IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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KIM REYNOLDS
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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 45856-C

December 26, 2013

Ms. Annette Grochala, Administrator
Vintage Hills Retirement Community
604 E. Hillcrest Drive
Indianola, IA 50125

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - VINTAGE HILLS RETIREMENT COMMUNITY
II. *Reduction of Civil Penalty*
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Grochala:

I. Final Complaint/Incident Investigation Report – Vintage Hills Retirement Community, Indianola, IA

Enclosed is the **Final 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 **November 21 & 25, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Criteria for Admission and Retention, Tenant Rights, Program Reporting to Department, Occupancy Agreement, Evaluation and Service Plans.

Vintage Hills Retirement Community ("Program") is being assessed a **$1,000 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 Evaluations and Service Plans.

The determination of a **$1,000 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Evaluations and Service Plans. As the enclosed Report details, the Program failed to complete Evaluations and Service Plans as required by the administrative rules.

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 **six hundred and fifty dollars ($650)** 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 **$1,000 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 December 23, 2013, has been reviewed and will constitute the final POC related to the on-site visit of November 21 & 25, 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 Complaint/Incident Investigation Report

Assisted Living Program:

Annette Grochala, Administrator
Vintage Hills Retirement Community
604 E. Hillcrest Dr.
Indianola, Iowa 50125

Complaint/Incident Intake #:

45856-C

Date of Complaint/Incident Investigation:

November 21 & 25, 2013

Monitor(s):

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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	23
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	28

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	10
TOTAL census of Assisted Living Program	38

Program History – The program received regulatory insufficiencies during the Oct. 2012 Recertification on-site in the areas of: Evaluation, Service Plan, Food Service, Dementia Specific Education and Structural. During the July 2013 Incident Investigation (44318-I, 44425-I), the program received regulatory insufficiencies in the areas of Service Plan and Managed Risk.

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

A. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged multiple tenants residing in the program's dementia unit exceeded assisted living level of care.

- Monitoring Observation: The program identified nine cognitively impaired tenants who resided in the secured dementia unit. The program also identified Tenant #3 who was discharged from the secured dementia unit due to level of care issues in the previous three months..

  During interview, Staff #1, #2, #3 and #4 identified Tenants #3, #4 and #5 as requiring routine two person transfers and identified Tenants #1, #2 and #4 as exhibiting combative, aggressive behaviors toward staff members while staff provided care to each tenant.

  The monitor reviewed the program's September, October and November 2013 incident reports, noting Tenant #6 had multiple falls during the above stated time period.

  The clinical records of Tenants #1, #2, #3, #4, #5 and #6 were reviewed.

Tenant #1, a 70 year old, was admitted to the program on 10-7-13 and resided in the secured dementia unit. Tenant #1 had diagnoses of: Vascular Dementia, Depression, Anxiety and Peripheral Vascular Disease. Tenant #1 scored a 6 on the Global Deterioration Scale (GDS) completed on 9-30-13 and 11-5-13, indicating severe cognitive decline. According to Tenant #1's clinical record, Tenant #1 exhibited one episode of physical aggression toward staff members during the first week living at the program. Tenant #1 pushed and hit staff members but did not injure anyone. The program notified Tenant #1's physician of the aggressive behavior and medications were adjusted. Tenant #1 had no further documented episodes of physical aggression following the medication changes. The monitor observed Tenant #1 during the on-site visit, noting no level of care issues.

Tenant #2, an 88 year old, was admitted to the program on 7-24-13 and resided in the program's secured dementia unit. Tenant #2 had diagnoses of: Macular Degeneration, Glaucoma, Vascular Dementia, Schizophrenia and a History of Falls. Tenant #2 scored a 4 on the GDS completed on 7-24-13 and 8-22-13, indicating moderate cognitive decline. Tenant #2's vision was extensively impaired secondary to Macular Degeneration, allowing Tenant #2 to see shadows only. Tenant #2's service plan, dated 11-18-13, indicated Tenant #2 required assistance with bathing, grooming and dressing. Tenant #2 was independent with transfers, mobility and toileting. Tenant #2 required assistance with meals due to blindness, requiring staff members to tell Tenant #2 where each food item was located and cut up foods, open packets, etc. The monitor observed Tenant #2 during the on-site visit, noting Tenant #2 was able to transfer, ambulate and toilet independently and was able to feed him/herself after staff members prepared the foods and identified the location of the meal items. The monitor noted no level of care issues.

Tenant #3, an 82 year old, was admitted to the program on 10-1-12, previously resided in the secured dementia unit and was discharged from the program on 10-20-13 due to level of care issues. Tenant #3 had diagnoses of Alzheimer's Disease, Diabetes, Hypertension (HTN), Arthritis, Chronic Urinary Tract Infections and a History of Falls. Tenant #3 scored a 6 on the GDS completed on 9-30-13, indicating severe cognitive decline. Tenant #3's service plan, dated 9-30-13, indicated Tenant #3 began requiring two persons to assist with all transfers and was no longer able to stand or bear weight. Tenant #3 began using a wheelchair, propelled by staff members, for all mobility and became completely dependent with bathing, grooming, dressing and toileting. According to Resident Notes, Tenant #3 was diagnosed and treated for urinary tract infections in August 2013, September 2013 and October 2013. The program notified the physician each time Tenant #3 exhibited symptoms of urinary tract infection, the physician ordered a urinalysis and treated the positive urinary tract infections with antibiotics. Tenant #3's health and functional abilities deteriorated during the time of the chronic urinary tract infections, resulting in Tenant #3 exceeding assisted living level of care. On 9-23-13, the program gave Tenant #3's legal representative verbal notification of a 30 day notice to discharge due to level of care issues. Tenant #3 moved from the program on 10-20-13. Tenant #3 exceeded the level of care for an assisted living program; however, the program identified the level of care concerns, gave notice of discharge to Tenant #3's legal representative and Tenant #3 moved from the program to a higher level of care.

Tenant #4, an 89 year old, was admitted to the program on 1-14-13 and resided in the secured dementia unit. Tenant #4 had diagnoses of Alzheimer's Disease, Anxiety, Atrial Fibrillation, HTN, Osteoporosis, Osteoarthritis and a History of Cellulitis. Tenant #4 scored a 6 on the GDS completed on 7-31-13 and 10-28-13, indicating severe cognitive decline. According to Tenant #4's service plan, dated 10-28-13, Tenant #4 required routine two person assistance with transfers, was no longer able to ambulate, requiring the use of a wheelchair for all mobility. The service plan indicated Tenant #4 could eat independently with staff member cuing.

During the on-site visit, the monitor observed staff members routinely transferring Tenant #4 using two persons. Tenant #4 used a wheelchair for all mobility on 11-21-13 and 11-25-13. The monitor observed Tenant #4 transfer three times during the on-site visit to toilet. Tenant #4 did not bear weight well during all three visits, stooped over during the transfer and required two staff members to support his/her weight using a gait belt. During toileting, Tenant #4 became physically aggressive with staff members, swiping at staff members' hands, screaming and crying and hitting at staff. The monitor observed Tenant #4 eating three meals during the on-site visit, noting staff members cut up foods, opened packets, etc. then Tenant #4 ate independently with minimal cuing for all three meals.

On 10-21-13 the program gave Tenant #4's legal representative verbal notification of a 30 day notice to discharge due to level of care issues. Tenant #3 continued to remain at the program on 11-25-13. According to Resident Notes, Tenant #4's legal representative was currently trying to find placement for Tenant #4 in a long term care facility and was awaiting approval of an application for transfer. Tenant #4 exceeded the level of care for an assisted living program; however, the program identified the level of care concerns, gave notice of discharge to Tenant #4's legal representative and the representative was currently awaiting acceptance of Tenant #4 to a higher level of care.

Tenant #5, an 86 year old, was admitted to the program on 3-30-13 and currently resided in the program's secured dementia unit. Tenant #5 had diagnoses of Alzheimer's Disease, HTN, Coronary Artery Disease and a history of falls. Tenant #5 scored a 6 on the GDS completed on 7-19-13 and 10-16-13. According to the service plan, dated 10-16-13, Tenant #5 required the assistance of one to transfer, ambulate and toilet. The same service plan indicated Tenant #5 required prompting and cuing during meals.

During interview, Staff #1, #2, #3 and #4 reported Tenant #5 could eat finger foods independently but had to be fed all other types of foods by staff members. Staff #1, #2, #3 and #4 reported for at least two months, Tenant #5 had been requiring two persons for all transfers and ambulation. Staff #2 and #3, both universal workers who work full-time in the dementia unit, reported Tenant #5 had been requiring two person transfers and ambulation assistance 90 to 100 percent of the time for at least two months. Staff #1 and #4 worked part-time and Staff #4 had only been employed by the program for one month. Staff #4 reported Tenant #5 had been a two person transfer the entire time she had been employed by the program. Tenant #5 required the assistance of one staff member to toilet.

During the on-site visit, the monitor observed Tenant #5 during three meals. Tenant #5 was able to eat finger foods independently and drink liquids independently if handed a glass and cued to drink. Staff members fed Tenant #5 all other types of foods during all three meals. During the on-site visit, the monitor observed staff members transfer and ambulate Tenant #5 multiple times. Each time staff members transferred Tenant #5, two staff members used a gait belt and walked on each side of Tenant #5. Tenant #5's gait appeared to be unsteady and Tenant #5 walked with a stooped gait.

Regulations require all tenants residing in an assisted living to transfer and ambulate with no more than one person assistance. According to staff member report Tenant #5 had been requiring two person assistance with both 90 to 100 percent of the time for at least two months. Tenant #5 exceeded the level of care allowable for an assisted living program. The program had not given Tenant #5's legal representative a 30 day notice of discharge at the time of the on-site visit.

Tenant #6, an 83 year old, was admitted to the general population area of the program on 7-13-11, moved to the secured dementia unit on 10-18-13 and currently resided in the dementia unit. Tenant #6 had diagnoses of: Parkinson's Disease, HTN, Peripheral Vascular Disease and Lewey Body Dementia. Tenant #6 scored a 2 on the GDS completed on 10-18-13, indicating very mild cognitive decline. According to incident reports, Tenant #6 fell without injury on 9-26-13, 10-1-13, 10-7-13, 10-11-13 twice and 10-16-13. At this time, the program did an evaluation, determining Tenant #6 would benefit from closer supervision. Tenant #6 was transferred to the secured dementia unit so staff members could more closely supervise Tenant #6. According to the service plan, dated 10-18-13, Tenant #6 would continue to ambulate independently with a walker but would call staff members for assistance if the walker was not in reach. According to incident reports, Tenant #6 fell again with no injury on 10-26-13, 11-1-13, 11-2-13, 11-5-13 and 11-13-13. Tenant #6's service plan was updated on 11-4-13 requiring Tenant #6 to have the assistance of one staff member with all ambulation and on 11-8-13 to add a pad alarm to be placed under Tenant #6 at all times to help notify staff members should Tenant #6 stand without assistance. Tenant #6 had experienced no further falls since the change to the service plan. The monitor observed Tenant #6 during the on-site visit, noting no level of care concerns.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who requires routine, two-person assistance with standing, transfer or evacuation. (IAC r. 481-69.23(1)b)

B. Tenant Rights

Complaint/Incident Allegation: It was alleged a staff member yelled at a cognitively impaired tenant and grabbed the tenant's arm in a rough manner while caring for the tenant.

- Monitoring Observation: The monitor interviewed Staff #1, #2, #3 and #4, all universal workers who routinely work in the program's secured dementia unit. All four staff members reported never witnessing any verbal or physical abuse or any interactions that made them feel uncomfortable. During interview, Staff #5 and #6

reported Staff #1, Licensed Practical Nurse (LPN) yelled at Tenant #4 while providing toileting assistance in early October 2013.

Staff #5, a universal worker, reported being called to the secured dementia unit on Sunday 10-6-13 to assist Staff #1 and Staff #6 in toileting Tenant #4. Tenant #4 had an involuntary bowel movement in his/her incontinence product. While attempting to clean Tenant #4 up he/she became very combative, hitting staff members, screaming and crying. The bowel movement was very large and made a mess on the floor, toilet and on Tenant #4 and his/her clothes. Staff #5 reported during the attempt to clean Tenant #4 up Staff #1 screamed, "Shut up, shut up" to Tenant #4 and grabbed Tenant #4 at the elbow when yelling at Tenant #4. Staff #5 told the monitor she reported the incident to the registered nurse (RN) on Monday 10-7-13 as an allegation of dependent adult abuse. The RN reportedly instructed Staff #5 to write out a witness statement. Staff #5 reported she wrote out a witness statement and gave the written witness statement to Staff #7, Office Manager, at approximately 2:00 PM on Monday 10-7-13. Staff #5 reported she was interviewed about the incident by telephone the following day by the program Administrator.

Staff #6, a universal worker, reported on a Sunday in early October Tenant #4 had an involuntary bowel movement in his/her incontinence product. While attempting to clean Tenant #4 up he/she became very combative, hitting staff members, screaming and crying. The bowel movement was very large and made a mess on the floor, toilet and on Tenant #4 and his/her clothes. Staff #6 reported during the attempt to clean Tenant #4 up Staff #1 screamed, "Shut up, shut up" to Tenant #4. Staff #6 denied seeing Staff #1 grab Tenant #4 at the elbow when yelling at Tenant #4. Staff #6 told the monitor Tenant #4 was attempting to grab at his/her clothing, which was soiled with bowel movement. Staff #1 was reportedly holding Tenant #4's hands in attempt to keep Tenant #4 from touching the bowel movement. Staff #6 reported she told Staff #1 to leave the room when she told Tenant #4 to shut up. Staff #1 did leave the immediate area where Tenant #4 was. Staff #6 reported she was interviewed about the incident by telephone two days after the incident by the Administrator.

According to the program's investigation, dated 9-9-13 (in error) and signed by the Administrator and the RN, Staff #5 reported Staff #1 told Tenant #4 to shut up and grabbed Tenant #4's arm in anger. Staff #6 denied hearing Staff #1 tell Tenant #4 to shut up and denied seeing Staff #1 grab Tenant #4's arm. The RN examined Tenant #4, noting no bruises to the arm approximately two days after the incident. The Administrator reported she did investigate Staff #5's allegation of abuse and determined no abuse occurred. The Administrator reported she did not report the allegations of abuse to the Department of Inspections and Appeals.

The two witnesses to the incident involving Staff #1 and Tenant #4 both reported Staff #1 screamed, "Shut up, shut up" to Tenant #4. Tenant #4 was not treated with consideration and respect.

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

C. Program Reporting to the Department

Complaint/Incident Allegation: It was alleged a tenant who required staff member assistance fell, fractured his/her knee and the program did not report the incident to the Department of Inspections and Appeals.

- Monitoring Observation: The monitor reviewed the program's incident reports for September, October and November 2013 noting Tenants #2, #5 and #6 had one or more falls during the three months. Tenant #2 and Tenant #6's falls did not result in any injury. Tenant #5's clinical record indicated Tenant #5 fell while attempting to stand on 9-27-13 while unsupervised by staff. Tenant #5 required the assistance of one staff member for all transfers and ambulation at the time of the fall. Tenant #5's knee was swollen and bruised. A portable x-ray was taken of the knee, resulting in no fracture. The program would not have had to report this to the Department of Inspections and Appeals as the injury would not have been defined as major.

  Staff #5, a universal worker, reported being called to the secured dementia unit on Sunday 10-6-13 to assist Staff #1 and Staff #6 in toileting Tenant #4. Tenant #4 had an involuntary bowel movement in his/her incontinence product. While attempting to clean Tenant #4 up he/she became very combative, hitting staff members, screaming and crying. The bowel movement was very large and made a mess on the floor, toilet and on Tenant #4 and his/her clothes. Staff #5 reported during the attempt to clean Tenant #4 up Staff #1 screamed, "Shut up, shut up" to Tenant #4 and grabbed Tenant #4 at the elbow when yelling at Tenant #4. Staff #5 told the monitor she reported the incident to the RN on Monday 10-7-13 as an allegation of dependent adult abuse. The RN reportedly instructed Staff #5 to write out a witness statement. Staff #5 reported she wrote out a witness statement and gave the written witness statement to Staff #7, Office Manager, at approximately 2:00 PM on Monday 10-7-13. Staff #5 reported she was interviewed about the incident by telephone the following day by the Administrator.

  Staff #6, a universal worker, reported on a Sunday in early October Tenant #4 had an involuntary bowel movement in his/her incontinence product. While attempting to clean Tenant #4 up he/she became very combative, hitting staff members, screaming and crying. The bowel movement was very large and made a mess on the floor, toilet and on Tenant #4 and his/her clothes. Staff #6 reported during the attempt to clean Tenant #4 up Staff #1 screamed, "Shut up, shut up" to Tenant #4. Staff #6 denied seeing Staff #1 grab Tenant #4 at the elbow when yelling at Tenant #4. Staff #6 told the monitor Tenant #4 was attempting to grab at his/her clothing, which was soiled with bowel movement. Staff #1 was reportedly holding Tenant #4's hands in attempt to keep Tenant #4 from touching the bowel movement. Staff #6 reported she told Staff #1 to leave the room when she told Tenant #4 to shut up. Staff #1 did leave the immediate area where Tenant #4 was. Staff #6 reported she was interviewed about the incident by telephone two days after the incident by the Administrator.

  According to the program's investigation, dated 9-9-13 (in error) and signed by the Administrator and the RN, Staff #5 reported Staff #1 told Tenant #4 to shut up and grabbed Tenant #4's arm in anger. Staff #6 denied hearing Staff #1 tell Tenant #4 to

shut up and denied seeing Staff #1 grab Tenant #4's arm. The RN examined Tenant #4, noting no bruises to the arm approximately two days after the incident. The Administrator reported she did investigate Staff #5's allegation of abuse and determined no abuse occurred. The Administrator reported she did not report the allegations of abuse to the Department of Inspections and Appeals.

- Regulatory Insufficiency: A staff member or employee of a facility or program who, in the course of employment, examines, attends, counsels, or treats a dependent adult in a facility or program and reasonably believes the dependent adult has suffered abuse, shall report the suspected adult abuse to the department. If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged abuser, the staff member shall directly report the abuse to the department within twenty-four hours. (IAC r. 235 E, 2 and 3 a.)

During the on-site visit, the monitor identified the following:

D. Occupancy Agreement

- Monitoring Observation: Tenant #3's service plan, dated 9-30-13, indicated Tenant #3 began requiring two persons to assist with all transfers and was no longer able to stand or bear weight. Tenant #3 began using a wheelchair, propelled by staff members, for all mobility and became completely dependent with bathing, grooming, dressing and toileting. According to Resident Notes, Tenant #3 was diagnosed and treated for urinary tract infections in August 2013, September 2013 and October 2013. The program notified the physician each time Tenant #3 exhibited symptoms of urinary tract infection, the physician ordered a urinalysis and treated the positive urinary tract infections with antibiotics. Tenant #3's health and functional abilities deteriorated during the time of the chronic urinary tract infections, resulting in Tenant #3 exceeding assisted living level of care. On 9-23-13, the program gave Tenant #3's legal representative verbal notification of a 30 day notice to discharge due to level of care issues. Tenant #3 moved from the program on 10-20-13. The program identified the level of care concerns and gave verbal notice of discharge to Tenant #3's legal representative but failed to give written notice of the change to Tenant #3's occupancy agreement.

  Tenant #4's service plan, dated 10-28-13, indicated Tenant #4 required routine two person assistance with transfers, was no longer able to ambulate, requiring the use of a wheelchair for all mobility. During the on-site visit, the monitor observed staff members routinely transferring Tenant #4 using two persons. Tenant #4 used a wheelchair for all mobility on 11-21-13 and 11-25-13. The monitor observed Tenant #4 transfer three times during the on-site visit to toilet. Tenant #4 did not bear weight well during all three visits, stooped over during the transfer and required two staff members to support his/her weight using a gait belt. During toileting, Tenant #4 became physically aggressive with staff members, swiping at staff members' hands, screaming and crying and hitting at staff.

On 10-21-13 the program gave Tenant #4's legal representative verbal notification of a 30 day notice to discharge due to level of care issues. Tenant #3 continued to remain at the program on 11-25-13. According to Resident Notes, Tenant #4's legal representative was currently trying to find placement for Tenant #4 in a long term care facility and was awaiting approval of an application for transfer. Tenant #4 exceeded the level of care for an assisted living program. The program identified the level of care concerns and gave verbal notice of discharge to Tenant #4's legal representative but failed to give written notice of the change to Tenant #4's occupancy agreement.

- Regulatory Insufficiency: An assisted living program shall deliver to the tenant or the tenant's legal representative, at least thirty days prior to changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made. (IAC r. 231C.5.1)

E. Evaluation

- Monitoring Observation: Tenant #4's 90 day Nurse Review, dated as completed on 10-28-13 by Staff #8, LPN, documented Tenant #4 was dependent with all activities of daily living and was soon to be moving to a higher level of care. The evaluation, dated 7-31-13, indicated Tenant #4 was able to transfer, ambulate and toilet with the assistance of one staff member. Tenant #4's clinical record also included an evaluation of Tenant #4's health, cognitive and functional status, dated 10-28-13 and identified as a change of condition evaluation. The change of condition evaluation indicated Tenant #4 now required the assistance of two to transfer and toilet and could no longer ambulate, using a wheelchair for all mobility. The evaluation dated 10-28-13 was completed by Staff #8, LPN. All significant changs of condition evaluations must be completed by a registered nurse. Tenant #4's 10-28-13 significant change of condition evaluation of his/her health, cognitive and functional status was completed by an LPN.

  Tenant #6's clinical record included a change of condition evaluation of Tenant #6's health, cognitive and functional status. Tenant #6 began experiencing multiple falls. According to incident reports, Tenant #6 fell without injury on 9-26-13, 10-1-13, 10-7-13, 10-11-13 twice and 10-16-13. At this time, the program did an evaluation, determining Tenant #6 would benefit from closer supervision. Tenant #6 was transferred to the secured dementia unit so staff members could more closely supervise Tenant #6. According to the service plan, dated 10-18-13, Tenant #6 would continue to ambulate independently with a walker but would call staff members for assistance if the walker was not in reach. According to incident reports, Tenant #6 fell again with no injury on 10-26-13, 11-1-13, 11-2-13, 11-5-13 and 11-13-13. Tenant #6's service plan was updated on 11-4-13 requiring Tenant #6 to have the assistance of one staff member with all ambulation and on 11-8-13 to add a pad alarm to be placed under Tenant #6 at all times to help notify staff members should Tenant #6 stand without assistance. The program RN did not complete a change of condition evaluation of Tenant #6's health, cognitive and functional status when Tenant #6 began to require the assistance of one person for all transfers and ambulation and the pad alarm use.

Tenant #6's clinical record included a note to the physician, dated 11-21-13, documenting Tenant #6 lost 23.4 pounds in one month (from October to November 2013). As of 11-25-13 the program RN had not yet completed an evaluation of Tenant #6's health, cognitive and functional status following identification of the 23.4 pound weight loss.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall 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 with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

F. Service Plans

- Monitoring Observation: Tenant #5's service plan, dated 10-16-13, indicated Tenant #5 required the assistance of one to transfer, ambulate and toilet. The same service plan indicated Tenant #5 required only prompting and cuing during meals.

  During interview, Staff #1, #2, #3 and #4 reported Tenant #5 could eat finger foods independently but had to be fed all other types of foods by staff members. Staff #1, #2, #3 and #4 reported for at least two months, Tenant #5 had been requiring two persons for all transfers and ambulation. Staff #2 and #3, both universal workers who work full-time in the dementia unit, reported Tenant #5 had been requiring two person transfers and ambulation assistance 90 to 100 percent of the time for at least two months. Staff #1 and #4 worked part-time and Staff #4 had only been employed by the program for one month. Staff #4 reported Tenant #5 had been a two person transfer the entire time she had been employed by the program. Tenant #5 required the assistance of one staff member to toilet.

  During the on-site visit, the monitor observed Tenant #5 during three meals. Tenant #5 was able to eat finger foods independently and drink liquids independently if handed a glass and cued to drink. Staff members fed Tenant #5 all other types of foods during all three meals. During the on-site visit, the monitor observed staff members transfer and ambulate Tenant #5 multiple times. Each time staff members transferred Tenant #5, two staff members used a gait belt and walked on each side of Tenant #5. Tenant #5's gait appeared to be unsteady and Tenant #5 walked with a stooped gait.

  Tenant #5's service plan did not accurately reflect Tenant #5's needs and did not match what staff members had been required to do for Tenant #5 for the previous two month period.

  Tenant #6's clinical record included a change of condition evaluation of Tenant #6's health, cognitive and functional status. Tenant #6 began experiencing multiple falls. According to incident reports, Tenant #6 fell without injury on 9-26-13, 10-1-13, 10-7-13, 10-11-13 twice and 10-16-13. At this time, the program did an evaluation,

determining Tenant #6 would benefit from closer supervision. Tenant #6 was transferred to the secured dementia unit so staff members could more closely supervise Tenant #6. According to the service plan, dated 10-18-13, Tenant #6 would continue to ambulate independently with a walker but would call staff members for assistance if the walker was not in reach. According to incident reports, Tenant #6 fell again with no injury on 10-26-13, 11-1-13, 11-2-13, 11-5-13 and 11-13-13. Tenant #6's service plan was updated on 11-4-13 requiring Tenant #6 to have the assistance of one staff member with all ambulation and on 11-8-13 to add a pad alarm to be placed under Tenant #6 at all times to help notify staff members should Tenant #6 stand without assistance. The program RN did not complete a change of condition evaluation of Tenant #6's health, cognitive and functional status when Tenant #6 began to require the assistance of one person for all transfers and ambulation and the pad alarm use. Tenant #6's service plan was updated on 11-4-13 and 11-8-13, reflecting changes in Tenant #6's functional status and safety needs without completion of an evaluation. The service plan was not based on an evaluation.

- 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 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))

During the course of the complaint investigation, the monitor received a report of concerns that activities were not being done with tenants residing in the secured dementia unit. The monitor identified the following:

G. Activities

- Monitoring Observation: The monitor observed activities occurring during the on-site visit on 11-21-13 and 11-25-13. During interviews, Staff #1, #2, #3 and #4, all universal workers who routinely work in the dementia unit, reported doing exercises daily with dementia unit tenants, also do craft projects throughout the week and do spontaneous activities such as puzzles, reading the paper, threading beads and watching television programs or movies. During interview, Tenant #1's family member, who visits during the day and evenings every other day, reported observing activities occurring regularly in the dementia unit when visiting.

  The monitor reviewed the service plans for Tenants #1, #2, #4, #5 and #6. Each tenants' service plan included individualized spontaneous activities that staff members could utilize for each tenant. The program documented all spontaneous activities completed for each tenant. After review of the documentation, the monitor noted adequate activities were offered to and attended by tenants residing in the dementia unit.

- Regulatory Insufficiency: None noted.