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INSPECTIONS & APPEALS

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DEMAND LETTER

Complaint Intake #: 46612-M RV-1

May 28, 2014

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

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

Dear Ms. Ethofer:

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

Enclosed is the **Final Recertification and Complaint/Incident Investigation Revisit 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 12, 14 and 15, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plans, Nurse Review, Policies and Procedures and Compliance with Plan of Correction.

Vintage Hills at Prairie Trail Assisted Living ("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 Evaluation, Service Plans, Nurse Review and Policies and Procedures.

The determination of a **$1,000 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plans, Nurse Review and Policies and Procedures. As the enclosed Report details, the Program failed to update nurse reviews, evaluations and service plans 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 **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 Recertification and Incident Investigation Revisit Report

Assisted Living Program: **Complaint/Incident: # 46612-M RV-1**

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

Date of Monitoring Visit:

May 12, 14, and 15, 2014

Monitor(s):

Lori Miner, RN BSN

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

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

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

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

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	35
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	38
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	18
Total Population of Program at time of on-site	18
TOTAL census of Assisted Living Program	56

Program History – During the course of the Recertification and Incident (46612-M) visit conducted on January 8, 9, 13, 14, and 15, 2014 the program received regulatory insufficiencies in the areas of: Evaluations, Service Plans, Nurse Review, Medications, Food Service, Record Checks, Policies and Procedures, Tenant Documents, and Tenant Rights.

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

A. Evaluation of Tenant

During the course of the onsite visit in January 2014 the program received a regulatory insufficiency related to evaluations not being completed within 30 days of admission, and not completed with a change of condition. Tenants #1, #5, and #6 were identified.

Monitoring Observation: Tenants #1, #5, and #6 no longer resided at the program.

Tenant #2, a 78 year-old, was admitted to the program on 11-29-13 and had diagnoses of: Anxiety, Hypertension, and Chronic Obstructive Pulmonary Disease. On 12-29-13, Tenant #2 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive decline. Tenant #2 resided in the general population portion of the building. According to the functional capabilities form also completed on 12-29-13, Tenant #2 was alert with no impairment, and was generally oriented to person, place, and time.

On 3-28-14 a 90-day nurse review was completed by the licensed practical nurse (LPN), although the computerized signature indicated a registered nurse completed the review. According to the review, Tenant #2 was alert to self, but confused to surroundings. Tenant #2 thought he/she was at the hospital and recently had hip surgery. The review noted Tenant #2 was not at the hospital and did not have recent surgery. Tenant #2 also

reported it was April 2010, and the day of the week was Monday. According to the calendar 3-28-14 was a Friday.

The service plan dated 12-29-13, which was current at the time of the onsite visit, contained an entry dated 3-28-14 which indicated Tenant #2 was alert and oriented x1, a change from the original notation on the service plan which indicated alert and oriented x 3. The service plan also indicated Tenant #2 thought she was at the hospital post-operatively following a hip replacement.

Although the LPN documented in the nurse review that Tenant #2 had experienced no significant changes since the last review, the LPN did update the service plan to document changes to Tenant #2's cognitive status.

Tenant #2 experienced a significant change to the cognitive status, enough to warrant updates to the service plan. Evaluations were not completed by a registered nurse with a significant change of condition.

Tenant #7, an 82 year-old, was admitted on 5-4-13 and had a diagnosis of: Alzheimer's Disease and Parkinson's Disease. Tenant #7 was staged at six on the GDS on 5-4-14 and seven on the GDS on 5-12-14 which indicated severe to very severe cognitive decline. Tenant #7 resided in the dementia unit.

Progress notes and incident report dated 3-12-14 documented Tenant #7 stood up from the dining room table and lost balance and fell to the floor. No injuries were noted. The incident report documented actions taken to prevent reoccurrence included keeping the walker within reach when Tenant #7 was at the dining room table. The service plan was updated. Notes of 3-17-14 documented Tenant #7 was more confused. On 3-18-14 an antibiotic was started for a urinary infection.

Notes of 3-21-14 documented Tenant #7 continued to see things that weren't there. The program communicated with the physician's office. On 3-24-14, it was documented Tenant #7 had periods of increased agitation.

Progress notes and incident report of 3-24-14 documented after hearing a loud noise, Tenant #7 was found on the floor of the apartment. Tenant #7 complained of head pain with a bump on the left side of the head and above the left eye. The incident report documented a light was to be on in the bathroom at night so that Tenant #7 could see when getting up. The service plan was updated. Notes documented the family did not wish Tenant #7 taken to the ER for evaluation following a hit to the head with a fall. Notes of 3-25-14 documented the LPN followed up after the fall. Notes documented Tenant #7 needed constant reminders to use a walker with transfers and ambulation.

Notes of 3-26-14 documented Tenant #7 refuses to use the walker, but had a steady gait. The LPN documented unnecessary anxiety was created for Tenant #7 when given the walker to use. On 3-28-14, according to the progress notes, the physician agreed Tenant #7 did not have to use the walker but was to be encouraged to do so.

Progress notes and incident report dated 3-30-14 documented Tenant #7 was found on the floor in the dining room. Tenant #7 complained of neck and right leg, hip, and arm pain.

Tenant #7 was transferred to the ER for evaluation. Tenant #7 returned from the hospital on the same day with an order for an antibiotic for a urinary infection.

Tenant #7 had three falls within between 3-12 and 3-30-14. Tenant #7 sustained a head injury during one of the falls. The family refused ER evaluation for the head injury. On two occasions, interventions were placed on the service plan. Tenant #7 became more anxious when given the walker to use. The physician was contacted and indicated Tenant #7 did not need to use the walker, but was to be encouraged to do so. Tenant #7 sustained a third fall and complained of neck and hip pain. Tenant #7 was sent to the ER and returned with treatment for a urinary infection.

Tenant #7 exhibited falls for which injury occurred and interventions were put in place. Evaluations of function, cognition, and health were not completed after Tenant #7 sustained a series of falls with an injury. Evaluations were not completed by registered nurse with a change of condition.

Progress notes dated 4-6-14 documented Tenant #7 had increased confusion, decreased appetite and general decline. The family requested a hospice referral. On 4-9-14, Tenant #7 was admitted into hospice.

Progress notes of 4-15 and 4-16-14 documented Tenant #7 had increased confusion, was anxious, and wandered. Staff provided one-on-one activities. On 4-16-14, the physician increased the Haldol and ordered Ativan for anxiety as needed.

Progress notes dated 4-24-14 documented Tenant#7 was started on an antibiotic for an Upper Respiratory Infection with hypoxia, cough, and brown sputum. Evaluations were not completed by a registered nurse with a significant change of condition.

Progress notes dated 4-26-14 documented Tenant #7 was found siting on the floor with no injury. Tenant #7 was reported to be shaky at the time. A staff communication report dated 4-26-14 documented Tenant #7 was experiencing a change in ability to walk. On 4-27-14 Tenant #7 was found lying in front of the bedroom door with no injury. The progress note documented the hospice nurse would look at changing medications. According to the service plan dated 2-14-14, updates of 4-28-14 indicated Tenant #7 was to be checked hourly.

Evaluations were completed on 5-4-14 for a change of condition.

Progress notes documented falls on the following dates: 5-9 found on floor with back pain but no injury; 5-10 found on floor with no injury, and 5-10 found on floor with head bleeding.

On 5-10-14, Tenant #7 was sent to the ER for a head injury. Tenant #7 returned to the program with staples to the back of the head and discharge instructions which included head injury precautions with someone to check on Tenant #7 every hour during the first 24 hours. Evaluations by the program's registered nurse were not completed with a change of condition, a head injury which required treatment and head injury precautions.

Progress notes of 5-11-14 documented Tenant #7 was found on the knees by the bed. No injury was noted, however; the progress notes documented every 15 minutes checks were

instituted as an intervention. Interventions were put in place but evaluations were not completed at that time.

On 5-12-14, the Hospice RN completed an assessment which indicated Tenant #7 was pocketing food and had an increased difficulty swallowing. The RN completed evaluations on 5-12-14; however, the evaluations did not document the condition of Tenant #7's head wound received during a fall on 5-10-14 and did not include an evaluation of Tenant #7's ability to swallow, a concern identified by the Hospice RN.

Evaluations completed on 5-12-14 documented Tenant #7 had declined and required assistance of two persons for toileting and transfers.

Progress notes of 5-13-14 documented the RN had reviewed staff communication from 4-26-13 which documented falls. The Department was also contacted regarding waiver application for Tenant #7.

Tenant #7 experienced several changes of condition which resulted in medical and clinical interventions for care. Evaluations were not completed with changes of condition.

Tenant #10, a 77 year-old, was admitted on 4-26-12 and had diagnoses of: Dementia and Depressive Disorder. Tenant #10 was staged at six on the GDS which indicated severe cognitive decline. Tenant #10 resided in the dementia unit.

Progress notes and an incident report dated 4-12-14 documented Tenant #10 was found on the floor. Tenant #10 complained of elbow, shoulder, and arm pain severe enough for Tenant #10 to yell. Tenant #10 was transported to the hospital and returned with an order for an antibiotic for a urinary infection. Evaluations were not completed with a significant change of condition, a decline in Tenant #10's condition that required intervention.

Progress notes dated 4-15-14 documented Tenant #10 was very needy and tearful. Notes of 4-16-14 documented Tenant #10 was attached to staff and did not want to be alone. Notes of 4-17-14 documented Tenant #10 was very verbally aggressive, very tearful and crying. Tenant #10 was observed to be more confused and very agitated. On 4-17-14, a fax was sent to the physician documenting the behavioral changes. The physician increased the Sertraline, an antidepressant. Tenant #10 exhibited an increase in behaviors that required medicinal intervention. Evaluations were not completed with a change of condition.

On 4-28-14, the progress notes documented Tenant #10 had an open area to the skin where the absorbent undergarment met the thigh. A fax was sent to the physician which requested wound care orders. Evaluations were not completed with a change of condition, a wound which required intervention.

Progress notes dated 5-2-14 written by the RN indicated staff communication reports of 4-17 and 4-28 were reviewed which documented increased anxiety, and the development of an open area on Tenant #10's thigh. It was also noted an order was obtained for a hospice consult if the family desired. The RN documented this constituted a change of condition.

Tenant #10 was admitted into hospice on 5-6-14 and evaluations were completed. The evaluations did not include an assessment of the wound on Tenant #10's thigh other than to document the wound existed.

Evaluations were completed for Tenant #11 prior to moving into the program.

Evaluations were completed for Tenant #13 prior to moving into the program and within 30 days of admission.

Tenant #12, an 81 year-old, was admitted on 11-13-12 and had diagnoses of: Dementia, Diabetes, Hypertension, and Coronary Artery Disease. A cognitive evaluation was completed for Tenant #12 on 1-29-14 and Tenant #12 was staged at four on the GDS which indicated moderate cognitive decline. Tenant #12 resided in the dementia unit. The clinical record contained a completed Sexual Behaviors and Intimacy Worksheet. The worksheet indicated Tenant #12 was a GDS of four and capable of engaging in hand-holding, kissing, and cuddling. The worksheet was dated 4-5-13.

On 5-9-14, evaluations were completed for a change of condition for Tenant #12. The cognitive evaluation revealed Tenant #12 was staged at six on the GDS which indicated severe cognitive decline. The service plan dated by signature 5-15-14 continued to include Tenant #12's ability to continue to participate in hand-holding, kissing, and cuddling. Tenant #12's ability to consent to an intimate relationship was not re-evaluated with a change in cognitive ability.

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

B. Tenant Documents

During the onsite visit of January 2014 the program received a regulatory insufficiency related to tenant documents as evidenced by lack of documentation of physician-ordered tasks on Medication Administration Records (MARs). Tenants #1 and #5 were identified.

Monitoring Observation: Tenants #1 and #5 no longer resided at the program.

Regulatory Insufficiency: Clinical records were reviewed. No issues were identified with Tenants #2 #9, #11 #12, or #13.

Tenant #7 had oxygen ordered beginning 5-12-14 which was listed on the MAR.

Support stockings, which were physician ordered, were on the MAR for Tenant #10.

Regulatory Insufficiency: None noted.

C. Service Plan

During the onsite investigation of January 2014 the program received a regulatory insufficiency related to service plans not meeting identified tenant needs, not based on evaluations, not completed within 30 days of admission, not including outside service providers, and not including activities for persons with dementia. Tenants #1, #4, #5, #6, and #9 were identified.

Monitoring Observation: Tenants #1, #4, #5, and #6 no longer resided at the program. No issues were identified with Tenant #9.

Tenant #2 had a current service plan dated and signed on 12-29-13. Since the service plan was signed, the service plan was updated to include fall interventions on 4-1 and 4-24-14, and tray service in the apartment rather than going to the dining room on 3-28-14. The service plan was not signed by Tenant #2 after the updates were made.

Tenant #7's service plan dated 2-14-14 was updated on 3-12 and 3-24-14 with interventions following falls. On 3-30-14 an intervention of offering fluids for the frequent urinary infections was added to the service plan. The updates were not based on evaluations.

On 4-16-14 a fax was sent to the physician documenting Tenant #7's increased anxiety, pacing and hallucinations. Medication changes were made which included an "as needed" medication for anxiety. The service plan was not updated with interventions for anxiety, pacing, or hallucinations. The service plan did not give direction to direct care staff as to the administration of the "as needed" anti-anxiety medication.

On 4-28-14 the service plan for Tenant #7 was updated to include hourly checks. The update was not based on evaluations.

The service plan with a signature date of 5-8-14 and the service plan with updates after the 5-12-14 evaluations documented Tenant #7 had a history of infection and staff was to observe for signs of infection. The service plan did not identify specific signs and symptoms to be reported. The service plan identified Tenant #7 exhibited behaviors. The service plan identified one of the following applied: agitation, aggression, depression, or disturbed sleep, and direct care staff was to report behavior needs. The service plan was not developed to meet the specific needs of Tenant #7. According the MAR for May 2014, an "as needed" medication was administered five times between 5-1 and 5-7-14 for high anxiety and pacing and the medication was only slightly effective.

On 5-10-14, Tenant #7 fell and sustained a cut to the head which required staples. Tenant #7 was given discharge instructions from the hospital which included hourly checks. The service plan did not identify a head wound with staples, did not provide direction to direct care staff as to care needed with the head wound and staples while providing daily cares, did not provide directions for care of the wound as outlined in the discharge instruction. The service plan did not identify what staff was to look for when performing hourly checks. The service plan did not meet the specific needs of Tenant #7.

The service plan for Tenants #7, #10, and #11 identified activities for a person with dementia.

Evaluations were completed for Tenant #10 on 5-6-14. The service plan identified Tenant #10 had a wound but did not identify the location of the wound and did not identify specific interventions direct care staff were to utilize in the care of the wound.

The service plan identified Tenant #10 exhibited behaviors. The service plan identified two of the following applied: anxious, depression, or disturbed sleep, and direct care staff was to report behavior needs. The service plan was not developed to meet the specific needs of Tenant #7. Specific interventions were not identified for use by the direct care staff when Tenant #10 exhibited behaviors. The service plan did not meet the specific needs of Tenant #10.

Tenant #11's initial service plan was dated 2-18-14. Tenant #11 was determined to be cognitively impaired with a GDS of six. A notation on the service plan indicated the family member was unable to sign the service plan until move in, which occurred on 3-3-14. Tenant #11 was discharged from the program on 3-19-14. The service plan was not signed by the tenant or legal representative.

Progress notes for Tenant #12 documented the following: 3-6-14, set off door alarm; 3-12 verbally aggressive with another tenant and threatened to hit tenant; 3-13 tenant upset; 3-26 physician contacted in regards to Tenant #12's recent aggressive and agitated behaviors; 4-1 seen by physician in regards to increased aggressive behaviors, 4-16 verbally aggressive towards staff threatening to "bash their heads in"; 4-25 set off door alarm; and 5-10-14 followed staff out the door.

The service plan with a signature date of 5-15-14 does not identify Tenant #12's aggressive or exit-seeking behavior. Interventions for behaviors were not on the service plan. The service plan did not meet the specific needs of Tenant #12.

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: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

D. Medications

During the onsite visit of January 2014 the program received regulatory insufficiencies related to medications as evidenced by Tenant #2's nasal spray and inhaler not being administered because the medication was not available.

Monitoring Observation: The Medication Administration Records February through April 2014 were reviewed for Tenant #2. Medications including inhaler were administered as scheduled except when Tenant #2 was out of the program for the day. The physician's orders no longer had an order for nasal spray.

Medication Administration Records were also reviewed for the following tenants:

Tenant #7 for February through May 2014. Medications were documented as given.

Tenant #9 for April 2014. Medications were documented as given except for an entry dated 4-10-14. The entry indicated a nebulizer was to be given every seven hours while awake. A review of the physician's order did not indicate the medication was to be given only while awake. The nebulizer was not given after 9:00 p.m. on April 9th or 10th, and was not given at 7:00 a.m. on April 10th.

Tenant #10 for March and April 2014. Medications were documented as given except when Tenant #10 was out of the program.

Tenant #11 for March 2014. Medications were given unless refused by the tenant. Tenant #11 left the program permanently on 3-19-14.

Tenant #13 for April 2014. Medications were documented as given.

While a deviation from the 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.

E. Nurse Review

During the onsite visit of January 2014, the program received regulatory insufficiencies related to nurse review. Tenants #1, #4, and #9 were identified.

Monitoring Observation: Tenants #1 and #4 no longer resided at the program. No issues were identified with Tenant #9.

Tenant #7 sustained a fall on 5-10-14 which resulted in a head injury and care provided in the ER. Tenant #7 returned to the program with discharge instructions for hourly checks related to the head injury. A nurse review was not completed with a significant change of condition.

Progress notes and an incident report dated 4-12-14 documented Tenant #10 was found on the floor. Tenant #10 complained of elbow, shoulder, and arm pain severe enough for Tenant #10 to yell. Tenant #10 was transported to the hospital and returned with an order for an antibiotic for a urinary infection. A nurse review was not completed with a change of condition.

Tenant #12 exhibited aggressive behaviors that resulted in consultation with the physician and a medication change. A 90-day nurse review was completed on 4-29-14;

however, behaviors were not addressed. A nurse review was not completed with a change of condition.

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

Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

F. Food Service

During the onsite investigation of January 2014 the program received a regulatory insufficiency related to food service as evidenced by food safety training not completed prior to working in food service. Staff #4, #6, and #7 were previously identified.

Monitoring Observation: The January 2014 monitoring report noted the following: Staff #4 was hired 11-5-12 as a Universal Worker (UW). Staff #6, UW, was hired 8-12-13. Staff #7, UW was hired 6-24-13. Food safety training was not documented as completed until 11-29-13 for all three employees.

There were two employees hired after the plan of correction date: Staff #17 was hired 4-8-14 as a UW. Food safety training was completed on 4-9-14. Staff #18 was hired on 4-29-14 as a Cook. Food safety training was completed on 4-29-14.

Food safety training was completed in a timely manner for each employee.

Regulatory Insufficiency: None noted.

G. Record Checks

During the onsite visit of January 2014 the program received a regulatory insufficiency related to background checks as evidenced by Staff #5 not having a background check including Department of Human Services (DHS) response prior to hire.

Monitoring Observation: It was noted in the January 2014 monitoring report that on 1-15-14, the monitor was given a copy of just received DHS response which indicated Staff #5 was able to work at the program.

There were two employees hired after the plan of correction date: Staff #17 was hired 4-8-14 as a UW and Staff #18 was hired on 4-29-14 as a Cook.

Background checks were completed prior to hire.

Regulatory Insufficiency: None noted.

H. Policies and Procedures

During the onsite visit of January 2014 the program received a regulatory insufficiency related to policies and procedures. The policy in effect at the time of the January 2014 visit stated all narcotics would be administered/witnessed by two staff members. When narcotics were placed in envelopes, the envelopes were to be labeled with the tenant's name, the name of the medication, the dose, and the time. All narcotics were to be counted by two staff members, the staff member coming to work and the staff member leaving work, at every shift change. The narcotics policy also stated inaccuracies were to be reported immediately.

Monitoring Observation: The program was asked to provide a copy of the current narcotics administration policy. The policy no longer contained a requirement to have medication envelopes labeled.

A shift count was observed on 5-12-14 at 2:00 p.m. in the dementia unit. Four staff were observed: Staff #10, #12, #13, and #14. The oncoming shift was observed counting with the off-going shift. Each bubble pack card was counted and compared with a narcotic log sheet. After each pair counted the bubble packs for which they were responsible, a separate medication count sheet and key sign-out sheet was signed. It was observed two keys were required for entrance into the narcotics box and two different staff members had a key to use in one of the locks. It was observed the number of pills in the bubble packs matched the number of pills indicated on the individual narcotic log sheet.

On 5-14-14 at 11:30 a.m., Staff #3 and #8 were observed with a key to the general population narcotic box. Each used their own key to open the box. Staff #3 and #8 were observed signing out a narcotic with the other staff member co-signing the count was correct. It was observed the number of pills in the pack matched the number of pills indicated on the individual narcotic log sheet.

In an interview with the RN, shift counts were no longer completed on individual narcotic count sheets. Shift counts were completed on one of four "Controlled Medication Count and Key Sign-Out Sheets." The RN also reported there had been no errors with the narcotic counts. The RN reported the current system of bubble packs was set up with a separate bubble pack for each time a medication was scheduled. As an example, if a medication was ordered in the morning and at noon, even though it was the same medication there would be two bubble packs. The RN reported on one to two occasions a narcotic taken from the wrong bubble pack but the medication was the same and did not result in a medication error and did not result in missing narcotics. The RN reported she was notified on each occasion.

The "Controlled Medication Count and Key Sign-Out Sheets" were reviewed. On the following occasions two staff did not sign the sheet at shift change: 4-1-14 at 2200, 4-4-14 at 2200, 4-11-14 at 2200, 4-22-14 at 1000, 4-27 at 0610 (labeled "west"), 4-27-14 at 1800, 5-2-14 at 1400, 5-8-14 at 2100, and 5-9-14 at 2200.

According to the narcotics policy provided by the program, narcotics were to be counted by two associates at the time of change of shifts. The "Controlled Medication Count and Key Sign-Out Sheets" lacked two signatures for documentation of completion of the narcotics count on at least five occasions.

The program's policy on narcotic count at change of shift was not followed.

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

I. Tenant Rights

During the onsite visit of January 2014, the program received a regulatory insufficiency related tenant rights as evidenced by Tenant #6 who wandered into other tenants' apartments and urinated and defecated on furniture.

Monitoring Observation: Tenant #6 was discharged from the program on 2-21-14. Interviews were conducted with Staff #10, #11, and #12 who were working in the dementia unit. None of the staff members identified behaviors of any tenant that impeded on the rights of other tenants.

The surveyor made frequent observations in the dementia unit over the course of the three days onsite. No behaviors were observed that impeded on the rights of others.

Clinical records were reviewed for Tenants #7, #9, #10, #11, and #12 who resided in the dementia unit. There was no documentation in the clinical record to suggest those tenants had behaviors that impeded on the rights of others.

Regulatory Insufficiency: None noted.

J. Compliance with the Plan of Correction

Monitoring Observation: The program did not meet objectives set forth in the plan of correction submitted following the recertification and incident visit of January 2014 in the areas of: Evaluations, Service Plans, and Nurse Review.

Regulatory Insufficiency: The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. (IAC r. 481-67.13(4))