IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

January 3, 2014

Mr. Dan Donohue, Administrator
Heritage Court Assisted Living
1499 Office Park Road
West Des Moines, IA 50265

RE: Final Recertification Monitoring Evaluation Report – Heritage Court Assisted Living, West Des Moines, IA

Dear Mr. Donohue:

Enclosed is the **Final Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has completed the review of your Plan of Correction (POC) in response to the **Preliminary Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0056** with effective dates of **January 8, 2014** through **January 7, 2016**.

If you have any questions in regard to this certification, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Recertification Monitoring Evaluation Report

Assisted Living Program:

Dan Donohue, Administrator
Heritage Court Assisted Living
1499 Office Park Road
West Des Moines, IA 50265

Date of Monitoring Visit:

December 17 and 18, 2013

Monitor(s):

Lori Miner, RN BSN

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

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

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

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

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	28
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	28
TOTAL census of Assisted Living Program	28

Tenant/Family Satisfaction Results – A meeting was held with eight tenants. The best thing about the program was that things were done for the tenants such as cooking and cleaning. Some tenants thought cleaning could be done more frequently. Tenants thought persons smoking outside the building left a mess that required more attention. Tenants used a call button in the apartment to request assistance. Staff members were reported to respond in five to ten minutes. The care was described as good and staff members were described as friendly. The food was not always good with hot foods hot only part of the time. Foods were reheated upon request. More fresh fruits and vegetables were desired. There were enough activities but more crafts and exercise were requested. Tenants reported feeling safe at the program and would recommend it to others.

Program History – During the course of the Recertification visit conducted on December 17 and 18, 2013, the program received regulatory insufficiencies in the areas of: Medications, Evaluations, Service Plans, and Nurse Review.

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

A. Evaluation of Tenant

Monitoring Observation: Tenant #1, a 77 year-old, was admitted o 5-29-13 and had diagnoses of: Lewy Body Dementia, Depressive Disorder, Hypertension, and Anxiety. Tenant #1 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive decline.

A nurse review of 9-5-13 indicated Tenant #1 had episodes of confusion and inappropriate behaviors and recent medication changes had helped. Progress notes of 10-9-13 indicated Tenant #1 was standing by the nurse's station hollering down the hallway. Tenant #1 was dressed in a shirt and a disposable undergarment that was not entirely covering the body. Tenant #1 stated everything in the apartment was wet, but the LPN found that clothing and furniture were dry. Notes of 11-18-13 revealed Tenant #1 was assisting another tenant by pushing the wheelchair when staff intervened. Tenant #1 began swearing and screaming at the staff member and attempted to push the staff member. Tenant #1 continued to speak loudly about staff throughout the evening shift.

Tenant #1 continued to speak loudly and yell in the apartment. Notes of 11-20 documented as a late entry for 11-19 documented Tenant #1 was yelling and clenching fists and informing staff that Tenant #1 could do what he/she wanted to do and could do it when he/she wanted to.

Notes of 11-21-13 documented Tenant #1 thought people were stealing things from Tenant #1. Notes indicated because of the behaviors of the last few days, an appointment was being made with the physician.

A fax to the physician dated 11-21-13 documented Tenant #1 had an increase in behaviors and was threatening staff. Tenant #1's confusion had increased and Tenant #1 had been accusing other tenants of sneaking into the apartment and taking things. On 11-22-13 medications were changed.

Notes of 11-29-13 indicated Tenant #1 had an episode of anger and yelling, and the nurse review of 12-2 indicated Tenant #1 had bouts of confusion with anger. The nurse review indicated Tenant #1 yelled at staff and other tenants.

Notes of 12-3-13 indicated Tenant #1 was in the hallway screaming, only partially dressed. Staff assisted Tenant #1 to dress. When staff went to assist with suspenders, Tenant #1 screamed they would "chop off my head." Tenant #1 began hitting self in the head with a fly swatter. Tenant #1 indicated family wanted to kill Tenant #1. Tenant #1 went to pacing up and down the hallway.

Tenant #1 exhibited behaviors including yelling at other tenants as early as September and continuing into December 2013. Medication changes were ordered on 11-22-13. Evaluations of function cognition and health were not completed with a significant change of condition. Evaluations were not completed until 12-9-13.

Tenant #3, a 79 year-old, was admitted on 4-5-13 and had diagnoses of: Adjustment Disorder with Anxiety, Aortic Valve Disorder, Cataracts, Chronic Obstructive Pulmonary Disease, Peripheral Neuropathy, and Lung Cancer. A nurse review dated 11-1-13 documented Tenant #3 was oxygen dependent and had occasional shortness of breath.

Progress notes dated 11-24-13 through11-30-13 documented Tenant #3 was feeling short of breath with some arm discomfort. Tenant #3 felt somewhat better, but then had more episodes of shortness of breath treated with prescribed nebulizer. On 11-30-13 Tenant #3 went to the hospital for continued shortness of breath. Tenant #3 was admitted to the hospital for cardiac observation.

Tenant #3 returned to the program on 12-4-13, a Wednesday, after a new diagnosis of Non-ST elevated Myocardial Infarction. The documentation indicated, because of the lung cancer, Tenant #3 was not a candidate for bypass surgery. Progress notes dated 12-4-13 indicated Tenant #3 indicated there was nothing more that could be done. Tenant #3 required assistance with evening cares. On 12-5-13, Tenant #3 had chest pain, relieved with nitroglycerin. On 12-6-13, Tenant #3 required assistance with dressing. Evaluations of function, cognition, and health were not completed until 12-9-13, a Monday. Evaluations were not completed upon return from the hospital following a diagnosis of Myocardial Infarction.

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

B. Service Plan

Monitoring Observation: Tenant #1 was exhibiting behaviors as early as September of 2013. On 11-22-13 medication changes were ordered for increased threatening behaviors. The service plan dated 7-24-13 and updated on 8-27, 10-16, 10-30, 10-31, 11-6, and 11-22-13 did not identify interventions related to threatening behaviors.

On 9-26-13 per Tenant #1's request, the physician ordered a therapeutic diet of regular with mechanical meat due to Tenant #1's lack of lower dentures. The service plan of 7-24, current at the time of the order, was not updated to include the dietary change. The service plan did not meet the identified needs of Tenant #1

Tenant #2, an 87 year-old, was admitted on 1-7-13 and had diagnoses of: Congestive Heart Failure, Chronic Kidney Disease, Gastroesophageal Reflux Disease, Hypertension, and Depression. Tenant #2 was admitted into hospice in the fall of 2012 for Congestive Heart Failure. Tenant #2 was admitted to the program with an order for a mechanical soft diet. On 10-17-13, the healthcare provider ordered Speech Therapy after a request from family due to Tenant #2's trouble speaking. The service plan did not identify Speech Therapy as an outside service provider and did not identify the mechanical soft diet. The service plan did not meet the identified needs of Tenant #2.

Tenant #3 returned from hospitalization on 12-4-13 following a new diagnosis of Myocardial Infarction. Because of Tenant #3's existing Lung Cancer bypass surgery was not an option. Tenant #3 had episodes of shortness of breath and chest pain after return to the program. The service plan of 12-9-13 did not identify interventions for chest pain. The service plan did not meet the identified needs of Tenant #3.

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))

C. Medications

Monitoring Observation: The morning medication pass was observed on 12-18-13. The monitor began observations of the medication pass at 7:45 a.m. The Licensed Practical Nurse (LPN) was performing the 8:00 a.m. medication passes. The LPN continued to pass medications and was still passing 8:00 a.m. medications at 9:10 a.m. At that time the LPN was asked which tenants still needed to receive 8:00 a.m. medications. The LPN identified the following tenants: #1,#4, #5, #6, #7, #8, #9, #10, and #11.

Tenant	Review of Medication Administration Record (MAR)
#4	12 meds due at 8:00 a.m. including Metformin for Diabetes, scheduled twice daily
#5	1 med due at 8:00 a.m., eye drops
#6	7 meds due at 8:00 a.m. including a narcotic scheduled again for 1:00 p.m.
#7	16 meds due at 8:00 a.m. including two diuretics, and Senna which was scheduled again at noon,
#8	8 meds due at 8:00 a.m. including a diuretic, and a narcotic scheduled again for noon
#9	10 meds due at 8:00 a.m. including a diuretic, and a narcotic scheduled again at noon
#10	3 meds due at 8:00 a.m.
#1	The LPN was observed administering 8:00 a.m. meds to Tenant #1 at 10:04 a.m. 9 meds were on the MAR as due at 8:00 a.m. including an anti-anxiety agent and an antidepressant, both due again at noon
#11	The LPN was observed administering 8:00 a.m. meds to Tenant #11 at 10:10 a.m. 7 meds due at 8:00 a.m.

The accepted standard of practice for medication administration is to administer medications one hour before to one hour after the scheduled time of administration. The program's medication administration procedure was reviewed and did not indicate anything other than accepted standards of medication administration related to time of administration were to be used. Accepted standards of practice were not followed.

At 9:20 a.m., the LPN was observed administering eye drops to Tenant #5. According to the MAR, the eye drops were scheduled for 8:00 a.m. The LPN entered the room and took the bottle of eye drops from an unsecured table next to Tenant #5's chair. The LPN administered the eye drops but did not have the MAR present for comparison of the eye drop bottle to the MAR. The MAR indicated Tenant #5 self-administered all other medications. The LPN traditionally administered eye drops. The eye drops were not secured by the program.

During the medication pass, the following was observed:

The LPN was observed applying gloves to hands so that a gel medication could be applied to Tenant #12's knees. The gel medication was applied. The gloves were removed and new gloves were applied without washing hands/applying sanitizer in between. The new gloves were used to apply a numbing gel to the dialysis site on the left upper arm. The gloves were removed and hands were washed.

The LPN was observed applying gloves to set up a hand-held inhaler. The gloves were removed once the capsule was inserted into the inhaler. Tenant #13 was given the inhaler to use. The LPN used bare hands with a swab to cleanse the portion of the inhaler that had been in Tenant #13's mouth. Hands were not cleansed after gloves were removed or after the inhaler was cleansed.
The LPN was observed applying gloves to set up a hand-held inhaler. The gloves were removed once the capsule was inserted into the inhaler. Tenant #2 was given the inhaler to use. The LPN used bare hands with a swab to cleanse the portion of the inhaler that

had been in Tenant #2's mouth. Hands were not cleansed after gloves were removed or after the inhaler was cleansed.

The LPN was observed administering medications to Tenant #14. Gloves were applied and the Potassium pill was broken at the score line. Gloves were removed. Hands were not cleansed. Gloves were again applied and the Fentanyl patch was applied and the old patch removed. Gloves were removed. Hands were not cleansed. New gloves were applied. Gloved hands were used to touch a tissue box and to get the bottle of eye drops from a plastic bag. Eye drops were administered and the gloves were removed. Hands were washed. Hands were not cleansed with glove removal or before the administration of eye drops.

The LPN was observed administering eye drops to Tenant #5. Gloves were removed after the eye drops were given. Hands were not cleansed after the gloves were removed or before caring for the next tenant.

The program's procedures for general medication administration, eye medications, and inhalers were reviewed. The procedures did not address hand sanitation during medication administration. The program did have a document on Standard Precautions which indicated the "single most effective way to prevent the spread of infection is hand washing."

The program did have a policy regarding glove use while serving meals. The policy indicated if gloves were soiled or if going from one task to another, gloves were to be removed, hands washed, and a new pair of gloves applied. When the task was completed, gloves were to be removed and hands washed.

The Registered Nurse (RN) was interviewed and stated the expectation was that hands were washed when gloves were removed. Hands were also to be washed after equipment was cleaned.

Hand washing was not completed to the expectation of the program.

Regulatory Insufficiency: When medications are administered traditionally by the program: (a) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4). (b) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. (IAC r. 481-67.5(6)(a,b))

D. Nurse Review

Monitoring Observation: During the medication pass, Tenant #1 was observed receiving medications from program staff. Tenant #1 had a 90-day nurse reviews completed on 9-5-13 and 12-2-13. The nurse review did not document the whether physician orders were current, whether medications were administered consistent with physician orders, and did not document whether or not Tenant #1 was having any adverse reactions to routine medications.

During the medication pass, Tenant #2 was observed receiving medications from program staff. Tenant #2 had a 90-day nurse review completed on 11-1-13. The nurse review did not document whether physician orders were current, whether medications were administered consistent with physician orders, and did not document whether or not Tenant #2 was having any adverse reactions to routine medications.

According to the service plan, Tenant #3 received medications from program staff. Tenant #3 had a 90-day nurse review completed on 11-1-13. The nurse review did not document whether physician orders were current, whether medications were administered consistent with physician orders, and did not document whether or not Tenant #3 was having any adverse reactions to routine medications.

Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders; and (IAC r. 481-69.27(1))