IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
Complaint Intake #: 47163-C

May 6, 2014

Susan M. Wiley, Executive Director
Homestead Assisted Living
2501 W. State Street
Mason City, IA 50401

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - HOMESTEAD ASSISTED LIVING
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Wiley:

I. Final Complaint/Incident Investigation Report – Homestead Assisted Living, Mason City, 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 **April 23 & 24, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Medications, Evaluation, Service Plans, Tenant Documents, and Nurse Review.

Homestead Assisted Living ("Program") is being assessed a **$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/emailed to DIA to my attention 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 a Regulatory Insufficiency in the area of Nurse Review.

The determination of a **$500 civil penalty** is based upon repeated in the area(s) of: Nurse Review. As the enclosed Report details, the Program failed to conduct nurse reviews as required.

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 **three hundred twenty five dollars ($325)** 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. Conclusion

The Program is being assessed a **$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 Complaint/Incident Investigation Report

Assisted Living Program: **Complaint/Incident Intake #:** 47163-C

Susan M. Wiley, Executive Director
Homestead Assisted Living
2501 W. State Street
Mason City, IA 50401

Date of Complaint/Incident Investigation:

April 23 and 24, 2014

Monitor(s):

Stephanie Cummins, MA

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:	28
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	33
TOTAL census of Assisted Living Program	33

Program History – During the April 8, 2013 recertification visit the program received regulatory insufficiencies in the following areas: Evaluation, Service Plan, Tenant Documents and Food Service. During the September 25, 2013 Complaint Investigation (45219-C), the program received a regulatory insufficiency in the area of Nurse Review.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged there were concerns regarding a tenant's admission to the Program and not being allowed to leave.

- Monitoring Observation: Staff #1, Staff #2, the Nurse and the Executive Director (ED) did not identify any tenants that were forced to stay at the Program. Staff #1 said Tenant #3 did not want to be there but was coming around and getting settled. Four tenant files were reviewed (Tenants #1, #2, #3 and #4). Tenant #3's Clinical Notes indicated there was an entry dated 2-5-14 regarding Tenant #3 being upset about being at the Program.

  Tenant #3, an 87 year old, was admitted on 2-5-14 through 2-7-14 and then was admitted again on 4-9-14 and at the time of the investigation was a current tenant at the Program. According to Clinical Notes dated 2-5-14, Tenant #3 was brought to the Program by family on 2-5-14 and family had concerns regarding Tenant #3's safety and well-being. Tenant #3 was previously in an assisted living program after a hospitalization and was released on the condition that Tenant #3 would not drive, would have home health twice a week and would not go downstairs. According to the Clinical Notes, after speaking with friends and neighbors it was clear Tenant #3 was not following through with agreements that were made for Tenant #3 to live on Tenant #3's own. Clinical Notes dated 2-5-14 indicated Tenant #3 was very upset about being there, repeatedly said that Tenant #3 did not belong there and said they could not keep Tenant #3 there and Tenant #3 would climb out the window if Tenant

#3 had to. A wandering monitoring device and 30 minute checks were put into place. A family member had a medical power of attorney (POA).

Clinical Notes dated 2-6-14 indicated Tenant #3 was very upset and said it was not fair that someone was trying to control Tenant #3's life. Tenant #3 was reminded Tenant #3 had an appointment with a physician the next morning. According to a Clinical Notes dated 2-6-14, the Nurse received a phone call from a family member with the results of the neurological testing Tenant #3 had done the day before. The physician determined Tenant #3 had mild to moderate dementia with Alzheimer's features. It was also determined Tenant #3 was safe in Tenant #3's decision making and capable of living at home by Tenant #3's self. The wandering monitoring device was removed. Tenant #3 agreed to spend the night and go to the physician appointment the next day and then desired to go home (discharged from the Program) after the appointment.

Clinical Notes dated 4-10-14 indicated Tenant #3 moved into the Program due to family concern for Tenant #3's safety and well-being. A family member was the POA which was enacted. Tenant #3 admitted to not taking Tenant #3's medications the way Tenant #3 was supposed to (Tenant #3 took them every other day). Tenant #3 was unhappy about being at the Program and did not think Tenant #3 needed to be there. The Nurse and ED had spoken with Tenant #3 about Tenant #3's feelings and contacted the Ombudsman regarding Tenant #3's concerns.

The Nurse said she did not force anything with Tenant #3 and with the first admission Tenant #3 verbalized leaving and said Tenant #3 would climb out of the window. The Nurse told Tenant #3 they could not force Tenant #3 to be there. The Nurse said the medical POA was enacted prior to the second admission. She said Tenant #3 was doing much better and she could see improvement. She said Tenant #3 was getting involved. A wandering monitoring device was not used for Tenant #3's second admission. The Nurse said no one prohibited Tenant #3 from leaving and no one stopped Tenant #3 from leaving. The Nurse said Tenant #3 was doing much better the second time.

The ED said regarding the February admission, Tenant #3 was willing to stay and later on that day wanted to get home and Tenant #3 said Tenant #3 would jump out of the window. Wellness checks and a wandering monitoring device were initiated. The ED said Tenant #3 was free to go and Tenant #3 had a cellular phone. The Nurse got a call from a physician and the wandering monitoring device was removed. Tenant #3 went to a physician appointment and did not return to the Program. Family came and got Tenant #3's belongings. Regarding the second admission, family called the Nurse and wanted to move Tenant #3 in again. The Nurse told the family all items were needed prior to admission. The ED said Tenant #3 was agreeable to being there, assessments were completed and Tenant #3 was staying in an apartment temporarily until another apartment became available. The ED said Tenant #3 was welcome to be there if Tenant #3 wanted to stay. She said Tenant #3 would rather be at home but nothing was forcing Tenant #3 to stay. Tenant #3 came out to activities and meals. The ED said Tenant #3 was very comfortable. The ED said she was willing to comply with everything that advocated for the tenants and to do the right thing.

Tenant #3 was interviewed and did not think Tenant #3 was at the point where the attention was needed and Tenant #3 belonged back at home. Tenant #3 tried to participate in activities. Staff was very accommodating and nice. Tenant #3 felt safe and said it was a very safe place. Administrative staff was very nice and helpful.

The medical POA was enacted on 4-8-14 by a physician. When Tenant #3 was admitted the first time on 2-5-14, Tenant #3 had a medical POA; however, it was not enacted. Tenant #3 did not sign documents related to admission to the Program including: the Family Release of Information, the Authorization for Release of Information-Doctor, the service plan and the Resident Agreement. Tenant #3 was admitted again on 4-9-14. At the time of that admission the medical POA was enacted and the medical POA signed documents.

Review of tenant files, staff interviews, a tenant interview, an interview with the Nurse and ED indicated the Program did not force any tenants to live at the Program. Tenant #3's documents for the first admission were not signed by Tenant #3 and the medical POA was not enacted at that time. While a deviation from requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation: It was alleged a tenant was made to take medications which did not look like the normal medications and staff had over medicated the tenant.

- Monitoring Observation: Staff #1, Staff #2, the Nurse and the ED said tenants were not forced to take medications. Staff #1, Staff #2, the Nurse and the ED said tenants that received medications from staff received only medications prescribed by a physician. Staff #1, Staff #2, the Nurse and the ED did not identify concerns regarding tenants being over medicated.

  Tenant #1, #2, #3 and #4 received medications administered by staff. Tenants #1, #2 and #4 had Medication Administration Records (MARs) and physician's orders. According to the Nurse, there was no MAR for Tenant #3 for 2-5-14 to 2-7-14 because there were no physician's orders. There were no MAR and no medications were administered by staff for Tenant #3 during that time. Tenant #3 was admitted on 4-9-14 and had physician's orders and a MAR. Tenant #3's April 2014 MARs were reviewed and indicated medications were administered consistent with physician orders.

  Tenant #3 said the medications were administered on time; however, was a different time than at home. Tenant #3 said the medications were locked and Tenant #3 was not sure who told them to lock the medications. Staff was very accommodating and nice. Tenant #3 felt safe and said it was a very safe place. Administrative staff was very nice and helpful.

Tenant #4 said medications were administered on time. Tenant #4 said felt safe and said staff was helpful. Tenant #4 was pleased with the medication administration service from staff.

A medication pass was observed and appropriate medication administration protocol was observed.

Staff interviews, tenant interviews, an interview with the Nurse and ED and review of tenant files did not reveal concerns related to tenants being forced to take medications and there were no concerns identified by staff regarding tenants being over-medicated.

- Regulatory Insufficiency: None noted.

During the course of the investigation, the following information was obtained:

- Monitoring Observation: The table below represents medications or treatments not documented as administered or not administered and medications charted as refused without an explanation on the back of the MAR.

TENANT	MEDICATION/TREATMENT	DOCUMENTATION on MAR
Tenant #2	Ted Hose on in a.m. off in p.m.	a.m. (on) 4-2-14, 4-4-14 and 4-21-14 not documented as completed
Tenant #2	Ted Hose on in a.m. off in p.m.	p.m. (off) 4-10-14, 4-12-14, 4-13-14 and 4-17-14 not documented as completed
Tenant #4	Lasix 20 mg one tablet daily at 8:00 a.m.	4-16-14 at 8:00 a.m. documented as an R circled on the front of the MAR and no explanation on the back of the MAR
Tenant #5	NPH Insulin 13 units subcutaneously daily in the a.m. at 8:00 a.m.	4-23-14 at 8:00 a.m. not documented as administered
Tenant #5	Accuchecks twice daily at 7:00 a.m. and 5:00 p.m.	4-23-14 at 7:00 a.m. not documented as completed

- Regulatory Insufficiency: When medications are administered traditionally by the program: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645—Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). (IAC r. 481-67.5(6))

C. Evaluation

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Four tenant files were reviewed (Tenants #1, #2, #3 and #4).

  Tenant #2, a 95 year old, was admitted on 1-5-14 and diagnoses included: Hypertension (HTN), Dementia and Deep Vein Thrombosis. Tenant #2 was staged at five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline.

  According to Clinical Notes dated 3-6-14, Tenant #2 had been refusing to eat for about a week or so, Tenant #2 had lost 10 pounds in 60 days and the family and physician were aware of the weight loss and refusal to eat. Tenant #2's output had also decreased. Tenant #2 said Tenant #2 was not hungry when meal time came and Tenant #2 had withdrawn from activities. Family thought hospice would be an option and the physician was contacted. Clinical Notes dated 3-10-14 indicated an order was received from the physician for a hospice consultation only if family was okay and ready. Family said they would discuss it and let the Nurse know. According to Clinical Notes dated 3-12-14, family had decided to try some fortified foods and was eating with Tenant #2 to see if that would help Tenant #2 gain some weight. The notes indicated would continue to monitor for weight loss and hold off on contacting hospice per family wishes. According to a Monthly Vital Signs document, Tenant #2 weighed 150.4 in January 2014 and weighed 139.2 in April 2014, a weight loss of 11.2 pounds. Cognitive, health and functional evaluations were not completed as needed with a 10 pound weight loss, refusals to eat, decreased output, withdraw from activities, the addition of fortified foods and the physician was contacted and hospice was ordered. Hospice was ordered; however, was not contacted per family wishes. Evaluations were not completed as needed.

  Tenant #4, an 83 year old, was admitted on 10-26-13 and diagnoses included: HTN, Diabetes, Anemia, Vitamin B 12 Deficiency, Lumbar Stenosis, Hyperlipidemia and Squamous Cell Skin Cancer. According to a Physician Appointment Form dated 2-24-14, the physician ordered to elevate legs to reduce swelling, compression hose on in a.m. and off in p.m. and Furosemide 20 mg daily for swelling and to re-check in 10 days. The order was noted on 2-24-14. According to a document from the physician, Tenant #4's Glyburide was cut to ½ daily and to notify the physician if Tenant #4's glucose was below 90. The document was noted on 2-25-14. The MARs did not reflect the order to elevate legs to reduce swelling and compression hose on in a.m. and off in p.m. The MARs did not reflect the parameters to notify the physician if Tenant #4's glucose was below 90. A Patient Plan document from the physician's office dated 3-17-14 indicated to increase Furosemide to 20 mg "2 daily." Elevate legs when available and get compression hose to assist with edema. The medication list was faxed to nurses at assisted living. The physician wanted Tenant #4 to have access to the glucometer so Tenant #4 was able to check blood sugars at night if

needed. The Current Medications list (part of the Patient Plan document) indicated to test blood glucose twice a day due to HTN and fluctuating glucose. The Current Medications list also indicated Furosemide 20 mg take two tablets by mouth every day for swelling. The Patient Plan document including the Current Medications was not noted. The Nurse said she did not consider the document a physician's order as it was not signed by the physician. The physician order document signed by the physician on 4-1-14 reflected blood glucose check daily and Furosemide 20 mg one tablet by mouth daily. The orders did not reflect compression hose, elevate legs, Furosemide 20 mg two tablets daily and blood glucose checks twice daily. Cognitive, health and functional evaluations were not completed as needed with the edema and orders for elevating legs, compression hose and Furosemide. Evaluations were not completed as needed.

Review of tenant files indicated cognitive, health and functional evaluations were not completed as needed.

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

D. Service Plans

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Four tenant files were reviewed (Tenants #1, #2, #3 and #4).

Tenant #2's file was reviewed. According to Clinical Notes dated 3-6-14, Tenant #2 had been refusing to eat for about a week or so, Tenant #2 had lost 10 pounds in 60 days, the family and physician were aware of the weight loss and refusal to eat. Tenant #2's output had also decreased. Tenant #2 said Tenant #2 was not hungry when meal time came and Tenant #2 had withdrawn from activities. Family thought hospice would be an option and the physician was contacted. Clinical Notes dated 3-10-14 indicated an order was received from the physician for a hospice consultation only if family was okay and ready. Family said they would discuss it and let the Nurse know. According to Clinical Notes dated 3-12-14, family had decided to try some fortified foods and was eating with Tenant #2 to see if that would help Tenant #2 gain some weight. The notes indicated would continue to monitor for weight loss and hold off on contacting hospice per family wishes. The service plan was not updated as needed with a 10 pound weight loss, refusals to eat, decreased output, withdraw from activities, the addition of fortified foods and the physician was contacted and hospice was ordered. Hospice was ordered; however, was not

contacted per family wishes. The service plan was not updated as needed and did not reflect the identified needs of Tenant #2.

Tenant #4's file was reviewed. According to a Physician Appointment Form dated 2-24-14, the physician ordered to elevate legs to reduce swelling, compression hose on in a.m. and off in p.m. and Furosemide 20 mg daily for swelling and to re-check in 10 days. The order was noted on 2-24-14. According to a document from the physician, Tenant #4's Glyburide was cut to ½ daily and to notify the physician if Tenant #4's glucose was below 90. The document was noted on 2-25-14. The MARs did not reflect the order to elevate legs to reduce swelling and compression hose on in a.m. and off in p.m. The MARs did not reflect the parameters to notify the physician if Tenant #4's glucose was below 90. A Patient Plan document from the physician's office dated 3-17-14 indicated to increase Furosemide to 20 mg "2 daily." Elevate legs when available and get compression hose to assist with edema. The medication list was faxed to nurses at assisted living. The physician wanted Tenant #4 to have access to the glucometer so Tenant #4 was able to check blood sugars at night if needed. The Current Medications list (part of the Patient Plan document) indicated to test blood glucose twice a day due to HTN and fluctuating glucose. The Current Medications list also indicated Furosemide 20 mg take two tablets by mouth every day for swelling. The Patient Plan document including the Current Medications was not noted. The Nurse said she did not consider the document a physician's order as it was not signed by the physician. The physician order document signed by the physician on 4-1-14 reflected blood glucose check daily and Furosemide 20 mg one tablet by mouth daily. The orders did not reflect compression hose, elevate legs, Furosemide 20 mg two tablets daily and blood glucose checks twice daily. The service plan was not updated as needed with the edema and orders for elevating legs, compression hose and Furosemide. The service did not reflect Tenant #4 was to have accessibility to a glucometer to check blood glucose at night if needed. The service plan was not updated as needed and did not reflect the identified needs of Tenant #4.

Review of tenant files indicated service plans were not updated as needed and did not reflect the identified needs of the tenants.

- 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. (IAC r. 481-69.26(3))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

E. Tenant Documents

During the course of the investigation, the following information was obtained:

- Monitoring Observation: According to an Incident Report policy, the Program would fill out an incident report when anything out of the ordinary happened to a tenant, visitor, or employee. An incident was any happening that was not consistent with the routine operations of the Program, or the routine care of a particular tenant, visitor or

employee. It might be an accident or a situation that might result in an accident. All incidents would be recorded on the Incident Report Form.

Medication error reports for the past three months were requested by the monitor.

One Medication Error Report and three Performance Improvement Notices were provided. The Medication Error Report had information including: the tenant's name, the tenant's apartment number, physician, date, the physician's order, the reason for the error, effect of the medication error, if the error could endanger the life or welfare of the tenant, how it was discovered, who discovered the error, who notified the physician, follow-up care and precautions that could be taken to prevent a similar error.

The Medication Error Report identified for Tenant #6 on 2-10-14 Furosemide 40 mg by mouth daily at 12:00 p.m. was omitted. The reason was miscommunication with other staff. There was no actual effect of the error and the error could not endanger the life or welfare of the tenant. The precautions that could be taken to prevent a similar error included to double check the MAR and have better communication.

The Performance Improvement Notice had information including: staff's name, type of violation, result, details of event, expectations and corrective action to be taken by the staff, consequences and staff comments. The three Performance Improvement Notices dated 2-24-14 and 3-14-14 (2) were all medication errors and were either verbal consultation, written warning or both a verbal consultation and written warning. Medication Error Reports were not completed related to the medication errors noted on the Performance Improvement Notices.

Medication error reports or incident reports were not completed as needed when medication errors occurred.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: Incidents reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record). (IAC r. 481-69.25(1)(o))

F. Nurse Review

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Four tenant files were reviewed (Tenants #1, #2, #3 and #4).

Tenant #1, a 98 year old, was admitted on 6-3-06 and diagnoses included: Macular Degeneration and History of Arthritis. Tenant #1 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #1 received personal or health-related care, according to the service plan. A 90 day nurse review was completed on 12-23-13. On 4-16-14 cognitive, health and functional evaluations were completed. A nurse review was not completed every 90 days.

Tenant #4's file was reviewed. According to a Physician Appointment Form dated 2-24-14, the physician ordered to elevate legs to reduce swelling, compression hose on in a.m. and off in p.m. and Furosemide 20 mg daily for swelling and to re-check in 10 days. The order was noted on 2-24-14. According to a document from the physician, Tenant #4's Glyburide was cut to ½ daily and to notify the physician if Tenant #4's glucose was below 90. The document was noted on 2-25-14. The MARs did not reflect the order to elevate legs to reduce swelling and compression hose on in a.m. and off in p.m. The MARs did not reflect the parameters to notify the physician if Tenant #4's glucose was below 90. A Patient Plan document from the physician's office dated 3-17-14 indicated to increase Furosemide to 20 mg "2 daily." Elevate legs when available and get compression hose to assist with edema. The medication list was faxed to nurses at assisted living. The physician wanted Tenant #4 to have access to the glucometer so Tenant #4 was able to check blood sugars at night if needed. The Current Medications list (part of the Patient Plan document) indicated to test blood glucose twice a day due to HTN and fluctuating glucose. The Current Medications list also indicated Furosemide 20 mg take two tablets by mouth every day for swelling. The Patient Plan document including the Current Medications was not noted. The Nurse said she did not consider the document a physician's order as it was not signed by the physician. The physician order document signed by the physician on 4-1-14 reflected blood glucose check daily and Furosemide 20 mg one tablet by mouth daily. The orders did not reflect compression hose, elevate legs, Furosemide 20 mg two tablets daily and blood glucose checks twice daily. The Patient Plan document had documentation from the physician's office which contained a Current Medication list and an Assessment/Plan which had documentation including increase Furosemide to 20 mg "2 daily", elevate legs when available and to get compression hose to help with edema. The Patient Plan document with a visit date of 3-17-14 was not noted. The parameter to notify the physician if the blood glucose was below 90 was not on the MARs. The orders for compression hose and elevate legs were not on the MARs. A review was not completed to ensure that health care professionals' orders were current.

Review of tenant files indicated nurse reviews were not completed as needed including a 90 day nurse review and a review to ensure that health care professionals' orders were current.

- 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 ensure that health care professionals' orders are current for each tenants who receive health care professional-directed care from the program. (IAC r. 481-69.27(2))

- 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))