IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

August 19, 2013

Ms. Denise Elsner, AL Coordinator
Courtyard Terrace
717 West 3rd Street
Boone, IA 50036

RE: Final Recertification Monitoring Evaluation Report – Courtyard Terrace, Boone, IA

Dear Ms. Elsner:

Enclosed is the **Final Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has completed the review of your Plan of Correction (POC) in response to the **Preliminary Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0177** with effective dates of **August 20, 2013** through **August 19, 2015**.

If you have any questions in regard to this certification, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Recertification Monitoring Evaluation Report

Assisted Living Program:

Denise Elsner, Assisted Living Coordinator
Courtyard Terrace
717 W 3rd St.
Boone, Iowa 50036

Date of Monitoring Visit:

June 26, 2013

Monitor(s):

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 were provided by the Program at the time of the on-site.

General Population Program	
Number of tenants without cognitive disorder:	30
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	32
TOTAL census of Assisted Living Program	32

Tenant/Family Satisfaction Results – A community meeting was held with 20 tenants in attendance. The tenants reported general satisfaction with the program. They reported respectful staff interaction and routine timely response to calls made using emergency pendants. One tenant reported his/her pendant did not work when summoning staff due to a dead battery approximately 2 weeks ago. (The program had been checking the batteries on the pendants monthly prior to 2 weeks ago. The program initiated random testing on the pendant system weekly and all pendants are checked on monthly basis. The program implemented checking the batteries in the pagers carried by staff every shift and ordered multiple batteries for both pagers and pendants for replacement purposes. The pendant computer system tracks battery life on the pendants and notifies administration if pendant batteries are getting low on charge. While a deviation from the requirements of the rules was found, the program had already initiated a process to correct the deficient practice.) The tenants reported the food served by the program was generally palatable and the provision of scheduled activities plentiful. They reported the program's environment to be clean and safe, with all 20 tenants acknowledging they would recommend it to others.

Program History – During the course of this certification period investigation the following regulatory insufficiencies in the areas of Medications, Staffing and Transportation were found, .

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

A. Medications

Monitoring Observation: According to the program's policy, titled Courtyard Terrace Medication Policy, if a tenant chooses to delegate medication administration to the program, all medications and medication planners will be stored in a locked drawer in each tenant bathroom with only program staff members having a key to access the drawer.

According to the program's policy, titled Assistance from PSA's with Oral Medications, staff members are to empty medications directly from the medication planner into a cup and hand the cup to each tenant. The policy documented the direct care staff members were to initial on the MAR following administration of the medication.

During interview, the Assisted Living Coordinator reported when a tenant delegated medication management and administration to the program, Staff #1, certified medication aide (CMA), or the Assisted Living Coordinator pre-filled a medication planner on a weekly basis. After the medication planner is filled, the staff member initialed the Medication Administration Record (MAR). All tenant medications were stored in a locked drawer located in each tenant's apartment. The staff members pre-fill the medication planner in each tenant's apartment and all medications are administered in each tenant's apartment. The Coordinator indicated in May 2013 the program changed its practice from having staff members sign each medication individually on the MARs as stated above in the program's policy.

The Coordinator indicated the number of pills that should be in each planner was to be identified on the task sheet that staff members initial after administering each tenant's medications. A copy of each tenant's MAR was also kept in the drawer where the medications were stored. The Coordinator reported one tenant, Tenant #1, had his/her medications pre-filled by a family member and then staff members administer the medications from the planner multiple times daily. The program failed to update the medication policy to reflect the new practice.

Tenant #1, a 91 year old, was admitted to the program on 3-20-10 with diagnoses of: Hypertension (HTN); Coronary Artery Disease, Dementia; Chronic Back Pain and Renal Artery Stenosis. Tenant #1 answered all but 4 questions on the Short Portable Mental Status Questionnaire (SPMSQ) completed on 4-10-12, indicating mild intellectual functioning. According to Tenant #1's service plan, dated 11-15-12, the tenant's spouse pre-filled his/her medication planner and Tenant #1 had delegated the daily administration of the medications to the program.

The June 2013 MAR included physician's orders for Tenant #1 to take one levothyroxine 75 micrograms (mcg), which is a small purple rectangle tablet, and one fish oil capsule at 7:00 a.m. daily. Tenant #1's task sheets for June 2013 lacked documentation of how many pills should be administered at 7:30 a.m. The June 2013 MAR included physician's orders for Tenant #1 to take one multivitamin (a purple oblong tablet), one Calcium with Vitamin D (a pink oblong tablet), one Enalapril 20 milligram (mg) (a small round pinkish brown tablet) and one Enteric Coated Aspirin 81 mg (a small round red/orange tablet) totaling four pills to be taken at 9:00 a.m. The MAR included physician's orders for Tenant #1 to take Tylenol and Tramadol on an as needed basis for pain.

On 6-26-13 at approximately 9:00 a.m., the monitor observed Staff #1, CMA; administer medications to Tenant #1. Staff #1 removed 6 pills from a medication planner that had been set up by Tenant #1's spouse, placed the pills into a small medication cup and handed the medication to Tenant #1. The medication planner containing Tenant #1's medications was stored on the sink countertop unsecured. Each 7:00 a.m. slot on the medication planner contained one small purple rectangular pill. Each 9:00 a.m. slot on the medication planner contained one small round orange/red pill, one small round pinkish/brown pill, one larger round white pill, one pink oblong pill, one white oblong pill and one purple oblong pill.

Staff #1 did not take Tenant #1's Medication Administration Record (MAR) or Tenant #1's task sheet with her to administer the medications. Staff #1 did not review any document to verify the accuracy of the medications prior to giving Tenant #1 the six pills. During interview, Staff #1 reported she "gave whatever was in the planner" as the spouse is in charge of the medications.

During interview, Tenant #1's spouse reported filling Tenant #1's medication planner on a weekly basis. The spouse reported he/she had stopped adding the fish oil to Tenant #1's 7:00 a.m. slots for more than one month as Tenant #1 began experiencing gastrointestinal upset. Tenant #1's clinical record lacked documentation of the physician contact or change in physician orders for the fish oil capsules. Tenant #1's spouse reported also placing one Tylenol (white oblong tablet) and a Tramadol (round white tablet) in the 9:00 a.m. slots as Tenant #1 experienced chronic back pain and could take the pill on an as needed basis.

Tenant #1's medications administered by staff members and were not secured as required by regulation. The number of pills to be administered was not identified on Tenant #1's June 2013 task sheet. Staff members administered Tenant #1's medications without clarification of the number of pills to be administered.

Tenant #2, an 80 year old, was admitted to the program on 6-8-12 with diagnoses of Parkinson's Disease and Macular Degeneration. Tenant #2 answered all but two questions correctly on the SPMSQ completed on 6-19-13, indicating intact intellectual functioning. According to the service plan, dated 6-19-13, Tenant #2 delegated medication administration to the program.

On 6-26-13 at approximately 9:55 a.m. the monitor observed Staff #2, certified nursing assistant (CNA) administer Tenant #2 two pills from a pre-filled medication planner that was locked in the top drawer of Tenant #2's bathroom sink cabinet. The monitor noted three bottles of Multivitamin setting on the back side of the sink counter. The monitor also noted the large unsecured drawer in the same sink cabinet was full of pill bottles with Tenant #2's name on them. During interview, Tenant #2's spouse verified all of the bottles of pills were current medications taken by Tenant #2 and reported there were too many pill bottles to fit in the locked drawer so the larger unsecured drawer was being used to hold all Tenant #2's medication. Tenant #2's spouse verified the three bottles of multivitamin setting on the counter were also Tenant #2's current medication.

Staff #2 did not take Tenant #2's MAR or Tenant #2's task sheet with her to administer the medications. Staff #2 did not review any document to verify the accuracy of the medications prior to giving Tenant #1 the two pills. Tenant #2's June 2013 task sheets did not identify the number of pills staff members were to administer.

Tenant #2's medications administered by staff members and were not secured as required by regulation. The number of pills to be administered was not identified on Tenant #2's June 2013 task sheet. Staff members administered Tenant #2's medications without clarification of the number of pills to be administered.

The monitor identified the following concerns when reviewing the programs MARs and task sheet:

Tenant #5	8:00 a.m. 12:00 noon 4:00 p.m. and 8:00 p.m. number of pills not identified on the June 2013 task sheets for staff members to use to determine accuracy of medications before administration.
Tenant #6	Triamcinolone cream to be applied by staff members three times daily-not signed as applied once on 6-1-13; twice on 6-2-13; once on 6-4-13 and 6-5-13; and all three times on 6-24-13. Reason for omission not documented.
Tenant #7	8:00 a.m. 12:00 noon and 8:00 p.m. number of pills not identified on the June 2013 task sheets for staff members to use to determine accuracy of medications before administration.

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

Regulatory Insufficiency: When medications are administered traditionally by the program, medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. (IAC r. 481-67.5(6) b)

B. Staffing

Monitoring Observation: The monitor reviewed the personnel files of Staff #1, CMA, and Staff #2, CNA. Both personnel files contained documentation of the completion of a medication management course and registered nurse (RN) delegation.

Tenant #1's June 2013 MAR included physician's orders for Tenant #1 to take one levothyroxine 75 micrograms (mcg), which is a small purple rectangle tablet, and one fish oil capsule at 7:00 a.m. daily. Tenant #1's task sheets for June 2013 lacked documentation of how many pills should be administered at 7:30 a.m. The June 2013 MAR included physician's orders for Tenant #1 to take one multivitamin (a purple oblong tablet), one Calcium with Vitamin D (a pink oblong tablet), one Enalapril 20 milligram (mg) (a small round pinkish brown tablet) and one Enteric Coated Aspirin 81 mg (a small round red/orange tablet) totaling four pills to be taken at 9:00 a.m. The MAR included physician's orders for Tenant #1 to take Tylenol and Tramadol on an as needed basis for pain.

On 6-26-13 at approximately 9:00 a.m., the monitor observed Staff #1, CMA, administer medications to Tenant #1. Staff #1 removed 6 pills from a medication planner that had been set up by Tenant #1's spouse, placed the pills into a small medication cup and handed the medication to Tenant #1. The medication planner containing Tenant #1's medications was stored on the sink countertop unsecured. Each 7:00 a.m. slot on the medication planner contained one small purple rectangular pill. Each 9:00 a.m. slot on the medication planner contained one small round orange/red pill, one small round pinkish/brown pill, one larger round white pill, one pink oblong pill, one white oblong pill and one purple oblong pill.

Staff #1 did not take Tenant #1's Medication Administration Record (MAR) or Tenant #1's task sheet with her to administer the medications. Staff #1 did not review any document to verify the accuracy of the medications prior to giving Tenant #1 the six pills. During interview, Staff #1 reported she "gave whatever was in the planner" as the spouse is in charge of the medications.

During interview, Tenant #1's spouse reported filling Tenant #1's medication planner on a weekly basis. The spouse reported he/she had stopped adding the fish oil to Tenant #1's 7:00 a.m. slots for more than one month as Tenant #1 began experiencing gastrointestinal upset. Tenant #1's clinical record lacked documentation of the physician contact or change in physician orders for the fish oil capsules. Tenant #1's spouse reported also placing one Tylenol (white oblong tablet) and a Tramadol (round white tablet) in the 9:00 a.m. slots as Tenant #1 experienced chronic back pain and could take the pill on an as needed basis.

Staff #1 administered Tenant #1's medications without clarification of the number of pills to be administered.

On 6-26-13 at approximately 9:55 a.m. the monitor observed Staff #2, certified nursing assistant (CNA) administer Tenant #2 two pills from a pre-filled medication planner that was locked in the top drawer of Tenant #2's bathroom sink cabinet. Staff #2 did not take Tenant #2's MAR or Tenant #2's task sheet with her to administer the medications. Staff #2 did not review any document to verify the accuracy of the medications prior to giving Tenant #1 the two pills. Tenant #2's June 2013 task sheets did not identify the number of pills staff members were to administer.

Staff #2 administered Tenant #2's medications without clarification of the number of pills to be administered.

Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

C. Transportation

Monitoring Observation: The Assisted Living Coordinator reported the program provided transportation to tenants during activities. The Coordinator presented the monitor with copies of the front and back of the drivers' licenses of the staff member who transported program tenants using the program's van. The Coordinator indicated the program used a six passenger van for such transportation. The Coordinator identified the activity director as the staff member who drove the van to transport program tenants.

Staff #4's, activity director, driver license indicated she had been issued a Class C driver license by the State of Iowa, indicating approval to drive a non-commercial vehicle.

The State of Iowa requires persons to either have a CDL or have a class D (Chauffeur's) driver's license with endorsement 3, allowing non-commercial use of a vehicle when transporting less than 16 passengers for hire. Staff #4 did not have either.

Regulatory Insufficiency: When transportation services are provided directly or under contract with the program, the driver shall have a valid and appropriate driver's license or commercial driver's license as required by law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated. (IAC r. 481-69.33(6))