IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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October 30, 2013

Ms. Cyndi Rector, Nurse Manager
Deerfield Place Assisted Living
505 East Gilman Street
Sheffield, IA 50475

RE: Final Recertification Monitoring Evaluation Report – Deerfield Place Assisted Living, Sheffield, IA

Dear Ms. Rector:

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 **S0304** with effective dates of **December 4, 2013** through **December 3, 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
Final Recertification Monitoring Evaluation Report

Assisted Living Program:

Cyndi Rector RN, Nurse Manager
Deerfield Place Assisted Living
505 East Gilman Street
Sheffield IA 50475

Date of Monitoring Visit:

September 18th and 19th, 2013

Monitor(s):

Lori Miner, RN BSN

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

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

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

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

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	15
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	16
TOTAL census of Assisted Living Program	16

Tenant/Family Satisfaction Results – A meeting was held with 14 tenants. The best thing about the program was having everything done for them, never being alone, the availability of help, and prepared meals. Housekeeping was completed in apartments and common area to tenants' satisfaction. Maintenance responded to requests in a timely manner. Tenants used a call pendant to request assistance. Staff members were reported to respond in less than five minutes. Staff members were described as being very good, and treating tenants kindly and respectfully. Food was mostly good, and most of the time food was served hot. Sometimes the food was not as flavorful as the tenants would have liked. Sometimes food seemed tough and overcooked. Activities were provided and card games were well received. The activities were perceived as being mostly for the women, and more activities for the men were requested, including a pool table. Tenants reported feeling safe at the program and would generally recommend it to others.

Program History – During the course of the Recertification visit conducted on September 18 and 19, 2013, the program received regulatory insufficiencies in the areas of Tenant Documents, Evaluation, Nurse Review, Service Plan, Staffing, Background Checks and Food Safety.

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

A. Evaluation of Tenant

Monitoring Observation: Tenant #2, a 94 year-old, was admitted on 3-12-13 and had diagnoses of: Hypertension, Restless Leg Syndrome, and Atrial Fibrillation. Tenant #2 was staged at two on the Global Deterioration Scale (GDS) which indicated very mild cognitive decline. Evaluations of function, cognition, and health were completed on 3-11-13 and 4-13-13. Nurse's notes of 4-13-13 indicated Tenant #2 was on Coumadin, a blood thinner. The clinical record was reviewed. The clinical record contained home care instructions dated 4-22-13 which were for wrist fracture and facial fracture. A physician order sheet dated 4-22-13 indicated Tenant #2 had a right orbital blowout fracture and an ophthalmologist was to be consulted if there were concerns about ongoing vision changes. The Registered Nurse (RN) stated it was later determined there had not been an orbital blowout fracture. The RN stated Tenant #2 elected to not have surgery to repair the wrist fracture. The clinical record contained no further evaluations of function, cognition, and health, and the nurse's notes lacked documentation of the incident which

resulted in the fracture. The nurse's notes lacked any documentation of Tenant #2's condition at the time of the incident. The program was asked to provide an incident report documenting the event which resulted in the fracture and was unable to do so. Evaluations were not completed with a change of condition.

Tenant #3, an 88 year-old, was admitted on 3-17-11 and had diagnoses of: Hypertension, Glaucoma, Diverticulosis, Anemia, and Dependent Edema. Tenant #3 had no cognitive decline in a cognitive evaluation completed 3-12-13. The annual evaluation form dated 3-12-13 had space provided for documentation of vital signs; however, none were documented. The evaluation form was not completed.

Tenant #3 had an order dated 8-6-13 for Oxycontin 20 milligrams (mg) every 12 hours. According to the nurse's notes dated 8-22-13, Oxycontin was increased to 30 mg every 12 hours and an xray was ordered of the left hip and lower back. The clinical record contained documentation dated 9-16-13 of a phone call between a family member and Tenant #3's physician's office. The family member called regarding Tenant #3's pain, and documented the family member thought the pain may have been worse. The documentation indicated Tenant #3 had a good day because he/she was able to get up and go to the dining room to eat. On 9-17-13, the Oxycontin was increased to 40 mg according to the nurse's notes. Oxycodone was also prescribed "as needed" every 3-4 hours. Oxycodone was given at least 20 times during the month of August and September according to the MAR. Oxycontin was increased twice in less than one month. Supplemental Oxycontin was used 20 times each during August and September. Evaluations were not completed with the change of condition to determine the location and type of pain, the effectiveness of the medication, and the ability to provide self-cares.

Tenant #4, an 89 year-old, was admitted on 5-4-13 and had diagnoses of: Hypertension and Osteoporosis. Tenant #4 was staged at two on the GDS which indicated very mild cognitive decline. An evaluation was completed on 5-30-13, within 30 days of admission; however, the evaluation form had space provided for documentation of vital signs and none were documented. The evaluation form was not completed.

Nurse's notes dated 9-16-13 documented Tenant #4 experienced an increase in confusion during the past week. A urinalysis was completed on 9-13-13 and no new orders were received. A notation on the urinalysis results by the RN indicated Tenant #4 was experiencing increased confusion and verbally aggressive behavior. Staff #2 was interviewed and stated Tenant #4 thought everyone belonged to a cult and had the other tenants in an uproar. Staff #2 reported the RN was called to handle the situation. Evaluations were not completed with a 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))

B. Tenant Documents

Monitoring Observation: The clinical record for Tenant #2 was reviewed. The clinical record contained home care instructions dated 4-22-13 which were for wrist fracture and facial fracture. A physician order sheet dated 4-22-13 indicated Tenant #2 had a right orbital blowout fracture and an ophthalmologist was to be consulted if there were concerns about ongoing vision changes. The program was asked to provide an incident report documenting the event which resulted in the fracture(s) and was unable to do so.

Physician's orders dated 8-6-13 prescribed support stockings. The support stockings were not on the MAR for August 2013 and were not placed on the September MAR until 9-19-13. A physician-ordered task was not on the MAR.

Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: (o) Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record); and (IAC r. 481-69.25(1)(o))

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

C. Service Plan

Monitoring Observation: The nurse's notes for Tenant #2 were reviewed. Notes of 4-13-13 noted Tenant #2 had increased incontinence and was using incontinence products. On 6-4-13 the RN sent a note was sent to the physician asking for medication for incontinence as Tenant #2 was saturating incontinence products and Tenant #2 did not seem to realize he/she was urinating. The note also requested a medication for the strong urine odor. Nurse's notes of 6-20-13 indicated orders were received as requested. Chlorophyll was ordered as one to three tablets as needed for the strong urine odor according to the MARs. Staff #2 was interviewed and stated staff members needed to do Tenant #2's laundry frequently due to incontinence. A nurse's note dated 7-19-13 indicated staff members kept laundry and garbage picked up related to the incontinence. The current service plan, dated 4-13-12, did not identify Tenant #2 saturated depends, and did not give staff direction on administration of the "as needed" Chlorophyll for urine odor or to the frequency the laundry and garbage needed attention.

The service plan was not updated to include care of the wrist fracture, any cares related to a head injury, the use of a brace as indicated in the 7-19-13 nurse's notes, and PT. The current service plan did not indicate the use of a wheeled walker as indicated in the 7-19-13 nurse's note.

The current service plan for Tenant #3 indicated the program administered the medications. Nurse's notes dated 3-12-13 and MARs documented Tenant #3 self-administered gas relief medication and Cholestyramine. The service plan did not meet the identified needs of the tenant.

Tenant #4 was admitted to the program on 5-4-13. Evaluations of function, cognition and health were completed on 4-30-13. The initial service plan was not signed until 5-6-13. A service plan was not completed prior to admission

Tenant #4 exhibited verbally aggressive behavior as documented in a note to the physician on the results of a urinalysis. The service plan of 5-30-13 was not updated to include interventions for the verbal aggression.

Tenant #4 received Physical Therapy (PT) for a gait abnormality and history of fall. PT provided services between 8-20 and 9-3-13. Tenant #3 was discharged from PT after reaching a plateau. The current service plan dated 5-30-13 was not updated with the outside service provider PT.

Service plans were not completed prior to admission, did not meet identified needs of the tenants, and did not identify outside service providers.

Regulatory Insufficiency: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

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

Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (c) The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy. (IAC r. 481-69.26(4)(c))

D. Medications

Monitoring Observation: The following information was found on Tenant Medication Administration Records (MAR)

Tenant #1	No documentation of a blood sugar result on 7-5,7-15, and 7-28
	No documentation of Lantus administration at 8 p.m. on 7-15
	No documentation of Tamsulosin administration on 7-15
	No documentation of Novolog administration on 7-1, 7-3, 7-5, 7-6,7-8, 7-9, and 7-12 at 5:30 p.m.
	No documentation of a blood sugar result on 8-11, 8-14, 8-16, and 8-28
	No documentation of Novolog administration on 8-13
.	No documentation of a blood sugar result on 9-1 and 9-16
	No documentation of Donepezil administration on 9-17
	No documentation of Novolog administration on 9-4 and 9-16 at 11:30 a.m.

Tenant #2	Metoprolol to be held if pulse less than 55. Pulse not documented on 8-14, 8-15, 8-20, and 8-25.
Tenant #3	Metoprolol to be held if pulse less than 60. Pulse not documented on 8-24, 8-25, and 8-31.
	Gleevec was not documented as given on 8-30. Oxycontin was not documented as given on 8-24 at 8:00 a.m. Amitriptyline was not documented as given on 8-30.
Tenant #4	There was no documentation that 8:00 a.m. medications were given on 8-24.
	Metoprolol to be held if pulse less than 55. Pulse not documented on 8-24. 8-27, and 8-28.

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))

E. Nurse Review

Monitoring Observation: Tenant #1, an 82 year-old, was admitted on 10-1-10 and had diagnoses of: Diabetes, Hypertension, Chronic Renal Insufficiency, and Confusion. Tenant #1 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive decline. The service plan dated 9-27-12 indicated Tenant #1 needed reminders for bathing and the program administered medications. Nurse reviews were completed on 4-1-13 and 8-1-13. Nurse reviews were not completed every 90 days. The nurse review did not indicate whether or not Tenant #1 was experiencing adverse reactions to medications.

The August and September 2013 Medication Administration Records (MAR) were reviewed for Tenant #1. The printed MARs indicated one-half tablet of Donepezil 10 milligrams (mg) was to be taken at bedtime. The "one-half" was crossed out, and a handwritten note indicated one whole tablet was to be taken at bedtime. The entries did not include time, date, and signature of the person making the change to the MAR.

Tenant #2 sustained a right wrist fracture and head injury in April 2013. An order was received for Physical Therapy on 5-9-13 for walker safety and training. Therapy was completed on 6-7-13. A nurse review was not completed to determine Tenant #2's functional ability with the use of the walker.

The August and September 2013 MARS were reviewed for Tenant #2. The August MAR had handwritten entries for Trospium and Iron and the September MAR had a handwritten entry for Iron. The entries did not include time, date, and signature of the person making the change to the MAR.

The RN stated Tenant #2 elected not to have surgery to repair the right wrist fracture. The RN stated Tenant #2 would have chronic pain related to the fracture in the wrist.

The July 2013 MAR documented Tenant #2 was given Hydrocodone 11 times. Hydrocodone was given 15 times in August and three times in September. The MARs contained no other listings of available pain medications. A nurse review was not completed to determine Tenant #2's level of pain and the ability of Hydrocodone to control the pain.

A 90-day nurse review was completed for Tenant #2 on 7-19-13. According to the service plan dated 4-13-13, the program administered medications. The 90-day nurse review did not indicate whether or not Tenant #2 was experiencing adverse reactions to medications.

The August 2013 MAR was reviewed for Tenant #3. A handwritten entry for Oxycontin was present; however, the entry did not include date, time, and signature of the person making the change to the MAR. The September 2013 MAR contained a typed entry for Oxycontin 30 mg, one tablet every 12 hours. A handwritten note was contained in the same space which indicated the dosage had been changed to 40 mg. The handwritten entry did not contain a time and signature of the person making the change to the MAR.

A 90-day nurse review was completed on 6-12-13. The review did not evaluate Tenant #3's health status and did not indicate whether or not Tenant #3 was experiencing adverse reactions to medications. A 90-day nurse review was not completed by 9-12-13. A nurse review was not completed every 90 days.

The clinical record for Tenant #4 contained documentation of PT between 8-20 and 8-3-13. The PT documentation indicated Tenant #4 plateaued and PT services were discontinued. The nurse's notes dated 8-15-13 indicated Tenant #4 saw the physician and PT was ordered. A copy of a physician's prescription pad note dated 8-15-13 indicated Tenant #4 had facial trauma on 8-7-13 and PT was ordered for neck pain. PT notes indicated Tenant #4 had a history of a fall and gait abnormality. A nurse review was not completed following an injury and was not completed to determine Tenant #4's functional ability prior to the start of PT. On 9-4-13 with the 90-day review and approximately one month after injury, the RN documented Tenant #4 fell while out of the program with family and sustained a bruise to the left side of the face. A nurse review was not completed with a change of condition.

The 90-day nurse review did not indicate whether or not Tenant #4 was experiencing adverse reactions to medications which the program administered.

The August 2013 MAR was reviewed for Tenant #4. A handwritten entry indicated Meloxicam was ordered daily. The entry did not contain a time, date, or signature of the person making the change to the MAR.

Nurse reviews were not completed with changes in condition, every 90 days when the program provided services, and did not document the health status of a tenant, or any adverse reactions from program-administered medications. MARs did not contain a time, date, or signature when medications were changed.

Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide

for a registered nurse or a licensed practical nurse via nurse delegation: 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; and (IAC r. 481-69.27(3))

Regulatory Insufficiency: To provide the program with written documentation of the activities under the service plan, as set forth in rule 481—69.26(231C), showing the time, date and signature. (IAC r. 481-69.27(4))

F. Food Service

Monitoring Observation: Staff #2, Universal Worker (UW) was observed serving food to tenants on two occasions during the onsite visit. Staff #1 was hired 12-2-09 as a UW. Staff training records contained an undated certificate for completion of a food safety course. There was only one certificate of completion of a food safety course in the training file. The program did not provide documentation of completion of a food safety course annually.

Staff #2 was hired 5-15-12 as a UW. Staff training records contained one certificate dated 12-15-12 for completion of a food safety class, seven months after hire. The program did not provide documentation of completion of a food safety course prior to serving food.

Staff training records were reviewed for Staff #3, #4, and #5, all hired as UW's since January 2013. All three files contained an undated certificate of completion of a food safety course. The program did not provide documentation of completion of a food safety course prior to serving food.

The program did not provide documentation of food safety training prior to handling food and at least annually for five employees employed as UW's involved in serving food.

Regulatory Insufficiency: Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (IAC r. 481-69.28(5))

G. Staffing

Monitoring Observation: The service plan for Tenant #1 was reviewed. Tenant #1 received insulin four times a day and sliding scale insulin. Staff #2 was interviewed and stated Tenant #1 required staff members to inject the insulin. The Medication Administration Record (MAR) for Tenant #1 was reviewed for August and September 2013. Staff #5 documented the administration of insulin on approximately 10 occasions

during that timeframe. The program was asked to provide documentation of nurse-delegated training for Staff #5. The Registered Nurse (RN) stated she had not completed nurse delegated training for Staff #5. The RN confirmed Tenant #1 required staff to inject the insulin.

Staff #5 had administered insulin by injection to Tenant #1 on approximately 10 occasions during August and September 2013. Tenant #1 received insulin four times a day and sliding scale insulin. Staff #5 lacked training on the administration of insulin. There was no documentation of any nurse delegated training for Staff #5, employed since 7-1-13.

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

H. Record Checks

Monitoring Observation: : Staff #3 was hired 4-25-13 as a UW. Background checks were completed on 4-17-13. Staff #3 was not found on the child or dependent adult abuse registries. The criminal history check indicated further research was required. The Division of Criminal Investigation returned a record on 4-19-13. The program was unable to provide documentation from the Department of Human Services indicating Staff #3 was able to work at the program.

Regulatory Insufficiency: Pursuant to Iowa Code section 135C.33, a prospective employee of a program shall have a criminal history check, dependent adult abuse check, and child abuse check performed before the prospective employee begins work. If a prospective employee has a criminal history or an abuse history, the prospective employee shall not be employed by the program unless the department of human services has performed an evaluation and determined that the record does not warrant the employment prohibition. Proof of the preemployment background check shall be maintained in the program's employee file. The program must meet all requirements of Iowa Code section 135C.33 and administrative rules adopted pursuant to Iowa Code section 135C.33. (IAC r. 481-67.9(3))