IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
52764-C
53049-C

June 8, 2015

Ms. Misty Whitt, Executive Director
Allen Place
1406 East 19th Street
Atlantic, IA 50022

RE: Final Initial Certification Monitoring Evaluation and Complaint/Incident Investigation Report, Allen Place, Atlantic, Iowa

Dear Ms. Whitt:

Enclosed is the **Final Initial Certification Monitoring Evaluation and Complaint/Incident Investigation 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 an investigation by DIA on **June 1 - 3, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Staffing, Evaluation of Tenant, Service Plans and Nurse Review.

An initial certification visit and complaint investigation was completed. There were no regulatory insufficiencies related to the investigation of 52764-C in the areas of Medication Management and Tenant Rights.

Allegation: Medication Management
Findings: Unsubstantiated
Comments: Based on interviews and record review, the Program administered medications as prescribed. Staff administering medications had received training. Medication Administration Records (MAR) included the name of the medication and purpose for which it was given. It could not be determined there were any adverse outcomes due to medication errors. This portion of the complaint was not substantiated.

Allegation: Tenant Rights
Findings: Unsubstantiated
Comments: Based on interviews and record review, the Program did not violate tenant rights. Tenants generally expressed satisfaction with the program. They did not feel their rights were infringed upon. This portion of the complaint was not substantiated.

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.

Enclosed you will find the Assisted Living Program Certificate **S0347** with effective dates of **March 16, 2015 through March 15, 2017**. This certificate is to be posted in the building for public viewing.

If you have any questions in regard to the enclosed 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
	S0347	A. BUILDING: _____ B. WING _____	C 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEN PLACE	1406 EAST 19TH STREET ATLANTIC, IA 50022

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A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 27 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site: 33 TOTAL census of Assisted Living Program: 33 No regulatory insufficiencies were found during the investigation of Complaint 42764-C. The following regulatory insufficiencies were cited during the initial certification and the investigation of Complaint 53049-C:	A 000		
A 059	481-67.9(4)b Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program ' s registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	A 059		

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A 059	Continued From page 1 Program's registered nurse (RN) did not ensure staff were trained and could competently meet the needs of the tenants within 30 days of employment. Five personnel files were reviewed. Record review of personnel files on 6-2-15 revealed Staff A and Staff B, universal workers both hired on 2-6-15, had not received training from an RN within 30 days of employment. When interviewed on 6-2-15 at 3:30 p.m. the Executive Director and Interim RN confirmed the Program could not produce documentation to confirm Staff A and B had been trained.	A 059		
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 observations, interview and record	A 037		

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A 037	Continued From page 2 review, evaluations were not completed within 30 days of admission and with a significant change of condition. Five tenant files were reviewed. 1. Tenant #1, an 81 year-old was admitted on 12-26-11 and had diagnoses of: dementia, hypertension, hyperlipidemia and macular degeneration. On 4-21-15, Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 had cognitive and health evaluations completed on 4-21-15; however a functional evaluation had not been completed. When interviewed on 6-1-15, the Interim Nurse said the forms used for evaluations had been revised and the section for evaluating function had been left off the form; therefore, she had not evaluated Tenant #1's functional status. 2. Tenant #2, an 80 year-old, was admitted on 12-26-11 and had diagnoses of: diabetes, dementia hypertension, osteoarthritis, osteoporosis, and pulmonary edema. Evaluations completed 3-24-15 did not include an evaluation of function. 3. Tenant #3, a 92 year-old, was admitted on 4-27-15 and had diagnoses of: hypokalemia, bilateral lower leg edema, and urinary tract infection. Evaluations were not completed within 30 days of admission. Initial evaluations dated 4-27-15 for Tenant #3 documented Tenant #3 took medications independently, was alert and oriented, had no skin breakdown, and required assistance of one to transfer. Resident services notes dated 4-30-15 completed by physical therapy documented	A 037		

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A 037	Continued From page 3 Tenant #3 was confused, recommended two persons for transfer, and expressed concern that Tenant #3 was not managing medications appropriately. Resident service notes dated 4-30-15 completed by Interim RN A, documented Tenant #3 reported taking own medications; however, Interim RN A found Tenant #3 had only taken one antibiotic since admission. Tenant #3 agreed to let the Program administer medications. Notes of 5-7-15 documented Tenant #3 had "a couple of red areas" on the buttocks. A fax to the physician dated 5-6-15, requested cream for the reddened buttocks. A fax dated 5-15-15 documented a request to the physician for edema wear for lower leg swelling. A fax dated 5-19-15 documented a request to crush Tenant #3's medication due to difficulty swallowing medications. On 5-7-15 the physician wrote an order to work on nursing home placement. Evaluations were not completed with significant changes of condition. 4. Tenant #4, an 82 year-old, was admitted on 12-31-11 and had diagnoses of: senile dementia, diabetes, chronic obstructive pulmonary disease, and hypertension. Resident services notes dated 4-6-15 documented Tenant #4 was found on the floor complaining of knee pain. Tenant #4 was transported to the hospital. A home health case communication report dated 4-9-15 documented Tenant #4 had fractures of the right knee and was hospitalized 4-6 to 4-7-15. Tenant #4 was using a knee immobilizer over an ace wrap. The physician electronically signed the case communication report with orders for touch weight bearing for transfer to a wheelchair. A physician's order dated 4-7-15 documented	A 037		

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A 037	Continued From page 4 Tenant #4 required a wheelchair with right leg elevation leg rest. The case communication report dated 4-9-15 also documented Tenant #4 was found to have low oxygen levels and was transported to the hospital. Tenant #4 was to wear the CPAP breathing equipment while in bed resting and at all times while sleeping. Evaluations were not completed with a change of condition.	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 observations, interview and record reviews, service plans were not based on evaluations and developed to meet the specific needs of individual tenants. Five tenant files were reviewed. Complaint 53049-C alleged service plans did not meet tenants' needs. 1. Tenant #1, an 81 year-old was admitted on 12-26-11 and had diagnoses of: dementia, hypertension, hyperlipidemia, GERD and macular degeneration. On 4-21-15, Tenant #1	A 083		

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A 083	Continued From page 5 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 had a service plan completed on 4-21-15. Review of Universal Incident Reports for Tenant #1 revealed on 4-20-15 at 7:15 a.m. staff found Tenant #1 on the floor of the apartment bathroom. According to the report, the tenant may have been attempting to use the bathroom. A notation on the incident report by the Interim Nurse said "frequent toileting". On 4-21-15 staff noted Tenant #1 was found lying on the floor next to the bed. The Interim Nurse made a note to complete "frequent checks". On 4-28-15 staff noted Tenant #1 was found on the floor lying by the bedroom door and was hostile, hitting and biting. During interviews on 6/1 - 6/2/15, Staff C, D and E, universal workers, said Tenant #1 lay on the floor in the common areas of the facility. They all indicated administration had approved of this behavior as long as staff made sure Tenant #1 was comfortable. Staff also mentioned Tenant #1 argued with a spouse. All three staff said they took Tenant #1 to the bathroom on a regular schedule to decrease the behavior of attempting to urinate in public which resulted in exposure of genitals in the dining room. Review of documentation confirmed no further incidents of public urination after 4-13-15. Laying on the floor was not confirmed by observations during the on-site visit. The service plan was updated on 4-21-15 but did not include interventions to address Tenant #1's increased aggressive and inappropriate behavior	A 083		

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A 083	Continued From page 6 which included laying on the floor in the common area of the building and attempting to urinate in public. The service plan did not identify and meet the specific needs of Tenant #1. At the time of the exit interview on 6-3-15, the Executive Director confirmed the Program had not included needed interventions in Tenant #1's service plan. 2. Tenant #2, an 80 year-old, was admitted on 12-26-11 and had diagnoses of: diabetes, dementia hypertension, osteoarthritis, osteoporosis, and pulmonary edema. A physician's order dated 3-6-15 prescribed Seroquel 25 milligrams (mg) twice a day to Tenant #2 for behaviors. The March 2015 medication administration record (MAR) documented Ativan was to be given every four to six hours as needed for anxiety. The MAR documented the medication was given at least 25 times during the month of March 2015. The April 2015 MAR documented Ativan was given at least seven times. A fax to the physician dated 4-17-15 documented Tenant #2 had insomnia every night. Resident service notes for Tenant #2 dated 4-14-15 documented Tenant #2 was very agitated. Notes dated 4-16-15 documented Tenant #2 was afraid of the spouse. Notes dated 5-25-15 documented Tenant #2 was visibly upset, looking for a baby, and could not find it. The service plan for 3-24-15 to 4-30-15 did not identify Tenant #2's behavior and did not identify non-drug interventions for behaviors. The service plan did not give direction to staff as to behaviors Tenant #2 would exhibit to prompt the need for the "as needed" medication for anxiety. 3. Tenant #3, a 92 year-old, was admitted on 4-27-15 and had diagnoses of: hypokalemia, bilateral lower leg edema, and urinary tract	A 083		

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A 083	Continued From page 7 infection. Resident service notes dated 4-30-15 completed by Interim RN A documented Tenant #3 reported taking own medications; however, Interim RN A found Tenant #3 had only taken one antibiotic since admission. Tenant #3 agreed to let the Program administer medications. Notes of 5-7-15 documented Tenant #3 had "a couple of red areas" on the buttocks. A fax to the physician dated 5-6-15 requested cream for the reddened buttocks and documented the Program was repositioning Tenant #3 frequently. The initial service plan dated 4-27-15 was not updated when Tenant #3 allowed the Program to administer medications, and was not updated with interventions, including frequent repositioning, for reddened buttocks. 4. Tenant #4, an 82 year-old, was admitted on 12-31-11 and had diagnoses of: senile dementia, diabetes, chronic obstructive pulmonary disease, and hypertension. Resident services notes dated 4-6-15 documented Tenant #4 was found on the floor complaining of knee pain. Tenant #4 was transported to the hospital. A home health case communication report dated 4-9-15 documented Tenant #4 had fractures of the right knee and was hospitalized 4-6 to 4-7-15. Tenant #4 was using a knee immobilizer over an ace wrap. The physician electronically signed the case communication report with orders for touch weight bearing for transfer to a wheelchair. A physician's order dated 4-7-15 documented Tenant #4 required a wheelchair with right leg elevation leg rest. The case communication report dated 4-9-15 also documented Tenant #4 was found to have low oxygen levels and was transported to the hospital. Tenant #4 was to wear the CPAP	A 083		

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A 083	Continued From page 8 breathing equipment while in bed resting and at all times while sleeping. The current service plan dated 2-9-15 did not direct staff in the care of Tenant #4 with a right knee fracture and the use of a knee immobilizer, ace wrap, touch weight bearing, and the need for a right leg elevation leg rest. The service plan did not direct staff in the use of the CPAP breathing equipment.	A 083		
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 observations, interview and record review nurse review was not completed with a significant change in condition to assess and document health status and monitor progress related to previous recommendations. Five tenants files were completed. 1. Tenant #3, a 92 year-old, was admitted on 4-27-15 and had diagnoses of: hypokalemia, bilateral lower leg edema, and urinary tract	A 096		

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A 096	Continued From page 9 infection. Tenant #3 was admitted to the Program with a prescription for an antibiotic following a diagnosis of urinary tract infection. Resident service notes dated 4-30-15 completed by Interim RN A documented Tenant #3 reported taking own medications; however, Interim RN A found Tenant #3 had only taken one antibiotic since admission. Tenant #3 agreed to let the Program administer medications. Notes of 5-7-15, a late entry completed by Staff E, documented Tenant #3 had bloody urine. A nurse review was not completed following antibiotic administration to assess and document the health status of Tenant #3 and to monitor progress related to the urinary infection and antibiotic administration. 2. Tenant #4, an 82 year-old, was admitted on 12-31-11 and had diagnoses of: senile dementia, diabetes, chronic obstructive pulmonary disease, and hypertension. In an interview with the Executive Director on 6-2-15 at 2:50 p.m. she stated Tenant #4 was in the hospital for the knee fracture and returned to the Program on 4-7-15. The Executive Director reported Tenant #4 was not doing well and not eating well and left the Program on 4-12-15. A physician's order dated 4-10-15 documented oxygen levels were to be checked hourly while Tenant #4 was awake and a nutritional supplement was to be given twice a day. The clinical record lacked documentation of Tenant #4's condition after 4-6-15. A nurse review was not completed with a significant change of condition.	A 096		

June 19, 2015

Ms. Rose Boccella, Program Coordinator

Adult Services Bureau

Iowa Department of Inspections and Appeals

Lucas State Building

321 East 12th Street

Des Moines, IA 50319-0083

RE: Allen Place Plan of Correction

Dear Ms. Boccella

Enclosed is the required "Plan of Correction" regarding the Final Initial Certification Monitoring Evaluation Report at Allen Place which was conducted on June 1st-June 3rd, 2015. Submission of this response of the Plan of Correction is not a legal admission that a deficiency exists, or that the Statement of Deficiencies was correctly cited, and is also not to be constructed as an admission against interest by the residence, or any employees, agents or other individuals who drafted or may be discussed in the response on the Plan of Correction. In addition, preparation and submission of the Plan of Correction does NOT constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

IAC r 481-67.9(4)b – Staffing

- Regional Director of Care Services will conduct nurse delegation training with staff members A & B on 6/11/15. The new program nurse starts on 6/29/15 and she will document her own review of nurse delegation training with staff members by 8/25/15.
- Executive Director will conduct an audit for all staff members to ensure nurse delegation procedure training is complete by 6/12/15.
- Regional Director of Operations or Regional Director of Care Services will audit employee files for completion of orientation including delegation procedures monthly for the next 3 months and bi-annually thereafter.

IAC r 481-69.22(2) – Evaluation of Tenant

- A functional health status assessment was added to the programs physical assessment as of 6/5/15.
- Care Service Manage or Regional Director of Care Services will ensure all residents receive a functional, cognitive, and health status assessment by 9/1/15. The program Regional Director of Operations, Regional Director of Care Services, Executive Director, or Care Services Manager will monitor quarterly thereafter.

- Regional Director of Care Services and Regional Director of Operations will conduct an in-service with Executive Director and Care Service Manager to provide training and instruction on how to ensure 30 day assessments are completed on all residents by 7/1/15.
- Regional Director of Operations or Regional Director of Care Services will conduct monthly audits to ensure 30 day assessments are completed for all new admissions for the next 3 months and quarterly thereafter.
- Regional Director of Operations or Regional Director of Care Services will conduct an in-service with Executive Director and Care Service Manager to provide training and instruction on updating assessments with significant change in condition by 7/1/15.
- Regional Director of Operations or Regional Director of Care Services will conduct monthly audits to ensure significant change in conditions are being updated into the assessments appropriately monthly for the next 3 months and quarterly thereafter.

IAC r 481-69.26(1) – Service Plans

- The Care Services Manager will conduct a functional evaluation for Tenants #1, #2, and #3 a change to the plan to include functional, health, and cognitive evaluations will then be produced to support the resident's current needs by 7/3/15.
- Tenant #4 is no longer a resident as of 6/8/15 and has moved to a Skilled Nursing Facility.
- The Care Services Manager will be reeducated by Regional Director of Care Services on the Iowa regulations to include significant change of condition requirements. This will be completed by 7/10/15.
- The Regional Director of Care Services or designee will do a monthly audit on randomly selected residents to ensure proper documentation and assessments are being completed with a significant change in condition. This will be conducted for the next 6 months.

IAC r 481-69.27(3) – Nurse Review

- Tenant #4 is no longer a resident as of 6/8/15 and has moved to a Skilled Nursing Facility.
- Executive Director and Care Services Manager will be educated by the Regional Director of Operations and Regional Director of Care Services on following proper procedure when a resident has a significant change in condition by 7/10/15.
- The Care Services Manager will conduct a full nursing review for Tenant #3 and create a care plan with information obtained to support the resident's current needs by 7/3/15.
- The Regional Director of Care Services or designee will do a monthly audit on randomly selected residents to ensure proper documentation and nurse reviews are being completed with a significant change in condition. This will be conducted for the next 6 months.

Date of completion for the Plan of Correction is September 1st, 2015.

Sincerely,

Misty Whitt

Misty Whitt

Executive Director/Allen Place