IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER

Complaint Intake #: 47027-C, 47824-I, 48171-C, 48237-C

June 4, 2014

Ms. Annette Grochala, Executive Director
Vintage Hills Retirement Community
604 East Hillcrest Avenue
Indianola, IA 50125

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

Dear Ms. Grochala:

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

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **May 14, 15, 19, 20 & 21, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Medications, Activities, Policies and Procedures, Evaluations, and Service Plans.

Vintage Hills Retirement Community ("Program") is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(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 Regulatory Insufficiencies in the areas of Evaluations and Service Plans.

The determination of a **$1,000 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Evaluations and Service Plans. As the enclosed Report details, the Program updated service plans that were not based on comprehensive evaluations.

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 **six hundred and fifty dollars ($650)** 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 the document enclosed for more information.

IV. Conclusion

The Program is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(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

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Annette Grochala, Executive Director
Vintage Hills Retirement Community
604 East Hillcrest Avenue
Indianola, IA 50125

Complaint/Incident Intake #: 47027-C, 47824-I
48171-C, 48237-C

Date of Complaint/Incident Investigation:

May 14, 15, 19, 20 & 21, 2014

Monitor(s):

Margaret Kaltefleiter, RN MS

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:	27
Number of tenants with cognitive disorder:	8
Total Population of Program at time of on-site	35

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	13
TOTAL census of Assisted Living Program	48

Program History – The program received regulatory insufficiencies during the Oct. 2012 Recertification on-site in the areas of: Evaluation, Service Plan, Food Service, Dementia Specific Education and Structural. During the July 2013 Incident Investigation (44318-I, 44425-I), the program received regulatory insufficiencies in the areas of Service Plan and Managed Risk. During the November 2013 Complaint Investigation (45856-C), the program received regulatory insufficiencies in the areas of: Criteria for Admission and Retention, Tenant Rights, Program Reporting to the Department, Occupancy Agreement, Evaluation and Service Plan.

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

A. Tenant Rights

Complaint/Incident Allegation #47027-C: It was alleged staff did not answer pendant alarms. It was alleged staff removed pull string/personal alarms so they did not have to hear the alarms sound.

- Monitoring Observation: The Nurse stated there were two tenants with alarms and both tenants resided in the dementia unit. Tenant #1 used a chair alarm and Tenant #2 had a bed alarm.

  On 5-19-14 at 12:10 p.m. the monitor observed 11 tenants eating lunch in the dementia unit dining room. Tenant #1 was observed with a pad alarm connected to the back of Tenant #1's shirt with the connection cord connected to the chair pad on which Tenant #1 sat. Tenant #2 was eating lunch. Staff #1 stated Tenant #2's alarm was only used when Tenant #2 was in bed.

Staffs #1, #2, #3, #4 and the Nurse were interviewed and stated pendant alarms were answered and staff had not removed alarms so they wouldn't have to answer them. The Executive Director (ED) stated alarms were answered and the alarm response system was monitored daily. The ED stated staff did not remove alarms so they wouldn't have to answer them.

Per monitor observations and interviews with Staff #1, #2, #3, #4, the Nurse and ED indicated tenant alarms were kept in place and answered as needed.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47027-C: It was alleged Tenant #3 sustained bruising while staff changed Tenant #3's brief.

- Monitoring Observation: Tenant #3, a 70 year old, was admitted on 10-7-13 and diagnoses included: Dementia, Post Nasal Drip, Peripheral Vascular Disease, Depression and Anxiety. Tenant #3 was staged at a six on the Global Deterioration Scale (GDS) which indicated severe cognitive decline. Tenant #3 resided in the dementia unit. Tenant #3 was discharged from the Program on 2-14-14. According to a service plan dated 1-9-14, Tenant #3 needed reminders to use the bathroom and assistance with disposal of used products. Tenant #3 preferred briefs. Tenant #3 was to be toileted before and after meals, at bedtime and frequent checks at night. Perineal care after each incontinent episode and encourage Tenant #3 to wear protective undergarments.

  According to Nurse Notes dated 2-4-14 at 7:00 p.m., the Nurse was in the dementia unit when staff asked the Nurse to help with personal cares and changing wet/soiled clothing. Staff had approached Tenant #3 prior to change but Tenant #3 was uncooperative. The Nurse did keep Tenant #3 from hitting staff and helped to keep in one spot while the staff tried to change pants and brief. Tenant #3 was angry with staff, verbalizing an occasional swear word but most of the verbalizations were unintelligible.

  The Nurse stated she never saw anyone be mean to Tenant #3. Normally only two staff was needed to assist with changing Tenant #3's wet pants. Tenant #3 would kick and call staff names when staff tried to change soiled or wet clothes. Tenant #3 was never held in such a way that Tenant #3 had red marks or bruising. She stated she never saw any staff abuse Tenant #3. Staff had never made any negative statements about Tenant #3.

  Staffs #1, #2, #3 and #4 stated no present or past tenants had been bruised during cares. The Nurse and the ED stated no present or past tenants had been bruised during cares.

  Per Tenant #3's file review and interviews with Staff #1, #2, #3, #4, the Nurse and the ED did not reveal any tenants present or past had been bruised during cares.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47027-C: It was alleged a tenant was routinely forced to shower against the tenant's will.

- Monitoring Observation: The Nurse stated no tenants were forced to take a shower when they refused. It was their right to refuse. The ED stated tenants were not forced to take a shower if they refused. The tenant would be re-approached later or offered a sponge bath instead.

  Staff #1 stated staff would need to find another way to get the tenants to shower if they refused. Staff #2 stated tenants were not forced to shower; if they refused she would have someone else try to assist with the shower. Staffs #3 and #4 stated tenants were not forced to shower if they refused.

  Interviews with Staff #1, #2, #3, #4, the Nurse and ED indicated no tenants were forced to take a shower if they refused.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48237-C: It was alleged a staff pushed Tenant #3.

Monitoring Observation: The ED stated when a staff was terminated she called corporate and stated Tenant #3 had been pushed down in a chair by Staff #5. The ED stated Tenant #3 was sitting at a table holding dirty clothes and Staff #5 took the dirty clothes. Tenant #3 got angry. The ED met with Staff #5 and completed disciplinary action due to Staff #5 agitating Tenant #3. Staff #5 had not touched Tenant #3 and did not push Tenant #3.

A Program document provided by the ED indicated on 2-20-14, she and the Nurse met with Staff #5 after learning Staff #5 pulled some clothing out of Tenant #3's hands while at the dining room table, which made Tenant #3 angry. Staff #5 was issued a 1st written warning for not being sensitive to tenant, was educated on how she could have handled the situation better and was notified she would not return to work in the dementia unit.

The Nurse and the ED stated they were not aware of any staff pushing dementia unit tenants. Staffs #1, #2, #3 and #4 stated they were not aware of any staff pushing a dementia unit tenant.

Per interviews with Staff #1, #2, #3, #4, the Nurse and the ED and review of a Program document, there was no indication any staff had pushed Tenant #3.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation #47027-C: It was alleged staff was not trained regarding medication management.

- Monitoring Observation: The Nurse was interviewed and stated after an employee was hired, she waited a few weeks to make sure the staff did well with personal cares before starting medication administration training. The training lasted a couple days

and included paperwork, delegations, using the dementia unit medication cart to show bubble packs and how to compare the bubble pack to the Medication Administration Record (MARs). The staff followed coworkers administer medications and then the Nurse observed the staff pass medications.

The ED stated when a new employee started work, they followed other staff and when the employee felt comfortable, the Nurse completed delegations for medication administration. If the staff was not sure, the staff would be retrained and re-delegated. She stated periodic audits were completed by observation.

Staff #1 stated her medication administration training consisted of following her co-worker and then the nurse came to teach her. The nurse spent one day with her. She stated she was nervous but had passed medications at her other job. Staff #2 stated her medication administration training lasted one day and she felt it was enough time. She had passed medications at her previous job. Staff #3 stated she had three to four days of training and then the Nurse observed her pass medications for a couple days. She said she felt it was enough training. Staff #4 was hired on 4-28-14 and stated she had not yet been trained to administer medications.

According to the Medication Management policy, the RN is responsible for training the care assistant in medication management and making sure the tenant is taking their medications according to the physician orders. According to the Administering Medications policy individuals administering medications must be knowledgeable about the rationale for their use. This insight cues the need for specific responses possible from the tenant pre/post administration of the medications. Care assistants are not trained or expected to obtain and interpret essential tenant data necessary for decision making when administering medications. However, the AL nurse will educate the staff on what to observe for and report.

Per interviews with Staff #1, #2, #3, #4, the Nurse and ED and review of Medication Management and Administering Medications policies, medication administration training was provided for staff administering medications.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47027-C: It was alleged there were tenants who received liquid medications and staff was not trained on how to draw up and administer the liquid medications.

- Monitoring Observation: According to a Liquid Narcotic Administration policy dated May 2014, the narcotic solutions would be kept in the DON office double locked. The RN/LPN would prefill the medications into an individual syringe per each prescription dose amount and cap each syringe so no medication would leak out. The syringes would be kept in a large sealable plastic bag and marked correctly with tenant name, drug, dose, route and how often it was ordered by the doctor to be administered.

  Staff #1 stated staff was trained to draw up liquid medications. Staff #2 stated staff was not trained to draw up liquid medications as only the nurses pre-filled liquids in a

syringe. Staff #3 stated staff was not trained to draw up liquid medications as staff did not handle liquids, only the nurse administered liquid medications.

The Nurse stated before she worked at the Program, staff drew up liquid Haldol for a hospice tenant, but since she started working she prefilled the syringes.

Per review of the Liquid Narcotic Administration policy and interviews with Staff #1, #2, #3 and the Nurse, staff no longer draws up liquid medications.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47027-C: It was alleged there was a very high number of medication errors and staff was instructed to change narcotic counts because medications were missing. Staff was told to modify narcotic count sheets and ignore missing medications without performing an investigation.

- Monitoring Observation: The monitor requested copies of Medication Error Reports for the previous six months. The Program provided all reports completed from 11-25-13 through 5-3-14. There was a total of three Medication Error Reports. None of the medication errors involved narcotics.

  Staff #1 stated if there was ever a narcotic count error she would call the nurse and everyone would come and they'd figure out the error. Staff #2 stated she had never had a narcotics count error. Staff #3 stated she had never changed a narcotics count to correct an error. She stated there was only one time there was an error and it was taken to the Nurse immediately and the Nurse investigated it and found the error. The Nurse stated the narcotic count was off one time and staff reported it to her. The ED stated if a narcotic count was off, the nurse would look into it and fix it, if necessary.

  Staffs #1, #2 and #3 stated they had never been told to ignore a missing medication or narcotic and to not do an investigation. The Nurse stated she had never told staff to ignore a missing medication or narcotic and to not do an investigation. The ED stated she was not aware of staff being told to ignore missing medications and narcotics and to not do an investigation.

  The monitor reviewed narcotic count records for five random tenants, involving six different narcotic medications. The narcotics were dispensed between 10-24-13 and 5-12-14. Pill counts were not crossed through, covered up or scratched out. The narcotic count records did not reflect any errors or shortage of medications.

  The monitor observed shift change narcotic count processes on 5-19-14 at 2:05 p.m. in the dementia unit. Count was observed between one staff ending her shift and one staff coming on shift. All counts were correct, no errors noted on any pages and both staff signed the count record. On 5-20-14 at 2:00 p.m. the monitor observed the AL narcotics count between one staff ending her shift and one staff coming on shift. All counts were correct and both staff signed the count sheet. On 5-20-14 at 2:05 p.m. the monitor observed the narcotic count process between one shift ending her shift and one staff coming on shift in the dementia unit. All counts were correct and both staff signed the count record.

The Narcotic Administration policy indicated the RN/Program Director/designee would be informed immediately of any inconsistencies in narcotic count. Any discrepancy in the delivery, count or destruction of narcotics would be subject to investigation, disciplinary action or dismissal as appropriate by the associate found to be responsible.

Interviews with Staff #1, #2, #3, the Nurse and ED, observation of three shift change narcotic counts, review of Medication Error Reports and review of the Narcotic Administration policy indicated no narcotic count errors or had staff been told to ignore missing medications or narcotics and to not do an investigation.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47027-C: It was alleged staff did not use MARs when passing medications.

- Monitoring Observation: The monitor observed a medication pass on 5-20-14 at 11:15 a.m. with Staff #6. Medications were administered to six tenants and Staff #6 reviewed the MARS and documented the administration of the medication on the MAR for all six tenants.

  The Nurse stated staff better be using MARs now during medication administration. She stated she noticed two evening shift staff administering medications by stacking their medications and they only took the medications to the tenants' apartments. The MARs were not being used. The Nurse took the MARs off the medication cart and placed them on her desk. One of the staff passing medications saw them on her desk and asked to have them. The staff immediately put the MARs in the staff break room so the Nurse retrieved them again. The staff passed medications and did not document on the MAR until the end of the shift. The Nurse addressed the situation with each staff with disciplinary action. Both staff were terminated.

  Staff #1, #2, #3, the Nurse and the ED stated MARs were used during the medication administration process.

  Per observation of a medication pass, interviews with Staff #1, #2, #3, the Nurse and ED, MARs were currently being used when passing medications.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: The monitor observed a medication pass on 5-20-14 at 11:15 a.m. with Staff #6. Medications were administered to six tenants. Staff #6 was observed using hand sanitizer after unlocking the medication cabinet for the second, third, fourth and sixth tenant. Staff #6 used soap and water to wash her hands after unlocking the fifth tenant's medication cabinet.

The monitor observed Staff #6 pop the oral medications out of the bubble packs directly into her hand and put the medications into a paper medication cup. At the second tenant's medication pass, the pill popped out of Staff #6's hand and landed on top of the kitchen counter. Staff #6 picked up the pill with a bare hand and placed it into the paper medication cup.

During the medication pass for all six tenants, Staff #6 documented on the MAR prior to handing the medication cup to the tenant.

The Administering Medications policy indicated the appropriate steps in medication administration. The first step was to wash hands. The steps that followed included to explain to the tenant why you were there, unlock the medication drawer/safe, indicate correct slot from which to remove medication, watch the tenant consume medication, sign off on MAR, replace medication box in the drawer, lock drawer/safe and wash hands again.

The Nurse stated using hand sanitizer was used in between hand washing but she expected staff to wash their hands after administering medications to two tenants. The Nurse confirmed that documentation was to be completed after the medication was consumed by the tenant. She stated staff was trained to not touch the pills and if a pill was dropped it would be replaced with another pill.

During the medication pass Staff #6 did not wash hands as indicated per policy, dropped a pill without replacing it and punched all pills out of the bubble pack into her hands before putting them in a medication cup. Staff #6 also completed documentation on the MAR prior to observation of the tenant swallowing the medication.

- Regulatory Insufficiency: Each program shall follow its own written medication policy, which shall include the following: When medications are administered traditionally by the program: 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) 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)(a))

C. Criteria for Admission and Retention

Complaint/Incident Allegation #47027-C: It was alleged Tenants #3, #4 and #5 received hospice services and required more care than staff could provide.

- Monitoring Observation: According to a Program document, Tenant #3 was given a 30 day notice on 2-7-14 due to exceeding the Program's level of care and was transferred from the Program on 2-14-14. Tenant #4 passed away and was discharged from the Program on 2-14-14.

Tenant #5, an 88 year old, was admitted on 7-24-13 and diagnoses included: Macular Degeneration, Glaucoma, Senile Dementia, Schizophrenia and Umbilical Hernia. Tenant #5 was staged at a six on the GDS which indicated severe cognitive decline. Tenant #5 resided in the dementia unit. A service plan dated 5-5-14 indicated Tenant #5 needed extensive assistance with showering and bathing, perform all grooming and hygiene tasks, assist to and from the bathroom per schedule and assist with hygiene and incontinent supplies, cuing and one person assist during transfers, escorts to and from meals and events, housekeeping services and medication assistance. Tenant #5 received hospice services.

On 5-19-14 at 11:40 a.m. the monitor observed Tenant #5 sitting in a chair in Tenant #5's apartment, fully dressed. The monitor was able to converse with Tenant #5 who was blind and hard of hearing. At 12:10 p.m. Tenant #5 was observed sitting at the dining room table eating goulash with assistance from staff as needed. On 5-20-14 at 2:25 p.m. Tenant #5 was observed getting out of chair in Tenant #5's apartment with the assistance of one. Staff #8 walked with Tenant #5 from the apartment out to the living room. Staff #8 offered to assist Tenant #5 to sit at a table but Tenant #5 chose not to sit at the table and to keep walking. Tenant #5 and Staff #8 walked back to Tenant #5's apartment, approximately 45 feet in distance.

Staffs #1, #2, #3, #4, the Nurse and ED stated there were no tenants who exceeded level of care.

Review of Tenant #5's file, monitor observations and interviews with Staff #1, #2, #3, #4, the Nurse and ED did not reveal any tenants exceeded level of care.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48171-C: It was alleged a tenant with a high level of care was admitted to the Program.

- Monitoring Observation: Eleven tenant files were reviewed.

Tenant #6, a 91 year old, was admitted on 3-25-14 and diagnoses included: Lumbar Radiculopathy, Foot Numbness, Scoliosis, Urinary Tract Infection, History of Left Shoulder Pain, Polymyalgia, History of Decubitus, Depression, Lumbago and Obesity. Tenant #6 was staged at a two on the GDS which indicated very mild cognitive decline.

The Nurse stated she assessed Tenant #6 at a skilled nursing facility. She stated Tenant #6 was able to get in and out of bed, she observed Tenant #6 get in and out with family assistance. The family put one hand under Tenant #6's arm. The transfer observed was from the wheelchair to the bed. Tenant #6 stated during physical therapy Tenant #6 walked using parallel bars without a walker. The Nurse reviewed Therapy notes, stating Tenant #6 was discharged from therapy with recommended assist of one. The Nurse stated Tenant #6 was appropriate for assisted living level of care and she wouldn't admit someone if they needed two person assist. After admission, Tenant #6 would call staff for assistance but didn't need assistance of two staff until Tenant #6's arm hurt.

According to a Physical Therapy Discharge Summary note, dated 3-20-14, Tenant #6 was discharged from skilled therapy. Discharge recommendations were for assist of one for transfers and Activities of Daily Living (ADLs). According to an Occupational Therapy Discharge Summary dated 3-20-14 discharge recommendations of assistance for standing ADL tasks and all transfers and Tenant #6 was aware of this. Tenant #6 reported Tenant #6 was going to an AL and would likely dress, toilet and transfer independently.

According to a service plan dated 3-25-14, Tenant #6 required bathing assistance two times per week, medication assistance from a pill planner set up by the nurse, used a wheelchair, walker and rolling walker, was independent in transfers with the assist of Tenant #6's family, grab bars and wheelchair. Tenant #6 was independent in eating and toileting.

According to a Progress Note dated 4-1-14, a staff called the Nurse to report Tenant #6 had a skin tear on left mid shin. Upon inspection it was mostly approximated back together and steri-stripped by staff. Tenant #6 was unsure exactly when it happened. There was a 0.3 mm area along the skin line that did not come completely to the edge of tear. The area was seeping serous drainage. Triple antibiotic ointment and Telfa applied and wrapped with gauze. No signs or symptoms of infection at this time. Tenant #6's family planned to care for the area. Family and staff instructed to monitor for signs and symptoms of infection. Family stated understanding. The Nurse gave Tenant #6 the dressing supplies for a couple days and left family a list of what to purchase. On 4-2-14 the Nurse changed the dressing on lower left leg. There was a scant clear serous drainage noted and skin was mostly approximated. There was a 1 cm open area noted between the distal ½ of the steri-strip. The Nurse left dressing change materials for use as Tenant #6's family stated family would take care of it tomorrow.

According to Progress Notes dated 4-4-14, Tenant #6 told staff left arm hurt so bad Tenant #6 could not use it. The Nurse assessed the left arm and it was acutely tender to the touch and swollen. Physical Therapy had worked with Tenant #6 the day before and Tenant #6 stated "I think we did too much or I need another shot in my shoulder." Tenant #6 told the Nurse Tenant #6 usually got a shot every three months and needed to go to the doctor. The Nurse called family to take Tenant #6 to the doctor or to call of an appointment. According to Progress Notes dated 4-5-14, Tenant #6 did not come down for breakfast, staff took it up and family stated "arm hurts too much." The Nurse went up and Tenant #6 was in tears, holding arm in pain. The Nurse asked if Tenant #6 had an appointment and was told "not yet." The arm was red, hot to the touch and remained swollen. The Nurse asked family to take Tenant #6 to the emergency room due to concern regarding a blood clot in the arm. Tenant #6 was suffering in pain and it was worse, red and warm. Family came and took Tenant #6 to see the physician. Tenant #6 was admitted to the hospital and had not returned at the time of the onsite investigation.

Review of Tenant #6's file and an interview with the Nurse indicated Tenant #6 was appropriate for assisted living level of care.

- Regulatory Insufficiency: None noted.

D. Activities

Complaint/Incident Allegation #47027-C: It was alleged staff falsified documentation of activities. Staff did not actually perform any of the activities documented.

- Monitoring Observation: The Program provided activity calendars for the general assisted living program for March, April and May 2014 and for the dementia unit for May 2014. Documentation of activities that dementia unit tenants attended in the general assisted living program was provided for February, March and April 2014. Documentation was provided for a variety of activities including but not limited to: exercises, bowling, walking, Cribbage, Bingo, devotions, nail care, music and ministry. An activity book was maintained within the dementia unit and used to document activities offered in the dementia unit.

  Staffs #1, #2, #3 and #4 stated they had not falsified documentation of activities or knew of anyone who had falsified documentation of activities that were not actually provided.

  The Nurse and ED stated they were not aware of anyone falsifying documentation of activities that had not been performed.

  Review of documentation of activities and interviews with Staff #1, #2, #3, #4, the Nurse and ED did not indicate documentation of activities performed had been falsified.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: The activity calendar posted on the bulletin board in the dementia unit indicated on 5-19-14 at 1:00 p.m. Book Club with the ED. At 1:30 p.m. the monitor observed the ED reading to seven tenants and one family member. The activity calendar indicated at 2:00 p.m. craft corner in the AL dining room and at 3:30 p.m. was walking group. At 2:30 p.m. the monitor observed two dementia staff playing Hangman with three tenants. At 3:10 p.m. the monitor observed two staff playing cards with one tenant while another tenant watched.

  On 5-20-14 the dementia unit activity calendar reflected the following: 9:00 a.m. Exercises; 10:00 a.m. Sushi Making with staff; 11:00 a.m. music, 2:00 p.m. Ministerial Association (T) and 3:30 p.m. walking group. At 9:05 a.m. the monitor entered the dementia unit and observed a staff at the bulletin board crossing off the 10:00 a.m. activity of Sushi Making with staff and changed it to Sweet Tea. The Nurse and two staff were discussing taking tenants outside. No exercises were being performed. One tenant was sitting at the dining room table. No other tenants were observed as all apartment doors were closed. The monitor returned at 10:10 a.m. and noted two tenants and one visitor sitting in the living room area. No activities were taking place. The staff stated everyone was sleepy and they had not yet served the sweet tea. The monitor returned at 2:05 p.m. and asked staff what activities had been

completed that day. The staff stated a family was visiting and came out and showed the tenants some photos of Mother's Day. Before lunch they took some tenants outside into the courtyard. They did not have sweet tea but drank coffee instead. She stated she did not know what the 2:00 p.m. activity was, said it was in the town center. She also stated they did not have music as scheduled for 11:00 a.m. At 2:20 p.m. the monitor spoke to Staff #7 who confirmed the 2:00 p.m. activity was an assisted living activity and the minister had not yet shown up.

Monitor observations revealed the activity calendar for the dementia unit was not followed as published.

Based on activities listed on the dementia unit calendar and observations by the monitor, the program did not provide appropriate activities for each tenant to reflect individual abilities and skills by providing opportunities for a variety of types and levels of involvement.

- Regulatory Insufficiency: The program shall provide appropriate activities for each tenant. Activities shall reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement. (IAC r. 481-69.34(1).

E. Policies and Procedures

Complaint/Incident Allegation #47824-I: The Program reported five tenants had large sums of money missing from their apartments.

- Monitoring Observation: The Program reported to the Department reports of missing money from five tenants. Tenants #6, #7, #8, #9 and #10 reported money missing. The ED initiated an investigation and noted all thefts appeared to occur when tenants were at their evening meal. The ED reviewed staff schedules and narrowed the thefts down to the possibility of two staff, eventually narrowing it to one staff. Staff was terminated and the police department was notified.

  Tenant #8 was interviewed and stated in March Tenant #8 looked in billfold and had around $200 missing. The billfold was kept inside a purse, behind a lamp next to a chair behind the chair's side table. Tenant #8 reported the loss to the ED and talked with the police.

  Tenant #9 was interviewed and stated about a month ago was going to the beauty shop the next day, so the night before checked money. Tenant #9 had three $20 bills, one $10 bill, one $5 bill and five $1 bills. Tenant #9 laid the money on the night stand, planning to put in purse the next morning. Tenant #9 went to breakfast at 6:45 a.m. and when Tenant #9 returned the money was all gone except for the five $1 bills. Tenant #9 stated Tenant #9 had been gone for 45 minutes. Tenant #9 locked the apartment door every time Tenant #9 left the apartment.

  Tenant #10 was interviewed and stated Tenant #10 kept money in a drawer next to the bed in three different bank envelopes. Tenant #10 discovered the money missing

on March 25th. Tenant #10 said the money was there on a Sunday and the next day needed to purchase gas so went to get the cash and it was all gone. There had been $100 in each envelope for a total of $300. Tenant #10 had never had anything missed before or since. Tenant #10 had left purse by the chair for two years and money was never missing.

Tenant #6 was out of the Program at the time of the investigation and could not be interviewed. According to a written statement completed by Tenant #6, the money that was missing had been in a billfold in a night stand drawer. A total of $200 was missing. Tenant #7 was discharged from the Program and unable to be interviewed. A written statement completed by Tenant #7 indicated at approximately 9:30 a.m. on 4-3-14, Tenant #7 checked billfold. There had been two $100 bills in one compartment and smaller bills in another compartment, not certain how much, but at this time there was no money found. The billfold was laying on a stand in the bedroom by the bed.

On 4-7-14 a staff in-service was held and staff were informed that immediately no one was to enter a tenant's apartment unless the tenant was present. If for some reason it was necessary to enter without the tenant present, a second person must accompany the staff at all times. If anyone saw an employee in an apartment unaccompanied by the tenant or another person staff must notify the ED immediately.

The ED was interviewed and stated apartment keys were taken away from the maintenance staff, business office staff and kitchen staff. Two care staff are the only ones with apartment keys. The ED stated she did not complete incident reports regarding the thefts.

According to an Accident/Incident Reporting Policy, when there is an incident that needs to be reported to the State per AL regulations, the AL Program Director is responsible for State notification. The incident report and investigation needs to be sent to the National Director of Health Services, Regional Director of Health Services, Managing Director and copied to the National Director of Risk Management. A log of Incident Reports is maintained on an ongoing basis in the Program's Incident Report file.

The Program reported the incident to the Department but did not complete incident reports on the five separate incidents.

The Program did not complete incident reports for unusual occurrences within the Program or on the premises.

- 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. The program's policies and procedures on incident reports, at a minimum, shall include the following: All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. (IAC r. 481-67.2(1)(e))

F. Evaluations

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

- Monitoring Observation: Eleven tenant files were reviewed.

  Tenant #10, an 87 year old, was admitted on 10-27-11 and diagnoses included: Macular Degeneration, Osteoporosis and a Fractured Femur on 2-8-14. Tenant #10 was staged at a one on the GDS which indicated no cognitive decline. According to the Progress Notes dated 3-11-14, Tenant #10 returned from a skilled nursing facility after right hip fracture that required pinning. Physical and Occupational therapy ordered and stool riser seat ordered. Functional and health evaluations were completed and the service plan was updated. The service plan, functional evaluation and health evaluation indicated it was a significant change. A cognitive evaluation was not completed with a significant change.

  Tenant #11, a 79 year old, was admitted on 1-23-14 and diagnoses included: Altered Mental Status, Falls, Urinary Tract Infections (UTIs), Urine Retention, Parkinson's and Dementia. Tenant #11 was staged at a two on the GDS which indicated very mild cognitive decline. A nurse review dated 5-13-14 indicated a significant change as Tenant #11 had more frequent falls and episode where knees gave out. Tenant #11 did not consistently use walker in room to move around and stumbled or knees gave out and Tenant #11 dropped to knees. It took one to two staff to assist off floor. Tenant #11 had been incontinent a couple of times past few days and went to the doctor for treatment of a possible UTI. Tenant #11 was given three days of antibiotics. Functional and health evaluations were completed and the service plan was updated. The service plan, functional evaluation and health evaluation indicated it was a significant change. A cognitive evaluation was not completed with a significant change.

  Review of tenant files indicated cognitive evaluations were not completed as needed with a significant change.

- 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))

G. Service Plans

Complaint/Incident Allegation #47027-C: It was alleged staff did not follow the tenants' service plans.

- Monitoring Observation: Staffs #1, #2, #3 and #4 were interviewed and stated they followed the tenants service plans to direct the care provided. Staff #3 stated she follows what she is told to do for the tenants. The Nurse stated she felt staff provided good care but was not sure if all staff read the service plans. The ED stated there had been times when staff needed to review them. She stated the majority of time, yes; the staff followed the service plans.

  Interviews with Staffs #1, #2, #3, #4, the Nurse and the ED indicated staff did follow service plans in meeting the needs of the tenants.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: Eleven tenant files were reviewed.

  Tenant #10 returned from a skilled nursing facility after right hip fracture that required pinning. Physical and Occupational therapy ordered and stool riser seat ordered. Functional and health evaluations were completed and the service plan was updated. The service plan, functional evaluation and health evaluation indicated it was a significant change. A cognitive evaluation was not completed with a significant change. A service plan completed on 3-11-14 was not based on a cognitive evaluation.

  Tenant #11's file indicated a significant change as Tenant #11 was having more frequent falls and episode where knees gave out. Tenant #11 did not consistently use walker in room to move around and stumbled or knees gave out and Tenant #11 dropped to knees. It took one to two staff to assist off floor. Tenant #11 had been incontinent a couple of times past few days and went to the doctor for treatment of a possible UTI. Tenant #11 was given three days of antibiotics. Functional and health evaluations were completed and the service plan was updated. The service plan, functional evaluation and health evaluation indicated it was a significant change. A cognitive evaluation was not completed with a significant change. A service plan completed on 5-13-14 was not based on a cognitive evaluation. The service plan did not reflect the initiation of antibiotics.

  Review of tenant files indicated service plans were not based on cognitive evaluations and updated when changes were needed.

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