IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER

Complaint Intake #: 46612-M

February 4, 2014

Ms. Dawn Ethofer, Executive Director
Vintage Hills at Prairie Trail
1275 SW State Street
Ankeny, IA 50023

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL RECERTIFICATION AND COMPLAINT/INCIDENT INVESTIGATION REPORT - VINTAGE HILLS AT PRAIRIE TRAIL
II. Reduction of Civil Penalty
III. Informal Conference
IV. Standard Certification
V. Conclusion

Dear Ms. Ethofer:

I. Final Recertification and Complaint/Incident Investigation Report – Vintage Hills at Prairie Trail, Ankeny, IA

Enclosed is the **Final Recertification 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 **January 8, 9, 13, 14 and 15, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluations, Tenant Documents, Service Plans, Medications, Nurse Review, Food Service, Record Checks, Policies and Procedures and Tenant Rights.

Vintage Hills at Prairie Trail ("Program") is being assessed a **$1,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.17(1)(b), 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.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted to DIA within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) 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 Tenant Rights, Tenant Documents, Policies and Procedures, Evaluations, Service Plans, Nurse Review, and Record Checks.

The determination of a **$1,500 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Tenant Rights, Tenant Documents, Policies and Procedures, Evaluations, Service Plans, Nurse Review, and Record Checks. As the enclosed Report details, Program failed to perform Evaluations, Service Plans, Nurse Review and Record Checks as required. Doctor ordered tasks were not included on the Medication Administration Record. Two tenants were treated disrespectfully by a tenant whose service plan was not updated. Policies and procedures were not followed in relation to narcotics.

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 481−67.17(5). 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 **nine hundred seventy five dollars ($975)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

IV. Standard Certification

Also enclosed you will find the Assisted Living Program Certificate **S0326** with effective dates of **January 19, 2014 through January 18, 2016**.

V. Conclusion

The Program is being assessed a **$1,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

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 as provided in IAC rule 481-67.14.

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

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint/Incident#:** 46612-M

Dawn Ethofer, Executive Director
Vintage Hills at Prairie Trail Assisted Living
1275 SW State Street
Ankeny, IA 50023

Date of Monitoring Visit:

January 8, 9, 13, 14, and 15, 2014

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:	37
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	41
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	17
Total Population of Program at time of on-site	18
TOTAL census of Assisted Living Program	59

Tenant/Family Satisfaction Results – A meeting was held with 18 tenants. The best thing about the program was the staff, the independence, and being cared for well. Housekeeping was completed in apartments and common areas to the tenants' satisfaction. The tenants suggested ice in walkways and parking lots sometimes needed more attention, and additional parking for tenants who drive their own vehicles. Maintenance was reported to respond to requests in a timely manner. The tenants stated they used a panic button to request assistance. Staff members were reported to respond in five to 15 minutes. Staff members provided care that was described as good, excellent, and fantastic. Staff members were reported to treat tenants kindly and respectfully. The food was not necessarily good. The menu was described as repetitive, and a soup and sandwich was usually served at night. There were not enough fresh fruits and vegetables for the tenants' liking. Tenants reported portions were small, and beef was seldom served. There were enough activities offered, but more Bingo, more card games, and more outside entertainment was requested. Tenants reported feeling safe at the program, were generally satisfied, and would recommend it to others.

Program History – During the course of the Recertification visit conducted on January 8, 9, 13, 14, and 15, 2014 the program received regulatory insufficiencies in the areas of: Evaluations, Service Plans, Nurse Review, Medications, Food Service, Record Checks, Policies and Procedures, Tenant Documents, and Tenant Rights.

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

A. Evaluation of Tenant

Monitoring Observation: Tenant #1, an 81 year-old, was admitted on 12-12-13 and had diagnoses of: Chronic Airway Obstruction and Lung Cancer. The clinical record contained documentation Tenant #1 had been hospitalized in November 2013 for Radiation Pneumonia. During hospitalization, Tenant #1 had been unsteady on the feet

and noted to have fallen prior to and during the hospital stay. Tenant #1 was discharged from the hospital to a care center. A physician's discharge note dated 12-11-13, documented Tenant #1 was debilitated with pain, was using oxygen continuously, and had peripheral neuropathy. Tenant #1 was observed to have swelling in the extremities and cold extremities. Tenant #1 was also short of breath which was worse with exertion. The physician noted Tenant #1 appeared both acutely and chronically ill, appeared frail and debilitated. The physician noted Tenant #1 was to be followed by hospice upon discharge. Tenant #1 arrived at the program from the care center on 12-12-13.

An initial evaluation of function, cognition, and health dated 12-9-13, prior to admission, was partially completed by the previous Registered Nurse (RN). The initial evaluation of health lacked documentation of vital signs as indicated on the assessment form although the evaluation indicated Tenant #1 required routine monitoring of vital signs. Tenant #1 was also noted to have a weight loss that required monitoring. Tenant #1 was found to be independent with ambulation while using a walker, independent with transfers, and had a history of falls. Tenant #1 was to receive hospice services, and hospice was to provide assistance with bathing. Tenant #1 self-managed medications; however, the initial entry in the nurse's notes indicated the program was providing medication assistance. Tenant #1 had no cognitive impairment. The previous RN recorded vital signs in the nurse's notes on 12-12-13, the day of admission.

On 12-19-13, Tenant #1 exhibited signs and symptoms of a possible stroke. With guidance from hospice, the program sent Tenant #1 to the hospital via ambulance for evaluation.

Tenant #1 returned to the program later in the day and the nurse's notes documented an MRI indicated there was old blood from a recent brain bleed noted on the imaging of the brain. Documentation in the hospice notes indicated Tenant #1 had a Hygroma on the left side of the brain. An entry in the nurse's notes dated 12-19-13 at 5:30 p.m. documented, Tenant #1 was lethargic and weak, and required assist of two to transfer from the wheelchair to the bed. The right side was flaccid at times. Tenant #1 was noted to be a complete assist "with all ADL cares," and was incontinent. It was indicated Tenant #1 had episodes of unresponsiveness and the condition would increase as Tenant #1 declined. Evaluations of function, cognition, and health were not completed by an RN with a significant change in Tenant #1's condition.

On 12-20-13, nurse's notes documented the hospice nurse reported to the LPN that most of Tenant #1's medications had been discontinued and two liquid medications, Roxanol and Atropine had been ordered.

The nurse's notes of 12-23-13 documented the hospice nurse reported Tenant #1 had a left shin that had swelling, redness, and warmth. The nurse's notes documented a fax was sent to the physician for a topical antibacterial cream and wound care to the left shin. The nurse's notes also documented Tenant #1 had a red, excoriated peri-rectal area and the physician was contacted in regards for a medication order for the excoriated area. The documentation was signed by the LPN.

On 12-24-13, within 30 days of admission, Tenant #1 had evaluations of function and health completed by the Interim RN for a change of condition. A cognitive evaluation was not completed. Tenant #1 required no assistance with grooming, but required

bathing and dressing assistance. The evaluations indicated Tenant #1 self-managed any incontinence. The evaluation also indicated Tenant #1 had a history of falls and required a fall reduction program, required night checks, and assistance to meals. Tenant #1 was noted to use oxygen and required assistance from staff for breathing treatments. Tenant #1 was noted to require assistance in managing skin care needs and have a healing wound, but the evaluation did not include specific documentation of the wound. The location or condition of the wound was not noted. There was no documentation by a program RN of an evaluation of the shin and peri-rectal area as noted in the previous day's nurse's notes. The evaluation continued to note Tenant #1 had an infection, although the location was not identified, and Tenant #1 had daily pain management needs.

Tenant #5, an 86 year-old, was admitted on 9-9-13 and had diagnoses of: Lung Cancer, Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), Osteoarthritis, and Syndrome of Inappropriate AntiDiurectic Hormone Secretion (SIADH). A review of function and health was completed in the nurse's notes on 10-9-13. A cognitive evaluation was not completed at that time using a cognitive screening tool. Evaluations were not completed within 30 days of admission.

According to nurse's notes, Tenant #5 was admitted to the hospital on 11-3-13 for increased confusion and weakness. Tenant #5 returned to the program on 11-6-13 with a diagnosis of Urinary Tract Infection (UTI). Evaluations of function, cognition, and health were completed at that time. Tenant #5, who was initially staged at two on the Global Deterioration Scale (GDS) indicating very mild cognitive decline, was now staged at five, on the GDS, indicating moderately severe cognitive decline. Tenant #5 was admitted to hospice of 11-6-13 with a diagnosis of Lung Cancer.

A physician's order dated 11-14-13 documented Tenant #5 was rapidly declining and the physician asked about inpatient hospice. Hospice physician's orders form dated 11-27-13 and documented by the Hospice Nurse indicated Tenant #5 was starting to transition to end of life, having increased difficulty swallowing. Evaluations of function, cognition, and health were not completed by the program with a change of condition. Tenant #5 died on 11-29-13.

Tenant #6, a 71 year-old, was admitted on 12-18-13 and had diagnoses of: HTN, COPD, Hyperlipidemia, Dementia and Hypothyroidism. Tenant #6 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #6 resided in the secured dementia unit. The evaluations of 12-18-13 indicated Tenant #6 was in control of bowel and bladder and there was no documentation of behaviors. An elopement risk assessment was also completed on 12-18-13 which identified Tenant #6 as an elopement risk. A review of the service plan of 12-18-13 indicated Tenant #6 was continent of bowel and bladder and was independent with managing incontinence needs.

The program had documentation which contained the following:

Date	**Document**	**Documented the following:**
12-18-13	24 hour report	Very upset, confused, aggressive verbally. Wandering around and tried to escape.
12-19-13	24 hour report	Tenant #6 kept going into everyone else's apartment. Has tried to leave the

		dementia unit, setting off the alarms. Staff attempted redirection, but Tenant #6 just wanted to leave. Tenant #6 was agitated.
12-21-13	24 hour report	Threw stuffed animal at staff. Tried to get out for 20 minutes. Would not stay out of Tenant #7's room. Went to bed in Tenant #7's bed.
12-22-13	24 hour report	Tenant #6 tried to leave twice
12-27-13	24 hour report	Tenant #6 hit, spit on, and pulled the hair of a staff member. Tenant #6 tried to climb fence in the courtyard. At 4:45 a.m. Tenant #6 stated the need to leave and walked to the courtyard.
12-28-13	24 hour report	Tenant #6 set off the front door alarm trying to escape. Urinated in the chair.
12-31-13, 7:00 a.m.	Incident Report	Tenant #6 came out of the apartment wrapped in a blanket. Tenant #6 dropped the blanket and had no pants on. Tenant #6 had rubbed feces on another tenant. An incident report for Tenant #7 documented feces were smeared on him/her. The Interim RN documented looking into a door alarm for Tenant #6's apartment so staff would know when the apartment was vacated.
12-31-13, 11:20 a.m.	Incident Report	Tenant #6 tried getting out of the back door
1-4-14	24 hour report	Tenant #6 used trash can as toilet. Staff members were doing hourly checks.
1-5-14, 10:45 a.m.	Incident Report and 24 hour Report	Staff member could not find Tenant #6. A family member reported Tenant #8 had a chair that was wet. The staff member found the chair to contain urine, feces, and clothing that did not belong to the tenant. The incident report was completed for Tenant #6.
1-5-14	24 hour report	Tenant #6's apartment was cleaned for feces stains with feces everywhere. Tenant #6 also had food everywhere, behind furniture and in drawers. The 24-hour report also stated when doing hourly checks, Tenant #6's apartment was to be checked for feces and food.
1-7-14	24 hour report	Dirty dishes needed to be taken out of the apartment as soon as Tenant #6 was done because Tenant #6 was putting feces on the dishes.

There was no documentation of any incident of Tenant #6 using another tenant's room inappropriately after 1-5-14. An interview was conducted with the Interim RN. She stated the spouse had been a caregiver at home for Tenant #6 and the spouse was reported to be very protective. The spouse died and another relative assisted Tenant #6 with the move into the program and according to the relative, the spouse was so protective it was not known if the behaviors had been exhibited prior to admission. Tenant #6 exhibited behaviors of exit-seeking, wandering, aggression, and urinating and defecating in inappropriate places. Tenant #6 exhibited a change of behaviors since admission. Evaluations of function, cognition, and health were not completed with a change of condition.

Regulatory Insufficiency: A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional.
(IAC r. 481-69.22(1))

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

B. Tenant Documents

Monitoring Observation: Tenant #1 had physician orders dated 12-12-13 for oxygen at three to four liters per minute via nasal cannula continuously. The oxygen, physician ordered, was not on the Medication Administration Record (MAR) for December 2013 or January 2014.

On 12-26-13, a physician's order indicated staff members were to walk with Tenant #1 with a walker each day. The program provided documentation of a Distance Tracker form for Tenant #1 for January 2014. The form indicated staff members were to document the distance Tenant #1 walked, if he/she walked at all. The physician-ordered task of ambulation with directions to walk with a walker each day was not on listed on the MAR for January 20 14.

On 11-6-13 the hospice physician plan of treatment for Tenant #5 included the use of oxygen. On 11-14-13, Tenant #5 had another physician's order for oxygen. The physician ordered oxygen was not on the November 2013 MAR for Tenant #5.

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

C. Service Plan

Monitoring Observation: Tenant #1 was admitted to the program and admitted into hospice on 12-12-13. Tenant #1 had orders for oxygen, which was not on the service plan.

The initial evaluations completed on 12-9-13 indicated Tenant #1 had a history of falls and weight loss that required monitoring. The service pan of 12-9-13 did not identify interventions for a tenant with a history of falls. The service plan did not identify a monitoring plan for weight loss as identified in the initial evaluations. The service plan was not based on the evaluations. The service plan did not meet the identified needs of Tenant #1.

The service plan of 12-9-13 contained updates documented by the LPN dated 12-20-13 to include assists with grooming and hygiene, staff to provide perineal care due to incontinence, and "extensive assist with ADL cares" as Tenant #1 was unable to dress without assistance. Tenant #1 was also in need of an assist of one to two persons to transfer. Previously, Tenant #1 had been independent with hygiene and grooming, continence, dressing, and transfers. Evaluations of function, cognition, and health were not completed on 12-20-13. The service plan was not based on evaluations.
On 12-20-13, the LPN also indicated on the service plan Tenant #1 had periods of unresponsiveness. The service plan did not identify interventions for staff to follow when Tenant #1 was unresponsive. The service plan did not identify interventions for a tenant with a "brain bleed."

On 12-24-13, evaluations of function and health were completed. Tenant #1 was identified as no longer needing grooming assistance, self-managing incontinence, needing night checks, had a wound that required staff assistance, and pain management needs. The evaluations of 12-24-13 differed from the directives on the updates made to the service plan on 12-20-13. The service plan was not updated with the changes identified in the evaluations including wounds and pain management.

The hospice care plan of 12-19-13 identified pain, skin tears, and respiratory status as areas of concern which required intervention. The service plan of 12-9-13 with updates on 12-20-13 did not coordinate with the hospice plan of care.

On 1-9-14, a medication pass was observed by Staff #3 to Tenant #1. Staff #3 reported Tenant #1 had three wounds, two on the left leg and one on the right leg, that required treatment. Staff #3 reported program staff was only to care for spot on the shin of the left leg. The service plan did not identify multiple skin wounds and who was to care for each wound.

The service plan of 12-9-13 and updates of 12-20-13 indicated Tenant #1 would receive medications administered by the program. The December 2013 MAR indicated Tenant #1 self-administered an inhaler and nebulizer treatment. In an interview with Tenant #1 on 1-9-14 during the observed medication pass, Tenant #1 reported the self-administration of nebulizer treatments. The service plan did not identify Tenant #1 would self-administer some of the medications. The service plan did not meet the identified needs of Tenant #1.

Tenant #4, an 86 year-old, was admitted on 4-16-12 and had diagnoses of: Hypertension and B-12 Deficiency. Nurse's notes documented on 11-30-13, Tenant #4 had an unresponsive episode and was admitted to the hospital with return to the program on 12-3-13. On 12-12-13 nurse's notes and an incident report documented a staff member went in to administer medications and found Tenant #4 unsteady and repeating the same sentences. It was documented Tenant #4 reported falling during the night but did not remember hitting the head. Documentation indicated Tenant #4 had a hematoma on the back of the head, one on the side of the face, and the right hand was swollen. Tenant #4 also complained of bleeding from the rectum. Tenant #4 was taken to the hospital and admitted. Tenant #4 returned to the program on 12-15-13 following diagnoses of "brain bleed and blood in stool."

Tenant #4 returned to the program with orders for Physical Therapy (PT) and Occupational Therapy (OT), and incentive spirometry to be completed hourly while awake. Evaluations of function, cognition, and health were completed on 12-15-13. Nurse's notes of 12-19-13 indicated the family requested Tenant #4 be started on a multivitamin for anemia.

The service plan was updated on 12-15-13 but did not include PT and OT, did not include the use of the incentive spirometry, did not include interventions for falls in a tenant with a history of anemia, rectal bleeding, and dizziness, and did not include interventions for a tenant with a head injury. The service plan was updated to include home health assistance to provide showers and checks during the night. The service plan was not signed by Tenant #4 after the updates were made. The service plan did not meet the needs of Tenant #4.

Tenant #4 was scheduled for a follow-up scan of the head on 12-23-13 and did not return to the program.

Tenant #5 had initial evaluations completed on 9-5-13. The evaluations indicated Tenant #5 had his/her own nebulizer that was used as needed. A review of the November 2013 MAR indicated Tenant #5 self-administered eye drops and a hand-held inhaler. The service plan did not identify Tenant #5 self-administered some medications.

Tenant #5 had evaluations completed after hospitalization for a UTI. The evaluations of 11-6-13 indicated Tenant #5 had a history of falls, poor endurance and required escorts to meals and events. Tenant #5 was also noted to have a reddened buttock related to diarrhea, and required regular evaluation and assistance with skin care needs. Tenant #5 was also noted in the evaluations to have weight loss which would continue related to the progression of disease. Tenant #5 had an order for oxygen. The service plan did not include interventions for falls, interventions for a reddened buttock, interventions for

weight loss, and did not identify the use of oxygen. The service plan was not based on evaluations. The service plan did not meet the identified needs of Tenant #5.

The initial hospice care plan dated 11-6-13 identified pain and shortness of breath as areas of concern. The program's service plan of 11-6-13 did not identify interventions for pain or shortness of breath. The service plan did not coordinate with the hospice plan of care.

A physician's order dated 11-14-13 documented Tenant #5 was rapidly declining and the physician asked about inpatient hospice. Hospice physician's orders form dated 11-27-13 and documented by the Hospice Nurse indicated Tenant #5 was starting to transition to end of life, having increased difficulty swallowing. The service plan was not updated with interventions for end of life care nor difficulty swallowing.

Tenant #6 was admitted to the program on 12-18-13 and began to exhibit behaviors of exit-seeking, inappropriate toileting, and aggression towards staff. The service plan did not include interventions for behaviors until 1-13-14. The service plan did not meet the identified needs of Tenant #6

Interventions were added to the service plan of Tenant #6 on 1-13-14. The service plan updates was not based on evaluations of function, cognition, or health.

Tenant #6 was staged at five on the GDS and resided in the dementia unit. The service plan did not identify planned and spontaneous activities based on Tenant #6's abilities and interests.

Tenant #9, an 88 year-old, was admitted on 2-3-13 and had diagnoses of: Congestive Heart Failure, Sleep Apnea, and Dementia. Tenant #9 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #9 resided in the secured dementia unit. An Elopment Risk Assessment was performed on Tenant #9 on 8-19 and 10-23-13 which indicated Tenant #9 was at risk for elopement. Nurse's notes dated 12-26-13 documented Tenant #9 attempted to leave the dementia unit to see the spouse that resided in the general population of the program. Tenant #9 pushed staff out of the way and proceeded to leave the dementia unit. Tenant #9 did not leave the building and was stopped by a nurse who informed Tenant #9 the spouse was at an appointment and not in the building. Tenant #9 returned to the dementia unit. The service plan of 5-13-13, current at the time of the onsite visit, did not identify interventions for a tenant that was an elopement risk. The service plan did not meet the identified needs of Tenant #9.

The service plan of 5-13-13 was not signed by Tenant #9 or Tenant #9's legal representative.

Tenant #9 was staged at five on the GDS and resided in the dementia unit. The service plan did not identify planned and spontaneous activities based on Tenant #9's abilities and interests.

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))

Regulatory Insufficiency: When a tenant needs 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. (a) If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. (IAC r. 481-69.26(3)(a))

Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (a) The tenant's identified needs and preferences for assistance; (c) The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy; (d) For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. (IAC r. 481-69.26(4)(a,c,d))

D. Medications

Monitoring Observation: Tenant #2, a 77 year-old, was admitted on 11-29-13 and had diagnoses of: Osteoarthrosis, Anxiety, Hypertension, Esophageal Reflux and Chronic Airway Obstruction. Admission medication orders included an order for a hand-held inhaler (Spiriva) and a nasal spray for Chronic Obstructive Pulmonary Disease.

According to the December 2013 Medication Administration Record (MAR), the nasal spray was not given on the mornings of 12-1, 12-2, 12-3 and 12-4-13 because it was not available. The nasal spray was documented as given on the evenings of 12-1, 12-2, and 12-3 which would indicate the nasal spray was available. The nasal spray was discontinued on 12-4-13.

According to the service plan dated11-27-13, Tenant #2 delegated medication administration to the program. The service plan indicated staff members would administer medications as ordered by the physician. According to the December 20013 MAR, the inhaler was not given on 12-1, 12-2, 12-3, 12-4, 12-5, 12-6, 12-7, 12-8, 12-9, and 12-10-13 because the medication was not available. Documentation indicated a Licensed Practical Nurse (LPN) was aware of the unavailability on 12-8-13 and a Registered Nurse (RN) was aware of the unavailability on 12-10-13.

A review of the nurse's notes dated 11-27-13 through 12-13-13 lacked documentation of the nurse's knowledge of the absence of the hand-held inhaler or the reason for it, lacked documentation that the physician had been notified the inhaler was not being given, and lacked documentation of the tenant's respiratory status and response to the medication not given.

The previous RN sent a fax to the physician dated 12-9-13 requesting the hand-held inhaler be given on an as-needed basis only, rather than scheduled. The fax did not contain information to indicate the physician was notified the inhaler had not been given.

The fax had a physician's signature with a date of 12-13-13 which made the hand-held inhaler an as-needed medication.

A nasal spray was not given on three separate occasions as ordered. An inhaler was not given on ten separate occasions as ordered by the physician.

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).
(IAC r. 481-67.5(6)(a))

E. Nurse Review

Monitoring Observation: On 12-24-13 a fax was sent to the physician which indicated Tenant #1, a tenant with Lung Cancer, had coarse lung sounds with expiratory wheezing and was coughing up brown sputum. The fax contained an order dated 12-27-13 which indicated an antibiotic was to be given daily. The antibiotic was given for five days as noted on the MAR. A nurse review was not completed when the antibiotic was finished to determine the effectiveness of the medication or to evaluate Tenant #1's ability to breathe.

Tenant #4 had a 90-day nurse review completed on 10-11-13. The program was administering medications to Tenant #4 at the time. The nurse review did not indicate whether or not Tenant #4 was experiencing any side effects to medications.

On 11-13-13 Tenant #9 was prescribed an antibiotic for seven days for bronchitis. A nurse review was not completed after the antibiotic was completed to determine the effectiveness of the medication.

On 12-17-13 and incident report was completed for Tenant #9 which indicated the head was hit on a hand rail when Tenant #9 attempted to sit in a chair and missed. The incident report documented Tenant #9 went to the doctor for a head scan. According to the documentation from the emergency department on 12-27-13, Tenant #9 was diagnosed with blunt trauma head injury. A nurse review was not completed upon Tenant #9's return to the program on 12-27-13 to determine if a change of condition existed following a head injury.

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

Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to

previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

F. Food Service

Monitoring Observation: Staff #4 was hired 11-5-12 as a Universal Worker (UW). Staff #6, UW, was hired 8-12-13. Staff #7, UW was hired 6-24-13. Food safety training was not documented as completed until 11-29-13 for all three employees.

Staff #3 and #8, Universal Workers, were observed serving food in the dining room on 1-9-14. Both stated new employees were out on their own within two to 14 days of hire.

The Executive Director reported staff members were expected to serve food immediately after hire.

Food safety training was not completed by three employees prior to working in food service.

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

G. Record Checks

Monitoring Observation: Staff #5 was hired on 8-3-13. Background checks for child abuse, dependent adult abuse, and criminal history were completed on 7-24-13. The criminal history check indicated further research was needed. A Division of Criminal Investigation response dated 7-26-13 indicated a response was now required from the Department of Human Services (DHS). The personnel file lacked a response from DHS.

In an interview with the Executive Director, she reported an internal audit was completed and it was discovered the personnel file for Staff #5 lacked a response from DHS. On 12-27-13, background checks were repeated. On 1-15-14, the monitor was given a copy of just received DHS response which indicated Staff #5 was able to work at the program.

A background check including the DHS response was not completed prior to hire.

Regulatory Insufficiency: A person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services.
(IAC r. 481-67.19(5))

H. Policies and Procedures

Complaint/Incident Allegation: The program reported the narcotic count for a tenant was not correct.

Monitoring Observation: The program provided a copy of the narcotics policy dated 1-22-13. The policy stated all narcotics would be administered/witnessed by two staff members. The exception to this would be the night shift when only one staff member was available in the general population section of the building. When narcotics were placed in envelopes, the envelopes were to be labeled with the tenant's name, the name of the medication, the dose, and the time. All narcotics were to be counted by two staff members, the staff member coming to work and the staff member leaving work, at every shift change. The narcotics policy also stated inaccuracies were to be reported immediately.

A review of the narcotic count record for Tenant #1 for Roxanol, a liquid morphine, was reviewed. A narcotics count was not performed at 10:00 p.m., the end of the evening shift and beginning of the night shift, on 12-25-13. In a statement, Staff #1 reported she worked a double shift, evening and nights, and did not think it was necessary to count at 10:00 p.m. Other staff members who had worked the evening shift left the program at 10:00 p.m. Staff #1 also stated the count was not correct at 6:00 a.m. on 12-26-13. Staff #1 did not report the inconsistency to the nurse.

Staff #3 also counted the narcotics at 6:00 a.m. on 12-26-13 and noted the count to be incorrect. Staff #3 stated she forgot to report the inconsistency to the nurse until shift change at 2:00 p.m. on 12-26-13.

In a statement, Staff #2 reported the narcotic count was not correct on 12-26-13. Staff #2 stated he reported the inconsistency to his co-worker, Staff #4. There was no documentation that Staff #4 reported the inconsistency either. The narcotic count record indicated Staff #2 signed on 12-26-13 at 10:00 p.m.

In a statement, Staff #3 reported the narcotic count was not correct on 12-27-13 at 6:00 a.m. The incident was reported to a nurse at that time.

A narcotics count was not done on one occasion. At least three staff members on two separate occasions did not report a discrepancy in the narcotic count for Tenant #1. The program's policy on narcotics was not followed.

A medication pass was observed with Staff #3 on 1-9-14. At approximately 7:54 a.m., Staff #3 and the monitor entered Tenant #3's apartment with permission. Staff #3 was observed taking an envelope from her pocket only labeled with the tenant's first name and last initial. Staff #3 indicated the packet contained Tenant #'s Hydrocodone, a narcotic that was to be given routinely. Staff #3 stated she set up her narcotics for the day and was observed by another staff member at the time of set-up. The administration of the routine Hydrocodone was not observed by another staff member. Staff #3 reported another staff member was not present for routine administration, only for the administration of "as needed" narcotics.

The envelope was not labeled as instructed per policy. The narcotics policy indicated the administration of all narcotics was to be witnessed by two staff members, and did not differentiate between routine and "as needed" administration. The program's policy on narcotics was not followed.

Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)

I. Tenant Rights

Monitoring Observation: Tenant #6 was admitted to the program on 12-18-13. Tenant #6 exhibited wandering behaviors and was documented wandering into other tenant's apartments on more than one occasion. There were two documented occasions where Tenant #6 wandered into other tenant's apartments, Tenants #7 on 12-31-13 and #8 on 1-5-14, to urinate and defecate on furniture. Tenant #7 had feces smeared on him/her by Tenant #6.

Staff #9, #10, and #11 all reported there was a third incident where Tenant #6 went into Tenant #7's apartment and used a basket in the closet as a toilet.

Evaluations were not completed with the change of condition. The service plan was not updated with interventions until 1-13-14. Interventions were not put in place to attempt to limit inappropriate behavior.

Tenants #7 and #8 were not treated respectfully.

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