IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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RODNEY A. ROBERTS, DIRECTOR

February 27, 2015

Complaint/Incident Intake #: 50543-C
51703-C
50279-C

Mr. Paul Crane, Executive Director
Primrose Retirement Community
1801 East Kanesville Blvd.
Council Bluffs, IA 51503

RE: Final Complaint Investigation & Recertification Monitoring Evaluation Report – Primrose Retirement Community, Council Bluffs, IA

Dear Mr. Crane:

Enclosed is the **Final Complaint Investigation & Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following a survey by DIA on **February 9 - 12, 2015.**

The following allegations were investigated in regards to Complaint #50543-C: TB tests were administered but not read, tenants admitted without physician orders, level of care concerns, and medication errors.

Based on observations, staff interviews and review of staff and tenant files, discharged files, incident reports, and program policies the following areas were unsubstantiated:

1. Allegation - Policy and Procedure, TB tests not administered and read

   Findings - Not Substantiated

   Comments – Six staff files and eight tenant files were reviewed. There was no documentation to substantiate TB tests were not read following administration. Four staff interviews revealed TB tests had been read. Assisted living regulations do not require TB tests; however, the Program had a policy regarding TB tests and followed their policy.

2. Allegation – Admission/Discharge, tenants admitted without physician orders, and tenants admitted and retained who exceeded criteria for the Program.

   Findings – Not Substantiated
   Comments – Eight tenant files, incident reports, and staff interviews were conducted. Files were reviewed for the specific tenants outlined in the complaint. Assisted living rules do not require a physician's order for admission to the Program, and it could not be substantiated that medication orders were not in tenant files. Tenant file reviews and interviews did not reveal any tenant exceeded criteria for admission. Tenants were appropriately discharged from the Program.

The following allegations were investigated in regards to Complaint #51703-C: medication errors, insufficient amount of food, quality of care, program staffing, outdated service plans, level of care, and not enough 1:1 activities for tenants with dementia.

Based on observations, interviews, and review of menus, 9 tenant files, incident reports, and activity schedules, the following areas were unsubstantiated:

1. Allegation – Activities

   Findings – Not substantiated
   Comments: Review of activity schedules, staff interviews, and tenant interviews revealed the Program offered a variety of activities each day and evening. Assisted living rules do not require 1:1 activities for tenants with dementia and tenants were reminded to participate in scheduled activities.

2. Allegation – Staffing

   Findings – Not substantiated
   Comments: Staff and tenant interviews revealed staff may occasionally provide assistance in the independent living area. Tenants of assisted living reported they received assistance from staff in a timely and efficient manner and received the help they needed.

3. Allegation – Food Service

   Findings – Not substantiated
   Comments: Observations of five meals revealed a variety of food items served, and tenants could choose and order from a variety of items for their breakfast meals. Some tenants did not eat all the food served to them and took them back to their apartments in storage containers. Tenants interviewed reported they received enough to eat and if they didn't care for something served, substitutes were available.

4. Allegation – Service Plans, tenant required the assistance of 2 people which was not reflected on the service plan.

   Findings – Not substantiated
   Comments: Review of the tenants' files identified in the complaint, revealed those service plans had been updated appropriately related to the specific areas of concern.

The following allegations were investigated in regards to Complaint #50279-C: initial service plans, level of care and admission orders.

Based on review of tenant files, discharged files, and staff interviews the following areas could not be substantiated:

1. Allegation – Lack of initial service plans

   Findings – Not Substantiated
   Comments: Nine tenant files, including discharged tenants were reviewed. Service plans were developed and in place upon tenants' admission and staff reported they had been reviewed.

2. Allegation – Level of care, tenants who required nursing home level of care and required assistance of 2 for transfers were admitted to the Program.

   Findings – Not Substantiated
   Comments: Nine tenant files, including discharged tenants were reviewed, and tenants were discharged appropriately when their condition changed and they required more care than the Program could provide.

The Report notes Regulatory Insufficiencies in the area(s) of: Occupancy Agreement, Medications, Evaluation of Tenant, Service Plans, Nurse Review and Food Service..

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

The review of the recertification documents you submitted has been completed. Please submit an updated occupancy agreement along with the attachments. The State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program. The certificate will be mailed once we receive the above mentioned documents.

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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
	S0273	A. BUILDING _____ B. WING _____	C 02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY	1801 EAST KANESVILLE BLVD CO BLUFFS, IA 51503

(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 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: 29 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 29 A recertification visit and complaint investigations #50543-C, #51703-C, and #50279-C were conducted on 2/9/15 through 2/12/15. The following insufficiencies were cited during the recertification and complaint investigations to determine compliance with certification for an Assisted Living Program: 231C.5(1) An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant ' s legal representative, prior to the tenant ' s occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant ' s legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver; at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made.	A 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 000	Continued From page 1 As the result of the recertification visit this requirement is not met as evidenced by: Based on interview and a review of the current occupancy agreement and attachments, the Program failed to operate in accordance with the terms of the occupancy agreement. The Executive Director provided the Primrose Assisted Living Resident Occupancy Agreement, revised 7/25/13. Page 5 of the occupancy agreement stated the Program would make available three nutritionally balanced meals a day. Page 15 of the occupancy agreement referred to a Resident Handbook and indicated the " resident hereby acknowledges receipt of a copy of the current Resident Handbook. " The Program provided a copy of the Resident Handbook with a revision date of 12/11/13. Page 4 of the Handbook stated menus were designed by a Registered Dietitian and were in accordance with USDA guidelines. When interviewed on 2/10/15 at 3:30 p.m. the Executive Director stated the occupancy agreement and handbook with revision dates of 7/25 and 12/11/13 respectively constituted the current agreement. The Executive Director stated the Kitchen Manager made the menus and he trusted the Kitchen Manager ' s experience to provide nutritionally balanced meals. The Executive Director stated the Program did not utilize a registered dietitian to prepare menus. The Kitchen Manager was interviewed and stated she was not a dietitian. The Kitchen Manager stated she prepared the menus as provided to the	A 000		

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A 000	Continued From page 2 monitors; November and December 2014 and January 2015. The Kitchen Manager stated she could not guarantee the menus provided 100% of the daily recommended dietary allowances. The Kitchen Manager, who was not a dietitian, prepared the menus utilized by the Program. The Executive Director confirmed a Registered Dietitian did not design or review/approve the menus. The Program did not utilize a Registered Dietitian as outlined in the occupancy agreement and supporting documents.	A 000		
A 036	481-67.5(6)a Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Complaints #50543-C and #51703-C alleged medication errors occurred at the Program over the past several months.	A 036		

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A 036	Continued From page 3 Based on interview and record review the Program failed to ensure medications/treatments were administered according to physician orders, standard nursing practice, and without error. Seventeen files were reviewed. 1. Tenant #1, a 97 year-old, was admitted on 9/21/14 and had diagnoses of: memory loss, vitamin D deficiency, and hypertension. On 9/21/14 Tenant #1 scored 29 of 30 on the mini mental status exam which indicated normal cognitive function. Nurse ' s notes dated 9/23/14 at 8:45 p.m. documented Tenant #1 had a right foot that was too swollen to get a shoe on and needed to be seen by a physician. Nurse ' s notes dated 9/24/14 at 8:00 p.m. documented Tenant #1 was seen by the physician and orders were received for rest, ice, compression, and elevation. The nurse ' s notes did not document the treatments were " as needed. " Review of the physician ' s order documented the rest, ice compression, and elevation on one line of the order form. The next line contained an order for Tylenol as needed for pain. A review of the medication administration record (MAR) for October 2014 documented the 9/24/14 order for rest, ice and elevation as " as needed for pain. " The MAR did not document the order for compression. The physician-ordered tasks were not transcribed correctly. The MAR did not contain the treatments as given as ordered. 2. Tenant #2, a 91 year-old, was admitted on 12/26/13 and had diagnoses of: atrial fibrillation and vascular dementia. On 6/10/14 Tenant #2 was staged at two on the Global Deterioration	A 036		

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A 036	Continued From page 4 Scale (GDS) which indicated very mild cognitive decline. Review of the service plan dated 6/10/14 documented the Program administered medications to Tenant #2. Nurse ' s notes dated 10/28/14 documented the medication Lexapro (Escitalopram) had been discontinued. Review of the clinical record revealed the order for the Escitalopram was not contained in the record. When interviewed at 2/11/15 at 2:45 p.m., the RN confirmed there was no order in the record for the medication. The RN contacted the pharmacy and received a copy of the order for Escitalopram dated 10/22/14. The order to discontinue the medication for Tenant #2 was noted on 10/28/14. Review of Tenant #2's October 2014 MARs revealed the Escitalopram had been given for four days, then held for two days before being discontinued on 10/28/14. The MAR documented the 10/27 dose was held at the family ' s request. There was no documentation to indicate why the medication was held on 10/28/14. Review of November 2014 MAR revealed Escitalopram with circled initials in the dates for the 1st, 2nd, and 3rd day of the month. There was no documentation on the MAR to indicate the medication was held. Following the three dates with the circled initials was a notation " DC. " The RN was interviewed and stated circled initials meant that medications were held and not given; however, the MAR did not indicate a reason for the medication being held. The RN stated there should have been documentation indicating the reason. When asked for a medication error report, the RN stated there was no error as the medication was not given. The initials were	A 036		

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A 036	Continued From page 5 circled for three days in November after the medication was discontinued on 10/28/14. After further review, the RN found the controlled medication disposition record which documented five pills of the Escitalopram was destroyed on 10/31/14 after the medication was discontinued. The disposition record also documented 27 pills of the Escitalopram with the same prescription number were destroyed on 11/7/14. At that time, the RN stated the three pills must have been given in November otherwise 30 pills would have been destroyed. The RN stated she had not been aware of the medication error prior to this questioning by the monitor. In an interview with the RN, she stated when medications were discontinued notation on the MAR should include date, time and signature. The RN stated there was no written policy on how to make notations on the MAR. The Escitalopram for Tenant #2 was discontinued on 10/28/14. Three doses of the medication were given over three days in November 2014. The MAR indicated DC written in the column beginning on the 4th day of November. The notation did not include a time or signature of the person documenting the discontinuation of the order. The Program failed to discontinue the Escitalopram as ordered which resulted in medication errors. Nurse ' s notes for Tenant #2 dated 1/19/15 documented by LPN A stated there were no new orders from a physician appointment. The clinical record contained a three-page summary of the physician visit dated 1/19/15. The first page of	A 036		

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A 036	Continued From page 6 the document was noted by LPN A at 1:50 p.m. on 1/19/15. The third page of the document contained a signed physician order to discontinue SMZ-TMP, prescribed as prophylaxis for urinary infections. Review of Tenant #2's January 2015 MAR documented the SMZ-TMP had been originally prescribed on 12/22/14. Despite the order received on 1/19/15 to discontinue the medication, the SMZ-TMP was administered through the end of January 2015 A total of 13 doses of medication were given in January after the order was received to discontinue the medication. The Program failed to discontinue the SMZ-TMP which resulted in medication errors. 3. Tenant #3, an 83 year-old, was admitted on 11/27/12 and had diagnoses of: hypertension, anxiety, dementia, chronic back pain, depression, gastroesophageal reflux disease, and coronary artery disease. On 7/10/14 evaluations of function, cognition, and health were completed. Tenant #3 was staged at two on the GDS which indicated very mild cognitive decline. A fax, dated 10/10/14 was sent to the physician and returned with a physician ' s order dated 10/17/14 to discontinue Myrbetriq. The order was noted on 10/21/14 by LPN C. The MAR for October 2014 had a notation with date, initials, and " DC " which indicated the medication had been discontinued. Review of the November 2014 MAR revealed the Myrbetriq had been given 11/1 through 11/4/14. The notation " Disc " was entered into the fifth column of the form. There was no	A 036		

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A 036	Continued From page 7 documentation of the date or initials. The Program failed to discontinue the medication on the November MAR which resulted in medication errors. In addition, review of medication error reports revealed the following: 4. On 8/29/14 Tenant #6's 8/21/14 bedtime doses of magnesium oxide (1 tablet) and Tylenol ES 500 mg (2 tablets) were found to be in bubble packs of the medication. Review of the MAR revealed the magnesium oxide and Tylenol had been signed as given by LPN C. 5. On 10/21/14 LPN D found a physician order dated 10/15/14 for medrol pack for Tenant #9 for a red and swollen foot. The 10/15/14 order had been noted by LPN C but had not been transcribed to Tenant #9's MAR. The physician was notified of the error on 10/21/14 by LPN D via fax. The MAR dated October 2014 revealed the medrol pack was delivered by pharmacy and started on 10/22/14, after the error was discovered. 6. On 10/8/14 LPN A found Tenant #12's Glipizide XL 5 mg (3 tablets) and Lasix 40 mg (1 1/2 tablets) to be given at 7:30 a.m. on 10/8/14 still in the October bubble packs. LPN C signed the medication off on the MAR as having been given. 7. On 12/18/14, LPN A found Tenant #17's a.m. dose of Amoxicillin 875-125 mg still in the bubble	A 036		

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A 036	Continued From page 8 pack for 12/17/14. Review of Tenant #17's MAR revealed the medication had been signed by LPN C as given on 12/17/14. When interviewed on 2/10/15 at 9:55 a.m., the RN confirmed there had been an increase in medication errors, but thought they had improved recently.	A 036		
A 032	481-69.21(2) Occupancy Agreement 481-69.21(231C) Occupancy agreement. 69.21(2) In addition to the requirements of Iowa Code section 231C.5, the written occupancy agreement shall include, but not be limited to, the following information in the body of the agreement or in the supporting documents and attachments: a. The telephone number for filing a complaint with the department. b. The telephone number for the office of the tenant advocate. c. The telephone number for reporting dependent adult abuse. d. A copy of the program ' s statement on tenants ' rights. e. A statement that the tenant landlord law applies to assisted living programs. f. A statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 032		

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A 032	Continued From page 9 Program failed to include in the occupancy agreement and supporting documents, a statement that the tenant landlord law applies to assisted living programs, and did not include a statement that the Program would notify the tenant at least 90 days in advance of any planned Program cessation. The Executive Director provided the Primrose Assisted Living Resident Occupancy Agreement, revised 7/25/13. Page 15 of the occupancy agreement referred to a Resident Handbook. The Program provided a copy of the Resident Handbook with a revision date of 12/11/13. In an interview with the Executive Director on 2/10/15 at 3:30 p.m., he stated the occupancy agreement and handbook with revision dates of 7/25 and 12/11/13 respectively constituted the current agreement. Review of the occupancy agreement and handbook revealed no statements regarding the application of tenant landlord law. In addition, the documents failed to contain a statement that the Program would notify the tenant at least 90 days in advance of any planned Program cessation. Review of the following signed Resident Occupancy Agreements revealed no information regarding the tenant landlord law or 90 day notice of Program cessation. a. Tenant #5's, signed 9/30/14. b. Tenant #7's, signed 10/14/14. c. Tenant #8's, signed 5/5/14. When interviewed on 2/10/15 at 10:30 a.m., the Executive Director stated the occupancy agreement and handbook did not contain	A 032		

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A 032	Continued From page 10 statements about the application of tenant landlord law, or a 90-day notice for planned Program cessation.	A 032		
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 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: Based on interview and record review the Registered Nurse (RN) failed to evaluate tenants' functional, cognitive and health status when significant changes occurred in tenants' condition. Nine files were reviewed. 1. Tenant #1, a 97 year-old, was admitted on 9/21/14 and had diagnoses of: memory loss, vitamin D deficiency, and hypertension. On 9/21/14 Tenant #1 scored 29 of 30 on the mini mental status exam which indicated normal	A 037		

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PRIMROSE RETIREMENT COMMUNITY	1801 EAST KANESVILLE BLVD CO BLUFFS, IA 51503

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A 037	Continued From page 11 cognitive function. The initial service plan dated 9/21/14 documented Tenant #1 was oriented to person, place, and time, did not exhibit behaviors, was independent with mobility, and used a walker. Nurse ' s notes dated 9/22/14 at 2:20 a.m. documented Tenant #1 lost balance and fell, but had no injury. Notes dated 9/22/14 and timed 1:10 p.m. documented Tenant #1 had required assistance of two throughout the day shift. Tenant #1 refused breakfast and refused to stand. Notes dated 9/22/14 at 3:50 p.m. documented Tenant #1 required the assist of two to the bathroom with a slow gait and confusion. Tenant # was oriented to name only and required constant redirection. Notes timed 5:30 p.m. documented Tenant #1 was agitated, and refused to walk back from dinner. Notes of 9/23/14 timed 8.30 a.m. and noon documented Tenant #1 refused to eat but drank fluids. Notes timed 3:50 p.m. documented Tenant #1 had a urinary tract infection. Notes of 9/23/14 timed 5:30 p.m. and 8:30 p.m. documented Tenant #1 required assistance of two to go to the bathroom. Nurse ' s notes dated 9/23/14 and timed 8:45 p.m. documented Tenant #1 had a right foot that was too swollen to get a shoe on and needed to be seen by a physician. Notes dated 9/24/14 at 8:00 p.m. documented Tenant #1 was an assist of two at times. Tenant #1 was seen by the physician and orders were received for rest, ice, compression, and elevation of the foot. Notes of 9/30/14 timed 8:30 p.m. documented Tenant #1 had a reddened area near the left big toe about one inch in diameter.	A 037		

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A 037	Continued From page 12 Review of nurse ' s notes dated 10/1/14 at 10:45 a.m. documented Tenant #1 required the assist of one for all activities of daily living (ADLs), including ambulation. Nurse's notes dated 10/4/14 at 9:00 a.m. documented Tenant #1 had " very disruptive behavior, " banging the coffee cup and silverware on the table and waving arms. Tenant #1 requested to use the bathroom four times in 25 minutes. Notes of the same date timed 1:00 p.m. documented Tenant #1 had been to the bathroom at least 20 times, and had not eaten a full lunch. Review of Nurse's notes dated 10/4/14 at 8:00 p.m. revealed the family requested Tenant #1 not be taken out of the apartment for meals. Notes of 10/5/14 documented Tenant #1 continued to require assistance of one for all ADLs and ambulation, did not eat breakfast, and " constantly " wanted to use the bathroom. The family took Tenant #1 to the emergency room for evaluation on 10-5-14. Tenant #1 did not return to the Program. When interviewed on 2/12/15 at 9:20 a.m., the Registered Nurse (RN) stated Tenant #1 changed rapidly from admission. LPN A was interviewed on 2/12/15 at 8:57 a.m. and stated Tenant #1 required two persons for transfer the last week at the Program. Tenant #1 had behaviors of wanting to go to the bathroom and had declined since admission. Tenant #1 was admitted on 9/21/14. During the first night at the Program, Tenant #1 fell. Tenant #1 began to require increased assistance with	A 037		

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A 037	Continued From page 13 ADLs and ambulation; sometimes requiring assistance of two. Tenant #1 refused meals at times and did not eat all meals completely. Tenant #1 was treated for a urinary infection. Tenant #1 had a swollen right foot and was seen by a physician. Tenant #1 began to exhibit behaviors and displayed significant changes of condition since the admission evaluations of 9/21/14. Evaluations of function, cognition, and health were not completed with significant changes of condition. 2. Tenant #2, 91 years old, was admitted on 12/26/13 and had diagnoses of: atrial fibrillation and vascular dementia. On 6/10/14 Tenant #2 was staged at two on the Global Deterioration Scale (GDS) which indicated very mild cognitive decline. Nurse ' s notes dated 10/28/14 documented the medication Lexapro was discontinued. Notes dated 10/30/14 documented Tenant #2 had increased confusion. A urinalysis (UA) was completed with no orders received based on the results of the UA. Nurse ' s notes dated 11/25/14 documented Tenant #2 fell and hit the head and had a " big knot " on the left side of the head. 911 was called and Tenant #2 was taken to the hospital. Documentation from the hospital dated 11/25/14 revealed Tenant #2 had a head injury and was sent back to the Program with head injury precautions. Nurse ' s notes dated 11/30/14 documented Tenant #2 was upset, confused, and cried in the dining room. A family member took Tenant #2 to their home. There was no documentation in the nurse ' s notes to indicate when Tenant #2 returned to the Program.	A 037		

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A 037	Continued From page 14 Notes of 12/4/14 documented Tenant #2 was ready for bed at 4:45 p.m. and refused to go to dinner at that time. According to evaluations dated 6/10/14, Tenant #2 was independent with mobility. Task sheets, utilized by the Program for December 2014 and January 2015 documented Tenant #2 was provided staff assistance to go to meals. The January 2015 MAR revealed an antibiotic was ordered daily as preventative for urinary tract infections. Notes of 12/31/14 documented Tenant #2 was found on the floor with a scrape to the nose and forehead. Tenant #2 complained of the back of the head hurting. Notes of 1/13/15 documented Tenant #2 experienced weight loss. Notes of 1/14/14 documented the " fax returned with orders for supplements. " A review of the fax dated 1/13/15 documented Tenant #2 ' s weight went from 103.6 pounds to 92.2 pounds. The physician in fact did not order a supplement, but asked if Tenant #2 was " taking supplement. " There was no documentation of further response about the supplement from the Program. Nurse ' s notes dated 1/13/15 documented UA results were faxed to the physician. There was no documentation as to the symptoms Tenant #2 displayed to prompt the need for a UA. On 1/16/15 an order was received for an antibiotic for a urinary infection. The notes also documented staff would " monitor for signs and symptoms and encourage fluids and cranberry juice. " Notes of 1/17/15 documented the sensitivity report indicated the antibiotic ordered was not as	A 037		

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A 037	Continued From page 15 effective as another. The antibiotic was changed. Nurse ' s notes dated 1/17/15 documented Tenant #2 was confused. Notes of 1/19 through 1/22/14 documented fluids were encouraged. Review of nurse ' s notes dated 10/28/14 through 1/17/15 revealed Tenant #2 had increased confusion and Escitalopram was discontinued. Tenant #2 was treated for urinary tract infections and placed on an antibiotic as preventative. Tenant #2 fell twice and one required evaluation at an emergency room. Both falls resulted in hits to the head Tenant #2 had documented weight loss that the Program reported to the physician. Tenant #2 began receiving staff assistance to get to the dining room. The most recent evaluations were completed 6/10/14. At that time, Tenant #2 was staged at two on the GDS which indicated very mild cognitive decline. In an interview with the RN on 2/11/15 at 4:00 p.m. she stated Tenant #2 would no longer be staged at two on the GDS. Evaluations of function, cognition, and health for Tenant #2 were not completed with changes of condition. 3., Tenant #3, an 83 year-old, was admitted on 11/27/12 and had diagnoses of: hypertension, anxiety, dementia, chronic back pain, depression, gastroesophageal reflux disease, and coronary artery disease. On 7/10/14 evaluations of function, cognition, and health were completed. Tenant #3 was staged at two on the GDS which indicated very mild cognitive decline. A 90-day nurse review dated 10/10/14 documented Tenant #3 fell on 7/12/14 and sustained a rib fracture. Incident reports dated 9/23, 10/11, 10/24, 11/10, 11/18, 11/25, and	A 037		

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A 037	Continued From page 16 12/30/14, and 1/3, 1/7, and 1/8/15 documented Tenant #3 was found on the floor. The incident report of 12/30/14 documented a rug burn to the knee and the incident report of 1/3/15 documented the scab to the knee had opened with the fall. A fax to the physician dated 11/17/14 documented a request for physical therapy/occupational therapy (PT/OT) for improved strength and mobility following " a few falls. " Nurse ' s notes dated 11/19/14 documented Tenant #3 stated the falls were due to " passing out. " Notes dated 12/30/14 documented Tenant #3 was found on the floor holding a glass containing " peppermint schnopps" (sic). Notes dated 1/1/15 at 11:45 a.m. documented Tenant #3 was to use the walker at all times as an intervention. Notes dated 1/5/15 at 12:10 p.m. documented Tenant #3 was to make sure the catheter tubing was not caught in furniture as an intervention. Tenant #3 had at least 10 falls between 9/23/14 and 1/8/15, following a 7/12/14 fall which resulted in a rib fracture. Evaluations of function, cognition, and health were not completed with repeated falls requiring further intervention by PT/OT. When interviewed on 2/9/15 at 11:03 a.m., the RN stated Tenant #3 had received botox for tightening of the pelvic area and was unable to urinate following the treatment. Nurse ' s notes dated 9/11/14 documented the placement of an indwelling urinary catheter. Nurse ' s notes dated 10/4/14 at 7:30 p.m. documented Tenant #3 was sent to the	A 037		

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A 037	Continued From page 17 emergency room for " accidents " and no output from the urinary catheter. Notes of the same date at 11:00 p.m. documented the catheter was changed Notes dated 11/14/14 documented a urinary anti-infective was prescribed for a urinary infection for 10 days. Notes 11/14 through 11/17 documented fluids and cranberry juice were encouraged. The November 2014 MAR confirmed the anti-infective was completed on 11/24/14. Notes dated 1/2/15 and timed 12:45 p.m. documented Tenant #3 had a red eye. Notes dated 1/7/15 documented Tenant #3 had bronchitis and conjunctivitis. Antibiotics were prescribed. Notes dated 1/8/15 at 6:30 p.m. documented Tenant #3 felt weak and had an unsteady gait. Notes of 1/9/15 and timed 5:00 a.m. documented Tenant #3 was very weak and could not get out of the chair by self. Notes of 1/9/15 timed 4:45 p.m. documented an antibiotic was started for a urinary infection. Nurse review dated 1/14/15 at 10:00 a.m. documented the completion of antibiotics for the bronchitis and the urinary infection. The nurse review documented " no problems; " however, an entry of the same date timed at 2:30 p.m. documented an antibiotic was started for 10 days for a urinary infection, and fluids and cranberry juice were encouraged. Notes dated 1/19/15 timed 4:55 p.m. documented fluids were encouraged. Notes dated 1/22/15 at 12:30 p.m. documented Tenant #3 was leaning to the left side, the eyes had a glazed appearance, and Tenant #3 was unable to state the month. Notes dated 1/23/15	A 037		

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A 037	Continued From page 18 documented a fax was sent to the physician regarding the incident. Notes dated 1/26/15 and timed 5:45 p.m. documented Tenant #3 was found on the floor, with a small cut on the right eyebrow, and a bruise under the right eye. Notes of 1/28/15 at 11:40 a.m. documented an antibiotic was started for 10 days for a urinary infection. Fluids and cranberry juice were encouraged. Tenant #3 experienced multiple falls, some with injuries, resulting in a PT/OT consult, interventions put in place by the Program to remind Tenant #3 to keep the walker with self and to observe placement of catheter tubing so as to keep from tripping. Tenant #3 had an indwelling urinary catheter placed for the inability to urinate. Tenant #3 also experienced multiple urinary infections requiring treatment with several antibiotics, and interventions put in place by the Program to encourage fluids. Tenant #3 had bronchitis and conjunctivitis, and an episode of leaning to the left with a glazed appearance in the eyes. Tenant #3 experienced several changes of condition which resulted in the implementation of standard disease related interventions as well as interventions put in place by staff. Evaluations of function, cognition, and health were not completed with significant changes of condition after 7/10/14. 4. Tenant #4, an 81 year-old, was admitted on 1/2/13 and had diagnoses of: chronic obstructive pulmonary disease, osteoarthrosis involving multiple sites, hypertension, depression, anxiety	A 037		

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A 037	Continued From page 19 and esophageal reflux. Nurse ' s notes dated 12/23/14 documented Tenant #4 was on an antibiotic for a sinus infection. The order from the healthcare provider dated 12/23/14 documented the antibiotic was to be given for 10 days and was for acute sinusitis. Nurse ' s notes dated 1/10/15 and timed 12:00 p.m. documented Tenant #4 had a temperature of 100.3 degrees. The notes timed 1:15 p.m. documented Tenant #4 had wheezes in the lung. Notes timed 3:00 p.m. documented an inhaler had been prescribed as needed. Nurse ' s notes dated 1/11/5 at 10:40 a.m. documented Tenant #4 complained of chest pain and stated " my chest is heavy and fells like I ' m having a heart attack. " Nitroglycerin was given and was effective in relieving the chest pain. Tenant #4 has some audible wheezing and was given a nebulizer treatment. Notes dated 1/12/15 at around midnight documented Tenant #4 had chest pain. Tenant #4 was given two nitroglycerin and was still having some discomfort. Tenant #4 did not want to go to the hospital and stated was feeling better. A nebulizer treatment was given. Nurse ' s notes dated 1/12/15 and timed 4:00 p.m. documented Tenant #4 was prescribed an anti-infective for seven days for an upper respiratory infection. Fluids and cranberry juice were encouraged. Notes of 1/23/15 and timed 4:00 a.m. documented Tenant #4 had dark colored urine and fluids were encouraged. Notes dated 1/24 through 1/26/15 continued to document fluids	A 037		

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A 037	Continued From page 20 were encouraged. Notes of 1/31/15 at 2:00 a.m. documented Tenant #4 had a swollen left ankle. Notes dated 2/2/15 documented a urine sample had been obtained with result sent to the physician. Beginning 12/23/14, Tenant #4 was given an antibiotic for acute sinusitis, had a fever and wheezing in the lung and was prescribed an inhaler and used a nebulizer, was prescribed an anti-infective for an upper respiratory infection, and had two instances of chest pain requiring the use of nitroglycerin. Tenant #4 had a swollen ankle and dark colored urine for which staff utilized interventions of encouraging fluids and cranberry juice. A urine sample was collected. Tenant #4 had multiple conditions for which standard disease related clinical interventions were implemented as well as staff interventions. Tenant #4 exhibited changes of condition. Evaluations of function, cognition, and health were not completed with changes of condition. 5. Tenant #8, 90 years old, was admitted 5/5/14 with diagnoses of: diabetes, peripheral neuropathy, hypertension, and coronary artery disease (CAD). Tenant #8 had cognitive, functional and health evaluations completed on 5/20/14. The functional assessment stated Tenant #8 had one fall within the prior year and required skilled nursing for wound care. Mini mental exam completed 5/5/14 revealed a mini mental exam score of 30, indicating normal cognitive function. Review of nurse's notes dated 5/13/14 at 10:00 a.m. documented Tenant #8 requested gauze for legs. When checked by the nurse, Tenant #8's	A 037		

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A 037	Continued From page 21 lower legs appeared edematous and hard bilaterally. The right lower leg exhibited weeping of fluid. On 5/19/14, lower legs were found to be weeping bilaterally. Tenant #8 went to the physician that afternoon. Notes on 5/20/14 revealed an order had been received for assessment by skilled nursing. Faxed physician order signed 5/20/14 confirmed order for skilled nursing for assessment and monitoring of Tenant #8's legs. Review of Home Health Certification and Plan of Care revealed Tenant #8 was treated by a Home Health Agency from 5/21/14 - 7/19/14 for wounds on lower legs Review of nurse's notes dated 5/28/14 at 6:55 p.m. revealed Tenant #8 was found sitting on the bathroom floor with legs out and leaning against the wall. Staff reminded the tenant to wear the pendant and was assisted by two to the living room. Nurse's notes dated 6/8/14 revealed Tenant #8 was transferred to the hospital and admitted for increased abdominal fluid. Tenant #8 returned from the hospital on 6/11/14. Notes dated 7/10/14 at 2:00 a.m. stated the Tenant #8's spouse pressed the pendent for assistance. When the staff arrived to the room, Tenant #8 sat on the floor with legs in front and denied hitting head. Tenant #8 had no complaint of pain. Nurse's notes dated 7/24/14 at 8:40 p.m. revealed Tenant #8's spouse in the hallway to summon help. Then staff went into the apartment, Tenant #8 sat upright on the floor with legs extended straight out. Tenant #8 reported sliding out of a rocker in the room. No injuries were noted	A 037		

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A 037	Continued From page 22 Notes dated 8/16/14 at 11:39 p.m. documented Tenant #8 was found on living room floor without pendent on. Staff noted increased confusion as Tenant #8 didn't know how he/she got to the living room. Tenant #8 had a " fist size " bruised circle on the right mid side of back, and a 1 inch " V " shaped skin tear in the same spot. Tenant #8 reportedly could not lift left arm without pain and grimaced when moved right arm. Tenant #8 refused medical treatment. When staff phoned Tenant #8's daughter, she expressed concern of how much Tramadol Client #8 may be taking. Notes dated 8/26/14 at 8:00 p.m. documented Tenant #8's spouse pushed their pendant. When staff arrived they found Tenant #8 on the floor next to the bed. Tenant #8 didn't have pendant on. Tenant #8 denied injury. On 8/30/14 at 1:00 a.m., Tenant #8 was found lying on left side on the floor between the bedroom and bathroom. Tenant #8 was assisted up with the assist of 2 and denied any injury. Review of Resident Assessment dated 10/26/14 revealed on page 3, "Resident has had 1 fall within the last year". On page 4 the assessment stated, "Received home health skilled nurse for wound care..." Resident Assessment dated 1/1/15 listed on page 4, " Receives home health skilled nurse for wound care..." Resident Assessment dated 1/15/15 revealed on page 4, " Receives home health skilled nurse for wound care..." When interviewed on 2/11/15 at 11:00 a.m., the	A 037		

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A 037	Continued From page 23 RN confirmed the assessment dated 10/26/14 was not an accurate evaluation of the number of falls Tenant #8 had since admission on 5/5/14. She also confirmed Tenant #8 had not received home health services for wound care since some time in July 2014 and it should have not been on the recent and current assessments.	A 037		
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: Based on interview and record review the Program failed to develop/update tenants' service plans in services were needed and according to tenants' needs Nine files were reviewed. 1. Tenant #1, a 97 year-old, was admitted on 9/21/14 and had diagnoses of: memory loss, vitamin D deficiency, and hypertension. On 9/21/14 Tenant #1 scored 29 of 30 on the mini mental status exam which indicated normal cognitive function. The initial service plan dated 9/21/14 documented Tenant #1 was oriented to person, place, and	A 083		

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A 083	Continued From page 24 time, did not exhibit behaviors, was independent with mobility, and used a walker. Nurse ' s notes dated 9/22/14 at 2:20 a.m. documented Tenant #1 lost balance and fell, but had no injury. Notes dated 9/22/14 and timed 1:10 p.m. documented Tenant #1 had required the assistance of two throughout the day shift. Tenant #1 refused breakfast and refused to stand. Nurse ' s notes dated 9/22/14 and timed 1:10 p.m. documented a supplemental nutritional drink was given. Notes dated 9/22/14 at 3:50 p.m. documented Tenant #1 required the assist of two to the bathroom with a slow gait and confusion. Tenant #1 was oriented to name only and required constant redirection. Notes timed 5:30 p.m. documented Tenant #1 was agitated, and refused to walk back from dinner. Notes of 9/23/14 at 8:30 a.m. and noon documented Tenant #1 refused to eat but did take the supplemental nutritional drink. Notes timed 3:50 p.m. documented Tenant #1 had a urinary tract infection. The notes documented fluids would be encouraged including cranberry juice. Notes of 9/23/14 at 5:30 p.m. and 8:30 p.m. documented Tenant #1 required assistance of two to go to the bathroom. Tenant #1 refused all foods. Review of nurse ' s notes dated 9/23/14 at 8:45 p.m. documented Tenant #1 had a right foot that was too swollen to get a shoe on and needed to be seen by a physician. Notes dated 9/24/14 at 8:00 p.m. documented Tenant #1 required the assist of two at times. Tenant #1 was seen by the physician and orders were received for rest, ice, compression, and elevation of the foot. Notes of 9/30/14 at 8:30 p.m. documented Tenant #1 had a reddened area near the left big toe about one	A 083		

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A 083	Continued From page 25 inch in diameter. Nurse ' s notes dated 10/1/14 at 10:45 a.m. documented Tenant #1 required the assist of one for all activities of daily living (ADLs), including ambulation. Nurse ' s notes dated 10/4/14 and timed 9:00 a.m. documented Tenant #1 had " very disruptive behavior, " banging the coffee cup and silverware on the table and waving arms. Tenant #1 requested to use the bathroom four times in 25 minutes. Notes of the same date at 1:00 p.m. documented Tenant #1 had been to the bathroom at least 20 times, and had not eaten a full lunch. When interviewed on 2/12/15 at 9:20 a.m. the Registered Nurse (RN) stated Tenant #1 changed rapidly from admission. Licensed Practical Nurse (LPN) A was interviewed on 2/12/15 at 8:57 a.m. and stated Tenant #1 required two persons for transfer the last week at the program. Tenant #1 had behaviors of wanting to go to the bathroom and had declined since admission. Review of notes dated 10/4/14 at 8:00 p.m. documented family requested Tenant #1 not be taken out of the apartment for meals. Notes of 10/5/14 documented Tenant #1 continued to require the assist of one for all ADLs and ambulation, did not eat breakfast, and " constantly " wanted to use the bathroom. The family took Tenant #1 to the emergency room for evaluation on 10-5-14. Tenant #1 did not return to the Program. The service plan dated 9/21/14 did not contain interventions for decreased nutritional intake	A 083		

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A 083	Continued From page 26 including a supplemental nutritional drink when Tenant #1 refused meals or ate very little. The service plan failed to identify assistance needed with ambulation up to and including two persons. The service plan did not identify interventions for behavior of frequent requests to toilet. The service plan did not identify interventions related to a swollen foot including rest, ice, compression and elevation. The service plan did not identify interventions for a urinary infection including encouraging fluids and cranberry juice. The service plan dated 9/21/14 was not updated with changes of condition and did not meet the specific service needs of Tenant #1. 2. Tenant #2, a 91 year-old, was admitted on 12/26/13 and had diagnoses of: atrial fibrillation and vascular dementia. On 6/10/14 Tenant #2 was staged at two on the Global Deterioration Scale (GDS) which indicated very mild cognitive decline. Review of nurse ' s notes dated 10/28/14 documented the medication Lexapro was discontinued. Notes dated 10/30/14 documented Tenant #2 had increased confusion. A urinalysis (UA) was completed with no orders received based on the results of the UA. Nurse ' s notes dated 11/25/14 documented Tenant #2 fell and hit the head and had a " big knot " on the left side of the head. Emergency Medical Services (EMS) was called and Tenant #2 was taken to the hospital. Documentation from the hospital dated 11/25/14 revealed Tenant #2 had a head injury and was sent back to the Program with head injury precautions. Review of nurse ' s notes dated 11/30/14	A 083		

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A 083	Continued From page 27 documented Tenant #2 was upset and confused and cried in the dining room. A family member took Tenant #2 home. There was no documentation in the nurse ' s notes to indicate when Tenant #2 returned to the Program. Notes of 12/4/14 documented Tenant #2 was ready for bed at 4:45 p.m. Tenant #2 refused to go to dinner at that time. According to the evaluations dated 6/10/14, Tenant #2 was independent with mobility. Task sheets utilized by the Program for December 2014 and January 2015 documented Tenant #2 was provided staff assistance to go to meals. Review of the January 2015 MAR revealed an antibiotic was ordered daily as a preventative for urinary tract infections. Notes of 12/31/14 documented Tenant #2 was found on the floor with a scrape to the nose and forehead. Tenant #2 complained of the back of the head hurting. Notes of 1/13/15 documented Tenant #2 experienced weight loss. Notes of 1/14/14 documented the " fax returned with orders for supplements. " A review of the fax dated 1/13/15 documented Tenant #2 ' s weight went from 103.6 pounds to 92.2 pounds. The physician in fact did not order a supplement, but asked if Tenant #2 was " taking supplement. " There was no documentation of further response about the supplement from the Program. Nurse ' s notes dated 1/13/15 documented UA results were faxed to the physician. There was no documentation as to the symptoms Tenant #2 displayed to prompt the need for a UA. On	A 083		

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A 083	Continued From page 28 1/16/15 an order was received for an antibiotic for a urinary infection. The notes also documented staff would " monitor for signs and symptoms and encourage fluids and cranberry juice. " Notes of 1/17/15 documented the sensitivity report indicated the antibiotic ordered was not as effective as another. The antibiotic was changed. Nurse ' s notes dated 1/17/15 documented Tenant #2 was confused. Notes of 1/19 through 1/22/14 documented fluids were encouraged. Nurse ' s notes dated 10/28/14 through 1/17/15 documented Tenant #2 had increasing confusion and Escitalopram was discontinued. Tenant #2 was treated for urinary tract infections and placed on an antibiotic as a preventative. Tenant #2 had two falls, one requiring evaluation at an emergency room. Both falls resulted in hits to the head. Tenant #2 had documented weight loss that the Program reported to the physician. Tenant #2 began receiving staff assistance to get to the dining room. The current service plan dated 6/10/14 did not include interventions for fall prevention, did not document signs and symptoms to report based on Tenant #2 ' s history of frequent urinary infections, did not include interventions for urinary infections including to encourage fluids, did not identify interventions for the behavior of confusion, interventions for the prevention and monitoring of weight loss, and the need for staff assistance to get to the dining room. The service plan was not updated with changes and did not meet the specific service needs of Tenant #2. 3. Tenant #3, an 83 year-old, was admitted on 11/27/12 and had diagnoses of: hypertension, anxiety, dementia, chronic back pain, depression,	A 083		

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A 083	Continued From page 29 gastroesophageal reflux disease, and coronary artery disease. On 7/10/14 evaluations of function, cognition, and health were completed. Tenant #3 was staged at two on the GDS which indicated very mild cognitive decline. A 90-day nurse review dated 10/10/14 documented Tenant #3 fell on 7/12/14 and sustained a rib fracture. Incident reports dated 9/23, 10/11, 10/24, 11/10, 11/18, 11/25, and 12/30/14, and 1/3, 1/7, and 1/8/15 documented Tenant #3 was found on the floor. The incident report of 12/30/14 documented a rug burn to the knee and the incident report of 1/3/15 documented the scab to the knee had opened with the fall. A fax to the physician dated 11/17/14 documented a request for physical therapy/occupational therapy (PT/OT) for improved strength and mobility following " a few falls. " Nurse ' s notes dated 11/19/14 documented Tenant #3 stated the falls were due to " passing out. " Notes dated 12/30/14 documented Tenant #3 was found on the floor holding a glass containing " peppermint schnopps (sic). " Notes dated 1/1/15 at 11:45 a.m. documented Tenant #3 was to use the walker at all times as an intervention. Notes dated 1/5/15 at 12:10 p.m. documented Tenant #3 was to make sure the catheter tubing was not caught in furniture as an intervention. Tenant #3 had at least 10 falls between 9/23/14 and 1/8/15, following a 7/12/14 fall which resulted in a rib fracture. When interviewed on 2/9/15 at 11:03 a.m. the RN stated Tenant #3 had received botox for	A 083		

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A 083	Continued From page 30 tightening of the pelvic area. Tenant #3 was unable to urinate following the treatment. Nurse ' s notes dated 9/11/14 documented the placement of an indwelling urinary catheter. Review of nurse ' s notes dated 10/4/14 at 7:30 p.m. documented Tenant #3 was sent to the emergency room for " accidents " and no output from the urinary catheter. Notes of the same date at 11:00 p.m. documented the catheter was changed. Notes dated 11/14/14 documented a urinary anti-infective was prescribed for a urinary infection for 10 days. Notes 11/14 through 11/17 documented fluids and cranberry juice were encouraged. Notes dated 1/8/15 at 6:30 p.m. documented Tenant #3 felt weak and had an unsteady gait. Notes of 1/9/15 and timed 5:00 a.m. documented Tenant #3 was very weak and could not get out of the chair by self. Notes of 1/9/15 at 4:45 p.m. documented an antibiotic was started for a urinary infection. A nurse review dated 1/14/15 at 10:00 a.m. documented the completion of antibiotics for the urinary infection. The nurse review documented " no problems; " however, an entry of the same date timed at 2:30 p.m. documented an antibiotic was started for 10 days for a urinary infection, and fluids and cranberry juice were encouraged. Notes dated 1/19/15 timed 4:55 p.m. documented fluids were encouraged. Notes dated 1/26/15 at 5:45 p.m. documented Tenant #3 was found on the floor, with a small cut on the right eyebrow, and a bruise under the right eye. Notes of 1/28/15 at 11:40 a.m. documented an	A 083		

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A 083	Continued From page 31 antibiotic was started for 10 days for a urinary infection. Fluids and cranberry juice were encouraged. Tenant #3 experienced multiple falls, some with injuries, resulting in a PT/OT consult, interventions put in place by the Program to remind Tenant #3 to keep the walker with self and to observe placement of catheter tubing so as to keep from tripping. Tenant #3 had an indwelling urinary catheter placed for the inability to urinate. Tenant #3 also experienced multiple urinary infections requiring treatment with several antibiotics, and interventions put in place by the Program to encourage fluids. The service plan dated 7/10/14 did not document the outside service provider, PT. The service plan did not identify frequent falls and interventions for fall reduction. The service plan did not identify the use of an indwelling catheter, interventions to put in place with frequent urinary infections, and signs and symptoms for staff to report regarding the functioning of the urinary catheter and urinary tract infections. The service plan was not updated with changes and did not meet the specific service needs of Tenant #3 4. Tenant #5, a 90 year old was admitted on 9/30/14 with diagnoses of: anxiety, atrial fibrillation, insomnia, confusion, memory loss dementia, and congestive heart failure. Health evaluation dated 12/30/14 noted a home health agency was notified to see Tenant #5 for skilled nursing and physical therapy (PT) for increased mobility. Review of Tenant #5's current Service Plan signed 11/7/14 contained no updated information	A 083		

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A 083	Continued From page 32 regarding PT for Tenant #5. 5. Tenant #7, an 88 year-old, was admitted to the Program on 10/14/14 with diagnoses of: anxiety, hypertension, chronic insomnia, degenerative joint disease, speech articulation disorder, and recurrent UTI. Record review revealed physician dictation prior to admission (9/22/14) for treatment of UTI. Admitting physician orders dated 10/14/14 listed urinalysis for signs and symptoms of UTI. Review of Tenant #7's current service plan signed 10/14/14 did not list recurrent UTIs as an acute or chronic illness and subsequently listed no signs or symptoms of a UTI for staff to be alerted to. When interviewed on 2/10/15 at 2:30 p.m., the RN confirmed recurrent UTIs was not addressed on Tenant #7's current service plan. 6. Tenant #8, 90 years old, was admitted 5/5/14 with diagnoses of: diabetes, peripheral neuropathy, hypertension, and coronary artery disease (CAD). Tenant #8 had cognitive, functional and health evaluations completed on 5/20/14. The functional assessment stated Tenant #8 had one fall within the prior year and required routine evaluation of ability to self manage medications. Tenant #8 scored a 30 on mini mental exam completed 5/20/14 indicated normal cognitive impairment. Review of nurse's notes dated 5/13/14 at 10:00 a.m. documented Tenant #8 requested gauze for legs. When checked by the nurse, Tenant #8's lower legs appeared edematous and hard	A 083		

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A 083	Continued From page 33 bilaterally. The right lower leg exhibited weeping of fluid. On 5/19/14, lower legs were found to be weeping bilaterally. Tenant #8 went to the physician that afternoon. Notes on 5/20/14 revealed an order had been received for assessment by skilled nursing. Faxed physician order signed 5/20/14 confirmed order for skilled nursing for assessment and monitoring of Tenant #8's legs. Review of Home Health Certification and Plan of Care revealed Tenant #8 was treated by a Home Health Agency from 5/21/14 - 7/19/14 for wounds on lower legs. Review of nurse's notes dated 5/28/14 at 6:55 p.m. revealed Tenant #8 was found sitting on the bathroom floor with legs out and leaning against the wall. Staff reminded the tenant to wear the pendant and was assisted by two to the living room. Nurse's notes dated 6/8/14 revealed Tenant #8 was transferred to the hospital and admitted for increased abdominal fluid. Tenant #8 returned from the hospital on 6/11/14. Notes dated 7/10/14 at 2:00 a.m. stated Tenant #8's spouse pressed the pendent for assistance. When the staff arrived to the room, Tenant #8 sat on the floor with legs in front and denied hitting head. Tenant #8 had no complaint of pain. Nurse's notes dated 7/24/14 at 8:40 p.m. revealed Tenant #8's spouse in the hallway to summon help. Then staff went into the apartment, Tenant #8 sat upright on the floor with legs extended straight out. Tenant #8 reported sliding out of a rocker in the room. No injuries were noted. Notes dated 8/16/14 at 11:39 p.m. documented	A 083		

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A 083	Continued From page 34 Tenant #8 was found on living room floor without pendent on. Staff noted increased confusion as Tenant #8 didn't know how he/she got to the living room. Tenant #8 had a " fist size " bruised circle on the right mid side of back, and a 1 inch " V " shaped skin tear in the same spot. Tenant #9 reportedly could not lift left arm without pain and grimaced when moved right arm. Tenant #9 refused medical treatment. When staff phoned Tenant #8's daughter, she expressed concern of how much Tramadol Client #8 may be taking. Notes dated 8/26/14 at 8:00 p.m. documented Tenant #8's spouse pushed their pendant. When staff arrived they found Tenant #8 on the floor next to the bed. Tenant #8 didn't have pendant on. Tenant #8 denied injury. On 8/30/14 at 1:00 a.m., Tenant #8 was found lying on left side on the floor between the bedroom and bathroom. Tenant #8 was assisted up with the assist of 2 and denied any injury. Review of Resident Assessment dated 10/26/14 revealed on page 3, "Resident has had 1 fall within the last year". On page 4 the assessment stated, "Received home health skilled nurse for wound care..." Tenant #8's service plan dated and signed 10/27/14 also stated Tenant #8 had one fall in the past year and the tenant received skilled nursing for wound care. Resident Assessment dated 1/1/15 listed on page 4, " Receives home health skilled nurse for wound care...". Resident Assessment dated 1/15/15 revealed on page 4, " Receives home health skilled nurse for wound care...". Tenant #8's service plan dated and signed 1/15/15 also stated the tenant	A 083		

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A 083	Continued From page 35 continued to receive skilled nursing services for wound care. When interviewed on 2/11/15 at 11:00 a.m., the RN confirmed service plans dated and signed 10/26/14 and 1/15/15 contained inaccurate information regarding falls and wound care by skilled nursing. She also confirmed Tenant #8 had not received home health services for wound care since some time in July 2014 and it should have not been on the recent and current service plans.	A 083		
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 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 interview and record review the Registered Nurse (RN) failed to conduct nurse reviews at least every 90 days regarding prescription medications and/or referrals as	A 094		

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A 094	Continued From page 36 related to current health related care. Nine files were reviewed. 1. Tenant #2, a 91 year-old, was admitted on 12-26-13 and had diagnoses of: atrial fibrillation and vascular dementia. On 6/10/14 Tenant #2 was staged at two on the Global Deterioration Scale (GDS) which indicated very mild cognitive decline. A review of the service plan dated 6/10/14 documented the Program administered medications to Tenant #2. A 90-day nurse review was conducted on 9/10/14. The Escitalopram for Tenant #2 was discontinued on 10/28/14. Three doses of the medication were given over three days in November 2014. The MAR indicated DC written in the column beginning on the 4th day of November. The notation did not include a time or signature of the person documenting the discontinuation of the order. A review of the January 2015 MAR for Tenant #2 documented the SMZ-TMP had been originally prescribed on 12/22/14. Despite the order received on 1/19/15 to discontinue the medication, the medication was administered through the end of January 2015. A total of 13 doses of medication were given in January after the order was received to discontinue the medication. The RN was interviewed on 2/11/14 and stated a 90-day nurse review had not been completed after September 2014. A 90-day nurse review was not completed after 9/10/14 to monitor for adverse reactions to medications, to ensure that prescription medication orders were current, and that	A 094		

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A 094	Continued From page 37 prescription medications were administered consistent with the orders. 2. Tenant #3, an 83 year-old, was admitted on 11/27/12 and had diagnoses of: hypertension, anxiety, dementia, chronic back pain, depression, gastroesophageal reflux disease, and coronary artery disease. On 7/10/14 evaluations of function, cognition, and health were completed. Tenant #3 was staged at two on the GDS which indicated very mild cognitive decline. The service plan dated 7/10/14 documented the Program administered medications to Tenant #3. The Program received a faxed physician ' s order dated 10/17/14 and noted on 10/21/14 by LPN C to discontinue the medication Myrbetriq. The MAR for October 2014 had a notation with date, initials, and " DC " which indicated the medication had been discontinued. Review of the November 2014 MAR revealed the Myrbetriq had been given 11/1 through 11/4/14. The notation " Disc " was entered into the fifth column of the form. There was no documentation of the date or initials. The Program failed to discontinue the medication on the November MAR which resulted in medication errors. A 90-day nurse review dated 10/10/14 documented changes to medications but failed to monitor for adverse reactions to medications, to ensure prescription medication orders were current, and that prescription medications were administered consistent with the orders. 3. Tenant #4, an 81 year-old, was admitted on 1/2/13 and had diagnoses of: chronic obstructive	A 094		

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A 094	Continued From page 38 pulmonary disease, osteoarthrosis involving multiple sites, hypertension, depression, anxiety and esophageal reflux. The Program administered medications to Tenant #4. Nurse ' s notes dated 9/17/14 documented a 90-day assessment completed by LPN A related to a bed enabler for bed mobility. The 90-day review failed to monitor for adverse reactions to medications, failed to ensure prescription orders were current, and that medications were administered consistent with the orders. 4. Tenant #7, an 88 year-old, was admitted to the Program on 10/14/14 with diagnoses of anxiety, hypertension, chronic insomnia degenerative joint disease, speech articulation disorder, and recurrent urinary tract infections (UTI). The Program administered medication to Tenant #7. Review of nurse's notes revealed Tenant #7 was hospitalized 12/26/14 - 12/30/14 due to headache and confusion Tenant #7 ran a low grade fever on 12/30-31/14, and 1/1-3/15. According to nurse's notes, on 1/3/15 Tenant #7's physician ordered Azithromycin pack (Z-pack) for upper respiratory infection (URI). Nurse review dated 1/3/15 stated the tenant had a URI and lung sounds were diminished. Nurses notes dated 1/8/15 noted nurse review for post elevated temperature stated, "Antibiotic serves effective. Lungs sounds clear. No change in normal routine. No change ion cognitive, health, functional status or update to service	A 094		

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A 094	Continued From page 39 plan." Further review revealed a 90 day nurse review (health summary) dated 1/16/15 noted the rash on lower legs on 11/8/14 and antibacterial ointment ordered. On 11/14/14 Clindamycin was ordered for 7 days, however there was no mention of why the Clindamycin was administered. On 11/19/14 Tylenol/Hydrocodone was ordered to be given twice a day but no indication why it was ordered. On 11/21/14 Triamcinolone cream was ordered to lower legs and doppler was done, but no blood clot. The review/summary contained no symptoms or conditions to justify the order. The review continued, on 11/24/14 Cozaar, Lasix and consult with dermatologist were ordered with no indication of a reason. The review reported Tenant #7 had been hospitalized 12/26-30/14 but failed to state what led to the hospitalization. Further, the review listed, on 1/8/15 Tylenol 650 mg was ordered with no diagnosis or symptoms and on 1/14/15 Tramadol was ordered for pain. The review failed to address the Z-pack or why it had been used. In addition, the review failed to address if medications/treatments were administered according to physician orders, side effects or status of the conditions the medications were prescribed. When interviewed on 2/10/15 at 2:30 p.m., the RN confirmed the nurse review did not address Tenant #7's reasons for medications, evaluation of side effects, resolution of the symptoms medications were for, or whether medications were administered according to physician orders.	A 094		

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A 096	Continued From page 40	A 096		
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: Based on interview and record review the Registered Nurse (RN) failed to ensure assessment and nurse reviews were conducted every 90 days on tenants who required health care services and/or tenants who experienced change in health status. Nine files were reviewed. 1. Tenant #1, a 97 year-old, was admitted on 9/21/14 and had diagnoses of: memory loss, vitamin D deficiency, and hypertension. On 9/21/14 Tenant #1 scored 29 of 30 on the mini mental status exam which indicated normal cognitive function. The initial service plan dated 9/21/14 documented Tenant #1 was oriented to person, place, and time, did not exhibit behaviors, was independent with mobility, and used a walker. Review of nurse ' s notes dated 9/22/14 at 2:20	A 096		

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A 096	Continued From page 41 a.m. documented Tenant #1 lost balance and fell, but had no injury. Notes dated 9/22/14 and timed 1:10 p.m. documented Tenant #1 had required the assistance of two throughout the day shift. Tenant #1 refused breakfast and refused to stand. Notes dated 9/22/14 at 3:50 p.m. documented Tenant #1 required the assist of two to the bathroom with a slow gait and confusion. Constant redirection was required. Tenant #1 was oriented to name only and required constant redirection. Notes timed 5:30 p.m. documented Tenant #1 was agitated, and refused to walk back from dinner. Notes of 9/23/14 timed 8:30 a.m. and noon documented Tenant #1 refused to eat but was taking fluids Notes timed 3:50 p.m. documented Tenant #1 had a urinary tract infection. Notes of 9/23/14 timed 5:30 p.m. and 8:30 p.m. documented Tenant #1 required assistance of two to go to the bathroom. Nurse ' s notes dated 9/23/14 and timed 8:45 p.m. documented Tenant #1 had a right foot that was too swollen to get a shoe on and needed to be seen by a physician. Review of notes dated 9/24/14 at 8:00 p.m. revealed Tenant #1 required the assist of two at times. Tenant #1 was seen by the physician and orders were received for rest, ice, compression, and elevation of the foot. Notes of 9/30/14 timed 8:30 p.m. documented Tenant #1 had a reddened area near the left big toe about one inch in diameter. Nurse ' s notes dated 10/1/14 at 10:45 a.m. documented Tenant #1 required the assist of one for all activities of daily living (ADLs), including ambulation. Nurse ' s notes dated 10/4/14 at 9:00 a.m.	A 096		

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A 096	Continued From page 42 documented Tenant #1 had " very disruptive behavior, " banging the coffee cup and silverware on the table and waving arms. Tenant #1 requested to use the bathroom four times in 25 minutes. Notes of the same date timed at 1:00 p.m. documented Tenant #1 had been to the bathroom at least 20 times, and had not eaten a full lunch. Notes dated 10/4/14 and timed 8:00 p.m. documented family requested Tenant #1 not be taken out of the apartment for meals. Notes of 10/5/14 documented Tenant #1 continued to require the assist of one for all ADLs and ambulation, did not eat breakfast, and " constantly " wanted to use the bathroom. The family took Tenant #1 to the emergency room for evaluation on 10-5-14. Tenant #1 did not return to the Program. When interviewed on 2/12/15 at 9:20 a.m. the Registered Nurse (RN) stated Tenant #1 changed rapidly from admission. When interviewed on 2/2/15 at 8:57 a.m., Licensed Practical Nurse (LPN) A stated Tenant #1 required two persons for transfer the last week at the program. Tenant #1 had behaviors of wanting to go to the bathroom and had declined since admission. During the first night at the Program (9/21/14), Tenant #1 fell. Tenant #1 began to require increased assistance with ADLs and ambulation; sometimes requiring assistance of two. Tenant #1 refused meals at times and did not eat all meals fully. Tenant #1 was treated for a urinary infection. Tenant #1 had a swollen right foot and was seen by a physician. Tenant #1 began to exhibit behaviors. Tenant #1 displayed significant	A 096		

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A 096	Continued From page 43 changes of condition since the admission evaluations of 9/21/14. Evaluations of function, cognition, and health were not completed with significant changes of condition. Nurse review was not completed with a significant changes of condition to assess and document the health status of Tenant #1 and monitor progress related to previous recommendations related to changes in behavior, a swollen right foot, refusal to eat, and increasing need for assistance with ambulation. 2. Tenant #2, a 91 year-old, was admitted on 12/26/13 and had diagnoses of: atrial fibrillation and vascular dementia. On 6/10/14 Tenant #2 was staged at two on the Global Deterioration Scale (GDS) which indicated very mild cognitive decline. According to the service plan, the Program provided assistance with bathing, dressing, and grooming. Nurse ' s notes dated 10/28/14 documented the medication Lexapro (Escitalopram), an antidepressant originally ordered 10/22/14, was discontinued. Notes dated 10/30/14 documented Tenant #2 had increased confusion. A urinalysis (UA) was completed with no orders received based on the results of the UA. The clinical record did not document the behaviors or purpose of the Escitalopram. A nurse review was not completed with a change of condition that warranted a new prescription of an antidepressant. The medication was discontinued after six days. Tenant #2 was noted to have increased confusion not explained with a urinalysis. A nurse review was not completed with a change of condition to assess and document the health status of Tenant #2 and to monitor	A 096		

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A 096	Continued From page 44 progress related to previous recommendations. Nurse ' s notes dated 11/25/14 documented Tenant #2 fell and hit the head and had a " big knot " on the left side of the head. 911 was called and Tenant #2 was taken to the hospital. Documentation from the hospital dated 11/25/14 revealed Tenant #2 had a head injury and was sent back to the Program with head injury precautions. Nurse ' s notes dated 11/30/14 documented Tenant #2 was upset and confused. Tenant #2 was crying in the dining room. A family member came to get Tenant #2 and took Tenant #2 home. There was no documentation in the nurse ' s notes to indicate when Tenant #2 returned to the Program. Notes of 12/4/14 documented Tenant #2 was ready for bed at 4:45 p.m. Tenant #2 refused to go to dinner at that time. According to the evaluations dated 6/10/14, Tenant #2 was independent with mobility. Task sheets utilized by the Program December for 2014 and January 2015 documented Tenant #2 was provided staff assistance to go to meals. Review of the January 2015 MAR documented an antibiotic was ordered daily as a preventative for urinary tract infections. Notes of 12/31/14 documented Tenant #2 was found on the floor with a scrape to the nose and forehead. Tenant #2 complained of the back of the head hurting. Notes of 1/13/15 documented Tenant #2 experienced weight loss. Notes of 1/14/14 documented the " fax returned with orders for	A 096		

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A 096	Continued From page 45	A 096		

supplements. " A review of the fax dated 1/13/15 documented Tenant #2 ' s weight went from 103.6 pounds to 92.2 pounds. The physician in fact did not order a supplement, but asked if Tenant #2 was " taking supplement. " There was no documentation of further response about the supplement from the Program.

Nurse ' s notes dated 1/13/15 documented UA results were faxed to the physician. There was no documentation as to the symptoms Tenant #2 displayed to prompt the need for a UA. On 1/16/15 an order was received for an antibiotic for a urinary infection. The notes also documented staff would " monitor for signs and symptoms and encourage fluids and cranberry juice. " Notes of 1/17/15 documented the sensitivity report indicated the antibiotic ordered was not as effective as another. The antibiotic was changed.

Nurse ' s notes dated 1/17/15 documented Tenant #2 was confused. Notes of 1/19 through 1/22/14 documented fluids were encouraged.

Nurse ' s notes dated 10/28/14 through 1/17/15 documented Tenant #2 had increasing confusion and Escitalopram was discontinued. Tenant #2 was treated for urinary tract infections and placed on an antibiotic as a preventative. Tenant #2 had two falls, one requiring evaluation at an emergency room. Both falls resulted in hits to the head. Tenant #2 had documented weight loss that the Program reported to the physician. Tenant #2 began receiving staff assistance to get to the dining room.

The most recent evaluations were completed 6/10/14. At that time, Tenant #2 was staged at two on the GDS which indicated very mild cognitive decline. In an interview with the RN on

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A 096	Continued From page 46 2/11/15 at 4:00 p.m. she stated Tenant #2 would no longer be staged at two on the GDS. There was no documentation of a 90-day nurse review after 9/10/14. A nurse review was not completed every 90 days to assess and document the health status of Tenant #2, to monitor progress related to previous recommendations at least every 90 days and with changes of condition. 3. Tenant #3, an 83 year-old, was admitted on 11/27/12 and had diagnoses of: hypertension, anxiety, dementia, chronic back pain, depression, gastroesophageal reflux disease, and coronary artery disease. On 7/10/14 evaluations of function, cognition, and health were completed. Tenant #3 was staged at two on the GDS which indicated very mild cognitive decline. A 90-day nurse review dated 10/10/14 documented Tenant #3 fell on 7/12/14 and sustained a rib fracture. Incident reports dated 9/23, 10/11, 10/24, 11/10, 11/18, 11/25, and 12/30/14, and 1/3, 1/7, and 1/8/15 documented Tenant #3 was found on the floor. The incident report of 12/30/14 documented a rug burn to the knee and the incident report of 1/3/15 documented the scab to the knee had opened with the fall. A fax to the physician dated 11/17/14 documented a request for physical therapy/occupational therapy (PT/OT) for improved strength and mobility following " a few falls. " Review of nurse ' s notes dated 11/19/14 documented Tenant #3 stated the falls were due to " passing out. " Notes dated 12/30/14 documented Tenant #3 was found on the floor	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
	S0273	A. BUILDING: _____ B. WING _____	C 02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY	1801 EAST KANESVILLE BLVD CO BLUFFS, IA 51503

(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 47 holding a glass containing " peppermint schnopps (sic). " When interviewed on 2/9/15 at 11:03 a.m.the RN stated the interdisciplinary progress notes with dates 11/24 to 12/12 were 2014 notes from PT. The notes of 12/12 revealed Tenant #3 was discharged from PT. A nurse review was not completed to assess and document the health status of Tenant #3 and to monitor progress related to previous recommendations with a change of condition. 4. Tenant #4, an 81 year-old, was admitted on 1/2/13 and had diagnoses of: chronic obstructive pulmonary disease, osteoarthrosis involving multiple sites, hypertension, depression, anxiety and esophageal reflux. The Program administered medications to Tenant #4. Physician orders dated 9/3/14 documented Tenant #4 had redness to the right arm and staff was to call if the condition worsened. The physician ordered Tenant #4 ' s temperature to be monitored and for speech therapy to see Tenant #4 regarding complaints of choking. Nurse ' s notes dated 9/17/14 documented a 90-day assessment completed by LPN A related to a bed enabler for bed mobility. The 90-day review failed to assess and document the health status of Tenant #4 and monitor progress related to previous recommendations. Nurse ' s notes dated 12/23/14 documented Tenant #4 was on an antibiotic for a sinus infection. The order from the healthcare provider dated 12/23/14 documented the antibiotic was to be given for 10 days and was for acute sinusitis.	A 096		

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A 096	Continued From page 48 Nurse ' s notes dated 1/10/15 at 12:00 p.m. documented Tenant #4 had a temperature of 100 3 degrees. The notes timed 1:15 p.m. documented Tenant #4 had wheezes in the lung. Notes timed 3:00 p.m. documented an inhaler had been prescribed as needed. Review of nurse ' s notes dated 1/11/5 at 10:40 a.m. documented Tenant #4 complained of chest pain and stated " my chest is heavy and fells like I ' m having a heart attack. " Nitrogycerine was given and was effective in relieving the chest pain. Tenant #4 had some audible wheezing and was given a nebulizer treatment. Notes dated 1/12/15 and timed around midnight documented Tenant #4 had chest pain. Tenant #4 was given two nitroglycerin and was still having some discomfort. Tenant #4 did not want to go to the hospital and stated was feeling better. A nebulizer treatment was given. Nurse ' s notes dated 1/12/15 and timed 4:00 p.m. documented Tenant #4 was prescribed an anti-infective for seven days for an upper respiratory infection. Fluids and cranberry juice were encouraged. Notes of 1/23/15 at 4:00 a.m. documented Tenant #4 had dark colored urine and fluids were encouraged. Notes dated 1/24 through 1/26/15 continued to document fluids were encouraged. Notes of 1/31/15 at 2:00 a.m. documented Tenant #4 had a swollen left ankle. Notes dated 2/2/15 documented a urine sample had been obtained with result sent to the physician. Beginning 12/23/14, Tenant #4 was given an antibiotic for acute sinusitis, had a fever and wheezing in the lungs and was prescribed an inhaler and used a nebulizer, was prescribed an	A 096		

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A 096	Continued From page 49 anti-infective for an upper respiratory infection, and had two instances of chest pain requiring the use of nitroglycerin. Tenant #4 had a swollen ankle and dark colored urine for which staff utilized interventions of encouraging fluids and cranberry juice. A urine sample was collected. Tenant #4 had multiple conditions for which standard disease related clinical interventions were implemented as well as staff interventions. Tenant #4 exhibited changes of condition. Nurse reviews were not completed to assess and document the health status and to monitor progress related to previous recommendations with changes of condition. 5. Tenant #8, a 90 year-old was admitted on 5/5/14 with diagnosis of diabetes, hypertension, and peripheral neuropathy. Review of nurse's notes dated 5/13/14 - 5/20/14 documented edema and weeping of lower legs bilaterally. On 5/20/14, nurses notes stated a 30 day, change of condition Nurse Review was conducted. Nurse's notes said the review was conducted due to SN (skilled nursing) orders. No mention of edema or weeping of lower legs could be found in the review. Nurse's notes dated 6/8/14 stated Tenant #8 was transferred to the hospital and later admitted for increased abdominal fluid. Tenant #8 returned to the Program on 6/11/14. A nurse review in nurse's notes dated 6/13/14	A 096		

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A 096	Continued From page 50 stated tenant and family were not happy with home health services and another home health agency for skilled nursing services. There was no mention of why skilled nursing services were required or the tenant's condition following the hospitalization. 90 day nurse review dated 8/19/14 stated there had been no referrals and health status stable. The review made no mention of Tenant #8's hospitalization or edema and weeping of lower extremities. 90 day Nurse Review dated 12/21/14 listed skin tears, falls, and weight loss as health issues. The review made no mention of the status of edema and weeping of lower extremities. Further review revealed nurses notes dated 12/23/14 described a fall and injury to the back of Tenant #8's head that required transfer to the hospital. Nurses notes dated 12/29/14 stated Tenant #8 returned from the hospital with order for physical and occupational therapies. The note also stated Tenant #8 had changed to stand by assistance of 1 person when ambulating. Nurse review, completed on 12/30/14 post hospitalization, failed to address the fall that required hospitalization, injury to the back of the head, and contained no information pertaining to Tenant #8 requiring assistance of 1 when ambulating.	A 096		
A 102	481-69.28(3)c Food Service 481-69.28(231C) Food service. 69.28(3) Menus shall be planned to provide	A 102		

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A 102	Continued From page 51 the following percentage of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program: c. One hundred percent if the program provides three meals per day. This REQUIREMENT is not met as evidenced by: Based on interview and a review of menus, the Program failed to ensure the provision of 100% of the recommended dietary allowances to the tenants. In an interview with the Executive Director on 2/10/15 at 3:30 p.m., he stated the Program served three meals per day. The Program did not use a dietitian in the preparation of menus. The Executive Director stated he did not know if 100% of the dietary allowances were provided, but he trusted the Kitchen Manager's experience of 40 years. In an interview with the Kitchen Manager on 2/11/15 at 9:10 a.m. she stated she was not a dietitian. The Kitchen Manager stated she prepared the menus provided to the monitors dated November and December 2014, and January 2015. Although the Program provided breakfast, breakfast was not on the menu. The Kitchen Manager stated breakfast was served restaurant style. Tenants ordered what they wanted for breakfast and a variety of items were available. The Kitchen Manager stated menus were	A 102		

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A 102	*Continued From page 52* planned based on her past experience and past menus, as well as tenant preference. The Kitchen Manager provided a 1996-1997 menu customized by a food vendor. The menu contained no documentation as to whether or not 100% of the dietary allowances were provided. The Kitchen Manager stated she could not guarantee the menus provided 100% of the dietary allowances.	A 102		

Plan of Correction for Primrose Retirement Community of Council Bluffs for Survey Conducted on February 9-12, 2015

Occupancy Agreement A 000

Page 4 of the Resident Handbook has been changed to state that menus are designed by the Dietary Manager and reviewed by a registered dietician to ensure they are in accordance with USDA guidelines. The registered dietician's license and the revised Occupancy Agreement are attached. The Occupancy Agreement was put into effect on 3/11/15. The registered dietician reviewed the current menu on3/06/15. The dietician will review menus during all quarterly visits.

Medications A 036

In regards to residents #1, #2, #3, #6, #9, #12 and #17. To ensure the problems with transcription and discontinuation will not recur a double check of all new orders by 2 separate LPN's has been initiated. To ensure compliance and monitor performance, a monthly audit of all residents receiving medication administration assistance, past month orders and MARS. Audits will be conducted by our Director of Nursing or our Assistant Director of Nursing. Nursing training was completed on 3/12/15 for all nurses including A and B. Nurses C and D are no longer employed at Primrose.

Occupancy Agreement A 032

The Occupancy Agreement has been changed to include a statement that the tenant landlord law applies to assisted living. It has also been changed to include a statement that the program will notify the tenant at least 90 days in advance of any planned program cessation. The revised Occupancy Agreement is attached. Occupancy Agreement was put into effect on 3/11/15. All current residents will received the attached addendum by 3/19/15.

Evaluation of Tenant A 037

#1 no longer in facility, #2 Change of condition completed 2/20/15, #3 Change of condition completed 2/19/15, and #4 90 day completed and change of condition will be completed on 3/6/15. #8 is no longer in facility. To ensure evaluation of tenant is completed with significant change, RN will review communication log daily for acute changes that may require nurse review and/or change of condition assessment. RN will also review 90 day summary for any patterns that may indicate resident change. To ensure compliance RN will review 10% resident charts quarterly to monitor for change of condition. Will be corrected by 3/14/15. *please see policy attachment for change of condition.

Service Plan A 083

#1 no longer in facility, #2 Updated service plan on 2/20/15, #3 updated service plan on 2/19/15, #5 will update on 3/5/15, #7 will update on 3/5/15, #8 No longer in facility. To ensure service plan is up to date, RN will review communication log daily for acute changes that may require an update of residents personal needs. RN will also review 90 day summary for any patterns that may indicate resident change. To ensure compliance RN will review 10% resident charts quarterly to monitor for appropriateness of service plan. Will be corrected by 3/14/15.

Nurse Review A 094

#2 90 day done on 2/17/15 and change of condition on 2/20/15, #3 change of condition completed 2/19/15, # 4 2/17/15, #7 completed 3/5/2015. To ensure nurse reviews are done in 90 days or a significant change a 90 day schedule has been implemented on 2/13/15 for ADON and back up notification to DON through outlook calendar. To ensure compliance DON will review all 90 day reviews completed by ADON or designee. All 90 day assessments current as of 3/5/15.

Nurse Review A 096

#1 No longer in facility, #2 90 day done on 2/17/15 and change of condition on 2/20/15, #3 change of condition completed 2/19/15, #4 2/17/15, # 8 no longer in facility. To ensure nurse reviews are done in 90 days or a significant change a 90 day schedule has been implemented on 2/13/15 for ADON and back up notification to DON through outlook calendar. DON will review prior and present 90 day for appropriateness of previous recommendations. To ensure compliance DON will review all 90 day reviews completed by ADON or designee. All 90 day assessments current as of 3/5/15.

Food Service A 102

A registered dietician will review menus to ensure 100% of the daily recommended dietary allowances. The registered dietician's license is attached. The registered dietician reviewed the current menus on 3/06/15. They will be reviewed on all quarterly visits.