IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

April 24, 2014

Ms. Kathy Goede, Director
Elm Crest Retirement Community
2104 12th Street
Harlan, IA 51537

RE: Final Recertification Monitoring Evaluation Report – Elm Crest Retirement Community, Harlan, IA

Dear Ms. Goede:

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, following a survey by DIA on **April 9, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Occupancy Agreement, Evaluation of Tenant, Service Plans, Nurse Review, Food Service and Staffing.

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.

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.

The recertification process has not been completed. The certificate will be sent when the process has been completed.

If you have any questions in regard to this report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Kathy Goede, Director
Elm Crest Assisted Living
2104 12th Street
Harlan, IA 51537

Date of Monitoring Visit:

April 9th, 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:	28
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	31
TOTAL census of Assisted Living Program	31

Tenant/Family Satisfaction Results – A meeting was held with 22 tenants. The best thing about the program was the people and not having to do anything such as cooking, cleaning, and yard work. The housekeeping was completed to the tenants' satisfaction. Tenants reported having pull cords in the apartment which were used to call for assistance. Staff were reported to respond in less than five minutes when called. Staff were described as giving good care, and were kind and respectful with the tenants. The food was described as good, but the hot foods were not always hot. The tenants would like more Bingo, and regularly scheduled church activities. It was requested that tenants be taken to local churches on Sunday for services. The tenants reported some difficulty getting to the attached nursing facility where some of the activities were held. The 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 April 9, 2014, the program received regulatory insufficiencies in the areas of: Occupancy Agreement, Food Service Staffing, Evaluation, Service Plan, and Nurse Review.

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

A. Occupancy Agreement

Monitoring Observation: Tenant #1 was admitted to the program on 10-25-13. Tenant #2 was admitted on 10-5-13. The program was asked to provide occupancy agreements for Tenants #1 and #2 as well as any addendums that went with the agreement. The program provided occupancy agreements, resident rights, and the resident handbook. None of the documents provided included a reference to the application of tenant-landlord law, nor to a 90-day notice of program cessation.

The occupancy agreements did not contain information as required by regulation.

- Regulatory Insufficiency: In addition to the requirements of Iowa Code section 231C.5, the written occupancy agreement shall include, but not be limited to, the following information in the body of the agreement or in the supporting documents and attachments: (e) A statement that the tenant landlord law applies to assisted living programs. (f) A statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency.
(IAC r. 481-69.21(2)(e,f))

B. Evaluation of Tenant

Monitoring Observation: Tenant #1, a 96 year-old, was admitted on 10-25-13 and had diagnoses of: Aftercare healing following Traumatic Fracture of the Vertebrae, General Muscle Weakness, Dysphagia, Anxiety, Depressive Disorder, Osteoarthrosis, Hypertension, and Esophageal Reflux. An undated order by the physician for Physical Therapy (PT) documented Tenant #1 had experienced a cervical (neck) spine fracture. The clinical record documented the fracture was obtained in a motor vehicle crash. The initial cognitive ability evaluation dated 10-21-13 was completed by the LPN/Director and revealed Tenant #1 had six errors which indicated moderate risk for cognitive impairment. The initial health and functional evaluations were also completed by the LPN/director. Initial evaluations were not completed by a registered nurse.

The same evaluation forms were utilized for both the initial and 30-day evaluations. The health evaluation forms were a series of questions related to health problems. There was no documentation of vital signs including blood pressure for Tenant #1 who had a diagnosis of Hypertension. There was no hands-on evaluation of Tenant #1 following the initial notation of an open area on the neck from the neck brace. There was no review of body systems. The program received initial orders from the physician dated 10-2-13for Tenant #1 to have Immodium as needed for diarrhea, a Lidoderm patch to the upper back for pain, and medications including Mylanta and Nexium for Esophageal Reflux. The initial and 30-day evaluations did not reveal Tenant #2 was assessed for diarrhea, pain, or stomach distress. The initial evaluation was completed on 10-21-13 which documented Tenant #1's weight at 142 pounds. The resident notes dated 10-25-13 documented Tenant #1's weight at 133 pounds, a nine pound difference. The initial physician orders also included a mechanical soft diet, dietary supplements, and Speech Therapy to evaluate swallowing. The evaluation dated 11-25-13 documented Tenant #1 was to have ground meat. The initial and 30-day health evaluations did not include assessments of Tenant #1's ability to eat, and the ability to swallow without choking. Evaluations of health did not include a review of body systems pertinent to the underlying conditions of Tenant #1.

The resident notes dated 11-25-13 documented a 30-day nurse review was completed. It was documented ADL (activities of daily living), cognitive, and functional assessments were completed. The resident notes did not document the completion of a health evaluation.

An incident report dated 1-20-14 and timed 9:30 a.m. documented Tenant #1 was getting up from a chair in the dining room and fell backwards, hitting his/her head on a cabinet. The clinical record contained a 72-hour follow-up sheet beginning with entries made by the day shift on 1-20-14, which indicated new services were provided after the fall. Resident notes dated 1-20-14 were completed by Staff #2, Medication Manager, and RN #2. Neither of the entries were timed, so it is unclear that Tenant #1 was seen by a registered nurse immediately following the incident. Evaluations were not completed by a registered nurse following a significant change of condition; a tenant with a recent history of cervical spine fracture fell backwards hitting the head and the implementation of a 72-hour follow-up.

The incident report of 1-20-14 documented Tenant #1 had no pain and no injuries from the fall as documented by Staff #2, Medication Manager. The incident report went on to document Tenant #1 was sent to the Emergency Room (ER) at 4:00 p.m. on 1-20-14. The clinical record contained no documentation from the registered nurse as to the reason for the visit to the ER and the outcome of the ER visit. Evaluations were not completed with the change of condition which warranted a visit to the ER.

Tenant #2, a 93 year-old, was admitted on 10-5-13 and had diagnoses of: Senile Dementia, Osteoarthrosis, Chronic Pancreatitis, and Anxiety. The initial cognitive ability assessment documented 9-16-13 Tenant #2 had a score of 23 which indicated high risk for cognitive impairment. The initial cognitive evaluation was completed by the LPN/Director. The initial cognitive evaluation was not completed by a registered nurse.

The initial health evaluation did not document vital signs or documentation of the location of the arthritis, or whether or not there was any pain associated with the arthritis. The initial evaluation documented Tenant #2 had a weight of 97 pounds and Tenant #2 needed to maintain weight. A physical form completed by the healthcare provider dated 9-24-13 documented Tenant #2 had anxiety issues and was on a low fat diet due to Chronic Pancreatitis. The initial evaluations completed by the program did not document Tenant #2's behavior and did not document whether or not Tenant #2 was experiencing pain or any other symptoms with the pancreatitis or any changes in bowel movements. The initial evaluations did not include a completed health evaluation.

Staging on the GDS was completed on 10-7-13, within a week of admission, which indicated Tenant #2 was staged at three and four, indicating mild to moderate cognitive decline. There were no other evaluations completed at that time.

The same evaluation forms were used at 30 days of admission. Staging on the Global Deterioration Scale (GDS) was not completed after Tenant #2 initially failed the cognitive ability assessment. The health evaluation contained no entries to document Tenant #2's weight at 30 days of admission, or evaluation of any symptoms of pancreatitis or anxiety. The program failed to complete vital signs and a review of body systems following the change of condition. Resident notes dated 11-5-13 documented a 30-day nurse review was completed with cognitive, functional, and ADL assessments completed. There was no documentation of the completion of a health evaluation.

Documentation in the resident notes dated 11-26-13 documented Tenant #2 was very confused, frustrated, and argumentative. Notes of 1-10-14 documented Tenant #2 was awake most of the night, unaware of the time. Resident notes dated 2-5-14 documented Tenant #2 was started on Namenda, a dementia medication, on 1-7-14. Tenant #2 experienced a change in mental status which resulted in consultation with the healthcare provider and a new medication order for Namenda. Evaluations were not completed with a change of condition.

Resident notes dated 2-13-14 documented Tenant #2 had an unsteady gait and a fax was sent to the healthcare provider to request an order for Physical Therapy (PT). An order was also received to reduce the dose of Elavil, an antidepressant. A fax dated 2-25-14 documented Tenant #2 was more restless in the afternoon and it was requested the Elavil be changed to twice a day. Notes dated 2-27-14 documented Tenant #2 complained of hip pain and was sent to the ER. The entry in the notes was completed by a medication manager. The medication manager documented there was no fracture, but Tenant #2 had a lot of arthritis pain. Evaluations were not completed with changes of condition, unsteady gait, the initiation of PT, medication changes and changes in behavior, and hip pain severe enough to warrant a trip to the ER.

Tenant #3, a 92 year-old, was admitted on 11-18-13 and had diagnoses of: Hypertension, Congestive Heart Failure (CHF), and Osteoarthrosis. The initial cognitive evaluation was completed by the LPN/Director. The initial cognitive evaluation was not completed by a registered nurse. The same evaluation forms were used for all evaluations completed. The initial evaluations did not include vital signs or blood pressure reading for a person with a diagnosis of Hypertension. There was no review of body systems including and no further entries on the form for the 30-day evaluation. The resident notes dated 12-16-13 documented a 30-day nurse review was completed and included cognitive, ADL, and functional assessments. There was no documentation of a health evaluation completed at 30 days.

The initial documentation indicated Tenant #3 had experienced a five to ten pound weight loss in the last six months. There was no documentation of Tenant #3's weight on admission to the program.

Resident notes dated 11-23-13 documented by a medication manager revealed Tenant #3 was admitted to the hospital for Pneumonia. Notes documented Tenant #3 returned to the program on 11-27-13. Notes of 12-16-13 documented the hospitalization on 11-23-13 as Tenant #3 had Bronchitis with shortness of breath and cough. Evaluations were not completed for a change of condition, a hospitalization for a diagnosis of a lung condition.

Resident notes dated 1-30-14 and timed at 1:30 a.m. documented Tenant #3 was dizzy and felt hot. Audible wheezes were present and Tenant #3 had a dry cough. Tenant #3 was instructed to use the walker for the rest of the night. Notes dated 1-31-14 but not timed, documented Tenant #3 was seen by the healthcare provider and was reported to have "a little CHF." Tenant #3 was given an extra Lasix, a water pill. Evaluations were not completed with a change of condition.

Tenant #3 was to follow-up with the healthcare provider in a few days. Notes of 2-1-14 documented Tenant #3 did not feel well and had a cough. Tenant #3's temperature was checked and found to be normal.

On 2-2-14, Tenant #3's temperature was again checked and found not to be elevated. Tenant #3 was documented to be congested with a cough. Notes dated 2-3-14 documented Tenant #3 was admitted following the appointment with the healthcare provider. Tenant #3 was diagnosed with CHF. Resident notes entries 1-31-14 through 2-3-14 were completed by medication managers. There was no documentation of evaluations completed by a nurse at the program.

Resident notes dated 2-20-14 documented Tenant #3 returned to the program. The entry was completed by the LPN/Director. The note documented Tenant #3 returned to the program with an indwelling urinary catheter, Tenant #3 would be seen by PT and Occupational Therapy (OT), and the program would begin to administer medications. The notes documented ADL, cognitive, and functional assessments were completed. There was no documentation of the completion of a health evaluation. The same evaluation forms were used for all evaluations completed. The forms were dated 2-20-14 and signed by the LPN/Director. There was no documentation the change of condition evaluations were completed by a registered nurse. The health form did not contain vital signs or a review of systems. There did not appear to be any new entries on the health form. There was no documentation of Tenant #3's health related to a diagnosis of CHF. There was no documentation of lung sounds, the presence or absence of cough, the documentation as to whether or not Tenant #3 was retaining any fluid. There was no documentation as to the condition of the urine coming from the indwelling urinary catheter.

Resident notes dated 3-30-14 documented Tenant #3 was admitted to the hospital. Notes of 4-7-14 documented Tenant #3 returned to the program. There was no documentation as to the reason for the hospitalization. The discharge instructions documented Tenant #3 had been hospitalized with Pneumonia. Resident notes documented Tenant #3 had some weakness and medications were changed. Evaluations were not completed for a change of condition.

Tenant #4, a 92 year-old, was admitted on 8-15-08 and had diagnoses of: Hypertension, Atrial Fibrillation, Esophageal Reflux, and Osteoporosis. On 4-2-14, Tenant #4 was admitted to the hospital with Acute Renal Failure. According to the LPN/Director the recent new medication for Gout was thought to have been the reason for the kidney failure. Tenant #4 was to have been discharged from the hospital to a skilled nursing facility, but Tenant #4 refused. Tenant #4 returned to the program on 4-7-14. Evaluations of function, cognition, and health were not completed by a registered nurse with a significant change of condition.

In an interview with the LPN/Director, she stated she has been doing initial and change of condition evaluations. The LPN/Director reviews the evaluations with RN #1. On occasion, RN #1 has accompanied the LPN/Director when doing initial evaluations.

- 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))

C. Service Plan

Monitoring Observation: Tenant #1 was admitted to the program on 10-25-13. The initial evaluations completed by the LPN/Director revealed Tenant #1 had open areas on the neck from the neck brace used to stabilize the neck following a cervical spine fracture. On 11-25-13 according to the evaluations, Tenant #1 was placed on a ground meat diet.

One service plan was utilized by the program and was signed by Tenant #1 and the LPN/Director on 10-21, 10-25, and 11-25-13. The service plan did not identify open areas on the neck and who was responsible for the wound care. The service plan did not identify Tenant #1 was on a special diet.

The service plan identified Tenant #1 self-administered medications. A review of Medication Administration Records (MARs) for March 2014 documented the program administered some medications. The service plan was not updated to include the program's administration of some medications.

The service plan did not meet the identified needs of Tenant #1.

Tenant #2 was admitted to the program on 10-5-13. Tenant #2 had one service plan dated and signed on 9-16-13, 10-5-13, and 11-5-13. The service plan did not identify Tenant #2 was on a low fat diet for Chronic Pancreatitis. The service plan did not identify interventions for Tenant #2, with a weight of 97 pounds, to maintain weight as indicated on the initial functional evaluation. The service plan was not based on evaluations.

The service plan did not identify PT as an outside service provider. The service plan did not identify interventions for hip pain, which was severe enough for Tenant #2 to be sent to the ER. The service plan did not identify interventions for behaviors in a person with diagnoses of Senile Dementia and Anxiety which resulted in the initiation of Namenda and changes to Elavil. The service plan did not meet the identified needs of Tenant #2.

Tenant #2 initially failed the cognitive screening tool and was staged at four on the GDS on 10-7-13. Tenant #2 had a diagnosis of Senile Dementia. Activities were not identified on the service plan, planned or spontaneous, for a person with dementia.

Tenant #3 had one service plan that was signed and dated 11-5, 11-18, and 12-16-13 and 2-20-14. The initial documentation indicated Tenant #3 had experienced a five to ten pound weight loss in the last six months. The service plan did not identify interventions for a tenant identified with weight loss. The initial documentation indicated Tenant #3 did not always take medications on time. The service plan initially indicated Tenant #3 self-administered medications. The service plan did not identify interventions to determine Tenant #3 was self-administering medications correctly when a concern was identified initially. The service plan was not based on evaluations.

Tenant #3 was diagnosed with CHF and required changes to the medication Lasix. The service plan did not identify signs or symptoms Tenant #3 may have experienced that staff members should be reported to the nurse.

Tenant #3 had an indwelling urinary catheter. The service plan did not identify the use or care of the catheter.

The service plan did not meet the identified needs of Tenant #3.

Tenant #3 had an order for PT and OT. The outside service providers were not identified on the service plan.

Tenant #4 had an order for PT and OT. The PT notes of 4-4-14 documented Tenant #4 required a contact guard for sit to stand, and with ambulation. The service plan did not identify outside service providers.

- 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: 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; and (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. Nurse Review

Monitoring Observation: An incident report dated 1-20-14 and timed 9:30 a.m. documented Tenant #1 was getting up from a chair in the dining room and fell backwards, hitting his/her head on a cabinet. The clinical record contained a 72-hour follow up sheet beginning with entries made by the day shift on 1-20-14, which indicated new services were provided after the fall.

A nurse review was not completed following a significant change of condition; a tenant with a recent history of cervical spine fracture fell backwards hitting his/her head and the implementation of a 72-hour follow-up.

The incident report of 1-20-14 documented Tenant #1 had no pain and no injuries from the fall as documented by Staff #2, Medication Manager at 9:30 a.m. The incident report went on to document Tenant #1 was sent to the Emergency Room (ER) at 4:00 p.m. on 1-20-14. The tenants clinical record contained no documentation as to the reason for the visit to the ER and the outcome of the ER visit. A nurse review was not completed with the change of condition which warranted a visit to the ER.

According to the resident notes, a 90-day nurse review was completed on 2-18-14. The notes documented ADL, functional, and cognitive assessments were completed. Tenant #1 was not receiving program-administered medication at the time. The evaluation forms were dated 2-19-14, but there were no entries on the health evaluation section dated 2-19-14. The nurse review did not provide follow-up to previously noted concerns of history of cervical spine fracture, occupational therapy services, a fall with a bump to the head which resulted in an ER visit, or Tenant #1's ability to eat and the monitoring of Tenant #1's weight. The 90-day nurse review did not assess and document the health status of Tenant #1, or monitor Tenant #1's progress.

Not all of the resident notes entries for Tenant #1 documented the time the entry was made.

According to the resident notes, a 90-day nurse review was completed on 2-5-14. The notes documented cognitive, ADL, and functional assessments were completed. The assessment form revealed no new health information was documented. Tenant #2 was administered medications by the program. An evaluation of health and a review of medications to include whether or not Tenant #2 was experiencing any adverse reactions were not completed.

Documentation in the resident notes dated 11-26-13 documented Tenant #2 was very confused, frustrated, and argumentative. Notes of 1-10-14 documented Tenant #2 was awake most of the night, unaware of the time. Resident notes dated 2-5-14 documented Tenant #2 was started on Namenda, a dementia medication, on 1-7-14. Tenant #2 experienced a change in mental status which resulted in consultation with the healthcare provider and a new medication order for Namenda. A nurse review was not completed with a change of condition.

Resident notes dated 2-13-14 documented Tenant #2 had an unsteady gait and a fax was sent to the healthcare provider to request an order for PT. An order was also received to reduce the dose of Elavil, an antidepressant.

A fax dated 2-25-14 documented Tenant #2 was more restless in the afternoon and it was requested the Elavil be changed to twice a day. Notes dated 2-27-14 documented Tenant #2 complained of hip pain and was sent to the ER. The entry in the notes was completed by a medication manager. The medication manager documented there was no fracture, but Tenant #2 had a lot of arthritis pain. Nurse reviews were not completed with changes of condition, unsteady gait, and the initiation of PT, medication changes and changes in behavior, and hip pain severe enough to warrant a trip to the ER.

Not all of the resident notes entries for Tenant #2 documented the time the entry was made.

According to the resident notes dated 3-26-14, a 90-day nurse review was completed. The notes documented cognitive, ADL, and functional assessments were completed. The assessment form revealed no new health information was documented. Tenant #3 was administered medications by the program beginning 2-20-14. An evaluation of health to include a current blood pressure, current evaluation of body systems affected by CHF, and a review of medications to include whether or not Tenant #3 was experiencing any adverse reactions was not completed. A 90-day nurse review was not completed.

Tenant #3 was admitted to the hospital on 11-23-13, 2-3-14, and 3-30-14. Nurse reviews were not completed upon Tenant #3's return to the program following each hospitalization. Nurse reviews were not completed with significant changes of condition.

Not all of the resident notes entries for Tenant #3 documented the time the entry was made.

According to the resident notes dated 3-25-14, a 90-day nurse review was completed. The notes documented cognitive, ADL, and functional assessments were completed. There was no documentation of the completion of a health evaluation. Tenant #4 self-administered medications according to the service plan. A 90-day nurse review was not completed.

Not all of the resident notes entries for Tenant #4 documented the time the entry was made.

- 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; and (IAC r. 481-69.27(3))

- Regulatory Insufficiency: To provide the program with written documentation of the activities under the service plan, as set forth in rule 481—69.26(231C), showing the time, date and signature. (IAC r. 481-69.27(4))

E. Food Service

Monitoring Observation: Staff training records were reviewed for Staff #1, hired 7-18-12; Staff #2, hired 1-9-12; Staff #3, hired 10-5-12; and Staff #4, hired 8-2-11. All were employed as nursing assistants. None of the staff training records contained training related to safe food handling.

Staff #2 and #5 was interviewed. Both staff members identified themselves as medication managers. Both stated they served food. The noon meal was observed. Staff #2 and #5 was observed bringing food to the tenants seated at the dining table.

Training records lacked documentation of an annual in-service on food protection.

- 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))

F. Staffing

Monitoring Observation: The program was asked to complete a monitoring entrance form. On the form, the program identified RN #1 as the delegating nurse for the assisted living program. According to the Director of the assisted living program, who is also a Licensed Practical Nurse (LPN), RN #1 was the Director of Nursing for attached nursing facility and began as the delegating nurse for the assisted living program about one year ago. Interviews with Staff #2 and #5 confirmed RN #1 had been the registered nurse at the program for one to one and a half years. RN #1 was unable to provide documentation of the completion of an assisted living management or nursing class. After discussion on the need for a class, RN #1 provided documentation of registration for a management class beginning 4-14-14.

Staff #2 and #5 was interviewed. Both stated they had not received nurse-delegated training from RN #1, who had been the delegating registered nurse at the program for at least the last year.

Training records did not reveal any documentation that RN #1 had determined Staff #1, #2, #3, or #4 was trained and competent to provide cares.

RN #1 stated the nursing facility has a nurse that provided training, but RN #1 had not personally done training or observations with the assisted living staff to determine competency. RN #1 stated she had not completed delegations.

RN #1, the program's nurse, had not completed training on regulations for assisted living. RN #1 provided no documentation regarding the competency of the direct care staff.

- Regulatory Insufficiency: All programs employing a new delegating nurse after January 1, 2010, shall require the delegating nurse within six months of hire to complete an assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living. A minimum of one delegating nurse from each program must complete the training. If there are multiple delegating nurses and only one delegating nurse completes the training, the delegating nurse who completes the training shall train the other delegating nurses in the Iowa rules and laws on assisted living. As of January 1, 2011, all programs shall have a minimum of one delegating nurse who has completed the training described in this subrule. (IAC r. 481-69.29(6))

- Regulatory Insufficiency: The program's registered nurse shall ensure certified and noncertified staff is competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: (a) the program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff is sufficiently trained and competent in all tasks that are assigned or delegated. (IAC r. 481-67.9(4))