IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 44944-C

December 4, 2013

Ms. Kim Worrall, Regional Director
Traditions of West Union
609 Highway 150
West Union, IA 52175

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL RECERTIFICATION MONITORING EVALUATION AND COMPLAINT/INCIDENT INVESTIGATION REPORT - TRADITIONS OF WEST UNION
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Worrall:

I. Final Recertification Monitoring Evaluation and Complaint/Incident Investigation Report – Traditions of West Union, West Union, IA

Enclosed is the **Final Recertification Monitoring Evaluation and Complaint/Incident Investigation Report ("Report")** issued 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, following an investigation by DIA on **September 12, 16 and 17, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Medications, Staffing, Evaluation, Service Plans and Structural Requirements.

Traditions of West Union ("Program") is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.12(3)(a)(2), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of Medications.

The determination of a **$500 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Medications. As the enclosed Report details, the Program repeatedly failed to follow medication protocol for administration and documentation of medications.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of **three hundred twenty five dollars ($325)** within 30 days after the notice or service of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of the notice or service of this demand letter.

IV. Conclusion

The Program is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Plan of Correction (POC) submitted on October 16, 2013, has been reviewed and will constitute the final POC related to the on-site visit of September 12, 16 & 17, 2013.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of notice or service of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Recertification Monitoring Evaluation and Complaint/Incident Investigation Report

Assisted Living Program: **Complaint/Incident Intake #:** 44944-C

Kim Worrall, Regional Director
Traditions of West Union
609 Highway 150
West Union, IA 52175

Date of Monitoring Visit/Complaint/Incident Investigation:

September 12, 16 & 17, 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 below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	22
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	26
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	4
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	8
TOTAL census of Assisted Living Program	34

Tenant/Family Satisfaction Results – A community meeting with 11 tenants was held. There were no concerns with housekeeping in the apartments and the dining room and hallways were clean. The laundry room had an odor when the door was closed and there was recently clothes hanging in the laundry room. The fabric chairs were not properly cleaned in the common areas if someone was incontinent. Maintenance was very good. The tenants said the outside needed improvements and said two years ago they were going to build on and the siding was taken off and was still not replaced. Nursing services were available and were described as very good. It took staff between five to ten minutes to respond when they requested assistance. When asked if the tenants received the services expected when they signed the occupancy agreements the tenants said "close to it." They reported being promised an awning on the back patio. The tenants also reported concerns regarding transportation. The occupancy agreement did not address transportation or the awning. They described staff as hard working and said staff was running around. They said breakfast was served later and it took more time to be served at times. The beds were made late in the day on some days. One tenant reported having a urinary incontinent episode as a result of having to wait to get an assistive device in the dining room and return to the tenant's apartment. The tenants reported staff lost a float and there had been staff turnover. The tenants said the staffs' phones rang when they were in the apartments helping tenants. They said some staff was trained to provide the services and some were not. The tenants received enough food and said they got too much. One tenant reported there was not enough age appropriate foods served and said hot dogs and potato chips were served. Another tenant reporting liking the hot dogs served. The tenants said there was a good alternate list of food items. Hot foods were hot depending on who was working and staff would reheat the food if needed. They said the Activity Director was wonderful and there were sufficient activities offered. They said sometimes there were too many activities and they enjoyed going out for breakfast, playing cards, art, trivia, Bingo and cooking treats. They felt safe and made their own decisions. Some tenants felt they could not go to administration; however, they would go to the Nurse. They would recommend the Program to others and said it was the next best place to home.

Program History – During the course of the Recertification visit and complaint/incident investigation conducted on September 12, 16 and 17, 2013, the Program received regulatory insufficiencies in the areas of: Medications, Structure, Staffing, Evaluations and Service Plans.

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

A. Medications

- Monitoring Observation: Staff #1 was observed passing medications to Tenant #9 at 11:30 a.m. on 9-16-13. Staff #1 prepared the medication and then said the family wanted a liquid supplement given with the medications. She opened the refrigerator and removed an eight ounce single serving of a nutritional supplement. She removed the tab on the top and inserted a straw, then decided it would be better to pour the liquid into a glass. She poured in approximately four ounces. She handed Tenant #9 an oral medication and the glass of nutritional supplement. She encouraged Tenant #9 to drink all of the liquid. She then placed the remainder of the nutritional supplement in the refrigerator. The container was not sealed or labeled to indicate when the product was opened. The Medication Administration Record (MAR) indicated Boost or Ensure shake three times a day with meals to be given in a.m., noon and p.m. The MAR did not indicate an amount. The Nurse was notified and stated her expectation was the entire eight ounces would be given. A Policy on Food Safety and Storage was provided. The policy did not address storage and labeling of tenant products.

  Staff #1 then proceeded to Tenant #10's apartment. According to the MAR, Tenant #10 was to receive Metoprolol Tartrate tab 25 milligrams (mg) orally twice daily at 11:00 a.m. The times indicated on the MAR were 11:00 a.m. and at the Hour of Sleep (HS). Both times included a line to record Tenant #10's pulse. Staff #1 checked the pulse and indicated it was 68. No parameters regarding the pulse were on the MAR. Staff #1 was asked by the monitor if there were parameters for the administration of the medication based on the pulse result. Staff #1 stated she would hold the medication if the pulse was greater than 80. When asked how she knew that, she replied that she had heard it somewhere. A copy of the MAR obtained on 9-17-13 indicated Staff #1 initialed taking the pulse on the MAR but did not record the pulse rate. The physician's order noted on 4-19-13 indicated Metoprolol 25 mg, one tab, two times a day. The original order did not indicate a need to record the pulse. When asked the reason the pulse was being recorded, the Nurse stated it is sometimes a practice to check the pulse when this medication was started but it should not have been continued at this time. The Nurse stated she was not aware of the origin of checking the pulse for Tenant #10's medication. Staff #1 checked the MAR for Novolog Insulin 100u/ml 5 units, removed a syringe from the refrigerator marked 5 units and handed it to Tenant #10. Tenant #10 asked for an alcohol swab which Staff #1 obtained and handed to Tenant #10. According to a Program document for supervision of self-administration of insulin, staff was to triple check the insulin dosage in the syringe to the MAR to ensure the correct insulin dosage prior to handing the tenant the insulin syringe for injection. Staff #1 did not triple check the insulin.

Staff #1 proceeded to Tenant #11's apartment at 11:40 a.m. Tenant #11 was not in the apartment but was found in the dining room waiting to eat lunch. Staff #1 informed Tenant #11 that she would administer Tenant #11's medication and nebulizer treatment after lunch. At 12:25 p.m. Staff #1 was observed entering Tenant #11's apartment. Tenant #11 was self administering a nebulizer treatment. The monitor asked Tenant #11 if Tenant #11 normally self administered the treatment and Tenant #11 replied that Tenant #11 thought Tenant #11 would help out Staff #1. When asked how Tenant #11 obtained the medication for the treatment, Tenant #11 got up and opened a cabinet door and showed the monitor two boxes of Albuterol solution that held individual vials. The Albuterol was not stored in the locked medication cabinet. The physician order dated 6-23-13 indicated DuoNeb one unit dose Nebulizer (NEB) four times per day. The MAR indicated DuoNeb Solution one unit dose nebulizer four times a day. The MAR indicated the times for administration at 7:00 a.m., 11:00 a.m., 4:30 p.m. and at HS. Staff #1 documented completion of the treatment on the MAR but did not indicate Tenant #11 self administered the treatment. According to the Nurse, medications were to be administered within one hour prior to or within one hour after the designated time frame in order to be administered on time. The nebulizer treatment was completed outside of the time frame for administration. According to the Program's policy on Aerosolized Medications, including those with a nebulizer system, After Care was required to be documented in the tenant's records. Staff #1 did not clean the equipment after the treatment and did not document any After Care in Tenant #11's record.

Tenant #1, an 89 year old, was admitted on 4-10-10 and diagnoses included: Recent Intermittent Confusion, Rheumatoid Arthritis, Depression, Degenerative Joint Disease, Gastro Esophageal Reflux Disease, Renal Insufficiency and Osteoporosis. Tenant #1 was staged at five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline.

A fax to the doctor dated 7-10-13 indicated Tenant #1 had a red irritated abdomen and groin folds again. Nystatin Powder twice a day as needed was ordered and the order was noted on 7-11-13. According to Nurse Progress Notes dated 7-15-13, Tenant #1 experienced two falls on 7-13-13 and 7-14-13. Tenant #1 was taken to the hospital by family on 7-14-13 for weakness. Tenant #1 returned from the hospital on 7-15-13. Discharge instructions provided a list of medications to be continued. Nystatin Topical Powder apply topically two times per day in the morning and at bedtime was ordered. The, as needed, Nystatin Powder was not listed on the medications to be continued list. The orders were noted 7-15-13. The August 2013 MARs reflected Nystatin Powder apply topically twice daily to irritated skin folds in the a.m. and p.m. with an order date of 7-15-13. The August 2013 MARs reflected Nystatin Powder apply twice a day as needed for red irritated skin folds with an order date of 7-10-13. The MARs reflected there were no as needed doses documented as administered. The September 2013 MARs reflected Nystatin Powder apply topically twice daily to irritated skin folds in the a.m. and p.m. with an order date of 7-15-13. The September 2013 MARs reflected Nystatin Powder apply twice a day as needed for red irritated skin folds with an order date of 7-10-13. The MARs reflected there were no as needed doses documented as administered. According to a fax to the doctor dated 9-17-13, Tenant #1's skin folds were free of redness and irritation. Nystatin Powder twice daily was discontinued and the as needed order was continued.

The order was noted 9-18-13. The August and September MARs reflected an as needed order for Nystatin Powder that was not reflected on the post hospitalization orders.

The table below represents lack of documentation for administration of medications:

TENANT	MEDICATION	DOCUMENTATION ON THE MAR AND ON THE PRN, EMERGENCY AND MEDICATIONS NOT ADMINISTERED SHEET
Tenant #7	Bisacodyl Supp 10 mg rectally every day as needed	Front of the MAR had one entry documented as given on 8-6-13. The PRN, Emergency and Medications Not Administered sheet reflected a dose was administered on 8-6-13 at 4:30 p.m. and the result was not documented. The sheet also reflected it was administered on 8-6-13 at 3:45 p.m. and the result was a bowel movement. The medication was to be given every day as needed
Tenant #7	Bisacodyl Supp 10 mg rectally every day as needed	The MAR reflected it was administered on 8-11-13 The PRN, Emergency and Medications Not Administered sheet did not reflect the medication was administered on 8-11-13
Tenant #9	Cyanocobalamin 100 m one tab daily in AM	The MAR was blank for 9-15-13 in a.m. No reason documented
Tenant #11	Digoxin 0.25 mg one tab by mouth daily at 12:00 p.m. Hold if pulse is less than 50	The MAR did not reflect documentation of the pulse rate at 12:00 p.m. on 9-5-13. No reason was documented
Tenant #11	Digoxin 0.25 mg one tab by mouth daily at 12:00 p.m. Hold if pulse is less than 50	The MAR did not reflect documentation of the pulse rate at 12:00 p.m. on 9-10-13. No reason was documented

Review of a medication pass and tenant files indicated medication protocol was not followed regarding the administration and documentation of medications.

- Regulatory Insufficiency: When medications are administered traditionally by the program: 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-Chaper 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

B. Staffing

Complaint/Incident Allegation: It was alleged there was not appropriate supervision for tenants in the dementia unit.

- Monitoring Observation: The Program consisted of a secured memory care unit and a general population connected by structure. The secured memory care unit had a fenced courtyard area. There was also a concrete covered patio area that faced the highway that had a railing and an opening to walk through to the parking lot. The patio area was not a secured area.

  The tenant list provided indicated there were eight tenants in the memory care unit. The GDS score of those tenants ranged from a three (mild cognitive decline) to a six (severe cognitive decline). Tenants #4, #5 and #13 were identified on the ALP Monitoring Entrance Form as tenants who wandered throughout the Program. Tenants #4, #5 and #13 resided in the memory care unit.

  Staff #1 said staff routinely went from the general population to the memory care unit to relieve staff working there. Tenants were taken outside on the front patio and rarely went to the enclosed area. Memory care unit staff took the tenants out and most of them went out. Staff #1 said she had never left the tenants unattended and she was not aware of any staff that left them alone. She used chairs to block the open area when outside, sometimes, but not always. She said they had been using the patio for two to three years. She said the tenants had pull cords and most knew how to use them.

  Staff #2 stated other staff always came to the memory care unit to relieve her for breaks and meals. She stated she would take memory care unit tenants outside and sit with them on the front patio. She never took all of the tenants outside at the same time. Tenants were left unattended outside but she kept an eye on the tenants from inside the building. She stated tenants in the memory care unit did not use pendants but had pull cords in their rooms, one by the bed and one in the bathroom. Two tenants were able to operate the pull cords.

  Staff #3 said at 4:00 p.m. staff came automatically to relieve staff. She said (memory care unit) tenants were taken outside. She said all tenants except Tenant #12 went outside. Staff went back and forth (in and out). She said staff were inside for 10 minutes and could look outside through the window. Tenants were left unattended when staff checked on the tenants inside. Two tenants used the pull cords.

Staff #4 said when memory care unit tenants were taken out on the porch not all tenants went outside. Staff in charge would go inside and outside, going to check every five to ten minutes. She said approximately four to five tenants went outside. Staff went inside long enough to check on those tenants inside.

The Nurse said tenants did go and sit on the porch with staff present. Staff in the memory care unit encouraged everyone to go out. She was not aware of memory care unit tenants being left outside. She said if there were tenants left in the building staff from the general population went back.

The Director was interviewed and stated there was no staffing ratio. She normally ran one staff to 7 or 8 tenants in the memory care unit and one staff for 12 or 13 tenants in the general population. A float staff was available when the Program was at full occupancy. She stated she felt tenant needs were being met. The management company was involved in the staffing decision and it was based on census. The Director stated she was not aware of tenants being left unattended outside of the memory care unit. She had only witnessed staff being outside with tenants when all of the tenants were out there together or if some tenants wanted to stay indoors, another staff would come to the unit and stay inside the unit.

The Program was directed by the monitors to immediately stop the practice of allowing memory care unit tenants to be outside unattended.

There was not sufficient staffing in the memory care unit to fully meet tenants identified needs.

- Monitoring Observation: A community meeting with 11 tenants was held. They described staff as hard working and said staff was running around. They said breakfast was served later and it took more time to be served at times. The beds were made late in the day on some days. One tenant reported having a urinary incontinent episode as a result of having to wait to get an assistive device in the dining room and return to the tenant's apartment. The tenants reported staff lost a float and there had been staff turnover. The tenants said the staffs' phones rang when they were in apartments helping tenants. They said some staff was trained to provide the services and some were not.

  Staff #1 said she felt stress to get it all done, mostly during breakfast when asked if there enough staff to meet the needs of the tenants.

  Staff #2 said there was enough staff to meet the needs of the tenants in the general population but would like some help in the memory care unit at times.

  Staff #3 said "probably not" when asked if there was enough staff to meet the needs of the tenants. She said they used to have a 7:00 a.m. to 1:00 p.m. staff in the general population until about four months when census decreased. She said they also used to have a second shift float from 5:00 p.m. to 7:00 p.m. She said some baths were not done but were documented as done. She said staff was rushed at meal times.

  Staff #4 said sometimes beds were not made until 2:00 p.m. She said bathing was difficult in the morning and it was very hard to get everything done in the morning.

She said the float staff was taken away and it was pretty hard without that person. She was not aware of staff not giving showers. One staff had to stay in the dining room if there were tenants present and after meals there was approximately 5 to 15 minute wait for an escort back to tenant apartments. She said some really had to go to the restroom. She said the housekeeping could be better.

The Nurse said overall there was enough staff. There was nothing being delayed or not done because of staffing.

The Director was interviewed and stated there was no staffing ratio. She normally ran one staff to 7 or 8 tenants in the memory care unit and one staff for 12 or 13 tenants in the general population. A float staff was available when the Program was at full occupancy. She stated she felt tenant needs were being met.

The community meeting and staff interviews indicated there was not sufficient staff to meet the needs of the tenants.

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

C. Evaluation

Complaint/Incident Allegation: It was alleged there was a tenant who received Morphine and was high level of care.

- Monitoring Observation: Eight tenant files (Tenants #1, #2, #3, #4, #5, #6, #7 and #8) were reviewed. Tenant #2 was on hospice and received Morphine.

  Tenant #2, a 78 year old, was admitted on 8-4-13 and diagnoses included: Dementia, Diabetes, Kidney Failure, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Status/Post Coronary Artery Bypass Graft x4 and Stenosis of the Spine. Tenant #2 died on 8-18-13. Tenant #2 resided in the memory care unit and received hospice services.

  Nurse Progress Notes dated 8-5-13 indicated staff found Tenant #2 on the floor in front of Tenant #2's chair on Tenant #2's knees at 5:10 p.m. There was no injury reported but later staff noted a goose egg on right forehead and related headache, backache and a bruise on the right shoulder. Staff reported Tenant #2 did not sleep at all during the night and was up wandering in the memory care unit trying doors. Nurse Progress Notes dated 8-6-13 indicated a new script for Morphine Sulfate (MS) Concentrate was obtained and sent to the pharmacy. Notes dated 8-8-13 indicated staff reported Tenant #2 was very restless and was in constant motion. The home health nurse was there and felt Tenant #2 must have suffered a major health event as Tenant #2's confusion and condition had declined from previous home visits. The home health nurse contacted the doctor for updated orders and a hospice referral. Nurse Progress Notes dated 8-8-13 indicated hospice was there to admit and discussed with family to discontinue dialysis. Notes dated 8-9-13 indicated hospice was there that morning, there was less agitation reported by staff. Tenant #2 had a poor appetite and Morphine was changed to a scheduled dose four times daily and to

continue the as needed dose. Tenant #2 had a fall on 8-6-13 and 8-7-13 and family and the doctor were notified of the falls. According to Nurse Progress Notes dated 8-10-13, there was little oral intake and very little urine output. Tenant #2 talked about deceased relatives. Notes dated 8-12-13 indicated Lorazepam was increased by hospice that weekend and Tenant #2 had incoherent response to questions noted. Tenant #2 slept in the recliner with staff checking on Tenant #2 frequently. Staff reported poor intake when foods and fluids were offered. On 8-12-13 daily blood sugars were discontinued by hospice. Nurse Progress Notes dated 8-14-13 indicated Tenant #2 had a fall on 8-14-13 and all oral medications were discontinued. On 8-15-13 the hospice nurse increased as needed Lorazepam. On 8-16-13 staff was able to get Tenant #2 into bed and Tenant #2 was being repositioned every two hours. Tenant #2 was unable to take anything orally. Tenant #2 was incontinent of a small amount of urine that a.m. No mottling was noted and there were periods of apnea noted. Nurse Progress Notes dated 8-19-13 indicated staff called to report Tenant #2 expired on 8-18-13 at 2:50 a.m.

Hospice notes indicated on 8-12-13 blood sugar monitoring was discontinued and left elbow wound cares were discontinued as the site was healed. Hospice Notes dated 8-14-13 indicated Tenant #2 continued to be in the recliner. There was mottling noted to bilateral lower extremities, color ashen and 30 seconds of apnea noted when sleeping. On 8-14-13 all medications except Morphine, Lorazepam, Fentanyl and Biscodyl were discontinued. Hospice notes dated 8-15-13 indicated Tenant #2 was in the recliner, attempt to be in the hospital bed caused Tenant #2 increased discomfort and anxiety. There was no oral intake. On 8-16-13 Tenant #2 was noted as visibly more comfortable, family reported decreased calling out and decreased restlessness. There were periods of apnea noted with increased frequency since last visit.

Evaluations were completed on 8-4-13 and a Preliminary Service Agreement was signed on 8-4-13. Evaluations were not completed after 8-4-13. Evaluations were not completed as needed with significant change.

Staff #1, #2, #5, #6, #7, #8 had nurse delegated training on medication administration. The Nurse said the Morphine was in pre-filled syringes and staff had training for liquid medications in the medication administration training. The Nurse said Tenant #2's medications were administered consistent with orders.

Review of tenant files indicated Tenant #2 received Morphine. Review of staff files and an interview with the Nurse indicated staff had nurse delegations for medication administration, which included liquid medications. Tenant #2's file reflected evaluations were not completed as needed with significant change as Tenant #2's condition declined.

- 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: Eight tenant files (Tenants #1, #2, #3, #4, #5, #6, #7 and #8) were reviewed.

  Tenant #2's file was reviewed. Nurse Progress Notes dated 8-5-13 indicated staff found Tenant #2 on the floor in front of Tenant #2's chair on Tenant #2's knees at 5:10 p.m. There was no injury reported but later staff noted a goose egg on right forehead and related headache, backache and a bruise on the right shoulder. Staff reported Tenant #2 did not sleep at all during the night and was up wandering in the memory care unit trying doors. Nurse Progress Notes dated 8-6-13 indicated a new script for MS Concentrate was obtained and sent to the pharmacy. Notes dated 8-8-13 indicated staff reported Tenant #2 was very restless and was in constant motion. The home health nurse was there and felt Tenant #2 must have suffered a major health event as Tenant #2's confusion and condition had declined from previous home visits. The home health nurse contacted the doctor for updated orders and a hospice referral. Nurse Progress Notes dated 8-8-13 indicated hospice was there to admit and discussed with family to discontinue dialysis. Notes dated 8-9-13 indicated hospice was there that morning, there was less agitation reported by staff. Tenant #2 had a poor appetite and Morphine was changed to a scheduled dose four times daily and to continue the as needed dose. Tenant #2 had a fall on 8-6-13 and 8-7-13 and family and the doctor were notified of the falls. According to Nurse Progress Notes dated 8-10-13, there was little oral intake and very little urine output. Tenant #2 talked about deceased relatives. Notes dated 8-12-13 indicated Lorazepam was increased by hospice that weekend and Tenant #2 had incoherent response to questions noted. Tenant #2 slept in the recliner with staff checking on Tenant #2 frequently. Staff reported poor intake when foods and fluids were offered. On 8-12-13 daily blood sugars were discontinued by hospice. Nurse Progress Notes dated 8-14-13 indicated Tenant #2 had a fall on 8-14-13 and all oral medications were discontinued. On 8-15-13 the hospice nurse increased as needed Lorazepam. On 8-16-13 staff was able to get Tenant #2 into bed and Tenant #2 was being repositioned every two hours. Tenant #2 was unable to take anything orally. Tenant #2 was incontinent of a small amount of urine that a.m. No mottling was noted and there were periods of apnea noted. Nurse Progress Notes dated 8-19-13 indicated staff called to report Tenant #2 expired on 8-18-13 at 2:50 a.m.

  Hospice notes indicated on 8-12-13 blood sugar monitoring was discontinued and left elbow wound cares were discontinued as the site was healed. Hospice Notes dated 8-14-13 indicated Tenant #2 continued to be in the recliner. There was mottling noted to bilateral lower extremities, color ashen and 30 seconds of apnea noted when sleeping. On 8-14-13 all medications except Morphine, Lorazepam, Fentanyl and Biscodyl were discontinued. Hospice notes dated 8-15-13 indicated Tenant #2 was in the recliner, attempt to be in the hospital bed caused Tenant #2 increased discomfort and anxiety. There was no oral intake. On 8-16-13 Tenant #2 was noted as visibly more comfortable, family reported decreased calling out and decreased restlessness. There were periods of apnea noted with increased frequency since last visit.

Evaluations were completed on 8-4-13 and a Preliminary Service Agreement was signed on 8-4-13. Evaluations were not completed after 8-4-13. A service plan was developed on 8-10-13. The service plan was not updated as needed with significant change.

Tenant #2's file reflected the service plan was not completed as needed with significant change as Tenant #2's condition declined.

- Regulatory Insufficiency: When a tenant needed 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))

E. Structural Requirements

- Monitoring Observation: A community meeting with 11 tenants was held. The tenants said the exterior of the building needed improvements and said two years ago they were going to build on and the siding was taken off and the siding was not put back on or replaced.

  The monitors observed large areas of the exterior of the building did not have siding. The areas on the west end of the building did not have siding and insulation appeared to be exposed. There were some areas where the insulation appeared to be removed and some wood was exposed. There was an area located near the ground where the insulation was gone and wood was exposed where there could be the potential for rodents or pests to enter the structure.

  In addition to the lack of siding there were several observations made regarding the interior and exterior of the building. The following were observations made:

  - An area of sidewalk in the back of the building near an exit door was observed. The concrete appeared to be cracked and broken apart.
  - On second floor located near the unisex restroom the carpet had a bubbled appearance.
  - On second floor down from the unisex bathroom there was a raised ridge under the carpet that went across the hall from wall to wall.
  - In the dining room the floor which appeared to be laminate was worn and had white showing through the flooring.
  - The carpet near the pantry on first floor appeared to be dark in color and soiled.

  The Director stated she had been working with the management company for two years trying to resolve the issue of getting the outside siding on the building. She was not aware of any issues in regards to the building not having the siding in place. She stated she had asked for the dining room flooring to be replaced as the finish was

wearing off and asked for replacement of stained carpet. At that time she had not received a response to her requests.

The Maintenance Tech said approximately three to four years ago there were plans drawn up to expand and the siding was taken down. Wiring was re-routed, a new panel was put out and the siding was taken off. He said the insulation was what was exposed and he was not aware of any issues with mold and mildew. He said there were issues with the floor settling regarding the area on second floor.

The community meeting, observations and interviews indicated the building and grounds were not well-maintained, clean, safe and sanitary.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481-69.35(1)(b))