IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

September 13, 2013

**Complaint/Incident Intake #:** 44595-C

Ms. Karen Beck, RN Director
Prairie Hills at Des Moines
5815 SE 27th
Des Moines, IA 50320

**RE: Amended Final Recertification & Complaint/Incident Investigation Report – Prairie Hills at Des Moines, Des Moines, IA**

Dear Ms. Beck:

Enclosed is the **Amended Final Recertification & 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 completed the review of your Plan of Correction (POC) in response to the **Preliminary Recertification & Complaint/Incident Investigation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Request for Reconsideration is accepted in the area of narcotic handling and storage. The Request for Reconsideration has been denied in the area of medication; however, the report has been amended to include documentation from the June 12, 2013 nurse's note. The amended 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 **S0299** with effective dates of **October 15, 2013** through **October 14, 2015**.

If you have any questions in regard to this certification, please contact me at 515/281-7039.

Sincerely,

*Rose Boccella*

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

# IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
## Assisted Living Program
## Amended Final Recertification & Complaint/Incident Investigation Report

**Assisted Living Program:**

Karen Beck, RN Director
Prairie Hills at Des Moines
5815 SE 27th
Des Moines, IA 50320

**Complaint/Incident Intake #:** 44595-C

**Date of Investigation:**

July 30, 31 & August 5, 2013

**Monitor(s):**

Lori Miner, RN BSN
Margaret Kaltefleiter, RN MS

**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.

| **Dementia Specific Program by Definition** | |
|---|---|
| Number of tenants without cognitive disorder: | 35 |
| Number of tenants with cognitive disorder: | 7 |
| Total Population of Program at time of on-site | 42 |

| **Dementia-Specific Program by Dedication** | |
|---|---|
| Number of tenants without cognitive disorder: | 1 |
| Number of tenants with cognitive disorder: | 4 |
| Total Population of Program at time of on-site | 5 |

| | |
|---|---|
| **TOTAL census of Assisted Living Program** | 47 |

**Tenant/Family Satisfaction Results** – A community meeting with 16 tenants was held. The tenants said they liked living at the Program because they didn't have to do their own housework, laundry was done for them and put away, there was plenty of parking and the furniture was comfortable. Housekeeping services were completed to their satisfaction and the building and grounds were beautifully maintained. One tenant requested more open areas for outdoor walking. Nursing services were available and staff responded real fast, within a few minutes and in less than five minutes when called for assistance. Tenants received the services expected when they signed the occupancy agreement. Staff was described as good and treated the tenants well, wonderfully, and like family. Staff knew what services to provide. The tenants liked the food and said it was good. A variety of meats, vegetables and desserts was served and food was served at the appropriate temperature. One tenant said the food could be spiced up a bit. Plenty of activities were offered and tenants enjoyed playing Bingo and having exercise class. The tenants stated the showers and whirlpool were nice but they would like to see a rubber carpet or mat on the inside and outside to avoid slipping or falls. One tenant requested staff training on the correct temperature of the water for whirlpool baths for diabetics. Tenants felt safe, made their own decisions, were generally satisfied with the Program and would recommend it to others. They stated overall they were happy and enjoyed good living.

**Program History** – The program received regulatory insufficiencies during the recertification and complaint investigation of July 30, 31, and August 5, 2013 in the areas of: Tenant Rights, Evaluations, Service Plan, Nurse Review, Involuntary Discharge, Medications, and Policies and Procedures.

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

## A. Tenant Rights

Complaint/Incident Allegation: It was alleged a tenant was charged $100 for leaving the Program early.

- Monitoring Observation: Occupancy agreements were reviewed for Tenants #1, #2, #3, and #4. The agreements indicated tenants were charged a $100 cleaning fee upon discharge. There was no documentation a tenant was charged a fee for leaving early.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged a tenant was discharged from the Program because they required a two person assist when they only required partial assist with transfer. It was alleged a tenant was only given an eight hour notice prior to discharge.

- Monitoring Observation: The program was asked to provide a list of all tenants discharged in the last three months. Four tenants were identified: Tenant #5 was deceased, and Tenants #1, #2, and #4 were identified as transferring from the program for health reasons. During the investigation, Tenant #3 was identified as still residing at the program, but had been given a 30-day notice of discharge.

  Tenant #1, a 92 year-old, was admitted on 8-16-12 and had diagnoses of: Diabetes, Hypertension (HTN), and Congestive Heart Failure. On 6-25-13 Tenant #1 was admitted to the hospital for pneumonia. Nurse's notes dated 7-17-13 documented Tenant #1's health had declined and Tenant #1 would not be returning to the program. A letter dated 7-22-13 signed by Tenant #1's Power of Attorney for Healthcare (DPOA) indicated Tenant #1 had moved to a nursing facility for health reasons.

  Tenant #2, an 80 year-old, was admitted on 5-1-13 and had diagnoses of: Diabetes, Restless Leg Syndrome, Hypothyroidism, Mechanical Valve, Recurrent Urinary Tract Infections, Esophageal Reflux, Hyperlipidemia, and HTN. Tenant #2 had no errors on a cognitive ability assessment completed on 5-31-13 which indicated low risk for cognitive decline.

  The clinical record documented the following:

| Date | Location of Documentation | Documentation |
|---|---|---|
| 5/1 & 5/2/13 | Nurse's notes | Orders received and clarified for blood thinner, blood sugar checks, and insulin administration time. |
| 5/2 through 5/6/13 | Blood Sugar flow sheets | Morning blood sugars were less than(<) 60 four out of five days |

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|---|---|---|
| 5/6/13 | Nurse's notes | Tenant #2 to healthcare provider's office. Blood sugar checks increased to four times a day, morning insulin increased, night time insulin discontinued, and insulin added in the evening |
| 5/6 through 5/15/13 | Blood Sugar flow sheets | Morning blood sugars were < 60 eight of 10 days. Noon blood sugars were <60 one of nine days. Bedtime blood sugars were greater than (>) 300 two of four days. |
| 5/13/13<br><br>5/14/13 | Healthcare provider's order<br><br>Healthcare provider's order | Order for Tylenol or Hydrocodone every four hours as needed for pain<br><br>Lantus insulin was discontinued and Novolog was started twice a day. |
| 5/15/13 | Nurse's notes dated 5/16/13 | Tenant had appointment with doctor on 5/15/13. Furosemide and antihistamine ordered. Order for antihistamine clarified. |
| Undated | Healthcare provider's note | Tenant #2 had appointment for lower extremity edema and shortness of breath. More short of breath with exertion. Weight up. 3+ edema in extremities. Allergic Conjunctivitis and Possible Congestive Heart Failure. Furosemide (water pill) ordered for seven days. Antihistamine ordered daily. |
| 5/16/13 | Blood Sugar flow sheet | Morning and noon blood sugar 44. |
| 5/16/13<br><br>5/17/13 | Nurse's note<br><br>Nurse's note | To hospital via ambulance after noon blood sugar of 44. Tenant was not feeling well, and observed to be shaky and slurring words.<br><br>Tenant in hospital for observation, to return to program on 5/17/13. Upon return to program it was noted "multiple changes" were made to medications. Tenant #2 will have nurse from hospital follow. |
| 5/17 through 5/20/13 | Blood Sugar flow sheet | None of the blood sugars were < 60 or >300. |
| 5/20/13 | Healthcare provider's order | Medication changes made, including an increase in the dosage of Furosemide. Support stockings were ordered. |
| 5/21 through 5/24/13 | Blood Sugar flow sheet | None of the blood sugars were < 60. Two of four noon blood sugars were > 300 (484 and 446). One evening blood sugar was 506 and two bedtime blood sugars were > 300 (346 and 544). |
| 5/24/13 | Nurse's notes | Tenant #2 was admitted directly to the hospital from the doctor's office. |

| | | |
|---|---|---|
| 5/26/13 | Nurse's notes | Tenant #2 returned from the hospital. Orders were clarified on 5/28/13. |
| 5/26/13 | Discharge Note | Tenant #2 was discharged from the hospital on 5/26/13 following an admission for altered mental status. |
| 5/26 through 5/30/13 | Blood Sugar flow sheet | For the five day period, blood sugar was >300 once in the morning and at noon, three times in the evening and five times at night. |
| 5/30/13<br><br>5/30/13<br><br>5/31/13 | Nurse's notes<br><br>Healthcare provider's order<br><br>Nurse's notes | Orders received to change insulin, orders clarified.<br><br>Order to hold insulin if blood sugar <120<br><br>Orders received to change insulin, Furosemide and blood thinner. Documentation indicated a family member took Tenant #2 to an appointment. |
| 5/31 through 6/10/13 | Blood sugar flow sheets<br><br>Nurse's notes | For the 11 day period, the blood sugar was >300, once in the morning, once at noon, three times in the evening (as high as 470), and four times at night (as high as 400).<br><br>Blood sugar results were sent to the healthcare provider twice. |
| 6/11/13<br><br>6/12/13 | Nurse's notes<br><br>Nurse's notes | Information on Tenant #2 was sent to another facility for review for possible admission.<br><br>Tenant #2 returned from doctor's appointment with changes to insulin, pain medication, and blood thinner. |
| 6/13/13 | Notice of Decision | Tenant #2 was approved for waiver services for the period 6/7/13 through 5/31/14 |
| 6/11 through 6/20/13 | Blood Sugar flow sheets | For the 10 day period, the blood sugar was <60 once at noon, >300 once at noon, >300 once in the evening, and >300 twice at night |
| 6/21/13<br><br>6/26/13 | Nurse's notes<br><br>Nurse's notes | Home health visited Tenant #2.<br><br>Family considering move to another facility. Information on Tenant #2 sent to facility for review for possible admission. |
| 6/21 through 6/28/13 | Blood Sugar flow sheets | For the eight day period, the blood sugar was < 60 twice in the morning. A notation on the flow sheet indicated notification was to be made for blood sugars <70 or >400. |
| 6/28/13 | Nurse's notes | Family notified program Tenant #2 would be leaving program to be with family for the weekend then would be moving to a nursing facility over the weekend. The program sent information to the nursing facility. |

| | | |
|---|---|---|
| 7/1/13 | Nurse's notes | Medications were returned to the pharmacy for credit; narcotics were destroyed per policy. |

In a fax to the healthcare provider dated 5-17-13. the program indicated Tenant #2 could not be on a diabetic diet "per assisted living regulations no specific diets are allowed." The healthcare provider changed the diet order to regular per request of the program. Assisted living regulations allow for program's to decide whether or not to offer therapeutic diets. Assisted living regulations do not prohibit programs from providing special diets. The notation on the fax indicated a lack of understanding of assisted living regulations.

The nurse's notes for Tenant #2 dated 5-30-13 indicated the healthcare provider's office was notified that sliding scale insulin was "not done in assisted living." Assisted living regulations allow for each program to have its own medication policy with medications administered under the direction of the program's nurse. Assisted living regulations do not prohibit the use of sliding scale insulin. The notation in the nurse's notes indicated a lack of understanding of assisted living regulations.

Tenant #2's service plan, dated 5-31-13 indicated Tenant #2 was independent with bathing dressing, grooming, eating, ambulation, transfers, and toileting. The program administered medications to Tenant #2.

Tenant #2 began living at the program on 5-1-13. The program checked Tenant #2's blood sugar up to four times a day. Tenant #2 was sent to the emergency room once and observed for an episode of low blood sugar. Tenant #2 was admitted to the hospital once for altered mental status following high blood sugars. Tenant #2 had documented doctor's appointments, and was seen by a home health nurse. Tenant #2 was seen for an allergic condition and possible Congestive Heart Failure. Tenant #2 had several medication changes. Tenant #2 did not exceed criteria for retention in an assisted living program. Tenant #2 was voluntarily discharged on 6-28-13 to home with family to be admitted to a nursing facility on 6-30-13.

Tenant #3, a 90 year-old, was admitted on 2-16-12 and had diagnoses of: Constipation, Esophageal Reflux, Hyperlipidemia, HTN, Hypothyroidism, History of Urinary Tract Infections, and Alzheimer's. The most recent cognitive screening tool dated 4-8-13 indicated Tenant #3 had two errors which indicated low risk for cognitive decline. The clinical record lacked documentation of Tenant #3's cognitive impairment. There was no documentation a DPOA had been activated as indicated in the DPOA agreement.

On 4-5-13, the program entered into a negotiated risk agreement with Tenant #3 related to the use of an electric wheelchair. The cause of concern was Tenant #3's lack of concern for safety for self and others. Tenant #3 was noted to run into objects such as furniture, doors, and walls. Tenant #3 was also noted to "run over" other tenants in the way in the hallways rather than going around the other tenants or patiently waiting for them to move. The final agreement between Tenant #3 and the program was that Tenant #3 would notify staff to assist in getting the apartment door open after meals, walking with a walker and caregiver to at least one meal a day, and

with reminders would attend exercise classes. The negotiated risk agreement indicated a review would occur weekly for one month, then twice monthly.

Nurse's notes dated 4-8-13 documented per family's request, a fax was sent to the healthcare provider requesting Physical Therapy (PT) for strengthening and evaluation for safe use of the electric wheelchair. There was no documentation Tenant #3 was involved in the process of requesting PT.

Nurse's notes dated 4-8-13 indicated Tenant #3 had been asking for assistance to return to the apartment, participating with PT, attending exercise, and walking to one meal daily. Tenant #3 had not run into furniture, walls or doors with the electric wheelchair.

Nurse's notes dated 4-10-13 indicated an order had been received to start PT for strengthening and electric wheelchair safety. The nurse review of 4-10-113 indicated PT was ordered for strengthening and motor scooter safety. The nurse review indicated there was no change in condition, no change to mental status or activities of daily living (ADLs); however, an evaluation of cognition and function was not completed. There was no documentation in the nurse review as to the behavior exhibited by Tenant #3 to indicate concern for safety. Notes of 4-15-13 indicated there were no reports of unsafe use of the electric wheelchair; Tenant #3 participated in PT, requested assistance when returning to the apartment, attended exercise, and walked to one meal daily. There was no further review of the use of the electric wheelchair for the month of April, despite the agreement which indicated a review would occur weekly for one month.

Notes dated 5-1, 5-8, 5-15, 5-30, and 6-6 documented follow-up to the use of the electric wheelchair with only one report of unsafe use of the electric wheelchair. On 5-8-13 it was documented Tenant #3 was using the electric wheelchair and driving towards a staff member and did not slow down until the staff member asked Tenant #3 to slow down. An incident report dated 5-30-13 documented Tenant #3 obtained a skin injury after an arm got caught between the wheelchair and the table.

An incident report dated 6-24-13 documented Tenant #3 came into the dining room and didn't stop the wheelchair. Tenant #3 ran into the table pushing the table about three feet from the original spot. Another tenant was at the end of the table, and was pushed with the table. The other tenant sustained no injuries. Nurse's notes of the same date indicated a family member was called to discuss the incident. The family member agreed to have Tenant #3 evaluated and fitted for a regular, non-electric wheelchair. According to the nurse's notes, an order was received for PT. The nurse's notes lacked documentation Tenant #3, who was cognitively well by the program's evaluation, was consulted regarding the change. The clinical record lacked documentation the Power of Attorney for Healthcare had been activated.

On 7-4-13, nurse's notes indicated Tenant #3 was meeting with PT and no further incidents hat been noted with the electric wheelchair. The nurse's notes contained no further documentation regarding use of the electric wheelchair.

Nurse's notes dated 7-11-13 indicated the RN/Director spoke with Tenant #3 regarding a 30-day notice. Documentation did not indicate the healthcare provider

was notified. The 30-day notice, dated 7-11-13 identified the program could not retain a tenant who was beyond the program's level of care. The reason for the discharge was identified as 1) displayed behavior that placed another tenant or staff at risk, and 2) had unmanageable incontinence on a routine basis despite an individualized toileting plan.

In an interview with the RN/Director, she stated Tenant #3 was unable to use the electric wheelchair. The RN/Director reported Tenant #3 did not make safe decisions, and would try to run over staff with the electric wheelchair. Tenant #3 was also described as pushing away from staff with a fist. Tenant #3 was reported to have no control of own behavior. The RN/Director stated Tenant #3 lived in the general population because the secured dementia unit had no waiver beds available, and Tenant #3 was not an elopement risk. The RN/Director indicated there were no further injuries or incidents caused by Tenant #3 since 6-24-13. Tenant #3 had been using a slow speed. The RN/Director indicated Tenant #3 had been following the agreement established in the negotiated risk agreement.

In an interview LPN #1 stated Tenant #3 had multiple falls and did not safely use the electric wheelchair.

In an interview, LPN #2 stated she had never observed Tenant #3 run into things. LPN #2 reported Tenant #3 was not safe because Tenant #3 came close to hitting things with the electric wheelchair. Tenant #3 had been observed by LPN #2 walking to the dining room which was new. LPN #2 indicated the final agreement of the negotiated risk agreement was being followed. Tenant #3 was reported to use the call light "a lot." LPN #2 described Tenant #3 as "with it" but stubborn.

In an interview Staff #3 stated Tenant #3 only had one incident on 6-24-13, but was otherwise good at keeping the electric wheelchair at a slow speed. Staff #3 reported Tenant #3 did not bump into things and was good at driving the electric wheelchair. The final agreement was being followed.

In an interview, Staff #4 stated Tenant #3 always used the electric wheelchair and refused the manual wheelchair. Tenant #3 was reported to be "pretty good" with the chair. Sometimes Tenant #3 would hit a chair with the wheelchair, or would be too close to objects but would not hit objects.

A monitor observed Tenant #3 in the electric wheelchair in a common area on three occasions. During the first, Tenant #3 was observed to bump an unoccupied chair to the left as Tenant #3 was looking right. Tenant #3 stated he/she had been distracted. During two other occasions, Tenant #3 was observed driving the electric wheelchair at a slow speed moving around furniture in the common area with no objects being hit.

PT service notes indicated Tenant #3 began PT services on 6-26-13 and completed PT on 7-20-13. The program did not evaluate Tenant #3 to determine the effectiveness of PT or if Tenant #3 required any new services. There was no documentation related to the effectiveness of PT and use of the electric wheelchair.

The service plan dated 6-25-13, under mobility, indicated Tenant #3 ambulated independently with a wheeled walker in the apartment. A motorized scooter was used for longer distances and sometimes required assistance with navigation. The service plan also referenced the agreement of negotiated risk. The current service plan dated 7-19-13, one week after the 30-day notice was issued, was unchanged under mobility from the service plan of 6-25-13. The service plan was not updated once Tenant #3 was identified in the 30-day notice as displaying behavior that placed another at risk.

The documentation in the clinical record did not indicate Tenant #3 was displaying behaviors that put other tenants or staff at risk.

In an interview the RN/Director stated Tenant #3 was incontinent and the family was unaware of the incontinence. The RN/Director stated Tenant #3 wanted to be independent, but could not do perineal care after toileting. The RN/Director reported Tenant #3 could report the need to toilet, and would report having already gone to the bathroom when that was not the case. Tenant #3 was reported to urinate when placed on the toilet at times. Tenant #3 attempted to remove garments for toileting but was unsuccessful. Tenant #3 was reported to assist with toileting. The RN/Director reported Tenant #3 was on a toileting schedule.

In an interview LPN #1 stated Tenant #3 was not on a toileting schedule, and let staff members know of the need to toilet. LPN #1 reported Tenant #3 completed perineal care after toileting. LPN #1 was not concerned about incontinence. Tenant #3 was reported to use the call light to notify staff of toileting needs.

In an interview, LPN #2 stated Tenant #3 used the call light to report the need to toilet. LPN #2 was not aware of a problem with toileting. LPN #2 stated she noticed no odors on Tenant #3. Tenant #3 was able to dress and undress for toileting and use the call light to request help with hygiene after toileting. LPN #2 was not aware of incontinence in Tenant #3 until recently. Staff members encouraged Tenant #3 to use the toilet.

Staff #1 reported Tenant #3 was on a two-hour toileting schedule 24-hours a day. Tenant #3 used the call light to report the need to toilet. Tenant #3 assisted with dressing and undressing for toileting needs.

Staff #3 reported Tenant #3 turned on the call light to request help to get into the apartment, and sometimes needed assistance getting into the bathroom because Tenant #3 walked to the bathroom. Tenant #3 assisted with removal and reapplication of clothing before and after toileting. Tenant #3 was able to provide perineal care with toileting.

Staff #4 reported Tenant #3 was independent with toileting. Sometimes Tenant #3 was wet in the mornings, but was dry during the day. Tenant #3 was not on a toileting schedule, and did not ask for help. Tenant #3 was able to manage incontinence products independently. Staff #4 had no concerns about Tenant #3's mental ability.

The service plan dated 6-25-13, under toileting, indicated Tenant #3 was incontinent at times, and required some assistance with toileting. Tenant #3 notified staff

members if assistance was required. Incontinence products were used. Under the category orientation, two-hour safety checks were completed through the night. There was no documentation of a two-hour toileting schedule.

The current service plan dated 7-19-13, under the category of toileting and one week after the 30-day notice was issued, was changed to indicate Tenant #3 had a history of urinary infections and was to be encouraged to drink water and change incontinence products if soiled. There was no documentation of a two-hour toileting schedule. Unmanageable incontinence in an assisted living program, as defined in the Iowa Administrative Code 481.69, is a condition that requires staff provision of total care for an incontinent tenant who lacks the ability to assist in bladder or bowel continence care. The criteria for exclusion from an assisted living program and as indicated in Tenant #3's discharge letter of 7-11-13 was unmanageable incontinence on a routine basis despite an individualized toileting program.

Tenant #3 was not cognitively impaired according to the program's cognitive screening tool. Staff members identified Tenant #3 was able to assist with toileting and staff members were not providing total toileting care. The service plan did not identify an individualized toileting plan. The program did not demonstrate an understanding of assisted living regulations.

Tenant #3 did not exceed criteria for retention in an assisted living program.

Tenant #4, an 82 year-old, was admitted on 5-1-13 and had diagnoses of: Dementia, Diabetes Type II, Gastro Esophageal Reflux Disease, HTN, and Headaches. A cognitive ability assessment was completed on 4-22-13. Tenant #4 had 14 errors which indicated high risk for cognitive impairment. Staging on the Global Deterioration Scale (GDS) was also completed on 4-22-13. Tenant #4 was staged at three on the GDS which indicated mild cognitive decline. Tenant #4 resided in the general population.

A healthcare provider's note dated 4-24-13 indicated Tenant #4 had occipital neuralgia with chronic headaches. Tenant #4 had recently undergone an occipital nerve ablation, but continued to have a lot of head pain, especially with certain positions. A review of the MAR for Tenant #4 for the month of May indicated one dose of Tramadol was given on 5-5-13 for pain. Tenant #4 had some relief after one hour. On 5-10-13 one dose of Toradol was given for pain. Tenant #4 was still having discomfort one hour later. There were no other "as needed" doses of pain medication given during the month of May.

A review of the MAR for Tenant #4 for the month of June indicated seven doses of "as needed" Toradol were given for pain between 6-19 and 6-25-13. The medication was given for back pain, headache, and belly pain. The MAR did not contain documentation to indicate the effect of the medication on the pain for two occasions. On two other occasions, Tenant #4 was out of the facility and staff was unable to determine the effectiveness of the medication.

The RN/Director was asked to describe Tenant #4's pain. The RN/Director stated Tenant #4 could not explain the pain due to dementia. Tenant #4 had headaches. Tenant #4 would hold the head and would sometimes verbalize head pain. Tenant #4

had days where he/she did not want to get out of bed, probably related to the pain in the head, or dementia. The RN/Director stated she may not have specifically documented pain. The family took Tenant #4 to the healthcare provider for pain, and the healthcare provider was monitoring the pain.

Nurse's notes and healthcare provider orders documented several pain medication changes over the two months Tenant #4 resided at the program. Nurse reviews were not completed to determine the effectiveness of the medications. LPN #1 stated Tenant #4 would grab the head on both sides when in pain. Tenant #4 frequently had head pain. Pain pills were offered if Tenant #4 was observed holding the head.

LPN #1 indicated Tenant #4 would also verbalize the pain. Tenant #4 would stay in bed but not always because of pain. LPN #1 reported Tenant #4 had constant medication changes and last saw a neurologist for pain.

LPN #2 reported staff members tried to keep Tenant #4 comfortable if staff members reported medication was ineffective. Tenant #4 would verbally report headaches. Tenant #4 would be guarded and not moving, lying still because of the headache. Tenant #4 stayed in bed due to pain.

Staff #1 reported Tenant #4 refused to take medications often. Staff #1 would work with Tenant #4 to take medications. Tenant #4 would not want to get out of bed. Staff #1 would get Tenant #4's mind on another topic. Staff #1 stated Tenant #4 sometimes complained of head pain. Most of the time, Tenant #4 stayed in bed and refused to do things. When Tenant #4 had pain, Tenant #4 stayed in bed and didn't do anything. Pain medications dulled the pain, and Tenant #4 would then talk some after medication was given.

Staff #6 stated a lot of days Tenant #4 did not want to get out of bed due to a headache. It took two people to assist Tenant #4 from a lying position to sitting on some days, but most days Tenant #4 could change position by self or with a spouse's help. Staff #6 reported Tenant #4 was in a lot of pain and went to the hospital a lot.

The clinical record documented the following:

| **Date** | **Location of Documentation** | **Documentation** |
|---|---|---|
| 5/1/13 | Nurse's notes | Ambulating independently. Blood Pressure (BP) 157/78. Insulin to be given in the morning rather than in the evening. |
| 5/3/13<br>8:52 a.m. | Nurse's notes | Complaints of chest pain, vomiting, feeling of impending doom. Skin clammy, complaints of weakness and unable to stand up. Refused food and fluids-Blood sugar 75. BP 187/90. Transported via ambulance to emergency room. |
| 5/3/13 | Emergency Dept. notes | Seen for Headache, Chest Pain, and Low Blood Sugar |
| 5/3/13 | Nurse's notes | Returned to program with order for Fentanyl |

| | | |
|---|---|---|
| 2:30 p.m | | patch for pain. |
| 5/6/13<br><br><br><br><br>5/6/13 | Nurse's notes<br><br><br><br><br>Healthcare provider Progress notes | Doctor's appointment. Aricept and Fentanyl patch discontinued. Gabapentin increased. Toradol injection given in doctor's office.<br><br>Previous hypoglycemia, no insulin changes. To be set up with pain management. |
| 5/7/13 | Healthcare provider's order | Toradol ordered as needed (for pain). Nurse's notes dated 5/8/13 indicate the orders were clarified. |
| 5/10/13 | Nurse's notes | Requesting orders from healthcare provider's office following a visit "yesterday." |
| 5/13/13<br><br><br>5/13/13 | Healthcare provider's order<br><br><br>Fax | Tylenol ordered every four hours as needed for pain<br><br>No new orders after blood sugar results were faxed to the healthcare provider |
| 5/2 through 5/14/13 | Blood Sugar flow sheets | Blood sugars were checked in the morning and at night. For the 13 day period, there was one blood sugar >300. There were no blood sugars <60. |
| 5/15/13 | Healthcare provider's Progress Note | Cymbalta started, Gabapentin increased. Referral for occipital neuralgia. |
| 5/15/13 | Fax | Tenant #4 was prescribed two different medications "as needed" for pain. Because non-licensed staff could not assess pain and Tenant #4 was not able to choose which medication to use, it was requested to discontinue the Tylenol. |
| 5/17/13 | Fax | Tenant #4 was prescribed two different medications for pain including Toradol. Because Tenant #4 could not decide which pain medicine to take, it was requested to discontinue the Tramadol. |
| 5/28/13 | Nurse's note | Doctor's appointment on 5-24-13 with no orders except to return in three months. |
| 5/15 through 5/31/13 | Blood sugar flow sheets | For the 17 day period, there were no blood sugars <60 or >300. |
| 6/10/13 | Nurse's notes | Reported Tenant #4 fell in the shower on 6/8/13. On 6/9/13 Tenant #4 had back pain and refused to get up. Was taken to emergency room via ambulance and returned to program later in the day. Started on Relafen, an anti-inflammatory. |
| 6/11/13 | Nurse's notes | Information on Tenant #4 was sent to another facility for review for possible admission. |
| 6/1 through 6/15/13 | Blood Sugar flow sheets | For the 15 day period, there were no blood sugars <60 or >300. |

| | | |
|---|---|---|
| 6/13/13 | Notice of Decision | Tenant #4 was approved for waiver services for the period 6/7/13 through 5/31/14 |
| 6/17/13<br>8:45 a.m.<br><br><br><br><br>3:20 p.m. | Nurse's notes<br><br><br><br><br>Nurse's notes | Tenant #4 complained of a severe headache, stomach pain, and back pain. "I think I'm going to die." BP 170/110. Ambulance called and Tenant #4 was taken to the hospital.<br><br>Returned to program with no new orders. |
| 6/17/13 | Nurse's notes | Family reported facility had no rooms available. Family looking at a different facility for transfer. |
| 6/19/13 | Nurse's notes | PT ordered due to back injury. |
| 6/20/13<br>12:05 p.m.<br><br><br><br>12:38 p.m. | Nurse's notes<br><br><br><br>Nurse's notes | Home health nurse received order to send Tenant #4 to the emergency room for complaints of severe lower abdominal pain, back pain, and headache. BP 180/90.<br><br>Tenant #4 feeling better, Tenant #4 was not taken to the emergency room. Home health nurse following. |
| 6/25/13 | Nurse's notes | Toradol ordered to be given every eight hours PT ordered. |
| 6/26/13 | Nurse's notes. | Family requested Tenant #4's information be sent to a facility for transfer. |
| 6/16 through 6/28/13 | Blood sugar flow sheets | For the 13 day period, there were no blood sugars <60 or >300. |
| 6/28/13<br>8:20 a.m.<br><br><br><br><br><br>10:20 a.m.<br><br><br><br><br><br><br>4:08 p.m. | Nurses's notes<br><br><br><br><br><br><br>Nurse's notes<br><br><br><br><br><br><br>Nurse's notes | Reported to RN/Director by caregiver that Tenant #4 required the assist of two to get out of bed. Complained of headache. Refused medications. After 15 minutes, Tenant #4 took medications, and laid back down, refused to get up, walk, or sit.<br><br>RN/Director met with family to explain refusal of food and medications. Explained need for higher level of care and Tenant #4's medical condition was declining. The nurse's notes indicated the family agreed and understood this was for the health and safety of Tenant #4.<br><br>Family decided to take Tenant #4 home for the weekend for a family gathering and would be moving Tenant #4 to a nursing facility on 6/30/13. Information on Tenant #4 was sent to the nursing facility. |

PT documented a visit to Tenant #4 on 6-28-13 at 10:50 a.m. BP was 164/96. The PT note documented Tenant #4 had a headache off and on since waking up, a throbbing pain at the back of the head. According to PT documentation, Tenant #4 did not think he/she had been receiving pain medication as often as it should be given. PT notes indicated Tenant #4 was oriented to person and place but not time. PT also noted exercises were limited on the date of the visit secondary to fatigue and increased head pain with activity. In an interview with the PT assistant, she stated Tenant #4 was not a two-person transfer at the time of the visit on 6-28-13.

A visit was made to the nursing facility to which Tenant #4 transferred on 6-30-12. The administrator stated the nursing facility was prepared to take Tenant #4 on 6/28/13 but the family decided to take Tenant #4 home for a gathering. In a letter to Tenant #4 dated 6-28-13, Tenant #4 was given a transfer and discharge letter. The letter indicated Tenant #4 no longer complied with occupancy criteria based on the need for two-person assist with transfers, more than part time or intermittent care and was medically unstable. The letter indicated while under normal circumstances a 30-day notice was required, it did not apply in the circumstances listed: two-person transfer, more than part time care, and medically unstable.

The letter indicated the recent change in condition manifested in behaviors including two-person transfer, more than part time health care, medically unstable with blood sugars, and uncontrolled hypertension constituted both a substantial threat to Tenant #4's health and safety, and the care needs exceeded the level of care allowed in assisted living.

The letter stated Tenant #4 was transferred to a nursing facility on 6-30-13, even though the letter was dated 6-28-13. The letter was signed by the RN/Director and the Community Relations Director with copies going to family and the long-term care ombudsman. The letter did not indicate the physician was notified.

The Community Relations Director was interviewed and stated the family of Tenant #4 knew Tenant #4 was not doing well. The Community Relations Director indicated there were three meetings with the family to keep talking them through the process. The family had looked at three nursing facilities, and the Community Relations Director told the family they could not wait. The Community Relations Director indicated it was no longer safe for Tenant #4 to remain at the program because Tenant #4 did not meet state standards. The Community Relations Director reported she worked hard with the family to help them understand Tenant #4 was medically unstable. The family chose to take Tenant #4 home on 6-28 for a gathering. The Community Relations Director stated she wrote the letter after the RN/Director of Nursing told her what to write. The letter was not sent certified mail.

The RN/Director was interviewed. She stated Tenant #4's condition changed on 6-28-13. The RN/Director called the family to take Tenant #4 to the doctor to be evaluated and offered if the family did not want to take Tenant #4, an ambulance could be called. According to the RN/Director, the family did not want Tenant #4 sent out to be evaluated. The RN/Director stated she told the family "today" would be a good day to transfer Tenant #4 for safety reasons. The RN/Director stated the family had been looking at placement elsewhere but had not found anything so that Tenant #4 could be with the spouse.

The RN/Director reported because of the sudden decline and change of condition in Tenant #4, a two-person transfer, and the family declined to have Tenant #4 seen, the RN/Director reported she made the decision to have Tenant #4 sent out that day. The RN/Director wanted Tenant #4 moved for safety reasons. There was no documentation the RN/Director contacted the healthcare provider for the sudden decline and change of condition.

The RN/Director was asked if she completed evaluations on Tenant #4 with the identified change of condition on 6-28-13. The RN/Director stated she did evaluate Tenant #4, but did not document it. There was no documentation of an evaluation of Tenant #4's leg strength, upper body strength, ability to bear weight, or the ability to follow directions, necessary when providing transfer assistance. According to the nurse's notes, the RN/Director was notified of a change of condition at 8:20 a.m. and Tenant #4 did not leave the program until 4:30 p.m. Tenant #4 remained at the program eight hours after the RN/Director identified a change of condition resulting in the RN/Director's concern for Tenant #4's safety. The clinical record lacked documentation of an evaluation of Tenant #4's function, cognition, and health with a change of condition on 6-28-13. The current service plan at the time of Tenant #4's discharge was dated 6-19-13. The service plan indicated Tenant #4 ambulated independently and sometimes required the assist of one for transfers. The service plan was not updated to direct staff on cares required for Tenant #4, a tenant for whom the RN/Director had safety concerns. The service plan did not indicate Tenant #4 was on two-hour checks.

LPN #1 stated she was not involved in Tenant #4's discharge. LPN #1 stated Tenant #4 had chronic head pain for which Tenant #4 saw a healthcare provider. LPN #1 reported Tenant #4 had unstable blood sugars and uncontrolled pain.

LPN #2 reported she was not involved in Tenant #4's discharge. LPN #2 did not observe Tenant #4 during the last day at the program LPN #2 last observed Tenant #4 requiring the assistance of one for transfer.

Staff #1 stated it sometimes took two people to get Tenant #4 out of bed. Staff #1 reported she told the RN/Director it was getting more difficult to care for Tenant #4 and harder to get Tenant #4 to do things. For two to three weeks it took two people to transfer Tenant #4. Staff #1 went in periodically to check on Tenant #4 as two-hour checks had been in place for about three weeks.

Staff #3, employed at the program a month, stated Tenant #4 only left the apartment for dinner. Tenant #4 did not fall a lot. Staff #3 described Tenant #4 as independent with transfers. Staff #3 was not aware of the circumstances of Tenant #4's departure from the program.

Staff #5 began employment after Tenant #4 left the program.

Staff #6 stated a lot of days Tenant #4 did not want to get out of bed due to a headache. It took two people to get Tenant #4 from a lying position to sitting on some days, but most days Tenant #4 could change position by self or with a spouse's help. Staff #6 reported Tenant #4 was in a lot of pain and went to the hospital a lot.

Tenant #4 did not meet the definition of a routine two-person transfer.

The discharge letter dated 6-28-13 indicated Tenant #4 was medically unstable because of blood sugars and uncontrolled high blood pressures. Tenant #4 had no hospital admissions while living at the program.

Blood pressure readings were documented in the clinical record as follows:

| Date | Location of Documentation/Reason | BP reading |
|---|---|---|
| 4/22/13 | Initial assessment | 142/68 |
| 5/1/13 | Nurse's notes, Move in | 157/78 |
| 5/3/13 | Nurse's notes, not feeling well, chest pain-to Emergency Room | 187/90 |
| 5/3/13 | Nurse Review following Emergency Room evaluation | Not taken |
| 5/6/13 | Nurse review after doctor visit. Repositioning does not relieve pain. Only relief from pain is medication. | Not taken |
| 5/31/13 | Constant head pain, described as mild. Independent with Activities of Daily Living (ADLs) GDS 4 | 167/86 |
| 6/10/13 | Nurse review for fall on 6/8/13. Change of condition - tenant required assist with transfer and use of walker | Not taken. |
| 6/10/13 | Assessment for change of condition-daily but not constant pain, distressing pain in the low back. Transfers independently, ambulates independently with walker according to functional assessment, full weight bearing. Handwritten notes document stand-by assistance for showers, assist with transfers. Unable to use call pendant appropriately, staff to check every two hours. GDS 5 | 138/62 |
| 6/17/13 | Nurse's notes, severe headache, to Emergency Room | 170/110 |
| 6/19/13 | Nurse review due to new order for PT for back injury. No change to mental status or Activities of Daily Living (ADLs) | Not taken |

The service plans were reviewed for 4-22, 5-3, 5-6, 5-31, and 6-19-23. All of the service plans directed staff members to report to the nurse blood sugars <60 or >300. The RN/Director was asked to review the Blood Sugar flow sheets for May and June 2013 because the discharge notice indicated Tenant #4 was medically unstable due to blood sugars. The RN/Director identified one blood sugar on 5-12-12 that was outside the parameters given.

The RN/Director was asked about a flow sheet for blood pressures since the discharge notice indicated Tenant #4 was medically unstable due to uncontrolled hypertension. The RN/Director stated flow sheets would be used if the healthcare provider ordered blood pressures to be checked.

On 5-3-13 Tenant #4 had a blood pressure of 187/90 and chest pain with a feeling of impending doom. On 6-17-13 Tenant #4 had a blood pressure of 170/110 and complained of a severe headache. On both occasions Tenant #4 was sent to the emergency room. When Tenant #4 returned on the same day, there were no orders for new blood pressure medications. A review of the MARs for May and June 2013 indicated Tenant #4 had been on Losartan 50 milligrams daily, with no changes since admission. On 5-28-13, Tenant #4 was seen by the healthcare provider and returned with no new orders except to be seen in three months.

LPN #1 stated Tenant #4 was reported to have multiple falls, and home health and PT were ordered. LPN #1 was not aware of any injuries with the falls. LPN #1 reported blood sugar levels were chronically low, and there were multiple changes to insulin.

LPN #2 stated Tenant #4 had many changes to orders and went to the doctor frequently. LPN #2 stated she had no concerns about Tenant #4's blood sugars after reviewing the Blood Sugar flow sheets for May and June 2013. Blood pressures were an issue for Tenant #4 but blood pressures were not checked on a routine basis without an order.

Medically unstable in an assisted living program is defined in the Iowa Administrative Code 481-69 as a tenant who has a condition(s) 1) which indicate physiological frailty as determined by program staff in consultation with a physician or physician-extender, 2) three or more significant hospitalizations within a consecutive three-month period for more than observation, and 3) requiring frequent supervision for more than 21 days by a registered nurse.

Tenant #4 did not meet the definition of medically unstable as defined in the regulations.

The discharge notice indicated Tenant #4 required more than part time or intermittent health related care. The RN/Director stated because of the order processing, preparing paperwork for doctor visits, physician follow-up, pharmacy follow-up and clarifying orders took time. A nurse also needed to make sure Tenant #4 got to meals. According to the service plan dated 6-19-13, current at the time of discharge, staff members provided the following services to Tenant #4: gathered supplies and provided stand-by assist with bathing, fingernail care, assisted with dressing by laying out clothing and providing limited reminders and cueing, reminders to use a walker, some supervision with transfers, and assist of one when tired, no assistance with eating, administered medications, reminders to attend activities, and was independent with toileting. Tenant #4 utilized home health services and PT services while residing at the Program.

The RN/Director was asked the definition of part time and intermittent health care as indicated in the assisted living rules. The RN/Director was unable to provide the definition.

Part-time or intermittent care in an assisted living program as defined in the Iowa Administrative Code 481-67 means licensed nursing services and professional therapies that are provided no more than five days a week, or 6-7 days a week with a predictable end within 21 days, or do not exceed 28 hours a week. If a tenant exceeded those parameters listed, the tenant could not be retained at the program according to Iowa Administrative Code 481-69.23(1)(f).

Tenant #4 did not exceed the definition of part-time or intermittent care as defined in the regulations.

Tenant #4 did not exceed criteria for retention in an assisted living program.

In summary, Tenant #3 was issued a 30-day discharge notice, but did not exceed criteria for retention in an assisted living program. Tenant #4 was given a less than 30-day discharge notice because of behaviors of a two person assistance with standing, transfer or evacuation, requiring more than part time or intermittent care, and medically unstable with blood glucose and blood pressure which constituted a substantial threat to health and safety. Tenant #4 did not exceed criteria for retention in an assisted living program.

Two tenants were given discharge notices for exceeding criteria for retention, when the criteria were not met.

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

**B. Involuntary Discharge**

- Monitoring Observation: Nurse's notes dated 7-11-13 indicated the RN/Director spoke with Tenant #3 regarding a 30-day notice. The letter indicated Tenant #3 no longer complied with occupancy criteria based on a display of behavior that placed another tenant or staff at risk and unmanageable incontinence. Documentation did not indicate the healthcare provider was notified.

  The 30-day notice dated 7-11-13 was addressed to Tenant #3 and family. The letter contained a certified mail receipt to the long-term care ombudsman dated 7-30-12, more than two weeks after the letter had been given to Tenant #3. A second copy of the letter contained a handwritten note indicating a copy of the letter was for the healthcare provider. In an interview with the RN/Director, she stated she was unaware a 30-day notice needed to be sent certified mail to the long-term care ombudsman. The RN/Director stated after the monitors requested the 30-day notice for Tenant #4, the RN/Director asked Community Relations to re-send the 30-day notice for Tenant #3, and to send it certified mail.

  In a letter to Tenant #4 dated 6-28-13, Tenant #4 was given a transfer and discharge letter. The letter indicated Tenant #4 no longer complied with occupancy criteria based on the need for two-person assist with transfers, more than part time or

intermittent care and was medically unstable. The letter indicated while under normal circumstances a 30-day notice was required, it did not apply in the circumstances listed: two-person transfer, more than part time care, and medically unstable. The letter lacked documentation of a certified letter sent to the long-term care ombudsman. There was no documentation the healthcare provider was notified.

The program gave letters of discharge to Tenants #3 and #4. One letter lacked documentation of notification to the physician. Both letters lacked documentation the long-term care ombudsman was notified by certified mail.

- Regulatory Insufficiency: If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: The program shall immediately provide to the tenant advocate, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. (IAC r. 481-69.24 (b))

**C. Evaluation**

- Monitoring Observation: Tenant #2 was taken to the Emergency Room on 5-16-13 for a blood sugar of 44. Tenant #2 reported not feeling well and was observed to be shaky and slurring words according to the nurse's notes. Tenant #2 returned to the program on 5-17-13 after being admitted for observation. There was no documentation a registered nurse (RN) completed evaluations with a change of condition.

  Tenant #2 was admitted to the hospital directly from the healthcare provider's office on 5-24-13 according to the nurse's notes. Tenant #2 returned to the program on 5-26-13. According to the hospital discharge records contained in the clinical record at the program, Tenant #2 was in the hospital for Altered Mental Status. There was no documentation an RN completed evaluations of function, cognition, and health with significant change of condition.

  On 6-28-13, the RN/Director indicated Tenant #4 exhibited a sudden change of condition as evidenced by the routine need for the assistance of two persons for transfer. Evaluations of function, cognition, and health were not completed with a significant change of condition.

- 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))

D Service Plans

- Monitoring Observation: In a form dated 5-1-13, Tenant #2 indicated a preference for cardiopulmonary resuscitation (CPR) to be started if needed. Service plans dated 4-22, 5-15, 5-20, and 5-31-13 all indicated Tenant #2 did not want CPR. The service plan did not meet Tenant #2's preference for assistance.

  In a form dated 5-1-13, Tenant #4 indicated a preference for CPR to be started if needed. Service plans dated 4-22, 5-6, 5-31, 6-10, and 6-19-13 all indicated Tenant #4 did not want CPR. The service plan did not meet Tenant #4's preference for assistance.

  On 7-11-13, Tenant #3 was given a 30-day notice of discharge for behavior that placed others at risk. The program identified Tenant #3 was unsafe with the electric wheelchair. The service plan of 7-19-13, completed about one week after the discharge notice was given, contained the steps in the negotiated risk agreement which was unchanged from the service plan of 6-25-13. The service plan did not indicate interventions for Tenant #3 who had been identified as unsafe in the electric wheelchair.

  On 6-10-13, an evaluation was completed which indicated Tenant #4 could not use a call pendant appropriately. Staff was to check on Tenant #4 every two hours. A review of the service plan of 6-10-13 did not indicate Tenant #4 required any kind of check. The service plan was not based on evaluations.

  A healthcare provider's note dated 4-24-13 indicated Tenant #4 had occipital neuralgia with chronic headaches. Tenant #4 had recently undergone an occipital nerve ablation, but continued to have a lot of head pain, especially with certain positions. A review of the MAR for Tenant #4 for the month of May indicated one dose of Tramadol was given on 5-5-13 for pain. Tenant #4 had some relief after one hour. On 5-10-13 one does of Toradol was given for pain. Tenant #4 was still having discomfort one hour later. There were no other "as needed" doses of pain medication given during the month of May.

  A review of the MAR for Tenant #4 for the month of June indicated seven doses of "as needed" Toradol were given for pain between 6-19 and 6-25-13. The medication was given for back pain, headache, and belly pain. The MAR did not contain documentation to indicate the effect of the medication on the pain for two occasions. On two other occasions, Tenant #4 was out of the facility and staff was unable to determine the effectiveness of the medication.

  The RN/Director was asked to describe Tenant #4's pain. The RN/Director stated Tenant #4 could not explain the pain due to dementia. Tenant #4 had headaches. Tenant #4 would hold the head and would sometimes verbalize head pain. Tenant #4 had days where he/she did not want to get out of bed, probably related to the pain in the head, or dementia. The RN/Director state she may not have specifically documented pain. The family took Tenant #4 to the healthcare provider for pain, and the healthcare provider was monitoring the pain.

Nurse's notes and healthcare provider orders documented several pain medication changes over the two months Tenant #4 resided at the program. Nurse reviews were not completed to determine the effectiveness of the medications. LPN #1 stated Tenant #4 would grab the head on both sides when in pain. Tenant #4 frequently had head pain. Pain pills were offered if Tenant #4 was observed holding the head.

LPN #1 indicated Tenant #4 would also verbalize the pain. Tenant #4 would stay in bed but not always because of pain. LPN #1 reported Tenant #4 had constant medication changes and last saw a neurologist for pain.

LPN #2 reported staff members tried to keep Tenant #4 comfortable if staff members reported medication was ineffective. Tenant #4 would verbally report headaches. Tenant #4 would be guarded and not moving, lying still because of the headache. Tenant #4 stayed in bed due to pain.

Staff #1 reported Tenant #4 refused to take medications often. Staff #1 would work with Tenant #4 to take medications. Tenant #4 would not want to get out of bed. Staff #1 would get Tenant #4's mind on another topic. Staff #1 stated Tenant #4 sometimes complained of head pain. Most of the time, Tenant #4 stayed in bed and refused to do things. When Tenant #4 had pain, Tenant #4 stayed in bed and didn't do anything. Pain medications dulled the pain, and Tenant #4 would then talk some after medication was given.

Staff #6 stated a lot of days Tenant #4 did not want to get out of bed due to a headache. It took two people to get Tenant #4 from a lying position to sitting on some days, but most days Tenant #4 could change position by self or with a spouse's help. Staff #6 reported Tenant #4 was in a lot of pain and went to the hospital a lot.

Service plans were reviewed for Tenant #4. The service plans dated 4-22 and 5-3-13 indicated staff was to monitor for headaches twice a day. The clinical record lacked documentation of two-hour checks for headache.

On the service plan 5-6-13 the twice a day headache checks were discontinued and "as needed" medications were listed. On 5-6-13, a nurse review indicated Tenant #4 had no pain relief with repositioning, laying down. It was noted the only relief from pain was medication. The service plan of 5-6-13 indicated Tenant #4 had chronic pain and if Tenant #4 verbalized pain, or showed signs of pain through facial grimacing, wringing of hands, or holding an area of the body, staff was to "offer." The sentence was not completed. On 5-15-13 a fax was sent to the healthcare provider which indicated Tenant #4 could not choose which medication to use for pain. The Program requested the healthcare provider discontinue a medication because the unlicensed staff was unable to assess pain. The service plan of 5-31-13 indicated staff was to offer Toradol if Tenant #4 exhibited signs of pain. Staff interviews indicated Tenant #4 stayed in bed at times because of pain. The service plan did not identify staying in bed as a sign of pain. Cognitive evaluations of 5-31-13 staged Tenant #4 at four on the GDS, indicating moderate cognitive decline. On 6-10-13, Tenant #4 was stated at five on the GDS which indicated moderately severe cognitive decline. The service plans of 6-10 and 6-19 did not provide any further directions or interventions for Tenant #4 with chronic pain and dementia. The service plan did not meet the needs of Tenant #4

- 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))

**E. Nurse Review**

Monitoring Observation: On 5-16-13 Tenant #2 was seen by the healthcare provider for edema in the extremities and possible Congestive Heart Failure. Tenant #2 returned to the program with an order for Furosemide, a water pill, for seven days. A nurse review was not completed with a change of condition.

On 5-3-13, Tenant #4 was sent to the Emergency Room for chest pain and high blood pressure. Tenant #4 returned to the program with an order for a Fentanyl patch. Nurse's notes documented Tenant #4 felt better, but did not identify the location of pain, if any. The blood pressure was not checked upon return. On 5-6-13, Tenant #4 saw the healthcare provider who discontinued the Fentanyl patch and increased Gabapentin for pain. Tenant #4 received an injection of Toradol for pain at the provider's office. On 5-15-13, Gabapentin was increased and Cymbalta was started for pain. A review of the MAR for Tenant #4 for the month of May indicated one dose of Tramadol was given on 5-5-13 for pain. Tenant #4 had some relief after one hour. On 5-10-13 one dose of Toradol was given for pain. Tenant #4 was still having discomfort one hour later. There were no other "as needed" doses of pain medication given during the month of May.

A review of the MAR for Tenant #4 for the month of June indicated seven doses of "as needed" Toradol were given for pain between 6-19 and 6-25-13. The medication was given for back pain, headache, and belly pain. The MAR did not contain documentation to indicate the effect of the medication on the pain on two occasions. On two other occasions, Tenant #4 was out of the facility and staff was unable to determine the effectiveness of the medication.

On 6-17-13, nurse's notes indicated Tenant #4 complained of a severe headache. On 6-20-13 Tenant #4 complained of a headache.

Nurse reviews were not completed with the medication changes to review the effectiveness of the medications for chronic pain in a person with dementia as determined by cognitive evaluations completed by the program.

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

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating

to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

**F. Medications**

Complaint/Incident Allegation: It was alleged medications, insulin and narcotics were placed in plastic bags with the tenant name, day of administration and time to administer but the bag did not include the name of the medication.

- Monitoring Observation: The monitors asked to observe the process of preparing medications for tenant use when a tenant was to be gone from the program for several hours. The program reported there were no tenants leaving the building for any length of time during the onsite visit. A mock medication process for handling medications, insulin, and narcotics for tenants who were leaving the program for a few hours was demonstrated by Staff #1. Staff #1 used hand sanitizer and then checked the MAR for the dose and time of medications for the time period the tenant would be out of the program. The medications were compared to the MAR. Staff #1 wrote the tenant's name on a plastic bag, along with the date and time the medication needed to be given. If a noon medication, a note was written to give the medication between 11:00 A.M. and 1:00 P.M. Staff #1 initialed and circled the time on the MAR and noted on the back side of the MAR the reason medications were sent with the tenant. Staff #1 then signed the MAR. A form was completed by Staff #1 that would be signed by the person taking the tenant out of the building indicating the responsibility of administering the medication, insulin or narcotic. Staff #1 stated she had never sent an as needed narcotic or a scheduled narcotic with a tenant. When a tenant was discharged the nurse handled the process for sending medications with the tenant.

  Staff #2 stated when tenants left the program she found out the time frame the tenant would be gone and put all medications into a medication cup and then placed the cup inside a plastic bag. She labeled the bag with the name and time of the doses. A form was completed for the family member to sign. Staff #2 stated the nurses handled the medications when a tenant was discharged, thus, she was not aware of that process.

  Staff #3 stated the date and time medications were due was put on a baggie and pills were placed in the baggie when a tenant left the program for several hours.

  Staff #5 stated when tenants left the program, medications were placed into a medication cup, and the placed into a plastic baggie. The general time the medications were due was written on the baggie, as well at the tenant's name. The medications were documented on the MAR with a notation the tenant was out of the program.

  The program's policy on medication set-up when a tenant was out of the facility at a scheduled administration time indicated medications were placed in a baggie with the name of the tenant and the time the medications were to be administered. The medications were documented on the MAR. According to the RN/Director, the policy was updated on 7-1-13 to include the use of a sheet to document instructions given to a tenant representative regarding the administration of medications when

tenants were out of the program during a scheduled medication administration time. The policy was updated to include the use of the sheet following concerns raised by a family member.

The program followed its policy on setting up medications for tenants who were planning to be out of the facility during a scheduled medication time. Staff members were verbally or physically able to correctly demonstrate knowledge of the policy.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: The June 2013 MAR was reviewed for Tenant #2. The MAR documented oral medications were set up in a pill minder. Oral medications were placed in the pill minder on the 3rd and the 10th of June, according to the documentation on the MAR. On June 10th, Tenant #2 was receiving Warfarin, a blood thinner, in different doses on alternating days. The MAR lacked documentation that the Warfarin was placed in the pill minder on June 10th.

  The MAR indicated on 6-12-13 the dose of Warfarin changed from different doses on alternating days to one dose of two milligrams (mg) daily. A nurses note dated 6/12/2013 documented the new dose of Warfarin was placed in the pill minder on June 12th; however, this was not documented on the MAR. The MAR indicated the program changed from a pill minder to administering pills individually. According to the RN/Director, a bubble-pack system was initiated on 6-17-13. Warfarin was documented as given beginning 6-17-13.

  There was no documentation on the MAR that Warfarin was placed in the pill minder 6-10-13 through 6-16-13 and administered to Tenant #2. A bubble-pack system was initiated on 6-17-13.

  According to the June 2013 MAR for Tenant #2, two tablets of Hydrocodone/APAP 5/325 mg was ordered to be given daily at bedtime beginning 6-12-13. The MAR documented the dose was given as prescribed beginning 6-12-13 through the end of June 2013. The narcotic record for Tenant #2 was reviewed. The narcotic records did not contain documentation on 6-25-13 that the Hydrocodone/APAP was signed out. The narcotic count sheet was reviewed for June 2013. There was no documentation the count was off. Tenant #2 was not given Hydrocodone/APAP on 6-25-13.

  Tenant #2 did not receive medications as prescribed.

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

## G. Policies and Procedures

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

- Monitoring Observation: Tenant #3 was given a 30-day discharge notice by the program on 7-11-13. According to the program's procedure for involuntary discharge, the 30-day notice was to include an objective to be met which may avert discharge. The notice to Tenant #3 did not include an objective to possibly avert discharge. The program did not follow its procedure for involuntary discharge.

- 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)