IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

October 28, 2013

Mr. Jamie Scherer, AL Manager
Sylvan Woods Assisted Living
2 Pennsylvania Place
Ottumwa, IA 52501

RE: Final Recertification Monitoring Evaluation Report – Sylvan Woods Assisted Living, Ottumwa, IA

Dear Mr. Scherer:

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 **S0022** with effective dates of **December 1, 2013** through **November 30, 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:

Jamie Scherer, RN, AL Manager
Sylvan Woods Assisted Living
2 Pennsylvania Place
Ottumwa, IA 52501

Date of Monitoring Visit:

August 7, 2013

Monitor(s):

Stephanie Cummins, MA
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 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:	3
Total Population of Program at time of on-site	33

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	13
Total Population of Program at time of on-site	15
TOTAL census of Assisted Living Program	48

Tenant/Family Satisfaction Results – A community meeting with 17 tenants was held. Housekeeping services were completed to their satisfaction. The building and grounds were safe, clean and sanitary. There were no improvements provided. Nursing services were available and the tenants described them as very competent. They said it took approximately 10 to 15 minutes for staff to come when tenants called. The tenants said the response time varied and at night the times could be longer. They were getting all the services expected when the occupancy agreement was signed. They described the care received as good and said staff treated them fine, very good and excellent. Staff knew what services to provide and the majority of the tenants said staff was trained to provide those services. Some of the tenants liked the food. There were too many pre-cooked items and the tenants requested less repetition and more variety of foods. Staff served tenants appropriately and cold foods were served cold. The temperature of some of the hot foods needed improvement. There were enough activities offered and they enjoyed Bingo, Wii Bowling, bus tours, entertainment and poetry. They received a sheet every week with activities. The tenants commented the television in the dining room was too dark. The tenants felt safe and there were no problems with safety. They made their own decisions. The tenants were generally satisfied with the Program and would recommend it to others. A comment was made that if one could not be at home it was a nice place to be.

Program History – During the course of the Recertification visit conducted on August 7, 2013, the Program received regulatory insufficiencies in the areas of: Evaluation of Tenant, Service Plan, Medications, and Other.

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

A. Evaluation of Tenant

Monitoring Observation: Five tenant files were reviewed.
Tenant #1, a 97 year old, was admitted on 9-27-10 and diagnoses included: Ataxia, Depression, Benign Prostate Hypertrophy, Insomnia, Vertigo, Peripheral Neuropathy, and Alzheimer's Disease. Tenant #1 was staged a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. According to Resident Notes on 7-16-13, Tenant #1 was walking to lunch with staff and Tenant #1 said Tenant #1 was tired. Tenant #1 wanted to sit on the seat of the walker and Tenant #1 could not turn around to sit on the seat and just basically sat on the floor. On 7-17-13 Tenant #1 was unable to walk to the dining room and activity. The note indicated Tenant #1 continued to decline with mobility. According to Resident Notes dated 7-24-13, Tenant #1 was assisted into the small elevator and Tenant #1 was not able to stand. Tenant #1 started to go down and staff held Tenant #1 up while standing behind Tenant #1. On 7-28-13 Tenant #1 fell forward off the shower chair. Three staff could not get Tenant #1 up. According to Resident Notes dated 7-29-13, it was noted again Tenant #1 had difficulty with ambulation. Tenant #1 had to sit down and almost fell. Family was to be notified for need for a higher level of care or Hospice. According to Resident Notes dated 7-31-13, there was a discussion with family regarding Tenant #1's level of care. Tenant #1 had decreased mobility, increased falls, Tenant #1 needed two assist with Activities of Daily Living (ADLs) and had unmanageable incontinence. Functional, cognitive and health evaluations were not completed as needed with significant change.

Tenant #2, an 82 year old, was admitted on 3-8-13 and diagnoses included: History of Appendectomy, Cholecystectomy, Cataract Surgery, Moderate-Severe Dementia Alzheimer's Type, Chronic Constipation, Hyperlipidemia, Irritable Bowel Syndrome, Gastro Esophageal Reflux Disease (GERD) and Anemia. Tenant #2 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #2 resided in the dementia unit. According to Resident Notes dated 6-3-13, Tenant #2 had spells of agitation and was hard to redirect at times. The Resident Notes dated 6-4-13 indicated Depakote was increased due to erratic mood changes and being unable to redirect. Tenant #2 was disruptive with staff and visitors. On 6-26-13 Resident Notes indicated Tenant #2 had edema and Tenant #2 had difficulty walking. According to a 90 Day Review in Resident Notes dated 7-8-13, on 6-28-13 Tenant #2 had a choking spell with a potassium pill and was sent to the Emergency Room (ER) and potassium was changed to liquid. Orders were received to crush medications except, Depakote. According to Resident Notes dated 7-17-13, Tenant #2 had increased agitation and urinated on the floor, which was new for Tenant #2. Resident Notes dated 7-22-13 indicated Tenant #2 had a rough weekend, had decreased mobility, needed to use the wheelchair and had poor intake. Resident Notes dated 7-31-13 indicated Tenant #2 had trouble defecating and was given an enema. According to Resident Notes dated 7-31-13, Tenant #2 had more difficulty with gait and balance was off. Tenant #2 was leaning forward and staff used a wheelchair for long distances and a walker in the room. Resident Notes dated 8-6-13 indicated Tenant #2 needed to be fed that a.m. There was a visit with Tenant #2's family regarding considering a higher level of care. Tenant #2 had decreased mobility, needed to be fed and more cues with ADLs. Functional, cognitive and health evaluations were not completed as needed with significant change.

Tenant #3, an 84 year old, was admitted on 10-12-09 and diagnoses included: Fracture of Right Hip with Repair, Diverticulitis, Colon Cancer, Chronic Diarrhea, Anxiety, Heart Palpitations, Dementia, GERD, Hyperlipidemia, Atrial Fibrillation, Vertigo and Anemia. Tenant #3 was staged at a five on the GDS, which indicated moderate severe cognitive decline. Tenant #3 resided in the dementia unit. According to an Event Record on 7-3-13 at 3:00 P.M., Tenant #3 was seen with Tenant #4 at "each other. Arms flying each resident." Staff went to help as Tenant #3 fell to the floor. An indentation in the wall was found near where Tenant #3's left side of head hit. Physical Injury/Concerns were fall, bump to top of head. Tenant #3 complained of right hip pain when Emergency Ambulance Personnel arrived and was sent for evaluation and treatment. According to Resident Notes dated 7-3-13 at 3:00 p.m., Tenant #3 was sent to the ER after a fall and altercation with another tenant. Family was notified. Resident Notes dated 7-3-13 indicated Tenant #3 returned from the ER via private car with a diagnosis of a Head Injury. Functional, cognitive and health evaluations were not completed as needed with significant change.

Tenant #4, an 86 year old, was admitted on 4-20-11 and diagnoses included: Alzheimer's Type Dementia, Arthritis, Depression with Anxiety, Diarrhea, Fatigue, Anemia, Arthralgia's with Multiple Sites, Hypertension, Numbness and Tingling, Back Pain, History of Fractured Tailbone, Back Pain Chronic and Hip, Neck Pain/Side of Head Chronic since 1-11-13. Tenant #4 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit. According to Resident Notes dated 7-8-13, 90 Day Nurse Review, Tenant #4 had increased agitation noted and was confrontational with others at times, Tenant #4's physician had seen Tenant #4 at the Program and increased Seroquel to 25 milligram (mg) orally every a.m. for this. A urinalysis (UA) was done and was negative to rule out a Urinary Tract Infection (UTI). On 6-28-13 Seroquel was discontinued and Haldol 1 mg orally twice a day was started. Tenant #4 packed clothes on 6-28-13 and thought others were packing the clothes. The physician was notified and Haldol was increased to 2 mg orally twice a day and 1 mg every hour as needed for severe agitation. Functional, cognitive and health evaluations were not completed as needed with significant change.

Review of tenant files indicated functional, cognitive and health evaluations were not completed as needed with significant change.

Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Service Plan

Monitoring Observation: Five tenant files were reviewed.

Tenant #1's file was reviewed. According to Resident Notes, on 7-16-13 Tenant #1 was walking to lunch with staff and Tenant #1 said Tenant #1 was tired.

Tenant #1 wanted to sit on the seat of the walker and Tenant #1 could not turn around to sit on the seat and just basically sat on the floor. On 7-17-13 Tenant #1 was unable to walk to the dining room and activity. The note indicated Tenant #1 continued to decline with mobility. According to Resident Notes dated 7-24-13, Tenant #1 was assisted into the small elevator and Tenant #1 was not able to stand. Tenant #1 started to go down and staff held Tenant #1 up while standing behind Tenant #1. On 7-28-13 Tenant #1 fell forward off the shower chair. Three staff could not get Tenant #1 up. According to Resident Notes dated 7-29-13, it was noted again Tenant #1 had difficulty with ambulation. Tenant #1 had to sit down and almost fell. Family was to be notified for need for a higher level of care or Hospice. According to Resident Notes dated 7-31-13, there was a discussion with family regarding Tenant #1's level of care. Tenant #1 had decreased mobility, increased falls, Tenant #1 needed two assist with ADLs and had unmanageable incontinence. The service plan was not updated as needed and did not reflect the identified needs of Tenant #1.

Tenant #2's file was reviewed. According to Resident Notes dated 6-3-13, Tenant #2 had spells of agitation and was hard to redirect at times. The Resident Notes dated 6-4-13 indicated Depakote was increased due to erratic mood changes and being unable to redirect. Tenant #2 was disruptive with staff and visitors. On 6-26-13 Resident Notes indicated Tenant #2 had edema and Tenant #2 had difficulty walking. According to a 90 Day Review in Resident Notes dated 7-8-13, on 6-28-13 Tenant #2 had a choking spell with a potassium pill and was sent to the ER and potassium was changed to liquid. Orders were received to crush medications except, Depakote. According to Resident Notes dated 7-17-13, Tenant #2 had increased agitation and urinated on the floor, which was new for Tenant #2. Resident Notes dated 7-22-13 indicated Tenant #2 had a rough weekend, had decreased mobility, needed to use the wheelchair and had poor intake. Resident Notes dated 7-31-13 indicated Tenant #2 had trouble defecating and was given an enema. According to Resident Notes dated 7-31-13, Tenant #2 had more difficulty with gait and balance was off. Tenant #2 was leaning forward and staff used a wheelchair for long distances and a walker in the room. Resident Notes dated 8-6-13 indicated Tenant #2 needed to be fed that a.m. There was a visit with Tenant #2's family regarding considering a higher level of care. Tenant #2 had decreased mobility, needed to be fed and more cues with ADLs. The service plan was updated on 6-4-13 and indicated increased agitation; doctor was notified and increased Depakote. On 7-31-13 the service plan was updated and reflected decreased mobility and cues with feeding. The service plan was not updated as needed and did not reflect the identified needs of Tenant #2.

Tenant #3's file was reviewed. Tenant #3's annual service plan was dated 4-16-13. According to an Event Record on 7-3-13 at 3:00 P.M., Tenant #3 was seen with Tenant #4 at "each other. Arms flying each resident." Staff went to help as Tenant #3 fell to the floor. An indentation in the wall was found near where Tenant #3's left side of head hit. Physical Injury/Concerns were fall, bump to top of head. Tenant #3 complained of right hip pain when Emergency Ambulance Personnel arrived and was sent for evaluation and treatment. According to Resident Notes dated 7-3-13 at 3:00 p.m., Tenant #3 was sent to the ER after a fall and altercation with another tenant. Family was notified. Resident Notes dated 7-3-13 indicated Tenant #3 returned from the ER via private car with a diagnosis of a Head Injury. The service plan was not updated as needed and did not reflect the identified needs of Tenant #3.

Tenant #4's file was reviewed. According to Resident Notes dated 7-8-13, 90 Day Nurse Review, Tenant #4 had increased agitation noted and was confrontational with others at times, Tenant #4's physician had seen Tenant #4 at the Program and increased Seroquel to 25 mg orally every a.m. for this. A UA was done and was negative to rule out a UTI. On 6-28-13 Seroquel was discontinued and Haldol 1 mg orally twice a day was started. Tenant #4 packed clothes on 6-28-13 and thought others were packing the clothes. The physician was notified and Haldol was increased to 2 mg orally twice a day and 1 mg every hour as needed for severe agitation. According to an Event Record on 7-3-13 at 3:00 P.M., Tenant #3 was seen with Tenant #4 at "each other. Arms flying each resident." Staff went to help as Tenant #3 fell to the floor. Documentation of this event was not reflected in Tenant #4's file. An undated document titled Care Plan addition indicated Tenant #4 would not make contact or touch Tenant #2, staff would redirect and help Tenant #4 understand the situations if any arose. Staff was educated and the family, nurse and manager were notified of Tenant #4's behavior and revenge towards another tenant. The service plan was not updated as needed and did not reflect the identified needs of Tenant #4.

Review of tenant files indicated service plans were not updated as needed and did not reflect the identified needs of the tenants.

Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3))

Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

C. Medications

Monitoring Observation: A medication pass was observed with Staff #1. Medications were administered to five tenants. Staff #1 was consistent in washing her hands or using hand sanitizer. Staff #1 greeted the tenants and informed them she was there to assist with their medications. She would unlock the medication cabinet and remove the bubble pack cards, punch out the medication into a medication cup and hand the medication to the tenant. In four out of five tenants, Staff #1 did not check the medications against the Medication Administration Record (MAR) prior to offering the medications to the tenants. After the tenants took the medications, Staff #1 would open up the MAR or take it out of the sleeve on the medication cabinet door and document the medication(s) had been given.

According to a Program document, the bubble pack cards should be compared against the MAR prior to removing the pills from the bubble pack cards and prior to putting the medications into a medication cup. The Medication Management Agreement stated MARs would be carried by each person administering medications each time they entered a tenant's apartment to administer medications and would be verified at the time of administration, documentation of administration would be completed at that time.

According to the RN, AL Manager, Staff #1 did not complete the medication pass per Program expectations.

The Program did not follow accepted professional standards for medication administration.

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))

D. Other

Monitoring Observation: Seven staff files were reviewed.

Staff #2 was hired on 7-17-12 and had a Mandatory Reporter Dependent Adult and Child Abuse combined course completed on 7-17-12. The course was listed as two hours for Continuing Education Units (CEUs). The course was completed within six months of hire; however, the course was a combined dependent adult and child abuse course.

Staff #3 was hired on 11-19-12 and had a Mandatory Reporter Dependent Adult and Child Abuse combined course completed on 11-20-12. The course was listed as two hours for CEUs. The course was completed within six months of hire; however, the course was a combined dependent adult and child abuse course.

Staff #4 was hired on 11-12-12 and had a Mandatory Reporter Dependent Adult and Child Abuse combined course completed on 11-12-12. The course was listed as two hours for CEUs. The course was completed within six months of hire; however, the course was a combined dependent adult and child abuse course.

Staff #5 was hired on 6-28-12 and had a Mandatory Reporter Dependent Adult and Child Abuse combined course completed on 6-28-12. The course was listed as two hours for CEUs. The course was completed within six months of hire; however, the course was a combined dependent adult and child abuse course.

Review of staff files indicated staff did not have two hours of dependent adult abuse training.

Regulatory Insufficiency: A person required to report cases of dependent adult abuse pursuant to sections 235B.3 and 235E.2, other than a physician whose professional practice does not regularly involve providing primary health care to adults, shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment or self-employment which involves the examination, attending, counseling, or treatment of adults on a regular basis. Within one month of initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person's employer or, if self-employed, from the department. The person shall complete at least two hours of additional dependent adult abuse identification and reporting every five years. (IAC r. 481-235B.16.5.b)