IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #: 51998-I

May 11, 2015

Ms. Randee Blietz, Executive Director
Garden View Senior Community
800 Darby Drive
Monona, IA 52159

RE: I. Final Recertification & Complaint/Incident Investigation Report – Garden View Senior Community
II. Reduction of Civil Penalty
III. Informal Conference
IV. Standard Certificate
V. Conclusion

Dear Ms. Blietz:

I. Final Recertification & Complaint/Incident Investigation Report – Garden View Senior Community, Monona, IA

Enclosed is the **Final Recertification & Complaint/Incident Investigation Report ("Report")** issued by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **April 28 & 29, 2015.**

Based on review of Tenants #1, #2, #3, #4 & #5's files, medication administration records and narcotic sheets, review of investigation notes, review of medication administration policies and procedures, review of staff schedules, observation of two medication passes, observation of a shift to shift narcotic count and staff interviews, the Program reported a diversion of 44 narcotic pills that were removed from the medication cassettes for Tenants #1, #2, #3, #4, and #5 and replaced with over the counter medications. The pharmacy notified the Program of the situation, met with the Program Nurse and Executive Director. The Program conducted staff interviews with all staff that had access to medications, but a clear perpetrator was not identified. The local police department and the Department were notified. The Program immediately changed the medication process from using cassettes to using bubble packs

and moving medications from a medication room to the tenant's apartment. All narcotics were placed in a metal lock box, adhered to the bottom of a locked drawer in the tenants' apartments. All staff were re-educated regarding the new medication administration policies.

The Report notes Regulatory Insufficiencies in the area(s) of: Program policies and procedures, Service Plans, Food Service, Dementia Specific Education for Program Personnel and Structural Requirements found during the survey for recertification that was conducted.

Garden View Senior Community ("Program") is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.17(1)(b), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

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

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

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

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

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

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and

(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of Service Plans during the incident investigation of February 19, 2015.

The determination of a **$500 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Service Plans. As the enclosed Report details, the Program failed to update Service Plans when tenants had significant changes in condition.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.17(5). If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the **State of Iowa** in the amount of **three hundred twenty five dollars ($325)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

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

IV. Standard Certificate

The recertification process has not been completed as the Department has not received your application for recertification and corresponding policies and procedures. In addition, the State Fire Marshal's (SFM) inspection report has not been received for your program. The certificate will be sent when the process has been completed.

V. Conclusion

The Program is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0215	A. BUILDING: _____ B. WING _____	C 04/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW SENIOR COMMUNITY	800 DARBY DRIVE MONONA, IA 52159

(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: 18 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 19 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 4 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 5 TOTAL census of Assisted Living Program: 24 The following regulatory insufficiencies were cited during the Recertification and investigation of Incident #51998-I.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by:	A 003		

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A 003	Continued From page 1 (Recertification) Based on review of policies and procedures and observation of a medication pass, staff did not follow policies and procedures for destruction of medications. Per observation of Staff B during a medication pass, a narcotic medication was dropped and was not destroyed as indicated in the policies and procedures for dropped medications. On 4-28-15 at 2:10 p.m., Staff B started a medication pass. She washed her hands, unlocked the medication drawer and removed the bubble pack for Tramadol from the locked narcotic box. As she punched the medication out of the bubble pack, the pill missed the medication cup and landed in the medication drawer. Staff B picked up the pill with bare hands, placed it in the medication cup and administered it to the tenant. According to the Medication Documentation on Medication Administration Record (MAR) policy, for medication dropped/soiled: Follow policy for destruction of medications. According to the Destruction of Medications policy, a controlled drug would be destroyed by the RN; a note would be placed in the tenant's record indicating the date, the name of the medication, the RX number and quantity of the medication. The note would be signed by the RN that destroyed the medication and the executive director. Staff B did not follow the procedure for a dropped medication.	A 003		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum:	A 089		

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A 089	Continued From page 2 a. The tenant ' s identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: (Recertification) Based on review of tenant files, (two of five files), service plans were not individualized to identify the tenants' identified needs and preferences for assistance. Per review of Tenants' #4 and #5 files, service plans were not individualized to reflect the tenants' identified needs and preferences for assistance. 1. Tenant #4, a 92 year old, was admitted on 4-20-12 and diagnoses included: senile dementia, hypertension, hypothyroidism and arthritis. Tenant #4 was staged at a four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. According to a Nurse Review dated 4-3-15, Tenant #4 used a wheelchair as primary mode of transportation and was able to propel independently. Tenant #4's service plan dated 4-3-15 reflected a notation dated 10-2-14 to provide escort assistance to meals/activities as needed. The service plan was not updated to reflect Tenant #4's ability to propel the wheelchair independently. The service plan did not indicate Tenant #4's identified needs and preferences for assistance with mobility, transfer, grooming, meals or activities The service plan was not updated to reflect Tenant #4's identified needs and preferences for assistance. 2. Tenant #5, a 77 year old, was admitted on 7-3-13 and diagnoses included: Alzheimer's, hypertension and urinary tract infections (UTI's). Tenant #5 was staged at a six on the GDS which	A 089		

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A 089	Continued From page 3 indicated severe cognitive decline. According to Tenant #5's service plan dated 3-11-15, a notation dated 2-6-14 reflected Tenant #5 had a history of recurrent UTI's. Staff would assist with toileting and provide pericare as needed; however, the service plan did not indicate the use of antibiotics for UTI's. According to a physician order dated 4-18-15, Tenant #5 was to take Ciprofloxacin 250 mg, one tablet by mouth two times a day for ten days. The service plan was not updated to reflect the initiation of the antibiotic for the treatment of the UTI.	A 089		
A 092	481-69.26(4)d Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant ' s abilities and personal interests This REQUIREMENT is not met as evidenced by: (Recertification) Based on review of tenant files, two of five files for tenants who were unable to plan their own activities, including tenants with dementia, were not individualized to indicate planned and spontaneous activities based on the tenant's abilities and personal interests. Per review of files for Tenants #4 and #5, the service plans were not individualized to include planned and spontaneous activities based on the tenant's abilities and personal interests for tenants who were unable to plan their own activities, including tenants with dementia.	A 092		

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A 092	Continued From page 4 1. Tenant #4, a 92 year old, was admitted on 4-20-12 and diagnoses included: senile dementia, hypertension, hypothyroidism and arthritis. Tenant #4 was staged at a four on the GDS which indicated moderate cognitive decline. Tenant #4's service plan dated 4-3-15, indicated an onset date of 7-10-14 that Tenant #4 had cognitive loss/dementia as evidenced by short-term memory loss, repetitive statements and impaired judgement. Tenant #4's service plan did not include planned and spontaneous activities. 2. Tenant #5, a 77 year old, was admitted on 7-3-13 and diagnoses included: Alzheimer's, hypertension and UTI's. Tenant #5 was staged at a six on the GDS which indicated severe cognitive decline. According to Tenant #5's service plan completed on 3-11-15, a notation dated 11-4-14, interventions to try when tenant is anxious: talking about family, looking at pictures and listening to music; however, it did not includet planned and spontaneous activities.	A 092		
A 104	481-69.28(5) Food Service 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by:	A 104		

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A 104	Continued From page 5 (Recertification) Based on staff file reviews, three of seven files reviewed indicated an orientation on sanitation and safe food handling prior to handling food or an annual in-service training on food protection was not completed. Per review of staff files, Staff A, B and C did not complete an orientation on sanitation and safe food handling prior to handling food or an annual in-service training on food protection. Staff A, a UW, was hired on 4-12-13 and assisted with meal service. Staff A did not have annual in-service training on food protection. Staff B, a UW, was hired on 2-9-15 and assisted with food preparation and meal service. Staff B did not have an orientation on sanitation and safe food handling prior to handling food. Staff C, a UW, was hired on 11-11-13 and assisted with meal service. Staff C did not have annual in-service training on food protection.	A 104		
A 123	481-69.30(3) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(3) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced	A 123		

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A 123	Continued From page 6 by: (Recertification) Based on review of staff files, three of seven staff did not have a minimum of eight hours of dementia-specific continuing education annually. Per review of staff files, Staff A, C and D, all direct-contact staff, did not have a minimum of eight hours of dementia-specific continuing education annually. Staff A, a UW, was hired on 4-12-13 and completed four hours of dementia-specific continuing education. Staff A did not have a minimum of eight hours of dementia-specific continuing education annually. Staff C, a UW, was hired on 11-11-13 and did not have any dementia-specific continuing education annually. Staff D, a UW/Kitchen Aide, was hired on 7-15-05, and did not have any dementia-specific continuing education annually.	A 123		
A 154	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: (Recertification) Based on monitor observations, the Program did not maintain a safe environment in the dementia-specific unit.	A 154		

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A 154	Continued From page 7 Per observation of an open, unlocked double door office/closet area in the dementia-specific unit, chemicals were within view and easily accessible to anyone. On 4-29-15 at 8:14 a.m., the monitor observed the office/closet doors in the dementia-specific unit open. On the computer stand was a bottle of Purell Advanced Hand Sanitizer and a bottle of Equate Cocoa Butter. Both bottles had a warning that indicated they were for external use only. The bottle of Purell also indicated to Keep Out Of Reach Of Children. The office/closet was approximately two and one half feet from the dining room table, easily accessible by all tenants who resided in the dementia-specific unit. Monitor observed tenants seated at the dining table, both at meal times and other times.	A 154		
A205	481-69.28(6) Food Service 69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. This REQUIREMENT is not met as evidenced by: On 4-28-15, at 5:00 p.m., the monitor observed staff preparing Reuben sandwiches, french fries and pears. Staff D was asked if the meat had been temperature checked and she responded no. After making the Reuben sandwiches, Staff	A205		

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A205	Continued From page 8 E obtained the thermometer from the drawer and checked the temperature of the meat inside the first two sandwiches. She stated she was expecting a temperature of 140 degrees. None of the remaining food items served were checked for appropriate temperatures. On 4-29-15 at 8:03 a.m., the monitor observed staff making toast, plating scrambled eggs, baked cinnamon rolls and fruit cocktail. Food items served were not checked for appropriate temperatures. On 4-29-15 at 11:53 a.m., the monitor observed staff making pork sandwiches and plating potato salad and baked beans. Food items served were not checked for appropriate temperatures. On 4-29-15 at 12:08 p.m., the Dietary Manager was asked if food items served were checked for the appropriate serving temperature. She stated she had checked the temperature of the pork while it was in the oven at 11:30 a.m. She stated the other food items had not been checked for serving temperatures.	A205		

May 20, 2015

Rose Boccella
Iowa Department of Inspections & Appeals
Health Facilities Division
321 East 12th Street
Des Moines, IA 50319-0083

Dear Rose Boccella,

Below is the Plan of Correction for Garden View Senior Community in response to the Final Recertification & Complaint/Incident Investigation Report received on May 11, 2015.

Program Policies & Procedures

A. Staff will follow Medication Documentation on Medication Administration Record (MAR) policy for medication dropped/soiled and follow the policy for destruction of medications by notifying the nurse of any dropped medications to be disposed of properly.
   a. Facility reviewed & revised dropped medications policy on 5/15/2015.
   b. Facility's registered nurse completed individual coaching on the policy for dropped medications with Staff B on 5/19/2015.
   c. Facility's registered nurse will complete delegation of revised dropped medication policy to noncertified staff in accordance with requirements in 655-Chapter 6 governing nurse delegation, by 5/29/2015.
   d. Periodic medication pass audits will be completed by the facility registered nurse.

Service Plans

A. Tenant #4 A service plan will be updated to identify the individual needs and preferences for assistance with mobility, transfer, grooming, meals and activities.
   a. Attached is a copy of the flow chart provided by the Dept. of Inspections & Appeals that will be used to determine if an evaluation does warrant a service plan update.
   b. Monthly chart audits of tenant's files will be conducted by facility's registered nurse.
   c. On 5/14/2015, service plan was updated by facility's registered nurse to reflect Tenant #4's current cares and strengths.

B. Tenant #5, in regards to updating service plan to reflect initiation of antibiotic treatment for a UTI.
   a. Tenant #5 was discharged from the program to a higher level of care on 5/9/2015.

Service Plans

A. Tenant #4 The service plan will include planned and spontaneous activities based on the tenant's abilities and personal interests when they are unable to plan their own activities due to cognitive loss.
   a. Attached is a copy of the flow chart provided by the Dept. of Inspections & Appeals that will be used to determine if an evaluation does warrant a service plan update.
   b. Monthly chart audits of tenant's files will be conducted by facility's registered nurse.
   c. On 5/14/2015, registered nurse updated Tenant #4's service plan to reflect planned and spontaneous activities based on the tenant's abilities and interests.

B. Tenant #5, in regards to the service plan including planned and spontaneous activities based on the tenant's abilities and personal interests when they are unable to plan their own activities due their diagnosis of dementia.
   a. Tenant #5 was discharged from the program to a higher level of care on 5/9/2015.

Food Service

A. Personnel who are employed by the program and are responsible for both food preparation and service shall have orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection.
   a. Staff A received annual in-service training on food protection on 5/18/2015.
   b. Staff B received orientation on sanitation and safe food handling on 5/20/2015.
   c. Staff C received annual in-service training on food protection on 5/18/2015.
   d. Facility Executive Director will conduct training audits of 2 employee files monthly.
   e. By 5/29/2015, all staff responsible for food preparation and service will receive annual in-service training on food protection.

Dementia-specific Education for Personnel

A. Staff A, hired on 4/12/2013, will have a minimum o f eight hours of dementia-specific continuing education annually.
   a. By 5/29/2015, Staff A will have completed 8 hours of annual dementia training.
   b. Facility Executive Director will conduct training audits of 2 employee files monthly.

B. Staff C, hired on 11/11/2013, will have a minimum o f eight hours of dementia-specific continuing education annually.
   a. By 5/29/2015, Staff C will have completed eight hours of dementia-specific continuing education annually. Staff C currently has 8.5 hours of dementia-specific training for the current year.
   b. Facility Executive Director will conduct training audits of 2 employee files monthly.

C. Staff D, hired on 7/15/2005, has eight hours of dementia-specific continuing education for previous year. Staff D currently has 3.15 hours of dementia-specific training for the current year.
   a. By 6/30/2015, Staff D will have an additional 4.5 hours of dementia specific education towards eight hours of dementia-specific continuing education.
   b. Facility Executive Director will conduct training audits of 2 employee files monthly.

Structural Requirements

A. The program will maintain a safe environment in the dementia-specific unit by keeping chemicals or products labeled Keep Out of Reach of Children or for external use only, locked at all times.
   a. The program has moved all chemicals or products labeled Keep Out of Reach of Children or for external use only to a locked cabinet.
   b. Facility Director will provide re-education of all staff by 5/29/2015.
   c. Facility Director will perform periodic audits of dementia-specific unit.

Food Service

A. A program engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food, by checking that cooking temperatures are reached and maintained according to regulations, laws, and standardized recipes while cooking.
   a. On 5/1/2015, the program began logging food temperatures on current menu posted in kitchen.
   b. By 5/29/2015, all staff responsible for food preparation and service will receive annual in-service training on food protection.
   c. Facility Executive Director will conduct periodic audits of meal preparation.

This concludes Garden View Senior Community's Plan of Correction in response to the Final Recertification & Complaint/Incident Investigation Report.

Sincerely,

Randee Blietz, Executive Director
Garden View Senior Community
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