IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER

Complaint Intake #:
49726-I
50215-C
50041-I
50920-I

January 9, 2015

Mr. Nick Lensch, Director
Courtyard Estates at Hawthorne Crossing
601 Hawthorne Crossing Drive SE
Bondurant, IA 50035

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - COURTYARD ESTATES AT HAWTHORNE CROSSING
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Mr. Lensch:

I. Final Complaint/Incident Investigation Report – Courtyard Estates at Hawthorne Crossing, Bondurant, 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 **December 18 - 29, 2014.**

The following allegations were investigated in regards to Complaint #50215-C:
Based on observations, staff interviews, tenant interviews, a review of tenant files, discharged files, incident reports, program procedures, and staff schedules, the following was found:
1. Allegation – Tenant Rights: It was alleged a tenant was dropped off at an urgent care clinic, not associated with the primary physician's practice, without prior notification and without a caregiver in attendance.

Findings- Not Substantiated
Comments – The events as described could not be determined through tenant and staff interview, document review, or record review. The records did indicate the Program identified a change in a tenant's condition and further care was sought. The Program did provide documentation that it does provide transportation for tenants for personal needs. Service plans identified family assisted with transportation. In an interview with a Registered Nurse (RN) associated with the program as well as the sister program in Pleasant Hill, she stated urgent care clinics do not require an appointment. As a practice, the programs utilize the urgent care clinics closest to the programs regardless of primary provider when a need arises. The RN stated there had been no issues with this practice in the past and primary providers are notified following a visit to urgent care.

2. Allegation – Staffing: It was alleged a tenant received an order for an antibiotic every 18 hours, and it was not clear the medication was given as ordered.
Findings – Not Substantiated
Comments – A review of the clinical record for the tenant in question was completed. The clinical record contained the order for an antibiotic every 18 hours. The clinical record documented the administration of the medication as ordered until seen by the primary physician and the orders were changed.

The following allegations were investigated in regards to Incident #49726-I:

Based on observation, record review, staff and family interviews, and the Program's investigation, the following was found:

1. Allegation – Tenant Rights: The program reported an incident that may have occurred involving an employee and a tenant residing in memory care. A staff member may have pushed the tenant.
Findings – Not Substantiated
Comments: Staff and family interviews were conducted. There were no direct witnesses to the alleged event. Per interview with the family of the tenant and the documentation of the nurse, the tenant sustained no injury. The staff member involved in the alleged incident is no longer employed by the program.

The Program also reported to the Department two other incidents: 50041-I and 50920-I. Regulatory insufficiencies were cited in relation to these incidents. The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Criteria for Admission/Retention of Tenants, Tenant Documents, Service Plans, Nurse Review, and Structural Requirements.

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

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.17(1)(a), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000 and 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 service plans.

The determination of a **civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm and for repeated Regulatory Insufficiencies in the areas of service plans. As the enclosed Report details, the Program failed to secure an exterior courtyard gate and a tenant eloped resulting in an injury.

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.

IV. Conclusion

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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP261	A. BUILDING _____ B. WING _____	C 12/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ESTATES AT HAWTHORNE CRO	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

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A 000	481-67 Initial Comments 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: 17 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 19 Dementia-Specific Program by DedicationNumber of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 19 Total Population of Program at time of on-site: 21 TOTAL census of Assisted Living Program: 40 No insufficiencies were cited related to 49726-I and 50215-C. The following insufficiencies were cited during the investigation of Incident/Complaint 50041-I and 50920-I.	A 000		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. 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	A 037		

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A 037	Continued From page 1	A 037		

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.

This REQUIREMENT is not met as evidenced by:
50920-I: The Program reported to the department Tenant #4 fell and sustained a hip fracture. The following was noted as investigation into the incident.

Based on interviews and record review, evaluations were not completed with significant change of condition to determine continued eligibility for the program and determine any changes to services needed. Tenant #4 had a history of falls prior to moving into the Program and had multiple falls with injury while at the Program. The last fall resulted in a fracture to the hip. Tenant #4 did not return to the Program.

1. Tenant #4, an 87 year-old, was admitted on 10-1-14 and had diagnoses of: dementia, history of falls, and pain. On 9-25-14, Tenant #4 had three errors on the short portable mental status questionnaire (SPMSQ) which indicated mild cognitive impairment. Tenant #4 was staged at four on the global deterioration scale (GDS) which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit.

The initial evaluations completed 9-25-14 documented Tenant #4 was independent with transfers and mobility, used a walker, and had back pain for which Tenant #4 required routine medication. According to nurse's notes dated

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A 037	Continued From page 2 10-1-14, Tenant #4 had a history of falls, used a walker independently, and the physician had ordered physical therapy (PT) and occupational therapy (OT). Nurse's notes dated 10-2-14 and timed 11:30 a.m. and documented in an incident report revealed Tenant #4 was found wandering in the apartment bleeding profusely down the neck with blood on the floor. RN A held pressure to the wound and 911 was called to transport Tenant #4 to the emergency room. Nurse's notes dated 10-2-14 and timed 4:30 p.m. documented Tenant #4 returned to the program with four staples in the back of the head. Tenant #4 sustained a head injury which resulted in staples to the back of the head. Evaluations of function, cognition, and health were not completed with a significant change of condition. Nurses notes dated 10-14-14 and timed 3:00 p.m. and documented in an incident report revealed Tenant #4 fell and hit the head and was bleeding from the back of the head. Nurse's noted documented a family member took Tenant #4 to the emergency room. Documentation from the physician at the hospital dated 10-14-14 documented Tenant #4 had frequent falls and dizziness. Thy physician recommended wheelchair for transport to reduce fall risk. The second physician noted Tenant #4 had two trips to the emergency room in the last two weeks with two CT scans of the head. The physician's documentation was noted by RN A. The clinical record contained documentation Tenant #4 had been seen by a physician on 10-16-14 and also documented Tenant #4 had	A 037		

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A 037	Continued From page 3 been seen twice in the emergency room for falls due to dizziness. The physician recommended Tenant #4 use a wheelchair, or use a walker with the assistance of another to prevent future falls. The physician also prescribed Meclizine for the dizziness. The physician's documentation of 10-16-14 was noted by RN A on 10-16-14. According to the nurse's notes, rather than returning to the program on 10-14-16, Tenant #4 stayed with the family member "for a couple nights" but had returned to the Program by 10-16-14. Evaluations were not completed with a significant change of condition, a fall with head injury resulting in a trip to the emergency room. Two physicians recommended assistive devices and/or assistance with ambulation to decrease the fall risk. Medication was prescribed for dizziness which contributed to the falls according to the physicians. Evaluations were not completed to evaluate Tenant #4's status and to determine any changes to services needed. Nurse's noted dated 10-30-14 documented Tenant #4 had black diarrhea and was leaning backwards over a chair. An incident report dated 10-30-14 documented Tenant #4 reported a fall to a staff member. Documentation on the incident report indicated a small cut was found on the back of the head. Tenant #4 was sent to the hospital. Documentation in the clinical record included a report of a gastroscopy completed on 10-30-14. The documentation included the statement that if the ulcer re-bleeds, it may very well be torrential bleeding and difficult to control.	A 037		

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A 037	Continued From page 4 Tenant #4 returned to the Program on 11-3-14 and 30-day evaluations were completed. Nurse's notes dated 11-21-14 documented on 11-17-14 Tenant #4 reported falling onto the couch and had two scuff marks on the back of the head. Nurse's notes dated 11-21-14 and timed 2:35 p.m. documented Tenant #4 had been found on the floor "last evening" at 9:45 p.m. with the head bleeding. The nurse's notes documented Tenant #4 was not talking to the family like usual and the family was going to take Tenant #4 to the hospital. Nurse's notes dated 11-24-14 and timed 9:30 a.m. documented Tenant #4 was found on the floor at 5:35 a.m. on 11-22-14. On 12-22-14 at 9:35 a.m. the Nurse Clinician was interviewed and stated she would have expected evaluations to have been completed following a head injury. Task sheets provided by the Program documented Tenant #4 was observed 32 times a shift beginning 11-22-14. Interventions were put in place; however, evaluations were not completed with a significant change of condition, continued falls with head injury requiring interventions. Nurse's notes dated 11-28-14 and timed 8:00 a.m. documented Tenant #4 was found sitting on the floor and initially had no complaints of pain. Tenant #4 was moving all extremities well. Notes of 11-28-14 and timed 12:30 p.m. documented Tenant #4 was complaining of left leg pain and was unable to bear weight. Tenant #4 was	A 037		

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A 037	Continued From page 5 transported to the hospital via ambulance and was diagnosed with a fractured left hip. Tenant #4 did not return to the Program. Tenant #4, with a history of falls, experienced multiple falls, some with head injury, prior to the fall of 11-28-14 which resulted in a fractured hip. Evaluations were not completed with multiple falls, some with head injury. Evaluations were not completed with significant changes of condition to determine continued eligibility for the program and to determine any changes to services needed and continued eligibility for the program. During the course of the investigation, the following was noted: Based on interviews and record review, evaluations were not completed within 30 days of occupancy and were not completed with significant change of condition to determine continued eligibility for the Program and determine any changes to services needed. Seven records were reviewed. 1. Tenant #1, an 86 year-old, was admitted on 10-25-14 and had diagnoses of: glaucoma, high blood pressure, Alzheimer's, and history of cancer. On 10-23-14, Tenant #1 had 10 errors on the short portable mental status questionnaire (SPMSQ) which indicated severe cognitive impairment. Tenant #1 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit. The clinical record lacked documentation of evaluations completed within 30 days of admission.	A 037		

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A 037	Continued From page 6 RN A was interviewed on 12-22-14 at 3:40 p.m. and stated evaluations had not been completed within 30 days of admission for Tenant #1. Evaluations were not completed within 30 days of admission for Tenant #1. RN A stated several times a day, Tenant #1 required two persons for transfer. RN A stated Tenant #1 had an upper respiratory infection and required more assistance at that time. RN A stated Tenant #1 had been a two-person transfer for two to three weeks. RN A stated she had not evaluated Tenant #1's ability to transfer. RN A stated PT and OT had been seeing Tenant #1, but did not know if services were continuing or the findings of the PT and OT visits. An order from the healthcare provider dated 11-19-14 revealed Tenant #1 was to receive PT and OT serviced due to weakness, it was ok to crush medications, and Seroquel 25 milligrams (mg), an antipsychotic, was to be given at bedtime and increase to 50 mg in seven days if tolerating. Staff A was interviewed on 12-22-14 at 10:25 a.m. and stated he usually worked in the dementia unit and Tenant #1 routinely required two persons for transfer. Staff B was interviewed on 12-22-14 at 10:55 a.m. and stated she worked in the dementia unit. Tenant #1 routinely required two persons for transfer. Evaluations were not completed when Tenant #1 became ill with a respiratory infection, became a routine two-person transfer, began PT and OT services, and had changes to medications	A 037		

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A 037	Continued From page 7 including Seroquel. Evaluations of Tenant #1 were not completed with significant changes of condition. 2. Tenant #7, a 93 year-old, was admitted on 12-27-12 and had diagnoses of: gastroesophageal reflux disease, benign prostatic hypertrophy, indwelling urinary catheter, fragile skin and history of open areas on buttocks. Tenant #7 was staged at four on the global deterioration scale (GDS) which indicated moderate cognitive decline. Tenant #7 resided in the general population. Nurse's notes dated 9-16-14 documented Tenant #7 had multiple changes over the previous month. Tenant #7 had increased weakness and PT and OT were ordered. In the middle of August Tenant #7 was on an antibiotic for a urinary tract infection. Documentation by the physician dated 8-28-14 revealed Tenant #7 had recurrent urinary tract infections and the culture indicated the microorganism was not fully susceptible to the antibiotic prescribed and the antibiotic was changed on 8-28-14. The new antibiotic (Keflex) was ordered for 14 days. Tenant #7 was also noted to have a weight loss of 10 pounds since May 1014. The nurse's notes dated 9-16-14 went on to document on 9-10-14 Tenant #7 was seen by a new healthcare provider because of increased confusion. Tenant #7 was diagnosed with a urinary tract infection and a new antibiotic (Cipro) was ordered. A physicians order sheet contained documentation on 9-16-14 the Cipro had been discontinued until lab work was obtained. In a verbal physician's order dated 9-18-14, Trimethoprim, an antibiotic, was prescribed to be	A 037		

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A 037	Continued From page 8 given twice a day for 10 days. A review of the Medication Administration Record (MAR) revealed the medication was given for nine days as the medication had not been delivered in time to administer the first two doses as indicated on the MAR. Tenant #7 had an indwelling urinary catheter, recurrent urinary tract infections, and a history of open areas on the buttocks. A fax to the physician dated 10-2-14 documented Tenant #7 had skin breakdown on the coccyx and a request was made for cream for the buttocks. In a fax to the physician dated 10-17-14 the Program requested the buttocks cream be changed to Calmoseptine to see if this would help Tenant #7's buttocks. The nurse's notes lacked documentation of the condition of Tenant #7's buttocks that required physician orders for treatment. Evaluations of Tenant #7's function, cognition, and health were not completed with a change of condition.	A 037		
A 039	481-69.23(1)b Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: During the course of the investigation, the following was noted:	A 039		

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A 039	Continued From page 9 Based on interviews, observations, and record review, Tenant #1 required routine, two-person assistance with transfers and exceeded criteria for retention in an assisted living program. Observations were made on three days over a one week period 12-22, 12-23, and 12-29-14. Seven records were reviewed. 1. Tenant #1, an 86 year-old, was admitted on 10-25-14 and had diagnoses of: glaucoma, high blood pressure, Alzheimer's, and history of cancer. On 10-23-14, Tenant #1 had 10 errors on the short portable mental status questionnaire (SPMSQ) which indicated severe cognitive impairment. Tenant #1 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit. Staff A was interviewed on 12-22-14 at 10:25 a.m. and stated he usually worked in the dementia unit and Tenant #1 routinely required two persons for transfer. Staff B was interviewed on 12-22-14 at 10:55 a.m. and stated she worked in the dementia unit. Tenant #1 routinely required two persons for transfer. On 12-22-14 at 11:23 a.m. Staff B and Staff D indicated Tenant #1 needed to use the restroom. Tenant #1 was observed sitting in a chair in the dining room of the dementia unit. A walker was placed in from of Tenant #1. Tenant #1 was sitting in the chair with the feet crossed and Tenant #1 did not initially uncross the feet with cueing. Staff guided Tenant #1's hands to the walker and then with one staff member on each side under each of Tenant #1's arms, Tenant #1	A 039		

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A 039	Continued From page 10 was lifted to a standing position. When Tenant #1 was standing the feet were uncrossed and Tenant #1 was standing on the tips of the toes. Tenant #1 was positioned with the buttocks protruding and Tenant #1 was not standing upright. Staff B and Staff D stated Tenant #1 walked on the tip toes and was pulling against the staff. Both Staff B and Staff D stated if they let go, Tenant #1 would fall. Tenant #1 walked slowly and with much cueing from Staff B and Staff D. Tenant #1 walked from the dining room to the apartment with the assist of two staff. Tenant #1 was taken into the bathroom. As Tenant #1 attempted to pivot at the toilet, Tenant #1's buttocks continued to protrude, and the feet crossed, getting caught in a throw rug. The throw rug was removed by staff. After toileting, Staff B and Staff D assisted Tenant #1 to stand. Tenant #1 did not provide lift assistance. Staff B and Staff D ambulated Tenant #1 from the toilet to a wheelchair. Staff B and Staff D were observed assisting Tenant #1 to sit in the wheelchair. Two staff members were observed to transfer Tenant #1 from a chair to standing with a walker, from standing with the walker to the toilet, and from the toilet to a standing position, and from standing to a wheelchair. Tenant #1 required two persons for transfers. On 12-22-14 at 3:10 p.m. Staff C and Staff D were observed in Tenant #1's apartment. Tenant #1 was sitting in a wheelchair and the staff members were present to transfer Tenant #1 to the toilet. The brakes to the wheelchair were unlocked and the wheelchair was pivoted.	A 039		

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A 039	Continued From page 11 Tenant #1's feet did not move and the feet twisted. Staff lifted Tenant #1's feet and placed the feet on the foot pedals. Tenant #1 was wheeled into the bathroom and the brakes were locked. Staff C and Staff D were under each of Tenant #1's arms and Tenant #1 was cued to stand. According to Staff C and Staff D, Tenant #1 did not provide lift to stand. Tenant #1 kept the buttocks out and did not straighten. Tenant #1 used small steps and pivoted with much cueing. Tenant #1 tried to sit on the toilet, but was not positioned above the toilet when trying to sit. Staff guided Tenant #1 to a seated position on the toilet. Tenant #1 was observed by Staff D to have wet briefs and Staff removed them. Tenant #1 did not lift the feet to apply new briefs despite direction. After toileting, Staff C and Staff D cued Tenant #1 to stand. Both Staff C and Staff D stated if they were to let go of Tenant #1, Tenant #1 would fall. Tenant #1 kept the buttocks out and did not straighten, and did not pivot to meet the wheelchair. Tenant #1 lowered the buttocks to sit, but was not positioned over the wheelchair. Staff guided Tenant #1 to the wheelchair seat. Tenant #1 was wheeled into the living room of the apartment and was transferred by Staff C and Staff D from the wheelchair to the lift chair. Two staff members were observed to provide transfer assistance during the transfers from the wheelchair to the toilet, the toilet to the wheelchair, and the wheelchair to the lift chair. Tenant #1 was not observed to provide assistance during transfers. Tenant #1 required	A 039		

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A 039	Continued From page 12 two persons for transfer. The spouse of Tenant #1 was interviewed following the transfers and stated Tenant #1 was able to walk and transfer when moving in, but had an infection that had been going around. The spouse reported Tenant #1's legs gave out after being sick and Tenant #1 has required more assistance since the illness. RN A was interviewed on 12-22-14 at 3:40 p.m. and stated evaluations had not been completed within 30 days of admission for Tenant #1. RN A stated several times a day, Tenant #1 required two persons for transfer. RN A stated Tenant #1 had an upper respiratory infection and required more assistance at that time. RN A stated Tenant #1 had been a two-person transfer for two to three weeks. RN A stated she had not evaluated Tenant #1's ability to transfer. RN A stated PT and OT had been seeing Tenant #1, but did not know if services were continuing or the findings of the PT and OT visits. An order from the healthcare provider dated 11-19-14 revealed Tenant #1 was to receive PT and OT serviced due to weakness, it was ok to crush medications, and Seroquel 25 milligrams (mg) was to be given at bedtime and increase to 50 mg in seven days if tolerating. There was no documentation after 10-23-14 of a registered nurse evaluation of Tenant #1's upper body strength, lower body strength, and cognitive ability to follow direction to determine Tenant #1's ability to transfer safely. Evaluations were completed on 12-22-14 after the monitor indicated evaluations had not been completed within 30 days of admission.	A 039		

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A 039	Continued From page 13 PT notes dated 12-23-14 documented Tenant #1 required significant assistance for all transfers and gait with fatigue with poor safety as limiters. The notes documented Tenant #1 was resistant and required assistance due to "retropulsion and refusal to get body upright." Staff E was interviewed on 12-29-14 at 9:20 a.m. and stated Tenant #1 took two persons to transfer earlier in the day. Staff E reported there had been no change in Tenant #1's care recently. At 10:20 a.m. on 12-29-14 Staff E reported only two days out of seven, Tenant #1 did not require two persons for transfer. Sometimes it took three persons to transfer, but otherwise, Tenant #1 took two persons for transfer. On 12-29-14 at 9:35 a.m., Staff E and Staff F were observed transferring Tenant #1 from the wheelchair to the toilet. Staff E asked Tenant #1 to raise the feet from the wheelchair foot pedals. Tenant #1 did not raise the feet. Staff E asked Tenant #1 to lean forward so a gait belt could be applied. Tenant #1 did not lean forward. Staff E eased the gait belt behind Tenant #1 for application of the belt. Staff E and Staff F were under each arm of Tenant #1 who was seated in the wheelchair. Tenant #1 was cued on the count of three to stand. Tenant #1 did not provide lift assistance. Tenant #1 kept the buttocks protruding and did not stand upright. Tenant #1 was assisted to reach for a grab bar in the bathroom. Tenant #1 was cued to pivot and sit on the toilet. Staff E and Staff F assisted Tenant #1 to sit on the toilet. Tenant #1's pants were wet. Tenant #1 did not assist with the changing of the pants.	A 039		

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A 039	Continued From page 14 When it was time to get off of the toilet, Tenant #1 held onto the arms of the toilet riser and would not let go. Staff E and Staff F guided Tenant #1's hands from the riser as one staff member was on each side of Tenant #1. Tenant #1 continued to protrude the buttocks and did not stand upright. Tenant #1 stood on the tips of the toes, grunted and reached forward for the shower curtain. Staff E and Staff F guided Tenant #1's hands away from the shower curtain and kept cueing to pivot Tenant #1 into the wheelchair. Staff E and Staff F stated Tenant #1 was not providing assistance and would fall if they let go. Tenant #1 was transferred to the wheelchair. Tenant #1 was transferred in the wheelchair to the living room. The wheelchair was placed next to the lift chair in the living room of the apartment. Staff directed Tenant #1 to stand, and Tenant #1 grabbed the arm rest of the wheelchair and would not let go. Grabbing onto the arm rests prevented Tenant #1 from standing upright. Tenant #1 did not follow directions from staff. Tenant #1 was transferred from the wheelchair to the lift chair with the assist of two staff members. Two staff members were observed to transfer Tenant #1 from the wheelchair to the toilet, the toilet to the wheelchair, and the wheelchair to the lift chair. Tenant #1 required the assistance of two persons for transfer on multiple occasions.	A 039		
A 079	481-69.25(1)q Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant ' s own behalf or the	A 079		

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A 079	Continued From page 15 tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs) This REQUIREMENT is not met as evidenced by: Based on record review and interviews, documentation of the completion of routine personal care was not completed for a tenant with dementia. Tenant #5 was identified as having weight loss, 35 pounds over eight months. The nurse recommended supplements be given with meals and at night. Tenant #5 was cognitively impaired and unable to advocate for self. Staff members stated they were not offering the supplement to Tenant #5. The supplements, a routine health-related care task was not on the task sheet. Seven records were reviewed. 1. Tenant #5, an 80 year-old, was admitted on 2-17-14 and had diagnoses of: Alzheimer's, hypertension, coronary artery disease, depression, fatigue, and weakness. Tenant #5 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline. Tenant #5 resided in the dementia unit. Nurse's notes dated 10-30-14 documented Tenant #5 had lost 35 pounds over the previous eight months. The nurse's notes also documented a supplement would be given to increase calories and nutrition. Nurse's notes dated 11-21-14 documented	A 079		

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A 079	Continued From page 16 Tenant #5's weight as 139.6 pounds. Evaluations completed on 12-5-14 documented as a recommendation that Tenant #5 have the nutritional supplement three times a day with the supplement also being given at night. The service plan of 12-5-14 revealed Tenant #5 was to get a supplement with each meal and a shake in the evening. The task sheet for December 2014 documented on 12-15 Tenant #5's weight was 145 pounds. On 12-22, Tenant #5's weight was down five pounds to 140 pounds. On 12-23-14, RN A was interviewed at 12:00 p.m. and stated the supplements were not on task sheets, but were on the service plan. The task sheet for December 2014 was reviewed and the nutritional supplement was not on the task sheet. Staff B was interviewed on 12-23-14 at 12:13 p.m. and she stated she had not been offering a supplement with meals. Staff F was interviewed on 12-23-14 at 12:14 p.m. and stated she had not been offering a supplement with meals. Tenant #5 was identified as having weight loss, 35 pounds over eight months. The nurse recommended supplements be given with meals and at night. Tenant #5 was cognitively impaired and unable to advocate for self. Staff members stated they were not offering the supplement to Tenant #5. The supplements, a routine health-related care task was not on the task sheet.	A 079		

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A 083	Continued From page 17	A 083		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) 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. This REQUIREMENT is not met as evidenced by: 50920-I: The Program reported to the department Tenant #4 fell and sustained a hip fracture. The following was noted as investigation into the incident. Based on interviews and record review, evaluations were not completed with significant change of condition to determine continued eligibility for the program and determine any changes to services needed. Tenant #4 had a history of falls prior to moving into the Program and had multiple falls with injury while at the Program. The last fall resulted in a fracture to the hip. Tenant #4 did not return to the Program. 1. Tenant #4, an 87 year-old, was admitted on 10-1-14 and had diagnoses of: dementia, history of falls, and pain. On 9-25-14, Tenant #4 had three errors on the short portable mental status questionnaire (SPMSQ) which indicated mild cognitive impairment. Tenant #4 was staged at four on the global deterioration scale (GDS) which indicated moderate cognitive decline.	A 083		

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A 083	Continued From page 18 Tenant #4 resided in the dementia unit. The initial evaluations completed 9-25-14 documented Tenant #4 was independent with transfers and mobility, used a walker, and had back pain for which Tenant #4 required routine medication. According to nurse's notes dated 10-1-14, Tenant $4 had a history of falls, used a walker independently, and the physician had ordered PT and OT. Nurse's notes dated 10-2-14 and timed 11:30 a.m. and documented in an incident report revealed Tenant #4 was found wandering in the apartment bleeding profusely down the neck with blood on the floor. RN A held pressure to the wound and 911 was called to transport Tenant #4 to the emergency room. Nurse's notes dated 10-2-14 and timed 4:30 p.m. documented Tenant #4 returned to the program with four staples in the back of the head. The initial service plan with a signature date of 10-1-14, was not updated to include directions to the unlicensed staff to care for a tenant with a head injury including signs and symptoms to report to the nurse, care of the head wound, and directions for care of the wound during bathing which the Program provided. The service plan was not updated with interventions for the prevention of falls. Nurses notes dated 10-14-14 and timed 3:00 p.m. and documented in an incident report revealed Tenant #4 fell and hit the heat and was bleeding from the back of the head. Nurse's noted documented a family member took Tenant #4 to the emergency room. Documentation from the physician at the hospital dated 10-14-14	A 083		

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A 083	Continued From page 19	A 083		

documented Tenant #4 had frequent falls and dizziness. Thy physician recommended wheelchair for transport to reduce fall risk. The physician noted Tenant #4 had two trips to the emergency room in the last two weeks with two CT scans of the head. The physician's documentation was noted by RN A.

The clinical record contained documentation Tenant #4 had been seen by a physician on 10-16-14 and also documented Tenant #4 had been seen twice in the emergency room for falls due to dizziness. The physician recommended Tenant #4 use a wheelchair, or use a walker with the assistance of another to prevent future falls. The physician also prescribed Meclizine as needed for the dizziness. The physician's documentation of 10-16-14 was noted by RN A on 10-16-14.

According to the nurse's notes, rather than returning to the program on 10-14-16, Tenant #4 stayed with the family member "for a couple nights" but had returned to the Program by 10-16-14.

The initial service plan with a signature date of 10-1-14 was not updated to include directions to the unlicensed staff to care for a tenant with a head injury including signs and symptoms to report to the nurse, care of the head wound, and directions for care of the wound during bathing which the Program provided. The service plan was not updated with interventions for the prevention of falls including the recommendations of the physician. The service plan did not provide direction for staff to determine when to give the "as needed" Meclizine for dizziness.

PT progress notes dated 10-22-14 documented

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A 083	Continued From page 20 Tenant #4 was agitated and seemed "extra confused." The notes also documented the nurse was notified. Nurse's noted dated 10-30-14 documented Tenant #4 had black diarrhea and was leaning backwards over a chair. An incident report dated 10-30-14 documented Tenant #4 reported a fall to a staff member. Documentation on the incident report indicated a small cut was found on the back of the head. Tenant #4 was sent to the hospital. Documentation in the clinical record included a report of a gastroscopy completed on 10-30-14. The documentation included the statement that if the ulcer re-bleeds, it may very well be torrential bleeding and difficult to control. Tenant #4 returned to the Program on 11-3-14 and 30-day evaluations were completed. The service plan was updated and indicated Tenant #4 used a walker with ambulation, used a wheelchair, and required the assist of one with ambulation and transfer. The service plan did not give unlicensed staff directions to care for Tenant #4 who was at risk for torrential bleeding that was difficult to control. PT progress notes dated 11-17-14 documented Tenant #4 had fallen on 11-17-14 and hit the back of the head and made it bleed. Nurse's notes dated 11-21-14 documented on 11-17-14 Tenant #4 reported falling onto the couch and had two scuff marks on the back of the head. Nurse's notes dated 11-21-14 and timed 2:35 p.m. documented Tenant #4 had been found on the floor "last evening" at 9:45 p.m. with the head bleeding. The nurse's notes documented Tenant	A 083		

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A 083	Continued From page 21 #4 was not talking to the family like usual and the family was going to take Tenant #4 to the hospital. The service plan of 11-3-14 was not updated to include directions to the unlicensed staff to care for a tenant with a head injury including signs and symptoms to report to the nurse. Nurse's notes dated 11-24-14 and timed 9:30 a.m. documented Tenant #4 was found on the floor at 5:35 a.m. on 11-22-14. Task sheets provided by the Program documented Tenant #4 was observed 32 times a shift beginning 11-22-14. The service plan of 11-3-14 was not updated to include the intervention of the 32 times a shift checks. Tenant #4 continued to have falls after interventions were placed on the service plan on 11-3-14. The service plan was not updated with new interventions following the falls. Nurse's notes dated 11-28-14 and timed 8:00 a.m. documented Tenant #4 was found sitting on the floor and initially had no complaints of pain. Tenant #4 was moving all extremities well. Notes of 11-28-14 and timed 12:30 p.m. documented Tenant #4 was complaining of left leg pain and was unable to bear weight. Tenant #4 was transported to the hospital via ambulance and was diagnosed with a fractured left hip. Tenant #4 did not return to the Program. Tenant #4 experienced multiple falls, some with head injury, prior to the fall of 11-28-14 which resulted in a fractured hip. The service plan had not been updated to meet the needs of Tenant #4.	A 083		

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COURTYARD ESTATES AT HAWTHORNE CRO{	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

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A 083	Continued From page 22 During the course of the investigation, the following was noted: Based on interviews and record review, service plans were not developed based on evaluations and did not meet the specific service needs of the individual tenants. Seven records were reviewed. 1. Tenant #1, an 86 year-old, was admitted on 10-25-14 and had diagnoses of: glaucoma, high blood pressure, Alzheimer's, and history of cancer. On 10-23-14, Tenant #1 had 10 errors on the short portable mental status questionnaire (SPMSQ) which indicated severe cognitive impairment. Tenant #1 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit. Evaluations were completed on 10-23-14 and revealed Tenant #1 used a cane for ambulation, was guided by the spouse most of the time, and needed assistance to get out of the chair. The evaluations did not indicate the use of a walker. The evaluations revealed Tenant #1 required assistance with mobility and transfers. At exit, RN A stated the initial service plan for Tenant #1 was not correctly dated. RN A stated she utilized the evaluations of 10-23-14 to complete the service plan dated 10-12-14 with a signature date of 10-13-14. The initial service plan indicated Tenant #1 was independent with ambulation and used a walker. The initial service plan was not based on initial evaluations completed 10-23-14. RN A was interviewed on 12-22-14 at 3:40 p.m. and stated several times a day, Tenant #1	A 083		

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A 083	Continued From page 23 required two persons for transfer. RN A stated Tenant #1 had an upper respiratory infection and required more assistance at that time. RN A stated Tenant #1 had been a two-person transfer for two to three weeks. An order from the healthcare provider dated 11-19-14 revealed Tenant #1 was to receive PT and OT serviced due to weakness. The service plan dated 10-23-14 was not updated with a change of condition to include staff assistance with transfers when Tenant #1 exhibited weakness requiring two persons for transfer and did not meet the needs of Tenant #1. 2. Tenant #7, a 93 year-old, was admitted on 12-27-12 and had diagnoses of: gastroesophageal reflux disease, benign prostatic hypertrophy, indwelling urinary catheter, fragile skin and history of open areas on buttocks. Tenant #7 was staged at four on the global deterioration scale (GDS) which indicated moderate cognitive decline. Tenant #7 resided in the general population. Nurse's notes dated 9-16-14 documented Tenant #7 had multiple changes over the previous month. Tenant #7 had increased weakness and PT and OT were ordered. In the middle of August Tenant #7 was on an antibiotic for a urinary tract infection. Documentation by the physician dated 8-28-14 revealed Tenant #7 had recurrent urinary tract infections and the culture indicated the microorganism was not fully susceptible to the antibiotic prescribed and the antibiotic was changed on 8-28-14. The new antibiotic (Keflex) was ordered for 14 days. Tenant #7 was also noted to have a weight loss of 10 pounds since May 1014.	A 083		

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A 083	Continued From page 24 Tenant #7 had an indwelling urinary catheter, recurrent urinary tract infections, and a history of open areas on the buttocks. A fax to the physician dated 10-2-14 documented Tenant #7 had skin breakdown on the coccyx and a request was made for cream for the buttocks. In a fax to the physician dated 10-17-14 the Program requested the buttocks cream be changed to Calmoseptine to see if this would help Tenant #7's buttocks. The service plan dated 9-16-14 was not updated to include interventions for skin breakdown and did not direct unlicensed staff in the care of Tenant #7 with skin breakdown on the coccyx including signs and symptoms to report to the nurse.	A 083		
A 091	481-69.26(4)c Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: 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 This REQUIREMENT is not met as evidenced by: During the course of the investigation, the following was noted: Based on record review, service plans were not individualized to include outside service providers. Seven records were reviewed.	A 091		

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A 091	Continued From page 25 1. Tenant #1, an 86 year-old, was admitted on 10-25-14 and had diagnoses of: glaucoma, high blood pressure, Alzheimer's, and history of cancer. On 10-23-14, Tenant #1 had 10 errors on the short portable mental status questionnaire (SPMSQ) which indicated severe cognitive impairment. Tenant #1 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit. An order from the healthcare provider dated 11-19-14 revealed Tenant #1 was to receive PT and OT serviced due to weakness. RN A was interviewed on 12-22-14 at 3:40 p.m. and stated PT and OT had been seeing Tenant #1, but did not know if services were continuing or the findings of the PT and OT visits. The initial service plan dated 10-12-14, current until updated on 12-22-14, did not identify outside service providers, PT and OT. 2. Tenant #4, an 87 year-old, was admitted on 10-1-14 and had diagnoses of: dementia, history of falls, and pain. On 9-25-14, Tenant #4 had three errors on the short portable mental status questionnaire (SPMSQ) which indicated mild cognitive impairment. Tenant #4 was staged at four on the global deterioration scale (GDS) which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit. The initial evaluations completed 9-25-14 documented Tenant #4 was independent with transfers and mobility, used a walker, and had back pain for which Tenant #4 required routine medication. According to nurse's notes dated 10-1-14, Tenant #4 had a history of falls, used a	A 091		

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A 091	Continued From page 26 walker independently, and the physician had ordered PT and OT. The physician's order dated 9-29-14 prescribed PT and OT for balance, gait training, and strengthening. The initial service plan with a signature date of 10-1-14 does not identify PT and OT as service providers. Evaluations were completed on 11-3-14 and the service plan was updated following hospitalization after a fall. The evaluations of 11-3-14 documented Tenant #4 was to receive services from PT and OT. The clinical record contained documentation from the PT and OT provider that services were provided between 10-3-14 and 11-19-14. The service plan of 11-3-14 was not updated to identify PT and OT as service providers. 3. Tenant #6, an 88 year-old, was admitted on 10-2-14 and had diagnoses of: general weakness, hypertension, depression, peripheral neuropathy, and benign prostatic hypertrophy. According to the evaluation completed on 9-29-14, Tenant #6 had a suprapubic catheter. On 10-10-14, a physician admission sheet documented an order for PT and OT following a fall. The service plan of 10-1-14 did not identify the outside service providers, PT and OT. The nurse's note dated 10-31-14 for Tenant #6 documented PT and OT was continuing to work with Tenant #6. The service plan of 10-31-14 did not identify the outside service providers, PT and OT.	A 091		

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A 092	481-69.26(4)d Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: 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 This REQUIREMENT is not met as evidenced by: Based on record review and interview, service plans were not individualized to include planned and spontaneous activities based on a tenant's abilities and interests for cognitively impaired persons who resided in the dementia unit. Seven records were reviewed. 1. Tenant #1, an 86 year-old, was admitted on 10-25-14 and had diagnoses of: glaucoma, high blood pressure, Alzheimer's, and history of cancer. On 10-23-14, Tenant #1 had 10 errors on the short portable mental status questionnaire (SPMSQ) which indicated severe cognitive impairment. Tenant #1 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit. The service plan for Tenant #1 dated 10-12-14 documented Tenant #1 preferred an activity calendar to attend activities of choice. In an interview with RN A on 12-22-14 at 3:40 p.m. she stated Tenant #1 was independent with activities, and stated there was an activities person to do activities.	A 092		

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A 092	Continued From page 28 The service plan was not individualized for Tenant #1, a cognitively impaired person who resided in the dementia unit. The service plan did not identify planned and spontaneous activities based on Tenant #1's abilities and interests. 2. Tenant #4, an 87 year-old, was admitted on 10-1-14 and had diagnoses of: dementia, history of falls, and pain. On 9-25-14, Tenant #4 had three errors on the short portable mental status questionnaire (SPMSQ) which indicated mild cognitive impairment. Tenant #4 was staged at four on the global deterioration scale (GDS) which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit. The initial service plan with a signature date of 10-1-14 and the service plan of 11-3-14 documented Tenant #4 liked to eat, sleep, and watch TV. The service plans did not identify any planned activities based on Tenant #4's abilities and interests.	A 092		
A 094	481-69.27(1) Nurse Review 481-69.27(231C) Nurse review. 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: 69.27(1) 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	A 094		

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A 094	Continued From page 29 to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. This REQUIREMENT is not met as evidenced by: Based on record review a nurse review was not completed with a significant change to ensure that prescription medications were administered consistent with orders. Seven files were reviewed. 1. Tenant #7, a 93 year-old, was admitted on 12-27-12 and had diagnoses of: gastroesophageal reflux disease, benign prostatic hypertrophy, indwelling urinary catheter, fragile skin and history of open areas on buttocks. Tenant #7 was staged at four on the global deterioration scale (GDS) which indicated moderate cognitive decline. Tenant #7 resided in the general population. Nurse's notes dated 9-16-14 documented Tenant #7 had multiple changes over the previous month. Tenant #7 had increased weakness and PT and OT were ordered. In the middle of August Tenant #7 was on an antibiotic for a urinary tract infection. Documentation by the physician dated 8-28-14 revealed Tenant #7 had recurrent urinary tract infections and the culture indicated the microorganism was not fully susceptible to the antibiotic prescribed and the antibiotic was changed on 8-28-14. The new antibiotic (Keflex) was ordered for 14 days. Tenant #7 was also noted to have a weight loss of 10 pounds since May 1014. The nurse's notes dated 9-16-14 went on to document on 9-10-14 Tenant #7 was seen by a new healthcare provider because of increased confusion. Tenant #7 was diagnosed with a	A 094		

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A 094	Continued From page 30 urinary tract infection and a new antibiotic (Cipro) was ordered. A physicians order sheet contained documentation on 9-16-14 the Cipro had been discontinued until lab work was obtained. In a verbal physician's order dated 9-18-14, Trimethoprim, an antibiotic, was prescribed to be given twice a day for 10 days. A review of the Medication Administration Record (MAR) revealed the medication was given for nine days as the medication had not been delivered in time to administer the first two doses as indicated on the MAR. Tenant #7 had an indwelling urinary catheter and recurrent urinary tract infections. A nurse review was not done with the completion of the antibiotic to ensure the prescribed medication had been administered consistent with the orders.	A 094		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. 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: 69.27(3) 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 This REQUIREMENT is not met as evidenced by:	A 096		

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A 096	Continued From page 31 During the course of the investigation, the following was noted: Based on interviews and record review, nurse reviews were not completed with changes of condition to assess and document the health status of a tenant, and to monitor progress relating to previous recommendations. Seven records were reviewed. 1. Tenant #1, an 86 year-old, was admitted on 10-25-14 and had diagnoses of: glaucoma, high blood pressure, Alzheimer's, and history of cancer. On 10-23-14, Tenant #1 had 10 errors on the short portable mental status questionnaire (SPMSQ) which indicated severe cognitive impairment. Tenant #1 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit. RN A was interviewed on 12-22-14 at 3:40 p.m. and stated evaluations had not been completed within 30 days of admission for Tenant #1. RN A stated several times a day, Tenant #1 required two persons for transfer. RN A stated Tenant #1 had an upper respiratory infection and required more assistance at that time. RN A stated Tenant #1 had been a two-person transfer for two to three weeks. RN A stated she had not evaluated Tenant #1's ability to transfer RN A stated PT and OT had been seeing Tenant #1, but did not know if services were continuing or the findings of the PT and OT visits. An order from the healthcare provider dated 11-19-14 revealed Tenant #1 was to receive PT and OT serviced due to weakness, it was ok to crush medications, and Seroquel 25 milligrams (mg) was to be given at bedtime and increase to	A 096		

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A 096	Continued From page 32 50 mg in seven days if tolerating. Nurse's notes were reviewed from 10-15-14 through 11-21-14. An entry was made on the nurse's notes on 12-22-14 after RN A was informed by the monitor that evaluations had not been completed within 30 days of admission. There were no nurse reviews which addressed Tenant #1's change in mobility to require two persons for transfer, PT and OT services for weakness, and the Seroquel. Tenant #1's health status was not assessed and documented with a change in health status. 2. Tenant #3, a 67 year-old, was admitted on 7-27-13 and had diagnoses of: Lewy body dementia, anxiety, low blood pressure and depression. Tenant #3 was staged at six on the GDS which indicated severe cognitive decline. Nurse's notes dated 10-1-14 documented the spouse had taken Tenant #3 to the emergency room on 9-29-14 for abdominal pain and returned the same day. There was no assessment and documentation of Tenant #3's health status related to abdominal pain on 10-1-14. A nurse review was not completed on 10-1-14 following a trip to the emergency room for abdominal pain. 3. Tenant #4, an 87 year-old, was admitted on 10-1-14 and had diagnoses of: dementia, history of falls, and pain. On 9-25-14, Tenant #4 had three errors on the short portable mental status questionnaire (SPMSQ) which indicated mild cognitive impairment. Tenant #4 was staged at four on the global deterioration scale (GDS) which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit. The initial evaluations completed 9-25-14 documented Tenant #4 was independent with	A 096		

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A 096	Continued From page 33 transfers and mobility, used a walker, and had back pain for which Tenant #4 required routine medication. According to nurse's notes dated 10-1-14, Tenant $4 had a history of falls, used a walker independently, and the physician had ordered physical therapy (PT) and occupational therapy (OT). Nurse's notes dated 10-2-14 and timed 11:30 a.m. and documented in an incident report revealed Tenant #4 was found wandering in the apartment bleeding profusely down the neck with blood on the floor. RN A held pressure to the wound and 911 was called to transport Tenant #4 to the emergency room. Nurse's notes dated 10-2-14 and timed 4:30 p.m. documented Tenant #4 returned to the program with four staples in the back of the head. Tenant #4 sustained a head injury which resulted in staples to the back of the head. A nurse review was not completed with a significant change of condition to assess and document health status and to monitor progress in a tenant with a history of falls. Nurses notes dated 10-14-14 and timed 3:00 p.m. and documented in an incident report revealed Tenant #4 fell and hit the heat and was bleeding from the back of the head. Nurse's noted documented a family member took Tenant #4 to the emergency room. Documentation from the physician at the hospital dated 10-14-14 documented Tenant #4 had frequent falls and dizziness. The physician recommended wheelchair for transport to reduce fall risk. The physician noted Tenant #4 had two trips to the emergency room in the last two weeks with two CT scans of the head. The physician's	A 096		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 096	Continued From page 34 documentation was noted by RN A. The clinical record contained documentation Tenant #4 had been seen by a physician on 10-16-14 and also documented Tenant #4 had been seen twice in the emergency room for falls due to dizziness. The physician recommended Tenant #4 use a wheelchair, or use a walker with the assistance of another to prevent future falls. The physician also prescribed Meclizine for the dizziness. The physician's documentation of 10-16-14 was noted by RN A on 10-16-14. According to the nurse's notes, rather than returning to the program on 10-14-16, Tenant #4 stayed with the family member "for a couple nights" but had returned to the Program by 10-16-14. A nurse review was not completed with a significant change of condition to assess and document health status and to monitor progress in a tenant with a history of falls. Nurse's noted dated 10-30-14 documented Tenant #4 had black diarrhea and was leaning backwards over a chair. An incident report dated 10-30-14 documented Tenant #4 reported a fall to a staff member. Documentation on the incident report indicated a small cut was found on the back of the head. Tenant #4 was sent to the hospital. Documentation in the clinical record included a report of a gastroscopy completed on 10-30-14. The documentation included the statement that if the ulcer re-bleeds, it may very well be torrential bleeding and difficult to control. Tenant #4 returned to the Program on 11-3-14	A 096		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP261	A BUILDING: _____ B WING _____	C 12/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ESTATES AT HAWTHORNE CRO	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

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A 096	Continued From page 35 and 30-day evaluations were completed. Nurse's notes dated 11-21-14 documented on 11-17-14 Tenant #4 reported falling onto the couch and had two scuff marks on the back of the head. Nurse's notes dated 11-21-14 and timed 2:35 p.m. documented Tenant #4 had been found on the floor "last evening" at 9:45 p.m. with the head bleeding. The nurse's notes documented Tenant #4 was not talking to the family like usual and the family was going to take Tenant #4 to the hospital. Nurse's notes dated 11-24-14 and timed 9:30 a.m. documented Tenant #4 was found on the floor at 5:35 a.m. on 11-22-14. A nurse review was not completed with a significant change of condition to assess and document health status and to monitor progress in a tenant with a history of falls, and to monitor progress related to the use of Meclizine for dizziness. The clinical record contained documentation from the PT and OT provider that services were provided to Tenant #4 between 10-3-14 and 11-19-14. The patient care summary report which contained a discharge summary for PT and OT documented Tenant #4 was discharged in fair condition, and lately "just wants to stay in bed again" and didn't want to walk to meals. A nurse review was not completed when PT and OT discharged Tenant #4 to assess and document Tenant #4's health status and to monitor progress related to the recommendation of PT and OT.	A 096		

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A 096	Continued From page 36 Nurse's notes dated 11-28-14 and timed 8:00 a.m. documented Tenant #4 was found sitting on the floor and initially had no complaints of pain. Tenant #4 was moving all extremities well. Notes of 11-28-14 and timed 12:30 p.m. documented Tenant #4 was complaining of left leg pain and was unable to bear weight. Tenant #4 was transported to the hospital via ambulance and was diagnosed with a fractured left hip. Tenant #4 did not return to the Program. Tenant #4 experienced multiple falls, some with head injury, prior to the fall of 11-28-14 which resulted in a fractured hip. Evaluations were not completed with multiple falls, some with head injury. Nurse reviews were not completed to document the health status of Tenant #4 and to monitor progress relating to previous recommendations with a change in health status. 4. Tenant #5, an 80 year-old, was admitted on 2-17-14 and had diagnoses of: Alzheimer's, hypertension, coronary artery disease, depression, fatigue, and weakness. Tenant #5 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline. Tenant #5 resided in the dementia unit. According to the Medication Administration Record (MAR) for November 2014, Tenant #5 received an antibiotic for seven days beginning 11-21-14. A nurse review was not completed to assess and document the health status of Tenant #5 and the reason for the antibiotic. A nurse review was not completed upon completion of the antibiotic to monitor the progress of Tenant #5 with a change of condition.	A 096		

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A 096	Continued From page 37 5. Tenant #6, an 88 year-old, was admitted on 10-2-14 and had diagnoses of: general weakness, hypertension, depression, peripheral neuropathy, and benign prostatic hypertrophy. According to the evaluation completed on 9-29-14, Tenant #6 had a suprapubic catheter. On 10-10-14, a physician admission sheet documented an order for PT and OT following a fall. The service plan of 10-1-14 did not identify the outside service providers, PT and OT. The nurse's note dated 10-31-14 for Tenant #6 documented PT and OT was continuing to work with Tenant #6. The service plan of 10-31-14 did not identify the outside service providers, PT and OT. The clinical record lacked documentation of nurse's notes after 10-31-14. A nurse review was not completed after 10-31-14 to monitor progress related to the recommendation of PT and OT which was ordered on 10-10-14. 6. Tenant #7, a 93 year-old, was admitted on 12-27-12 and had diagnoses of: gastroesophageal reflux disease, benign prostatic hypertrophy, indwelling urinary catheter, fragile skin and history of open areas on buttocks. Tenant #7 was staged at four on the global deterioration scale (GDS) which indicated moderate cognitive decline. Tenant #7 resided in the general population. Nurse's notes dated 9-16-14 documented Tenant #7 had multiple changes over the previous month. Tenant #7 had increased weakness and PT and OT were ordered. In the middle of August Tenant #7 was on an antibiotic for a urinary tract infection. Documentation by the physician dated	A 096		

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A 096	Continued From page 38 8-28-14 revealed Tenant #7 had recurrent urinary tract infections and the culture indicated the microorganism was not fully susceptible to the antibiotic prescribed and the antibiotic was changed on 8-28-14. The new antibiotic (Keflex) was ordered for 14 days. Tenant #7 was also noted to have a weight loss of 10 pounds since May 1014. The nurse's notes dated 9-16-14 went on to document on 9-10-14 Tenant #7 was seen by a new healthcare provider because of increased confusion. Tenant #7 was diagnosed with a urinary tract infection and a new antibiotic (Cipro) was ordered. A physicians order sheet contained documentation on 9-16-14 the Cipro had been discontinued until lab work was obtained. In a verbal physician's order dated 9-18-14, Trimethoprim, an antibiotic, was prescribed to be given twice a day for 10 days. A review of the Medication Administration Record (MAR) revealed the medication was given for nine days as the medication had not been delivered in time to administer the first two doses as indicated on the MAR. Tenant #7 had an indwelling urinary catheter, recurrent urinary tract infections, and a history of open areas on the buttocks. A fax to the physician dated 10-2-14 documented Tenant #7 had skin breakdown on the coccyx and a request was made for cream for the buttocks. In a fax to the physician dated 10-17-14 the Program requested the buttocks cream be changed to Calmoseptine to see if this would help Tenant #7's buttocks. The nurse's notes lacked documentation of the condition of Tenant #7's buttocks that required	A 096		

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A 096	Continued From page 39 physician orders for treatment. A nurse review was not completed with a change of condition to assess and document the health status of Tenant #7 and to monitor progress related to previous recommendations. The December 2014 task sheet for Tenant #7 documented on 12-13-14 Tenant #7 had blood in the urine for 16 hours. The documentation indicated the nurse was notified. In an interview with RN A on 12-22-14 at 12:50 p.m. she stated Tenant #7 had a home health company who provided a registered nurse to assist Tenant #7 with the indwelling urinary catheter. A nurse review was not completed following the 12-13-14 incident of blood in the urine to assess and document Tenant #7's health status and did not document collaboration with the home health company related to Tenant #7's change in urinary condition.	A 096		
A 154	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Incident #50041-I The Program reported to the department a tenant got out of the dementia unit courtyard on 9-2-14. The courtyard gait had been unlocked earlier in the day, and had not been checked to see that	A 154		

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A 154	Continued From page 40 the lock had been secured. Based on record review and interviews, the building and grounds were not kept safe as a lock on a dementia unit courtyard gate was unlocked and a tenant got out of the courtyard, walked into a bean field and fell. 1. Tenant #2, a 90 year-old, was admitted on 2-1-13 and had diagnoses of: hypertension, history of falls, dementia, history of cancer, esophageal reflux, and glaucoma. Tenant #2 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit. On 12-18-14 at 9:20 a.m. Staff B was interviewed. Staff B stated she did not recall the date, but the Program had a pest control company in the building. A service dog was brought into the dementia unit through the gate of the courtyard nearest the living room in the dementia unit. Staff B reported the tenants in the dementia unit were moved to the general population while the dog was in the building. The tenants were moved back into the dementia unit after the dog left the building. The back gate continued to be unlocked as the dog handler was coming back into the building with written documentation of the service provided. Staff B reported it was change of shift and Staff G and Staff H were coming on duty. Staff B stated she told Staff G and Staff H the gate to the courtyard off the dementia unit was unlocked and tenants were not to go outside until the gate was locked. Staff B stated the oncoming staff told her they would take care of it. Staff B reported Staff G and Staff H were no longer employed at the Program.	A 154		

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A 154	Continued From page 41 The next day Staff B came to work and learned Tenant #2 had gotten out of the building. Staff B spoke with Staff H who reported she looked out the window and the lock appeared to be secured and Tenant #2 was out in the courtyard. Maintenance was interviewed on 12-18-14 at 12:00 p.m. and stated he was working the day Tenant #2 left the building. Maintenance stated on the day of the elopement, Tenant #2 was last seen in the apartment. Maintenance did not know when Tenant #2 was last seen. Maintenance was notified to assist in the search for Tenant #2. Tenant #2 was found between 4:00 p.m. and 5:00 p.m. The day was warm. Maintenance recalled Tenant #2 was dressed for the weather including shoes on the feet. Maintenance exited the building from the dementia unit living room to the courtyard. At the time of the incident, Maintenance reported the padlock on the courtyard gate was on the gate, but the padlock was not locked. The monitor walked with Maintenance to the place he recalled Tenant #2 was found. The lock on the courtyard gate outside the dementia unit was locked at the time the monitor toured the area with Maintenance. The location where Maintenance identified Tenant #2 was found was approximately 92 steps from the building in what was reported to be a bean field. Maintenance reported Tenant #2 reported being ok at the time. A wheelchair was gotten and Tenant #2 was returned to the program in the wheelchair. An incident report was completed by Staff H on	A 154		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 154	Continued From page 42 9-2-14 which documented the following: Staff H wrote around 4:00 p.m. on 9-2-14 Tenant #2 was in the living room of the dementia unit. Staff H went to start passing medications to other tenants. Staff H then went to Tenant #2's apartment to get medications for Tenant #2. Staff H returned to the living room and did not see Tenant #2. Staff H asked Staff G about the whereabouts of Tenant #2. Staff G and Staff H searched the dementia unit without success. An incident report was completed by Staff G on 9-2-14 which documented at 3:45 p.m. Tenant #2 had not been located and Staff G went to the courtyard to look for Tenant #2. Staff G documented the lock was in the wrong place and was not latched. The Former Manager wrote a statement which revealed on 9-2-14 at about 4:00 p.m. he was notified by Staff G that Tenant #2 could not be located. A search was initiated. Upon arrival to the far east of the building, the Former Manager observed Tenant #2 in the field just beyond the building. The Former Manager approached Tenant #2 who was on the knees. With assistance, Tenant #2 stood but appeared shaky and unsteady, but was not complaining of pain. Tenant #2 was taken in a wheelchair from the field back to the Program. The Former Manager documented RN B evaluated Tenant #2. The State Climatologist reported the weather at the Ankeny Airport on 9-2-14 at approximately 4:00 p.m. was a temperature of 79 degrees, winds out of the west at 8 miles per hour, and clear skies. The nurse's notes documented RN B found Tenant #2's left ankle to be bruised and swollen.	A 154		

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A 154	Continued From page 43 Tenant #2 was sent to the emergency room and found to have a sprained ankle. Tenant #2 returned to the program on the same day. The clinical record contained evaluations of function, cognition, and health completed on 9-3-14. The service plan was updated to include interventions for exit-seeking behaviors. Tenant #2 was checked on 32 times per shift. Nurse's notes documented Tenant #2 was transferred to a higher level of care on 9-24-14. The Program provided documentation of a staff inservice on the implementation of gate lock checks dated 9-11-14. The Program also provided documentation of the lock checks for November 2014. The Program failed to secure the lock on the courtyard gate outside the dementia unit following use by a pest control company.	A 154		

Courtyard Estates
601 Hawthorne Crossing Dr SE
Bondurant, IA 50035

Date: January 20, 2015

Plan of Correction (POC) Submitted For:

- Complaint Intake#'s: 49726-I, 50041-I, 50920-I
- Monitor: Lori Miner, RN

POC:

A. Evaluation of Tenant:

a. Regulatory Insufficiency: Evaluation within 30 days of occupancy and with significant change. 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 services professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change

i. **Program POC:**

1. **Elements detailing how insufficiency was corrected for residents:** With respect to tenants #1, #4 and #7 and all other tenants in the program when a scheduled evaluation or when a change in condition occurs or tenant requests changes in preferences for assistance a comprehensive assessment will be completed, update to the service plan reflecting those changes and notation in the nurse note and/or a nurse review as indicated or appropriate. Tenant #4 moved out of the program. The program nurse updated the service plans for tenants, #1 and #7 on 1-20-2015 and 1-21-2015.

2. **Actions program taking to protect tenants in similar situations:** The program nurse was provided education for updating the service plans for scheduled evaluations and with each change in condition or with each tenants request(s) in preference of assistance for services on September 10, 2014 and on December 4, 2014. Education

is ongoing will continue per the community in-service program and through the community's QA Process.

3. **Measures taken to ensure problem does not recur:** The program nurse will review all scheduled evaluations and will review all changes in condition, incident reports, notifications to the program nurse and/or requests by tenants have been addressed as appropriate, scheduled evaluations or change in condition and update on the tenants' individual service plan(s) are completed as appropriate. Service plans will be reviewed through the community's QA process.

B. Criteria for Admission/Retention of Tenants

a. **Regulatory Insufficiency:** Persons who may not be admitted or retained. A Program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation.

i. **Program POC:**

1. **Elements detailing how insufficiency was corrected for residents:** With respect to tenant #1, and all tenants in the program, the program will not knowingly admit or retain any tenant that requires routine, two-person assistance with standing, transfer or evacuation. Tenant #1 is currently receiving Physical Therapy and Occupational Therapy and is a minimum of one person assist for ambulation and transfers.

2. **Actions program taking to protect tenants in similar situations:** The program nurse will review current tenants' changes in cognitive, functional and health status when they are reported or occur and notify the Manager, Operations Manager and Nurse Clinician of those that exceed criteria for admission or retention. The program nurse will complete an assessment and update the service plan to ensure that safety and service needs of the resident are being met until alternate placement can be made and a waiver, as appropriate, is obtained from the department for any resident who exceeds criteria.

3. **Measures taken to ensure problem does not recur:** The program manager and nurse will consult with the Nurse Clinician as necessary to ensure admission and retention criteria is being met for prospective and current tenants.

C. **Tenant Documents:**

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

i. **Program POC:**

1. **Elements detailing how insufficiency was corrected for residents:** With respect to tenant #5, and all other tenants in the program who are unable to advocate on their own behalf or that have multiple service providers will have accurate documentation on the completion of their routine personal or health-related care on their task sheet(s) and if doctor-ordered the tasks shall be part of the tenant(s) medication administration record(s). Tenant #5's task sheets were updated to accurately reflect their health-related tasks on 12-23-2014.

2. **Actions program taking to protect tenants in similar situations:** The program nurse will review tenants' task sheets and medication administration records to ensure that all health related services and doctor-ordered services are accurately documented for completion of the task(s) with each order received by the physician and with each scheduled evaluation, nurse review, change in condition and update to the service plan as appropriate.

3. **Measures taken to ensure problem does not recur:** The program nurse will routinely review all tenants' task sheets and medication administration orders and monthly with the community medication change over. Task sheets and medication administration records will be reviewed through the community's QA Process.

D. **Service Plans:**

a. **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.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents:** With respect to tenant #1, #4, #7, and all other tenants in the program, service plans will be developed based on evaluation and shall meet the specific service needs of the individual tenant and will be updated annually and whenever changes are needed. Tenant #4 has moved out of the program. Tenant #1 and #7 had an evaluation and update to the service plan on 1-20-2015 and 1-21-2015

2. **Actions program taking to protect tenants in similar situations:** The program nurse was provided education on September 10, 2014 and December 4, 2014 for identifying changes in condition with cognitive, functional and health status changes and with tenants request(s) in preference of assistance for services and updating the service plan(s). Education is ongoing and will continue per the community in-service program and through the community's QA Process.

3. **Measures taken to ensure problem does not recur:** The program nurse will review all changes in condition, incident reports, notifications to the Program Nurse and/or requests by tenants have been addressed as appropriate, change in condition and update on the tenants' individual service plan(s) are completed as appropriate. Service Plans will be reviewed through the community's QA process.

E. Service Plans:

a. **Regulatory Insufficiency:** The service plan shall be individualized and shall indicate, at a minimum: 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.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents:** With respect to tenants #1, #4 and #6 and all other tenants in the program will have their service plans individualized and indicate if providers other than the program including of hospice care, home health care, occupational therapy and physical therapy are on the tenants' individual service plan(s). Tenant #4 moved out of the program. Tenants' #1 and #6 service plans were updated on 1-21-2015 and 1-20-2015 to reflect other providers.

2. **Actions program taking to protect tenants in similar situations:** The program nurse was provided education on individualizing and indicated providers other than the program including hospice, home health care and therapy services (PT, OT and ST) with updates as appropriate to the tenants' service plan(s) on September 10, 2014 and on December 4, 2014. Education is ongoing will continue through the community's leadership training program and the community's QA Process.

3. **Measures taken to ensure problem does not recur:** The program nurse will update service plan(s) as appropriate for the addition or discontinuation of other provider services. Service Plans will be reviewed through the community's QA Process.

F. Service Plans:

a. **Regulatory Insufficiency:** The service plan shall be individualized and shall indicate, at a minimum: 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.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents:** With respect to tenants #1 and #4 and all other tenants in the program, service plans will be individualized and indicated, for tenants who are unable to plan their own activities, planned and spontaneous activities based on the tenant(s) abilities and personal interests. Tenant #4 has moved out of the program and tenant #1's service plan was updated to reflect planned and spontaneous activities on 12-30-2014.

2. **Actions program taking to protect tenants in similar situations:** The program nurse was provided education on updating the service plan to include planned and spontaneous interests on September 10, 2014 and December 4, 2014. Education is ongoing and will continue through the community leadership in-service program and through the community's QA Process.

3. **Measures taken to ensure problem does not recur:** The Program Nurse will ensure that planned and spontaneous interests are indicated on tenant service plan(s)

as appropriate. Service Plans will be reviewed through the community QA Process.

G. Nurse Review:

a. **Regulatory Insufficiency:** If a tenant does not receive personal or health-related care, but an observed significant 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 delegations: 69.27(1) To monitor, 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 mediations 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.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents:** With respect to tenants #1 and #7 and all other tenants in the program nurse will complete a nurse review 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 mediations and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current. Tenants #1 and #7 had a comprehensive assessment and update to their service plans completed on 1-20-2015 and 1-21-2015.

2. **Actions program taking to protect tenants in similar situations:** The program nurse was provided education on Nurse Review on September10, 2014 and December 4, 2014. Education is ongoing and will continue per the community leadership in-service program and through the community's QA Process.

3. **Measures taken to ensure problem does not recur:** The program nurse will track due dates and complete nurse review(s) at least every 90 days for all tenants and ensure that all required components for the nurse review are addressed in the nurse review. Nurse reviews will be reviewed through the community's QA Process.

H. Nurse Review:

a. **Regulatory Insufficiency:** If a tenant does not receive personal or health-related care, but an observed significant 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 delegations: 69.27(3) 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.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents:** With respect to tenants #1, #3, #5, #6 and #7 and all other tenants in the program, the Program Nurse will assess and document the health status of each tenant and make recommendations and referrals as appropriate and monitor the progress of previous recommendations every 90 days and whenever changes in the tenants health status occurs. Tenants #1, #3, #5 #6 and #7 had a comprehensive assessment and update to their service plans completed on 1-20-2015, 1-21-2015, 1-19-2015, 1-20-2015, 1-21-2015.

2. **Actions program taking to protect tenants in similar situations:** The program nurse was provided education on nurse review on September 10, 2014 and December 4, 2014. Education is ongoing and will continue per the community leadership in-service program and through the community's QA Process.

3. **Measures taken to ensure problem does not recur:** The program nurse will track assessments and review dates and complete nurse review(s) at least every 90 days for all tenants and ensure that all required components for the nurse review are addressed in the nurse review. Nurse reviews will be reviewed through the community's QA Process.

I. Structural Requirements:

a. **Regulatory Insufficiency:** General requirement. B. The buildings and grounds shall be well maintained, clean, safe and sanitary.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents:** The manager provided education with all staff regarding ensuring the Courtyard gates are secured before residents utilize the area and on securing the gate after vendors or visitors have had access and monitoring the security of the gate and performing checks every shift to ensure the Courtyard gate is secured at all times on 12-18-2014.

2. **Actions program taking to protect tenants in similar situations:** The manager and the maintenance coordinator will monitor the gate security during building rounds daily, Monday through Friday. Staff will monitor the security of the gate lock each shift.

3. **Measures taken to ensure problem does not recur:** The manager and the maintenance coordinator and or their designees will review the monitoring results daily, Monday through Friday, during the community staff stand-up meeting.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.