IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
45645-C
45647-C

November 20, 2013

Ms. Nwaneka Eke, *Administrator*
Rose of Des Moines
1330 19th Street
Des Moines, IA 50314

RE: Final Complaint/Incident Investigation Report, Rose of Des Moines, Des Moines, Iowa

Dear Ms. Eke:

Enclosed is the **Final 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 reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC. The Request for Reconsideration in the area of Policy and Procedures has been accepted.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Nwaneka Eke, Administrator
The Rose of Des Moines
1330 19th Street
Des Moines, IA 50314

Complaint/Incident Intake #: 45645-C
45647-C

Date of Complaint/Incident Investigation:

October 22 and 23, 2013

Monitor(s):

Lori Miner, RN BSN
Maribeth Freland, RN

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

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

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

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

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	46
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	48
TOTAL census of Assisted Living Program	48

Program History – The program received a regulatory insufficiency in the area of Record Checks during the August 28, 2013 Recertification on-site.

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

A. Involuntary Discharge

Complaint/Incident Allegation: 45645-C- It was alleged a tenant was given a 30-day notice of discharge without adequate reason.

- Monitoring Observation: The program identified only one tenant, Tenant #4, who had been given a 30-day notice of involuntary discharge from the program. The monitors reviewed the clinical record of Tenant #4. The monitors reviewed the clinical record of two discharged tenants, Tenants #2 and #8, both who voluntarily moved from the program.

  Tenant #2, a 54 year-old, was admitted on 3-7-12 and had diagnoses of: Diabetes, Hypertension, Osteoarthritis, Asthma, and Kidney Cyst. Progress notes dated 9-27-13 indicated Tenant #2 moved to independent living. Tenant #2 was voluntarily discharged.

  Tenant #4, a 63 year old, was admitted to the program on 6-23-13 and currently resided at the program. Tenant #4 had diagnoses of Hypertension, Chronic Obstructive Pulmonary Disease, Chronic Pain and Schizophrenia. Tenant #4 answered all but two questions on the Mini Mental Status Examination completed on 8-29-13, indicating no cognitive impairment to mild cognitive impairment.

  Initially Tenant #4 received medication set up and a general assessment from a registered nurse once weekly and home health aide assistance with bathing and dressing due to weakness. Tenant #4 refused home health aide visits on 8/12/13,

8/19/13 and 8/29/13. (Tenant #4's clinical record lacked any further documentation of refusal of home health aide services.)

According to clinical notes, Tenant #4 missed one noon dose of medications on 8-15-13 but had been compliant with all other doses in that seven day period. On 8-22-13 Tenant #4 had gotten up late so had not yet taken his/her pain medication, causing the pain to become excruciating.

The health and functional assessment, completed on 8-29-13, indicated Tenant #4 was alert and oriented to person, place and time. Tenant #4 was independent with eating, transfers and toileting. The assessment documented Tenant #4 required staff member assistance with grooming, dressing and bathing. Tenant #4 was able to ambulate independently using a walker. The nurse noted Tenant #4 exhibited some weakness and deconditioning. Physical therapy was initiated to work on strength training and ambulation. The therapist set goals for Tenant #4 to be independent with a home exercise program and to be able to ambulate 80 feet with a step through pattern to allow getting to the elevator in 8 weeks.

According to clinical notes, on 9-12-13 Tenant #4 had not taken a pain pill, again causing his/her pain to become excruciating.

On 9-13-13 the home health aide contacted the nurse to report Tenant #4's family were expressing concerns that Tenant #4 was "not acting right" and questioned if Tenant #4 needed to go to the hospital. The nurse told the home health aide to tell the family to take Tenant #4 to the emergency room for medical evaluation. The family discussed and made the decision to take Tenant #4 to the hospital.

On 9-16-13 the nurse returned to work from the weekend off, to discover Tenant #4 had not gone to the hospital as previously planned. Tenant #4 had refused to be taken to the hospital. The family summoned law enforcement and Tenant #4 also refused law enforcement attempts to get Tenant #4 to be medically evaluated.

On 9-17-13 the home health aides reported Tenant #4 required more assistance than usual while bathing and dressing and appeared to be off mentally. The nurse immediately went to Tenant #4's apartment. Tenant #4's significant other was present and assisting Tenant #4 with tasks that were usually performed independently by Tenant #4. Tenant #4 was oriented to person and place but not date or time, was having difficulty recalling recent events and reported he/she felt fatigue, had body aches and was having urinary symptoms indicative of a urinary tract infection. Tenant #4 denied hallucinations. The nurse administered Tenant #4's Risperdal (an antipsychotic medication) injection two days early after contact with Tenant #4's psychiatric physician.

On 9-18-13 the nurse contacted Tenant #4's medical physician, obtaining an order for a urinalysis and a basic metabolic panel to consider urinary tract infection or an electrolyte imbalance as reasons for Tenant #4's changes.

On 9-18-13 the home health aides again told the nurse Tenant #4 was completely dependent with dressing and other activities of daily living. Once during the day, Tenant #4 pushed the pendent requesting assistance. When staff members arrived at

Tenant #4's apartment, he/she did not recognize any of his/her noon medications. Tenant #4 appeared to be confused.

On 9-19-13 a meeting was held with program staff members and Tenant #4's family. The program expressed concerns that Tenant #4 was exhibiting symptoms of a potential acute exacerbation of mental illness. Tenant #4 was more confused, requiring dependence with activities of daily living and needed to be medically evaluated. The nurse then met with Tenant #4. Tenant #4 reported he/she did not feel like him/herself and agreed to go to the emergency room for evaluation. Tenant #4 was transported to the local hospital and was admitted overnight.

During the hospitalization, Tenant #4's urinalysis showed no signs of infection and the basic metabolic panel showed no electrolyte imbalance. Tenant #4's physician made medication changes and deemed Tenant #4 appropriate to return to the program. Tenant #4 was transported back to the program on 9-20-13. The program expressed level of care concerns based on Tenant #4's increased confusion and dependency with activities of daily living. Tenant #4 was allowed at that time to return to the program.

The nurse completed health, functional and cognitive evaluations on 9-20-13, noting Tenant #4 to be alert and oriented to person, place and time with some forgetfulness. Tenant #4 answered all but two questions correctly on the Mini Mental Status Exam, dated 9-20-13, indicating none to mild cognitive impairment. The functional evaluation indicated Tenant #4 had returned to the same functional abilities as identified on the 8-29-13 assessment. Tenant #4 was found to be independent with eating, transfers and toileting. The assessment documented Tenant #4 required staff member assistance with grooming, dressing and bathing. Tenant #4 was able to ambulate independently using a walker. None of the activities of daily living were identified as dependent.

During interview, the program Chief Executive Officer reported she would need to speak with the nurse who completed the evaluations on 9-20-13 as Tenant #4 had not exhibited abilities or cognitive status as identified in the 9-20-13 evaluation upon return home from the hospital. Tenant #4 reportedly continued to exhibit labile cognitive status and required increased home health aide assistance due to dependence with activities of daily living.

According to progress notes, dated 9-27-13, Tenant #4 was unable to stand, transfer or ambulate during a fire drill held at the program. Tenant #4 was weak and shaky. On 9-30-13 the program administration decided to give Tenant #4 a 30-day involuntary discharge from the program, citing Tenant #4's exacerbation of mental illness, dependency with activities of daily living, refusal of home health aide services and non-compliance with taking medications as ordered as reasons for the discharge. The family member Tenant #4 had identified on the occupancy agreement as the family member to contact with discharge notice was out of the country vacationing. The other listed family member could not be reached with multiple attempts. The program administration attached the involuntary discharge paperwork to an email and sent the document to the both family members to assure the notice was received in a timely manner.

On 10-3-13 Tenant #4 forgot to take his/her morning medications two of the seven preset days, forgot to take the evening medications one of the seven preset days and forgot to take the bedtime medications one of the seven preset days. (Tenant #4's clinical record lacked any other medication non-compliance after 10-3-13.) On 10-3-13 the program nurse completed health, cognitive and functional evaluations, noting Tenant #4 now exhibited moderate cognitive impairment based on incorrect answers on the Mini Mental Status Examination but remained independent with eating, transfers and toileting. Tenant #4 remained independent with ambulation using a walker and required staff member assistance with bathing, grooming and dressing. The evaluation did not indicate Tenant #4 was dependent with any activities of daily living.

During interview, the program's Chief Executive Officer reported at this time, Tenant #4 was exhibiting dependency with bathing, grooming and dressing and had been showing an inability to stand, transfer and ambulate without staff member assistance due to weakness. (Tenant #4 was receiving physical therapy assistance to work on strengthening and returned independence with ambulation.)

Initially, the family members and the tenant were agreeable with the transfer notice but later requested Tenant #4 be allowed to stay at the program as Tenant #4 had improved cognitively, functionally and in health status. Tenant advocates were notified and became involved in the conflict resolution. A meeting was held on 10-21-13, prior to the initiation of the monitoring visit, and the program rescinded the original 30-day involuntary discharge. Tenant #4 currently resided at the program and was not required to leave. The program initiated an increase in home health aide frequency of assistance with activities of daily living, initiated medication reminders twice daily and initiated a focused care plan to address communication issues with Tenant #4's family.

The program did give a 30-day involuntary transfer notice on 9-30-13 even though the program nurse had documented Tenant #4 had returned to his/her previous baseline status of none to mild cognitive impairment, was oriented to person, place and time and was no longer dependent with activities of daily living following return from the hospitalization where medication changes occurred. Tenant #4's clinical record lacked documentation of any refusal of home health aide services after 8-29-13 and Tenant #4's clinical record contained documentation of only two noted times of non-compliance with scheduled medications. Prior to the on-site visit, the program rescinded the involuntary discharge notice and Tenant #4 was not ever actually discharged. Even though the program gave the discharge notice despite Tenant #4's appeared improvements, the notice was rescinded prior to the Department of Inspections and Appeals becoming involved. While a deviation from the requirements of the rules was found, it did not meet the standard set forth in the rule 67.10(3) for determining that a regulatory insufficiency exits.

Tenant #8, a 66 year-old, was admitted on 8-9-13 and had diagnoses of: Lung Cancer and Hypertension. Tenant #8 was admitted to Hospice on 8-13-13. On 8-17-13, Tenant #8 was transferred to the hospice house for pain control. Tenant #8 was voluntarily discharged.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation: 45645-C and 45647-C- It was alleged medications were not set up as ordered.

Monitoring Observation: The service plans for Tenants #3, #4, #5, #6 and #7 identified the tenants received medication set-up by the program nurse.

Tenants #5 and #6 were interviewed. Both stated the medication planners were filled on time and neither reported any problems with medications. The medication planners were observed and medications were present in the planners for the remaining days of the week.

The clinical notes for Tenant #3 documented medication planners were filled regularly from 9-5-13 through 10-17-13 except for the period of time Tenant #3 was on vacation. Tenant #3's medication planner was refilled upon return from vacation.

The clinical notes for Tenant #5 documented medication planners were filled regularly from 9-6-13 through 10-17-13.

The clinical notes for Tenant #6 documented medication planners were filled regularly from 9-3-13 through 10-15-13.

Tenant #4 received medication set up from the program nurse once weekly. Documentation indicated the nurse prefilled Tenant #4's medication seven day planner routinely on a weekly basis. The nurse documented each medication that was placed in the planner and documented which medications were reordered from the pharmacy when low or empty following the medication set up. The nurse reordered medications multiple times in August, September and October 2013. Documentation in a spiral bound notebook located in Tenant #4's apartment beginning in late September 2013 indicated Tenant #4's family would pick up the ordered medications and leave the medications in Tenant #4's apartment.

The clinical note, dated 9-20-13, indicated Tenant #4 was hospitalized on 9-19-13 to 9-20-13. During the hospitalization, Tenant #4's physician discontinued Norvasc, Cogentin and Hydroxyzine Pamoate from Tenant #4's medication regime. The nurse removed the Norvasc, Cogentin and Hydroxyzine Pamoate from the pre-set medication planner during the visit on 9-20-13. The nurse indicated she noted Tenant #4's hospital discharge documents listed a new medication, Propranolol (an antihypertensive), to be added to Tenant #4's medication regime. Tenant #4 did not have the Propranolol prescription available for the nurse to add to the planner. The nurse documented Tenant #4 reported his/her sister took the prescription to the pharmacy to be filled and the tenant was awaiting the delivery of the prescription. The nurse instructed Tenant #4 to contact her when the medication arrived.

The medication did not get set up in Tenant #4's medication planner until 9-26-13; six days after the physician ordered the medication. The program presented documentation of a text message received on 9-25-13 at 6:54 p.m. from Tenant #4's sister which indicated the sister had dropped off the Propranolol at Tenant #4's

apartment the afternoon before and called the nurse station to tell the aide. The Chief Executive Officer immediately contacted the nurse who had set up the medications on 9-20-13, determining that the nurse had not gotten the message that the Propranolol was now available. The nurse made a visit the following morning to add the medication to Tenant #4's planner.

Pharmacy documents indicated the Propranolol was filled and ready for pick up on 9-20-13. Tenant #4's sister picked up the Propranolol on 9-23-13 at 6:01 p.m. During interview, the sister who picked up the Propranolol from the pharmacy reported she gave the medication to another sister to take to Tenant #4's apartment. According to the text message, Tenant #4's sister took the medication to Tenant #4's apartment on 9-24-13.

According to a notation found in a spiral bound notebook located in Tenant #4's apartment, Tenant #4's sister visited on 9-24-13 at 6:45 p.m.

The program's schedules indicated only Staff #1, home health aide, worked on 9-24-13. Staff #1 did not remember receiving a phone call telling her Tenant #4 had medications being left in the apartment on 9-24-13. Staff #1 indicated she has received such calls from Tenant #4's family members and other tenant family members in the past and she always either talks to or leaves a note for the nurse to address the next day.

Tenant #4 did have a delay in the initiation of the Propranolol due to the medication not being available for four days and not being notified the medication was present and available on 9-24-13. The program added the medication into Tenant #4's planners the next morning following the family's evening text message on 9-25-13. During interview, Tenant #4 reported one time in early October 2013 the nurse forgot to administer the scheduled Risperdal injection during the home visit. Tenant #4 reported notifying the program staff members of the omission and she returned later in the day to administer the Risperdal. Medication sheets indicated Tenant #4 received a Risperdal injection on 10-3-13.

Tenant #7, an 81 year-old, was admitted on 3-17-12 and had diagnoses of: Hypertension, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Neuropathy, Osteoarthritis, Anemia, and Thyroid Disorder. When reviewing the Medication Status sheet for 9-3-13, handwritten notes indicated Levothyroxine, a thyroid medication, was placed in planners for three weeks. On 9-23-13, Levothyroxine was placed in planners for two weeks. On 9-30-13, documentation indicated Tenant #7 was out of Levothyroxine. Notation at the bottom of the 9-30-13 indicated routine medications were placed in the planner for two weeks and refills were called in to the pharmacy.

Tenant #7's Medication Status sheet for 10-7-13 indicated Levothyroxine was out two weeks. The sheet for 10-14-13 indicated the Levothyroxine was filled on 8-13-13 and was filled for 90 days. The documentation indicated the bottle of Levothyroxine was empty. The Clinical Note dated 10-14-13 Tenant #7 was out of Levothyroxine and a pre-filled planner was given to Tenant #7 to ensure Tenant #7 received Levothyroxine. The Medication Status sheet dated 10-21-13 indicated

Tenant #7 was out of Levothyroxine with a notation "too soon." None of the Medication Status sheets indicated the dosage of the Levothyroxine had changed.

In an interview with a Home Health Nurse, she stated she had used the term "out" to indicate the medication was low. The Home Health Nurse stated Tenant #7 was not out of medication, as medication was in the planner on the day of the interview. The Home Health Nurse stated the medication had been refilled on 10-19-13 and therefore too soon to be filled on 10-21-13 when the pharmacy was called. The Home Health Nurse reported the number of pills in the bottle was correct.

- Regulatory Insufficiency: None noted.

C. Evaluation

Complaint/Incident Allegation: 45645-C- It was alleged evaluations were not completed following a change in condition.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2 and #4. The monitors found no concerns related to evaluations for Tenant #2.

  Tenant #1, a 97 year-old, was admitted on 5-17-12 and had diagnoses of: Hypertension and Osteoarthritis. A cognitive evaluation dated 9-4-13 indicated Tenant #1 scored 9 to 11 points which indicated none to mild cognitive impairment. A cognitive evaluation dated 9-19-13 indicated Tenant #1 again scored 9 points. A cognitive evaluation of 10-9-13 indicated there were enough errors on the cognitive screening tool to warrant the use of the Global Deterioration Scale, and staged Tenant #1 at four, which indicated moderate cognitive decline. A handwritten progress note dated 10-10-13 indicated Tenant #1 appeared to be back to baseline cognitively. Evaluations were not completed with a change of condition.

  Tenant #4's health, cognitive and functional evaluations, completed on 8-29-13, indicated Tenant #4 was alert and oriented to person, place and time. Tenant #4 was independent with eating, transfers and toileting. The evaluations documented Tenant #4 required staff member assistance with grooming, dressing and bathing. Tenant #4 was able to ambulate independently using a walker. The nurse noted Tenant #4 exhibited some weakness and deconditioning. Physical therapy was initiated to work on strength training and ambulation. The therapist set goals for Tenant #4 to be independent with a home exercise program and to be able to ambulate 80 feet with a step through pattern to allow getting to the elevator in 8 weeks. Tenant #4 answered all but two questions correctly on the program's cognitive evaluation, indicating none to mild cognitive impairment.

  On 9-13-13 Tenant #4 began "not acting right" making his/her family question if he/she needed hospitalization. Tenant #4 refused to be taken to the hospital. The family summoned law enforcement and Tenant #4 also refused law enforcement attempts to get Tenant #4 to be medically evaluated.

  On 9-17-13 Tenant #4 was noted to require more assistance than usual while bathing and dressing and appeared to be off mentally. The nurse immediately went to Tenant

#4's apartment. Tenant #4's significant other was present and assisting Tenant #4 with tasks that were usually performed independently by Tenant #4. Tenant #4 was oriented to person and place but not date or time, was having difficulty recalling recent events and reported he/she felt fatigue, had body aches and was having urinary symptoms indicative of a urinary tract infection. Tenant #4 denied hallucinations. The nurse administered Tenant #4's Risperdal (an antipsychotic medication) injection two days early after contact with Tenant #4's psychiatric physician.

On 9-18-13 the nurse contacted Tenant #4's medical physician, obtaining an order for a urinalysis and a basic metabolic panel to consider urinary tract infection or an electrolyte imbalance as reasons for Tenant #4's changes.

On 9-18-13 the home health aides again told the nurse Tenant #4 was completely dependent with dressing and other activities of daily living. Once during the day, Tenant #4 pushed the pendent requesting assistance. When staff members arrived at Tenant #4's apartment, he/she did not recognize any of his/her noon medications. Tenant #4 appeared to be confused.

On 9-19-13 a meeting was held with program staff members and Tenant #4's family. The program expressed concerns that Tenant #4 was exhibiting symptoms of a potential acute exacerbation of mental illness. Tenant #4 was more confused, requiring assistance with activities of daily living and needed to be medically evaluated. The nurse then met with Tenant #4. Tenant #4 reported he/she did not feel like him/herself and agreed to go to the emergency room for evaluation. Tenant #4 was transported to the local hospital and was admitted overnight.

During the hospitalization, Tenant #4's urinalysis showed no signs of infection and the basic metabolic panel showed no electrolyte imbalance. Tenant #4's physician made medication changes and deemed Tenant #4 appropriate to return to the program. Tenant #4 was transported back to the program on 9-20-13. The program expressed level of care concerns based on Tenant #4's increased confusion and dependency with activities of daily living. Tenant #4 was allowed at that time to return to the program.

The nurse completed health, functional and cognitive evaluations on 9-20-13, noting Tenant #4 to be alert and oriented to person, place and time with some forgetfulness. Tenant #4 answered all but two questions correctly on the Mini Mental Status Exam, dated 9-20-13, indicating none to mild cognitive impairment. The functional evaluation indicated Tenant #4 had returned to the same functional abilities as identified on the 8-29-13 assessment. Tenant #4 was found to be independent with eating, transfers and toileting. The assessment documented Tenant #4 required staff member assistance with grooming, dressing and bathing. Tenant #4 was able to ambulate independently using a walker. None of the activities of daily living were identified as dependent.

During interview, the program Chief Executive Officer reported she would need to speak with the nurse who completed the evaluations on 9-20-13 as Tenant #4 had not exhibited abilities or cognitive status as identified in the 9-20-13 evaluation upon return home from the hospital.

According to progress notes, dated 9-27-13, Tenant #4 was unable to stand, transfer or ambulate during a fire drill held at the program. Tenant #4 was weak and shaky.

On 9-30-13 the program administration decided to give Tenant #4 a 30-day involuntary discharge from the program, citing Tenant #4's exacerbation of mental illness, dependency with activities of daily living, refusal of home health aide services and non-compliance with taking medications as ordered as reasons for the discharge.

On 10-3-13 Tenant #4 forgot to take his/her morning medications two of the seven preset days, forgot to take the evening medications one of the seven preset days and forgot to take the bedtime medications one of the seven preset days, which was unusual for Tenant #4. On 10-3-13 the program nurse completed a health, cognitive and functional evaluation, noting Tenant #4 now exhibited moderate cognitive impairment based on incorrect answers on the Mini Mental Status Examination but remained independent with eating, transfers and toileting. Tenant #4 remained independent with ambulation using a walker and required staff member assistance with bathing, grooming and dressing. The evaluation did not indicate Tenant #4 was dependent with any activities of daily living.

During interview, the program's Chief Executive Officer reported at this time Tenant #4 was exhibiting dependency with bathing, grooming and dressing and had been showing an inability to stand, transfer and ambulate without staff member assistance due to weakness. (Tenant #4 was receiving physical therapy assistance to work on strengthening and returned independence with ambulation.)

According to notes kept in a spiral bound notebook located on the kitchen island counter in Tenant #4's apartment, Tenant #4 was ambulating independently around the apartment and could walk independently from his/her apartment to the elevators on multiple occasions beginning on 10-1-13.

A meeting was held on 10-21-13, and the program rescinded the original 30-day involuntary discharge after determination that Tenant #4 no longer exceeded the level of care allowed for an assisted living program. The program initiated a new service plan, dated 10-21-13, adding medication reminders twice daily to assist Tenant #4 with medication compliance and documented the discontinuation of the physical therapy services due to goals met. The service plan indicated improvement in Tenant #4's condition. Tenant #4's clinical record lacked documentation of health, cognitive or functional evaluations around the time of the 30 day notice revocation due to the stated improvement in Tenant #4's condition. Tenant #4 was being discharged from physical therapy services with all goals met.

Tenant #4's evaluations completed on 9-20-13 and 10-3-13 did not accurately reflect Tenant #4's reported functional and cognitive status as described by the Chief Executive Officer. The program gave a 30 day notice of involuntary discharge to Tenant #4 on 9-30-13; however, Tenant #4's condition improved at some point following the notice of discharge. The program rescinded the discharge notice, allowing Tenant #4 to stay at the program due to Tenant #4's improvements in condition. The program failed to complete health, cognitive and functional evaluations with the significant change in condition noted on 10-21-13.

- 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

Complaint/Incident Allegation: 45645-C- It was alleged service plans did not meet identified tenant needs.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #4 and #5.

  Tenant #1 had evaluations completed and a service plan created on 7-26-13. The evaluation did not include the use of a walker at that time. Evaluations completed on 9-19-13 indicated Tenant #1 now used a walker for ambulation due to recent falls. The evaluations of 10-9-13 continued to indicate Tenant #1's use of a walker for ambulation. The current service plan dated 7-26-13 and the home health aide care plan of the same date did not indicate Tenant #1's use of a walker. The service plan did not meet the identified needs of Tenant #1.

  Tenant #2, a 54 year-old, was admitted on 3-7-12 and had diagnoses of: Diabetes, Hypertension, Osteoarthritis, Asthma, and Kidney Cyst. Tenant #2 had evaluations completed on 8-2-13. The evaluations indicated Tenant #2 had a Suprapubic Catheter and required bathing assistance. A review of the service plan and the home health aide care plan did not identify Tenant #2's need for a Suprapubic Catheter or what staff members should do with the catheter during bathing. The service plan did not meet the identified needs of Tenant #2.

  Tenant #4's health, cognitive and functional assessment, completed on 8-29-13, indicated Tenant #4 was alert and oriented to person, place and time. Tenant #4 was independent with eating, transfers and toileting. The assessment documented Tenant #4 required staff member assistance with grooming, dressing and bathing. Tenant #4 was able to ambulate independently using a walker. The nurse noted Tenant #4 exhibited some weakness and deconditioning. Physical therapy was initiated to work on strength training and ambulation. The therapist set goals for Tenant #4 to be independent with a home exercise program and to be able to ambulate 80 feet with a step through pattern to allow getting to the elevator in 8 weeks. Tenant #4 answered all but two questions correctly on the program's cognitive evaluation, indicating none to mild cognitive impairment.

  On 9-13-13 Tenant #4 began "not acting right" making his/her family question if he/she needed hospitalization. Tenant #4 refused to be taken to the hospital. The

family summoned law enforcement and Tenant #4 also refused law enforcement attempts to get Tenant #4 to be medically evaluated.

On 9-17-13 Tenant #4 was noted to require more assistance than usual while bathing and dressing and appeared to be off mentally. The nurse immediately went to Tenant #4's apartment. Tenant #4's significant other was present and assisting Tenant #4 with tasks that were usually performed independently by Tenant #4. Tenant #4 was oriented to person and place but not date or time, was having difficulty recalling recent events and reported he/she felt fatigue, had body aches and was having urinary symptoms indicative of a urinary tract infection. Tenant #4 denied hallucinations. The nurse administered Tenant #4's Risperdal (an antipsychotic medication) injection two days early after contact with Tenant #4's psychiatric physician.

On 9-18-13 the nurse contacted Tenant #4's medical physician, obtaining an order for a urinalysis and a basic metabolic panel to consider urinary tract infection or an electrolyte imbalance as reasons for Tenant #4's changes.

On 9-18-13 the home health aides again told the nurse Tenant #4 was completely dependent with dressing and other activities of daily living. Once during the day, Tenant #4 pushed the pendent requesting assistance. When staff members arrived at Tenant #4's apartment, he/she did not recognize any of his/her noon medications. Tenant #4 appeared to be confused.

On 9-19-13 a meeting was held with program staff members and Tenant #4's family. The program expressed concerns that Tenant #4 was exhibiting symptoms of a potential acute exacerbation of mental illness. Tenant #4 was more confused, requiring dependence with activities of daily living and needed to be medically evaluated. The nurse then met with Tenant #4. Tenant #4 reported he/she did not feel like him/herself and agreed to go to the emergency room for evaluation. Tenant #4 was transported to the local hospital and was admitted overnight.

During the hospitalization, Tenant #4's urinalysis showed no signs of infection and the basic metabolic panel showed no electrolyte imbalance. Tenant #4's physician made medication changes and deemed Tenant #4 appropriate to return to the program. Tenant #4 was transported back to the program on 9-20-13. The program expressed level of care concerns based on Tenant #4's increased confusion and dependency with activities of daily living. Tenant #4 was allowed at that time to return to the program.

The nurse completed health, functional and cognitive evaluations on 9-20-13, noting Tenant #4 to be alert and oriented to person, place and time with some forgetfulness. Tenant #4 answered all but two questions correctly on the Mini Mental Status Exam, dated 9-20-13, indicating none to mild cognitive impairment. The functional evaluation indicated Tenant #4 had returned to the same functional abilities as identified on the 8-29-13 assessment. Tenant #4 was found to be independent with eating, transfers and toileting. The assessment documented Tenant #4 required staff member assistance with grooming, dressing and bathing. Tenant #4 was able to ambulate independently using a walker.

During interview, the program Chief Executive Officer reported she would need to speak with the nurse who completed the evaluations on 9-20-13 as Tenant #4 had not exhibited abilities or cognitive status as identified in the 9-20-13 evaluation upon return home from the hospital. Tenant #4 was reportedly dependent with bathing, grooming and dressing and had been unable to ambulate without staff member assistance.

According to progress notes, dated 9-27-13, Tenant #4 was unable to stand, transfer or ambulate during a fire drill held at the program. Tenant #4 was weak and shaky. Tenant #4's clinical record included a service plan, dated 9-27-13, which indicated Tenant #4 required assistance with bathing, grooming and dressing. The service plan did not indicate Tenant #4 was dependent with the three personal care tasks. The service plan indicated Tenant #4 was independent with ambulation despite staff member reports that Tenant #4 required assistance with transfers and ambulation.

On 9-30-13 the program administration decided to give Tenant #4 a 30-day involuntary discharge from the program, citing Tenant #4's exacerbation of mental illness, dependency with activities of daily living, refusal of home health aide services and non-compliance with taking medications as ordered as reasons for the discharge.

On 10-3-13 Tenant #4 forgot to take his/her morning medications two of the seven preset days, forgot to take the evening medications one of the seven preset days and forgot to take the bedtime medications one of the seven preset days, which was unusual for Tenant #4. On 10-3-13 the program nurse completed health, cognitive and functional evaluations, noting Tenant #4 now exhibited moderate cognitive impairment based on incorrect answers on the Mini Mental Status Examination but remained independent with eating, transfers and toileting. Tenant #4 remained independent with ambulation using a walker and required staff member assistance with bathing, grooming and dressing. The evaluation did not indicate Tenant #4 was dependent with any activities of daily living.

During interview, the program's Chief Executive Officer reported at this time, Tenant #4 was exhibiting dependency with bathing, grooming and dressing and had been showing an inability to stand, transfer and ambulate without staff member assistance due to weakness. (Tenant #4 was receiving physical therapy assistance to work on strengthening and returned independence with ambulation.)

A meeting was held on 10-21-13, and the program rescinded the original 30-day involuntary discharge after determination that Tenant #4 no longer exceeded the level of care. Tenant #4's clinical record lacked documentation of health, cognitive or functional evaluations around the time of the 30 day notice revocation due to the improvement in Tenant #4's condition. The program initiated a new service plan, dated 10-21-13, adding medication reminders twice daily to assist Tenant #4 with medication compliance and documented the discontinuation of the physical therapy services due to goals met. The service plan indicated improvement in Tenant #4's condition. The service plan update was not based on an evaluation of Tenant #4's health, cognitive and functional status.

Tenant #5, a 73 year-old, was admitted on 11-21-09 and had diagnoses of: Hypertension, Chronic Pain, and Osteoarthritis. According to the service plan of 8-9-

13, Tenant #5 required medications to be set up in a planner by a nurse. On 9-25-13, Tenant #5 received an order for Oxybutynin, one tablet daily. According to the Medication Status sheets dated 10-4 and 10-16-13, Tenant #5 was independent in the administration of Oxybutynin. The Program Nurse confirmed Tenant #5 was independent in the administration of the medication. The service plan did not identify Tenant #5 was independent with any medication.

- 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))