical therapist providing care to Tenant #10.

Tenant #10's clinical record included a health evaluation completed by the assisted living RN/DON on 3-18-13. The clinical record lacked any further health evaluations.

Tenant #10's clinical record included a cognitive evaluation completed by Staff #8, LPN on 6-24-13 and a functional evaluation completed by Staff #8, LPN, on 6-20-13.

Tenant #10 exhibited a pressure area on the coccyx that was being treated by the home health agency in June 2013 and healed on 6-24-13. Tenant #10 required a physical therapy evaluation and follow up treatment beginning on 7-3-13. Tenant #10's clinical record lacked a health evaluation completed by a registered nurse addressing the above stated changes in condition. Tenant #10's clinical record included a cognitive and functional evaluation addressing Tenant #10's changes in condition; however, both evaluations were completed by an LPN rather than an RN as required by regulation.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations 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: 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; and (d) For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. (IAC r. 481-69.26(4)(a,c,d))

E. Nurse Review

The program received regulatory insufficiency at the time of the onsite complaint investigation in December 2012 and was recited at the first onsite revisit completed on May 15 and 16, 2013 related to lack of documentation of a review of health, medications, and physician's orders every 90 days and with significant change for tenants receiving personal or health care from the program related to Tenants #1, #3, #6, and #9.

Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #3, #6, #9, #10, #11 and #12. The monitors identified no concerns related to nurse review for Tenants #1, #3, #6, #9, #10, #11 and #12. 90-day nurse reviews were completed prior to the date on the Plan of Correction for all seven tenants. The 90-day reviews documented a review of health, medications, and physician's orders for all seven tenants. The program provided documentation of audits of clinical records.

- Regulatory Insufficiency: None noted.

F. Policies and Procedures

The program received regulatory insufficiency at the time of the onsite complaint investigation in December 2012 and was recited at the first onsite revisit completed on May 15 and 16, 2013 for not following policies and procedures related to outside service agencies.

- Monitoring Observation: The policy Documentation from Outside Agencies was revised on 6-10-13 to indicate documentation would be provided to the program on a weekly basis by outside agencies providing services to tenants.

  The program provided documentation of audits of clinical records.

  The monitors reviewed the clinical records of Tenants #1, #3, #6, #10, #11 and #12. Tenants #1, #3, #6, #10, #11 and #12 were prescribed outside services from a home health agency. Each tenant's clinical record contained documentation of each home health discipline providing services.

- Regulatory Insufficiency: None noted.

G. Dependent Adult Abuse Training

The program received regulatory insufficiency at the time of the onsite complaint investigation in December 2012 and was recited at the first onsite revisit completed on May 15 and 16, 2013 related to lack of documented mandatory reporter training for dependent adult abuse for Staff #2.

- Monitoring Observation: The program reported no new employees had been hired since the first revisit. Training records for Staff #2 contained documentation of mandatory reporter training for dependent adult abuse completed on 5-15-13.

  According to the plan of correction, a tracker was created and maintained by an administrative assistant responsible for maintaining personnel files. The program provided documentation of the tracking system.

- Regulatory Insufficiency: None noted.

H. Compliance with Plan of Correction

The program received regulatory insufficiency at the first onsite revisit completed on May 15 and 16, 2013 related to related to staffing, evaluation, tenant documents, service plan, nurse review, policies and procedures, and dependent adult abuse training.

- Monitoring Observation: The Program's Plan of Correction dated 6-13-13 included a plan to correct the cited insufficiencies related to staffing, evaluation, tenant documents, service plan, nurse review, policies and procedures, and dependent adult abuse training.

  During the monitoring visit conducted 7-8-13 and 7-9-13, the monitors continued to find discrepancies related to evaluation and service plan.

- 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))

I. Tenant Rights

Complaint/Incident Allegation: 44323-C- It was alleged tenants residing at the program were not allowed to choose outside providers for services such as home health, hospice and therapies.

- Monitoring Observation: The program identified four tenants, Tenants #1, #3, #10 and #11 currently received home health services either for skilled nursing and/or therapy services. The program did not currently have any tenants receiving hospice services.

  The program identified two tenants, Tenants #6 and #12 who recently received home health services but the services had been discontinued prior to the on-site complaint visit.

  The monitors reviewed the clinical records of Tenants #1, #3, #6, #10, #11 and #12 noting the following:

  Tenant #1, a cognitively intact tenant, received skilled nursing services from a local home health agency for care of a suprapubic catheter and for simple dressing changes to a wound on the buttocks. Tenant #1's buttocks wound healed on 6-19-13. Tenant #1's service plan indicated Tenant #1 continued home health services for catheter care following the wound healing. Tenant #1's service plan indicated a change in home health providers occurred on 6-24-13 to provide the catheter care and the new home health agency initiated physical therapy and occupational therapy services per physician's order upon admission. Tenant #1's occupancy agreement did not identify a specific outside agency to be used by program tenants.

  During interview, Tenant #1 reported he/she was approached by the program's social worker to discuss satisfaction with the home health services. Tenant #1 indicated he/she had been unhappy with the previous home health agency's ability to send the same nurse to provide services and had been unhappy with the agency's routine inability to arrive to provide treatment at the planned time. The social worker told Tenant #1 of the other home health agencies in the area and Tenant #1 reported choosing the new home health provider on his/her own. Tenant #1 reported the social worker assisted in contacting the previous home health provider to cancel services and assisted with initiating services through the new provider. Tenant #1 denied being told he/she needed to change providers and felt he/she had made the decision independently. Tenant #1 reported having satisfaction with the new home health provider.

  Tenant #3, a cognitively intact tenant, began receiving home health services on 6-25-13 and had only one home health agency provide the therapy services while residing at the program. During interview, Tenant #3 reported he/she was able to choose the outside agency for home health services.

  Tenant #6, a cognitively intact tenant, received skilled nurse, physical therapy and occupational therapy services from a local home health agency following surgical repair of a compression fracture of the spine. Occupational therapy services were discontinued on 4-23-13 and physical therapy services were discontinued on 5-8-13. Home health services were discontinued and Tenant #6 did not have any other agency provide services at a later date. Tenant #6's occupancy agreement did not identify a specific outside agency to be used by program tenants.

During interview, Tenant #6 reported he/she had scheduling concerns with the home health agency but felt they worked with him/her to correct the problem. Tenant #6 indicated he/she was happy with the services provided by the home health agency.

Tenant #10, a cognitively intact tenant, received skilled nursing services from a local home health agency for coccyx wound care. Tenant #10's coccyx wound healed on 6-24-13. Tenant #10's service plan indicated Tenant #10 required an evaluation form physical therapy and occupational therapy services on 6-21-13. According to nurse notes, dated 6-20-13, Tenant #10 expressed concerns about the home health agency who had been providing wound care to program staff members and a family member. Tenant #1's service plan indicated a change in home health providers occurred on 6-25-13 to provide the physical therapy and occupational therapy services per physician's order. Tenant #10's occupancy agreement did not identify a specific outside agency to be used by program tenants.

During interview, Tenant #10 reported he/she reported concerns with the home health agency that had been providing wound care when the physician order therapy services. Tenant #10 indicated he/she had been unhappy with the previous home health agency's ability to send the same nurse to provide services and had been unhappy with the agency's routine inability to arrive to provide treatment at the planned time. Tenant #10 reported the program social worker came to visit with Tenant #10 and a family member about the tenant's concerns. The social worker told Tenant #10 of the other home health agencies in the area and Tenant #10 reported choosing the new home health provider on his/her own. Tenant #10 reported the social worker assisted in contacting the previous home health provider per his/her request to cancel services and assisted with initiating services through the new provider. Tenant #10 denied being told he/she needed to change providers and felt he/she had made the decision independently. Tenant #10 reported satisfaction with the new home health agency.

Tenant #11, a cognitively intact tenant, received skilled nursing services from a local home health agency for wound packing. Tenant #11's hip wound was currently open and continued to require packing. Tenant #11's clinical record indicated the program requested initiation of wound care to be provided by another home health agency on 6-21-13. Tenant #11's occupancy agreement did not identify a specific outside agency to be used by program tenants.

During interview, Tenant #11 reported he/she reported concerns with the home health agency that had been providing wound care previously. Tenant #10 indicated he/she had been unhappy with the previous home health agency's ability to send the same nurse to provide services and had been unhappy with the agency's routine inability to arrive to provide treatment at the planned time. Tenant #11 reported the program social worker came to visit with Tenant #11 to discuss his/her satisfaction with the previous home health agency. Tenant #11 expressed his/her concerns. The social worker told Tenant #11 of the other home health agencies in the area and Tenant #11 reported choosing the new home health provider on his/her own.

Tenant #11 reported he/she contacted the new agency to initiate services and indicated the social worker contacted the previous home health provider per his/her request to cancel services. Tenant #11 denied being told he/she needed to change providers and felt he/she had made the decision independently. Tenant #11 reported satisfaction with the new home health agency.

Tenant #12, a cognitively impaired tenant, received skilled nurse, physical therapy and occupational therapy services from a local home health agency previously. Occupational therapy and physical therapy services were discontinued on 5-7-13. The skilled nurse services continued through the end of the home health agency's certification period. Home health services were discontinued and Tenant #12 did not have any other agency provide services at a later date. Tenant #12's occupancy agreement did not identify a specific outside agency to be used by program tenants.

During interview, the Interim RN/DON reported the program allows tenants to choose from a list of five local home health agencies and from a list of several hospice agencies when services are required.

During interview, the Social Worker reported staff members told her of Tenant #10's concerns with a local home health agency sometime in mid-June 2013. The social worker spoke with Tenant #10 about the concerns and offered Tenant #10 other options for agencies that provide the same services locally. Tenant #10 chose to change providers and the social worker assisted Tenant #10 in doing so. The social worker reported she followed up with Tenants #1 and #11 to monitor satisfaction with home health services as both tenants used the same home health agency used by Tenant #10. Both Tenant #1 and Tenant #11 expressed similar concerns with the home health agency so the social worker provided each with a list of other home health agencies in the area. Both tenants chose to switch providers and the social worker assisted the tenants with the change.

- Regulatory Insufficiency: None noted.