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
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #: 56261-C

February 3, 2016

Ms. Gladys Rainey, Administrator
Rose of Waterloo
421 Oak Avenue
Waterloo, IA 50703

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL RECERTIFICATION & COMPLAINT/INCIDENT INVESTIGATION REPORT - ROSE OF WATERLOO
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Rainey:

I. Final Recertification & Complaint/Incident Investigation Report – Rose of Waterloo, Waterloo, 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 **January 11 - 25, 2016.**

A recertification visit and the investigation of Complaint #56261-C were completed. There were regulatory insufficiencies cited related to the recertification visit and during the course of the investigation of Complaint #56261-C. The regulatory insufficiencies are indicated on the enclosed report.

The following allegation was investigated in regards to Complaint #56261-C:

Allegation: Medication Management
Findings: Unsubstantiated
Comments: Review of tenant files and review of Program documents did not reveal a regulatory insufficiency related to medication management.

The Report notes Regulatory Insufficiencies in the area(s) of: Mandatory Reporting of Dependent Adult Abuse, Tenant Rights, Staffing, Evaluation of Tenant and Service Plans.

Rose of Waterloo ("Program") is being assessed a **$5,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a), (b) and 481 IAC 67.17(1)(a), (b).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.17(1)(a), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000 and the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

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

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

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

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

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

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

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;

(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The determination of a **$5,500 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm to a tenant and for repeated Regulatory Insufficiencies in the areas of: Evaluation of Tenant and Service Plans. As the enclosed Report details, the Program stopped providing services to a tenant for 6 days because the tenant's apartment had fleas. The tenant was admitted to the hospital and did not return to the Program.

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 thousand five hundred seventy five dollars ($3,575)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

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

IV. Conclusion

The Program is being assessed a **$5,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a), (b) and 481 IAC 67.17(1)(a), (b).

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

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

Sincerely,

Jim Friberg

Jim Friberg, 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
	S0266	A. BUILDING _____ B. WING _____	C 01/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF WATERLOO	421 OAK AVENUE WATERLOO, IA 50703

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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.	A 000		
	General Population Program Number of tenants without cognitive disorder: 52 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 56 TOTAL census of Assisted Living Program: 56 A recertification visit was conducted to determine compliance with certification for an Assisted Living Program. Complaint #56261-C was also investigated. The following regulatory insufficiencies were identified related to Complaint #56261-C and the recertification visit: Iowa Code 235B.16.5.b A person required to report cases of dependent adult abuse pursuant to section 235B.3 other than a physician whose professional practice does not regularly involve providing primary health to adults, shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment or self-employment which involves the examination, attending, counseling or treatment of adults on a regular basis. Within one month of initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person's employer or, if self-employed, from the department. The person shall complete at least two hours of additional dependent adult abuse identification and reporting training every			

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A 000	Continued From page 1 five years. This Requirement is not met as evidenced by: Based on review of staff files and Program documents the Program failed to have staff complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment for two of seven staff files reviewed (Staff A and D). Two staff did not have two hours of training related to the identification and reporting of dependent adult abuse within six months of employment. (Recertification) 1. Staff A, a home health aide (HHA), was hired on 2-18-15. Staff A had a Certificate of Completion document for a two hour combined dependent adult and child abuse mandatory reporting training. The date of the training was 2-24-15. The training was completed within six months of employment; however, the course was a combined two hour course and not two hours of dependent adult abuse training Staff A did not complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment. 2. Staff D, a HHA, was hired on 6-3-15. Staff D had a Certificate of Completion document for a two hour combined dependent adult and child abuse mandatory reporting training. The date of the training was 6-3-15. The training was completed within six months of employment; however, the course was a combined two hour course and not two hours of dependent adult abuse training. Staff D did not complete two hours of training relating to the identification and	A 000		

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A 000	Continued From page 2 reporting of dependent adult abuse within six months of initial employment. 3. According to the Program's training plan, within 30 days of hire HHA staff would complete the following, or could provide documentation of the following including: mandatory child and dependent adult abuse (within the last five years).	A 000		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on review of a tenant file, staff interviews, review of hospital records and review of Program documents the Program failed to maintain Tenant #2's rights, including providing care, treatment and services which were adequate and appropriate. Tenant #2's service plan indicated staff was to provide assistance with cares for Tenant #2. Due to an alleged issue with fleas in Tenant #2's apartment, staff did not provide the necessary services. (Complaint #56261-C) 1. Tenant #2, an 89 year old, was admitted on 8-29-13 and diagnoses included: congestive heart failure (CHF) with chronic atrial fibrillation, peripheral artery disease, type 2 diabetes mellitus, weakness, sleep apnea, chronic renal	A 013		

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A 013	Continued From page 3 disease/insufficiency, hypernatremia and history of alcohol abuse. Tenant #2 scored a 10 on the scored cognitive evaluation, which indicated no or mild cognitive impairment. Tenant #2 was given a 30 Day Notice of Non-Renewal and Termination of Lease dated 10-29-15. The document indicated Tenant #2's occupancy would be terminated on 11-30-15. Tenant #2 was discharged on 10-31-15. According to a Physician Interim Orders document dated 10-23-15, a verbal order was received to admit Tenant #2 for home health services, a skilled nursing visit once a week, home care aide one to two times per day (five to seven times per week), homemaking 25 hours per month and physical therapy to evaluate and treat. According to a Physician Interim Orders document dated 11-23-15, Tenant #2 was discharged from home health on 10-31-15 and was admitted to the hospital. According to Clinical Nurses Notes dated 10-22-15, Tenant #2 was admitted for home health services due to incontinence issues. Clinical Nurses Notes dated 10-26-15 indicated Tenant #2 "apparently has fleas again." A pest company was coming in the morning to confirm and would treat on Wednesday (10-28-15). An aide went in that morning and had fleas all over her. Services could not be provided until the "problem" was handled. Tenant #2 was informed of it as was Staff H (maintenance). Tenant #2 asked if they had seen the fleas and was told the pest company would confirm tomorrow (10-27-15). The service plan was updated. A Medical/Functional/Cognitive Assessment dated 10-22-15 indicated Tenant #2 had bilateral 2+ pitting edema and Tenant #2 was dependent	A 013		

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A 013	Continued From page 4 for bathing, ambulation, personal laundry and managing medication. Tenant #2 needed assistance with transfers, dressing/grooming and light housekeeping. Tenant #2 was independent with toileting, eating and preparation of light meals. According to a Drug Regimen Review document regarding Tenant #2 dated 10-22-15, Tenant #2 demonstrated non-compliance with medication use as prescribed by the physician. It also indicated new medications were delivered Tuesday by pharmacy and Tenant #2 had already missed doses. Tenant #2's service plan was signed by Tenant #2 on 9-28-15 and was updated on 10-20-15, 10-22-15 and 10-26-15. The service plan indicated Tenant #2 received services including: general assessment, physical therapy ordered 10-23-15, assistance with bathing (whirlpool twice a week and partial one to two times per day, five to seven times per week), assistance with dressing, verbal medication reminder, assistance with anti-embolism hose, reporting of abnormal signs or symptoms noted or reported by the tenant to the nurse and assistance with changing protective undergarments. The service plan also indicated Tenant #2 received assistance with light housekeeping and laundry, had an emergency pendant, had meals in the dining room and Tenant #2 had walker and scooter. The service plan was updated on 10-26-15 and indicated "services on hold due to fleas." The skilled nursing services, therapy, home health aide and homemaker services were indicated as on hold. According to a Client Care Communication Note regarding Tenant #2 dated 10-26-15, there were fleas and staff preferred not to go in. According	A 013		

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A 013	Continued From page 5 to an Interdiscipline Comm Note dated 10-26-15, services could not be provided for Tenant #2 until the fleas were treated per protocol. Staff H was informed and Staff H and RN #1 told Tenant #2. Tenant #2 voiced understanding. They planned to treat on Wednesday (10-28-15). According to a Patient Communication Note dated 10-28-15, Tenant #2's family was informed of the issues with the fleas again. Family was reminded staff could not go back in until the apartmentt had been treated and was cleaned and vacuumed. Family was informed a pest company was there on 10-27-15 and verified there were fleas and was there 10-28-15 to spray. It was also discussed that Tenant #2 was not taking medications as prescribed. Staff was not able to go in until the fleas were taken care of. According to a Patient Communication Note dated 10-28-15 Tenant #2's family called to find out what was going with Tenant #2. It was explained there were fleas in the apartment and a pest company had been out that day (10-28-15) to treat. Staff could not go in for three days after treatment and family or a professional company also had to come and clean before staff could come back. Tenant #2's family was upset Tenant #2 was not getting Tenant #2's medications administered. It was reinforced that staff could not go in due to the bug issue. The family was informed staff could resume Tenant #2's services on Sunday (11-1-15) if someone cleaned Tenant #2's apartment on Saturday (10-31-15). Family was going to come on Saturday (10-31-15) and do a good cleaning. According to a Visit Information document for Tenant #2 dated was 10-22-15, it was the first visit and the start of care date was 10-22-15. According to an Aide Intervention document for	A 013		

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A 013	Continued From page 6 Tenant #2, the visit date was 10-23-15 and the interventions provided included: a partial sponge bath, the bathroom was cleaned and trash was emptied. According to an Aide Intervention document for Tenant #2, the visit date was 10-24-15 and the interventions provided included: assistance with medications and a partial sponge bath. There were no other Aide Intervention documents provided after the visit date of 10-24-15. According to a pest control company's invoice, on 11-5-15 Tenant #2's apartment was sprayed for fleas. The invoice indicated there were a few fleas seen but not too many. Although a Patient Communication Note dated 10-28-15 indicated a pest control company had been out to treat that day no records were provided by the Program regarding the treatment of Tenant #2's apartment for that date. According to a Patient Communication Note dated 11-2-15, Tenant #2 was admitted to the hospital on 10-31-15 due to weakness, fatigue, acute chronic CHF, abdominal pain and increased swelling to lower extremities. A nurse at the hospital was informed that Tenant #2 did not take Tenant #2's medications as ordered and Tenant #2 had 2+ edema when Tenant #2 was seen a little over a week ago. The hospital nurse indicated Tenant #2 had 3+ edema. According to a Patient Communication Note dated 11-2-15, a staff from the hospital called about Tenant #2 and Tenant #2's appropriateness for the Program. It was explained Tenant #2 slept a lot, did not take medications as set up by pharmacy, had incontinence issues, probably would not be able to change Tenant #2's protective undergarment and Tenant #2 did not eat regularly.	A 013		

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A 013	Continued From page 7 2. In addition to the services being held in October 2015, review of Tenant #2's file indicated services were held previously for Tenant #2 due to fleas. According to a Client Care Communication Note dated 8-15-15, Tenant #2 had fleas in the apartment and staff did not want to take fleas to the staff's home. Tenant #2's apartment was being treated on Thursday (8-20-15). According to Client Care Communication Note dated 8-16-15, staff did not go into Tenant #2's apartment. The flea situation was still prominent. According to a Client Care Communication Note dated 8-16-15, staff encountered and killed a couple of fleas in Tenant #2's apartment. According to Client Care Communication Note dated 8-17-15, staff was not doing p.m. cares as Tenant #2's apartment had fleas. According to Client Care Communication Note dated 8-18-15, no services until further notice for Tenant #2. According to a pest control company document on 8-20-15, Tenant #2's apartment was treated for fleas/ticks. 3. According to hospital records Tenant #2 was admitted to the hospital on 10-31-15 and was discharged on 11-6-15. Tenant #2 transferred from the hospital to a skilled level of care at a nursing facility. Tenant #2 was then admitted to the hospital on 11-13-15 and died on 11-14-15 The information indicated below pertained to the first hospitalization from 10-31-15 to 11-6-15. According to a hospital document with a visit date 10-31-15, Tenant #2 had been feeling weak for a week. Family came to visit Tenant #2 at the Program and Tenant #2 was still in bed as Tenant #2 was unable to get up and get dressed. The visiting nurse that was supposed to come	A 013		

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A 013	Continued From page 8	A 013		

everyday for cares and medications had not been coming. Tenant #2 said Tenant #2 had been taking Tenant #2's medications. Swelling was noticed in Tenant #2's legs, genitals and abdomen. Tenant #2 reported Tenant #2 slipped off chair yesterday. A bruise was observed on Tenant #2's left side. It was reported staff at the Program told Tenant #2 there were fleas in the apartment so they would not allow nursing staff to enter until it had been taken care of. Family reported it had been sprayed three times and there were no fleas. Family reported the nurses were not coming to treat Tenant #2. According to a hospital document, Tenant #2 had pulmonary edema and would be need to be diuresed. It was an exacerbation of CHF.

According to hospital documents, on 10-31-15 a basic metabolic panel was completed and the troponin T test indicated a level of 0.046. Normal was indicated a less than 0.01.

According to a hospital discharge summary: Tenant #2 was admitted with CHF. Tenant #2 had a history of cellulitis of the genital area and was admitted on that occasion with severe edema including genital swelling. According to a hospital document, a secondary diagnosis included: chronic kidney disease (stage 4; severe). According to a hospital document, Tenant #2 had extensive genital edema and erythema with a moist rash (consistent with fungal dermatitis). Tenant #2 had evidence of anasarca, low blood pressure in the setting of low cardiac output. The prognosis was poor due to advanced age, extensive comorbidity and severe systolic heart failure

4. According to an interview with the Clinical Supervisor, there was no written policy regarding

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A 013	Continued From page 9 fleas and staff being not able to enter tenant apartments; however, it was based on the bed bug policy. That policy indicated staff could go into tenant apartments 24 to 48 hours after treatment and cleaning was completed. No services were provided from the health health service provider during that time. Tenants were informed verbally (of the policy) when they had bugs and the same applied to fleas. 5. According to an interview with RN #1, there were fleas in Tenant #2's apartment and services were put on hold per the home health management office and the apartment had to be treated. Program staff would let the home health agency know when the apartment treatment was completed and then there was a waiting period before staff could go back into the apartment. RN #1 said there was no policy on fleas and the company went by the bed bug policy. They received direction from the home heath agency's central office on what to do. RN #1 was not aware of any written disclosure to the tenants regarding the bed bug policy. 6. According to an interview with the Executive Director, the home health agency was informed they could not stop the provision of services due to pests. The Executive Director said there was an obligation to provide services. No tenants could be denied services and the Program (landlord) did not have a policy that prohibited the provision of services due to pests. 7. According to the home health agency's policy and procedure regarding bed bugs, staff would follow the protocol listed when it was discovered that a current tenant had/or was strongly suspected of having bed bugs. The procedure included: to inform the tenant that all homecare	A 013		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 013	Continued From page 10 services would need to be suspended until the home had been treated for bed bugs and immediately notify the supervisor that the tenant had/or was suspected of having bed bugs. The tenant would need to provide proof of treatment by a certified exterminator before care could be resumed. An employee could enter a tenant's home after the home had been treated, within 24 hours for a minor infestation and 72 hours if it was a severe infestation. 8. According to the Program's policy regarding tenant rights, tenants should be informed of their tenant rights and responsibilities prior to move-in and a copy the policy should be included in the occupancy agreement. Tenants had rights including: to receive fair and respectful treatment in regard to their person and property and personal values and beliefs.	A 013		
A 058	481-67.9(4)a 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: a. The program ' s newly hired registered nurse shall within 60 days of beginning employment as the program ' s registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on review of staff files, a staff interview	A 058		

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A 058	Continued From page 11 and review of Program documents the Program failed to ensure certified and noncertified staff were competent to meet the individual needs of tenants. The Program's newly hired registered nurse (RN) did not document a review to ensure staff were sufficiently trained and competent in all tasks assigned or delegated within 60 days of beginning employment as the Program's RN for three of seven staff files reviewed (Staff A, C and D). Three noncertified staff provided assistance with activities of daily living and assistance with medications and did not have a review documented by the Program's new RN within 60 days of employment as the Program's RN. (Recertification) 1. Staff A, an uncertified home health aide (HHA), was hired on 2-18-15. Staff A had training on tasks including: bathing (complete bed bath, sponge bath, tub bath, shower and shampoo hair), oral hygiene, safe transfer and ambulation techniques, applying anti-embolism hose and assisting with medications. The training did not include dressing or assistance with a whirlpool bath. A review was not documented by the Nurse Supervisor to ensure staff was sufficiently trained and competent in the tasks. 2. Staff C, an uncertified HHA, was hired on 8-18-15. Staff C had training on tasks including: bathing (complete bed bath, sponge bath, tub bath, shower and shampoo hair), oral hygiene, safe transfer and ambulation techniques, applying anti-embolism hose and assisting with medications. The training did not include dressing or assistance with a whirlpool bath. A review was not documented by the Nurse Supervisor to ensure staff was sufficiently trained and competent in the tasks.	A 058		

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A 058	Continued From page 12 3. Staff D, an uncertified HHA, was hired on 6-3-15. Staff D had training on tasks including: bathing (complete bed bath, sponge bath, tub bath, shower and shampoo hair), oral hygiene, safe transfer and ambulation techniques, applying anti-embolism hose and assisting with medications. The training did not include dressing or assistance with a whirlpool bath. A review was not documented by the Nurse Supervisor to ensure staff was sufficiently trained and competent in the tasks. 4. According to a Program document, the Nurse Supervisor started at the Program on 10-5-15. 5. According to an interview with the Nurse Supervisor, Staff A and Staff D assisted tenants with tasks including: whirlpool baths, showers, medication reminders, dressing, light housekeeping, anti-embolism hose, grooming as needed and stand by assistance (SBA) with ambulation. Staff C did not provide assistance with whirlpool baths; however, otherwise provided assistance with the same tasks including: dressing, light housekeeping, anti-embolism hose, medication reminders, grooming as needed and SBA with ambulation.	A 058		
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	A 037		

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A 037	Continued From page 13 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 review of tenant files and review of Program documents the Program failed to 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 for three of six tenant files reviewed (Tenants #1, #3 and #6). Three tenants did not have cognitive, health and functional evaluations completed as needed with significant change. (Recertification) 1. Tenant #1, a 52 year old, was admitted on 6-29-15 and diagnoses included: diabetes with polyneuropathy, right congestive heart failure (CHF) and chronic kidney disease. Tenant #1 was discharged on 11-30-15. According to a Patient Communication Note dated 11-5-15, an order was received to change the dressing to the right leg daily. The wound was on the anterior calf and there were three very small open areas, no drainage was noted and the wound was pink. Gauze was observed over the area. According to a Patient Communication	A 037		

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A 037	Continued From page 14 Note dated 11-20-15, a daily dressing change was no longer provided for Tenant #1. According to a Home Health Certification and Plan of Care document (certification period 10-3-15 to 11-30-15), Tenant #1 had again canceled or missed all home care aide visits, Tenant #1 had a broken glucometer and had not been taking Tenant #1's blood sugars, Tenant #1 refused to let a nurse fill insulin syringes and refused access to medication boxes. Tenant #1 was non-compliant with taking Tenant #1's medications as Tenant #1 did not pick up refills and did not have the medications in Tenant #1's home. Tenant #1 continued to spend most of Tenant #1's days smoking on the front porch and not at dialysis. According to a Visit Information document dated 10-28-15, insulin syringes were not filled as Tenant #1 did not have insulin syringes. According to a Visit Information document dated 11-10-15, Tenant #1 received dialysis three times per week. According to a Visit Information document dated 11-19-15, Tenant #1 had not been checking Tenant #1's blood sugars, Tenant #1 had diarrhea since 11-17-15 and had it three times that day. A Medical/Functional/Cognitive Assessment document was most recently completed on 9-9-15 Visit Information documents were completed; however, evaluations were not completed as needed with significant change regarding the wounds on Tenant #1's right leg with a dressing change and the discontinuation of the dressing change. Evaluations were not completed regarding Tenant #1's non-compliance with medications, not monitoring blood glucose, insulin syringes not filled and Tenant #1 not going	A 037		

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A 037	Continued From page 15 to dialysis. Evaluations were not completed as needed. 2. Tenant #3, an 89 year old was admitted on 2-25-15 and diagnoses included: cerebral infarction, malaise, dementia, reflux and hypertension (HTN). Tenant #3 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. According to a Patient Communication Note dated 12-1-15, Tenant #3 preferred cares be provided after 10:00 a.m. It was scheduled around 9:00 a.m. every morning due to the fact Tenant #3 would have another private aide coming in at 11:00 a.m. According to a Patient Communication Note dated 12-4-15, Tenant #3 had a hard time with showers and getting dressed. It was difficult for Tenant #3 to sit in the shower and wash Tenant #3's private area. Walking from the shower to bed, getting protective undergarments on and getting dressed was a struggle a little more than usual. According to a Patient Communication Note dated 12-5-15, Tenant #3 was still sleeping when staff arrived and was very hard to wake up. Tenant #3 was mad when Tenant #3 woke up and did not want to wake up so early. Tenant #3 did not make dressing easy and sat very limp with no motion of movement to help. According to a Nursing Intervention document dated 12-26-15, Tenant #3 had trouble chewing due to missing teeth. Tenant #3 declined bridge work due to age and cost. Tenant #3 did not eat in the dining room and Tenant #3's family brought soft foods Tenant #3 could tolerate. According to a Patient Communication Note	A 037		

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A 037	Continued From page 16 dated 12-14-15, Tenant #3 had a sore on the right buttock cheek and it also looked like there was a red rash on the middle of the back. Tenant #3's left foot looked swollen (with ankle). According to a Physician Interim Orders document dated 12-22-15, an order was received to apply Mepilex to the buttocks sore and change every three to five days. Medical/Functional/Cognitive Assessment documents were completed on 12-23-15 and 10-23-15. Evaluations on 12-23-15 indicated Tenant #1 was independent with eating and had a fair appetite. The evaluations did not reflect Tenant #3 had trouble chewing and missing teeth. Evaluations were not completed as needed when Tenant #3 had more difficulty with dressing and bathing. The evaluations completed on 12-23-15 reflected Tenant #3 had a wound on the right buttocks and Mepilex was applied; however, the wound was noted on a Patient Communication Note dated 12-14-15, which was nine days before the evaluations were completed. Nursing Intervention documents were completed; however, evaluations were not completed as needed with significant change when Tenant #3 developed a wound and had more difficulty with dressing and bathing. Evaluations were not completed as needed with significant change. 3. Tenant #6, a 71 year old, was admitted on 4-1-14 and diagnoses included: chronic obstructive pulmonary disease, HTN and diabetes mellitus. Tenant #6 was staged at a four on the GDS, which indicated moderate cognitive decline. According to a Patient Communication Note dated 11-18-15, Tenant #6 was refusing to go to doctor appointments and was not eating properly	A 037		

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A 037	Continued From page 17 Tenant #6 had lost significant weight. The doctor wanted Department of Human Services called if Tenant #6 refused to been seen by the social worker. According to a Physician Interim Orders document dated 11-19-15, social worker visits once per week for 60 days for resource coordination/referral, assistance in decision-making, support in following medical recommendations/orders, emotional support to address/intervene with symptoms of depression/anxiety, address/intervene in isolating behaviors and tenant advocacy were ordered. According to a Home Health Certification and Plan of Care document (certification period 12-6-15 to 2-3-16), Tenant #6 had a history of urinary tract infections (UTI's) (none recently). Encouragement was given to eat meals and drink plenty of fluids. According to a Physician Interim Orders document dated 12-15-15, Tenant #6 was sent to the emergency room on 12-14-15 and was discharged on 12-14-15 with a new order for Cephalexin 500 milligram, one capsule by mouth twice daily (14 doses) for a UTI. According to a Patient Communication Note dated 12-15-15, Tenant #6 had a couple of doses of Cephalexin and was feeling better. Tenant #6 did not have chest pain, fever or pain or burning with urination. Medical/Functional/Cognitive Assessment documents were completed on 12-3-15 and 10-5-15. Evaluations were not completed as needed with significant change with Tenant #6's significant weight loss, refusal of doctor appointments, not eating properly and an order for social worker visits to address/intervene with symptoms of depression/anxiety and isolation behaviors and a diagnosis of a UTI with antibiotic	A 037		

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A 037	Continued From page 18 therapy. Evaluations were not completed as needed. 4. According to the Service Plan Agreement, prior to and as a condition of occupancy each proposed tenant's functional, cognitive and health status would be evaluated in order to determine the tenant's need for services from the service provider and prepare a service plan.	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 review of tenant files and review of Program documents the Program failed to develop service plans for each tenant based on the evaluations, that were designed to meet the specific service needs of the individual tenant and were updated at least annually and whenever changes were needed for six of six tenant files reviewed (Tenants #1, #2, #3, #4, #5 and #6). Six tenants did not have service plans based on evaluations, that reflected the service needs of the tenants and were updated as needed.	A 083		

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A 083	Continued From page 19 (Recertification) 1. Tenant #1, a 52 year old, was admitted on 6-29-15 and diagnoses included: diabetes with polyneuropathy, right congestive heart failure (CHF) and chronic kidney disease. Tenant #1 was discharged on 11-30-15. According to a 30 Day Notice of Non-Renewal and Termination of Lease dated 10-5-15, Tenant #1's residency would be terminated on 11-30-15 for the following reason associated with the occupancy agreement including: the tenant should not engage in smoking except in designated exterior areas. According to a Patient Communication Note dated 11-5-15, an order was received to change the dressing to the right leg daily. The wound was on the anterior calf and there were three very small open areas, no drainage was noted and the wound was pink. Gauze was observed over the area. According to a Patient Communication Note dated 11-20-15, a daily dressing change was no longer provided for Tenant #1. According to a Home Health Certification and Plan of Care document (certification period 10-3-15 to 11-30-15), Tenant #1 had again canceled or missed all home care aide visits, Tenant #1 had a broken glucometer and had not been taking Tenant #1's blood sugars, Tenant #1 refused to let a nurse fill insulin syringes and refused access to medication boxes. Tenant #1 was non-compliant with taking Tenant #1's medications as Tenant #1 did not pick up refills and did not have the medications in Tenant #1's home. Tenant #1 continued to spend most of Tenant #1's days smoking on the front porch and not at dialysis. Tenant #1 also smoked in Tenant	A 083		

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A 083	Continued From page 20 #1's apartment and Tenant #1 had received several warnings from management. According to a Visit Information document dated 10-28-15, insulin syringes were not filled as Tenant #1 did not have insulin syringes. According to a Visit Information document dated 11-10-15, Tenant #1 received dialysis three times per week. According to a Visit Information document dated 11-19-15, Tenant #1 had not been checking Tenant #1's blood sugars, Tenant #1 had diarrhea since 11-17-15 and had it three times that day. The service plan updated on 10-27-15 did not reflect Tenant #1 smoked in non-designated areas and was given a 30 Day Notice of Non-Renewal and Termination of Lease related to the issue. The service plan was not updated as needed and did not reflect the wounds on Tenant #1's right leg with a dressing change and the discontinuation of the dressing change. The service plan was not updated as needed and did not reflect Tenant #1's non-compliance with medications, not monitoring blood glucose and insulin syringes not filled. The service plan did not reflect Tenant #1 had dialysis services and that Tenant #1 did not go to dialysis. The service plan was not updated as needed and did not reflect the needs of Tenant #1. 2. Tenant #2, an 89 year old, was admitted on 8-29-13 and diagnoses included: CHF with chronic atrial fibrillation, peripheral artery disease, type 2 diabetes mellitus (DM), weakness, sleep apnea, chronic renal disease/insufficiency, hypernatremia and history of alcohol abuse. Tenant #2 was discharged on 10-31-15. The service plan was most recently signed by a	A 083		

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A 083	Continued From page 21 health care professional on 10-26-15. The service plan was also dated 10-20-15 and 10-22-15 and signed by a health care professional. The service plan reflected staff assisted Tenant #2 with compression stockings. A Home Health Certification Plan of Care document (certification period from 10-22-15 to 12-20-15) indicated Tenant #2 had 2+ pitting edema to bilateral lower extremities and had been not wearing the compression stockings on a regular and consistent basis. A Medical/Functional/Cognitive Assessment dated 10-22-15 indicated Tenant #2 had 2+ pitting bilateral edema. The service plan reflected the compression stockings; however, did not reflect Tenant #2 had 2+ pitting edema The service plan was not based on evaluations and did not reflect the needs of Tenant #2. 3 Tenant #3, an 89 year old was admitted on 2-25-15 and diagnoses included: cerebral infarction, malaise, dementia, reflux and hypertension (HTN). Tenant #3 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. According to a Patient Communication Note dated 12-1-15, Tenant #3 preferred cares be provided after 10:00 a.m. It was scheduled around 9:00 a.m. every morning due to the fact Tenant #3 would have another private aide coming in at 11:00 a.m. According to a Patient Communication Note dated 12-4-15, Tenant #3 had a hard time with showers and getting dressed. It was difficult for Tenant #3 to sit in the shower and wash Tenant #3's private area. Walking from the shower to bed, getting protective undergarments on and getting dressed was a struggle a little more than usual. According	A 083		

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A 083	Continued From page 22 to a Patient Communication Note dated 12-5-15, Tenant #3 was still sleeping when staff arrived and was very hard to wake up. Tenant #3 was mad when Tenant #3 woke up and did not want to wake up so early. Tenant #3 did not make dressing easy and sat very limp with no motion of movement to help. According to a Nursing Intervention document dated 12-26-15, Tenant #3 had trouble chewing due to missing teeth. Tenant #3 declined bridge work due to age and cost. Tenant #3 did not eat in the dining room and Tenant #3's family brought soft foods Tenant #3 could tolerate. According to a Patient Communication Note dated 12-14-15, Tenant #3 had a sore on the right buttock cheek and it also looked like there was a red rash on the middle of the back. Tenant #3's left foot looked swollen (with ankle) According to a Physician Interim Orders document dated 12-22-15, an order was received to apply Mepilex to buttocks sore and change every three to five days. A Medical/Functional/Cognitive Assessment document was completed on 12-23-15 The service plan was signed on 12-22-15. The service plan was not based on evaluations as the evaluations were dated after the development of the service plan. The service plan was signed most recently on 12-22-15. The service plan was not updated as needed and did not reflect the following: Tenant #3 had a wound and the treatment of the wound, Tenant #3 preferred cares scheduled later in the morning, Tenant #3 was difficult at times to assist with dressing and bathing and Tenant #3 had a private aide. The service plan also did not reflect	A 083		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 23 Tenant #3 had difficulty chewing due to issues with missing teeth. The service plan was not updated as needed and did not reflect the needs of Tenant #3. 4. Tenant #4, a 77 year old, was admitted on 5-7-15 and diagnoses included: chronic obstructive pulmonary disease (COPD), paralysis, diastolic heart failure and coronary atherosclerosis. Tenant #4 received Hospice services. According to a Patient Communication Note dated 11-16-15, Tenant #4 was not feeling good, felt nauseous and when getting ready for the shower Tenant #4 vomited all over the floor and toilet. According to a Nursing Intervention document dated 11-16-15, Tenant #4 reported being sick for three days, started with diarrhea and then vomited once. According to a Nursing Intervention document dated 11-23-15, Tenant #4 had loose and watery bowel movements and Tenant #4's appetite was poor. According to a Nursing Intervention document dated 12-14-15, Tenant #4 had diarrhea stools every two days or so. According to a Patient Communication Note dated 12-17-15, Tenant #4 was not feeling well and vomited twice. According to a Nursing Intervention document dated 12-28-15, Tenant #4 had loose diarrhea stools one to two times daily and it was normal for Tenant #4. According to a Nursing Intervention document dated 12-7-15, Tenant #4 had medications set up in a machine for 10 days. Tenant #4 missed several days of medications and did not feel like taking them. According to a Nursing Intervention document dated 12-14-15, Tenant #4 missed only a couple times at noon and p.m (doses of medications). According to Nursing Intervention	A 083		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0266	A. BUILDING: _____ B. WING _____	C 01/25/2016

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A 083	Continued From page 24 document dated 12-21-15, Tenant #4 missed one dose of medications set up. According to a Nursing Intervention document dated 12-28-15, Tenant #4 missed five doses of the a.m. medications, seven days of the noon medications and two of the p.m. medications. According to a Visit Information document dated 1-4-16, Tenant #4 had not taken medications as set up and the doctor was notified of Tenant #4 missing six days of medications in the last week. According to a Nursing Intervention document dated 12-21-15, Tenant #4 had dialysis Tuesday, Thursday and Saturday. According to a Patient Communication Note dated 1-2-16, Tenant #4 told staff Tenant #4 was not going back to dialysis anymore, Tenant #4 was done and wanted to die. According to a Patient Communication Note dated 1-7-16, Tenant #4's family was called to let family know that Tenant #4 did not go to dialysis and Tenant #4 said Tenant #4 was done with dialysis. According to a Medical/Functional/Cognitive Assessment dated 1-4-16, Tenant #4 talked about quitting dialysis, was ready to die, said it hurt to get it done and if Tenant #4 stopped all together Tenant #4 would start Hospice. According to a Patient Communication Note dated 1-8-16, Tenant #4 was discharged from nursing and bathing due to being admitted to Hospice. According to a Patient Communication Note dated 1-11-16, Tenant #4 was discharged from the dialysis system and all communication needed to go through the doctor. The service plan was signed most recently by a health care professional on 1-8-16. The service plan was not updated as needed and did not reflect the following: Tenant #4 missed doses of medications, Tenant #4 had loose stools and	A 083		

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A 083	Continued From page 25 complaints of nausea and vomiting. The service plan did not reflect Tenant #4 had dialysis three times per week and the discontinuation of dialysis services. The service plan was not updated as needed and did not reflect the needs of Tenant #4. 5. Tenant #5, a 60 year old, was admitted on 5-15-15 and diagnoses include: DM, airway disease, HTN, obesity, depression and anxiety. According to a Patient Communication Note dated 11-17-15, Tenant #5 was sent to emergency room (ER) on 11-16-15 due to a nose bleed for over 30 minutes. Tenant #5 returned on 11-16-15. Tenant #5 had an inflated balloon in Tenant #5's left nostril that was to remain in place until Thursday when Tenant #5 returned to have it removed. Tenant #5 was not able to bathe until the balloon was removed. According to a Patient Communication Note dated 11-29-15, Tenant #5 returned from the hospital and Levaquin 750 mg for seven days was ordered. A Visit Information document dated 11-29-15 indicated the resumption of care (after inpatient stay) date was 11-29-15. The inpatient diagnosis was pneumonia. According to a Home Health Certification and Plan of Care (certification period from 11-29-15 to 1-27-16), Tenant #5 had continuous Oxygen, Nitrostat 0.4 milligram (mg) one tablet every five minutes as needed for three doses, Spirvia 18 microgram (mcg) daily and Combivent 20-100 mcg one puff, four times per day as needed. It also indicated Tenant #5 continued to have frequent ER visits mostly for dizziness and dehydration. It indicated Tenant #5 had periods of shortness of breath mostly because Tenant #5	A 083		

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A 083	Continued From page 26 forgot to put the Oxygen back on after removing it and had gone to the first floor without portable Oxygen. Tenant #5 did not drink enough and encouragement was provided to drink water throughout the day.	A 083		
	According to a Physician Interim Orders document dated 11-30-15, social worker visits one time a week for 60 days was ordered for education/emotional support related to Tenant #5 presented/expressed depression and anxiety and the need for coping skills. Addressing quality of life issues due to living with disease, guidance/education in socialization skills/opportunities was also indicated. Clinical Nurses Notes dated 12-7-15 indicated Tenant #5 went to a nursing facility for rehabilitation and all services were on hold. Clinical Nurses Notes dated 1-8-16 indicated services were resumed from discharge from the nursing facility on 1-7-16. Tenant #5 continued to wear a knee brace to the left leg as needed, which Tenant #5 was able to apply independently. The service plan which was updated on 1-8-16 and 10-23-15. The service plan was not updated as needed and did not reflect the nose balloon for Tenant #5's nose bleed and that Tenant #5 could not bathe until removed. The service plan was not updated as needed and did not reflect Tenant #5 had pneumonia and antibiotic treatment. The service plan did not reflect the following medications/treatments: Oxygen (at times forgetfulness to reapply the Oxygen), Nitrostat, Spirvia and Combivent. The service plan also did not reflect Tenant #5 had frequent trips to the ER due to dizziness and dehydration and Tenant #5 did not drink enough and encouragement to drink water throughout the day was needed. The			

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A 083	Continued From page 27 service plan was not updated as needed and did not reflect Tenant #5 had a brace as needed on the left leg (which Tenant #5 independently applied) and the social worker visits related to depression, anxiety and the need for coping skills. The service plan was not updated as needed and did not reflect the needs of Tenant #5. 6. Tenant #6, a 71 year old, was admitted on 4-1-14 and diagnoses included: COPD, HTN and DM. Tenant #6 was staged at a four on the GDS, which indicated moderate cognitive decline. According to a Patient Communication Note dated 11-18-15, Tenant #6 was refusing to go to doctor appointments and was not eating properly. Tenant #6 had lost significant weight. The doctor wanted Department of Human Services called if Tenant #6 refused to been seen by the social worker. According to a Physician Interim Orders document dated 11-19-15, social worker visits once per week for 60 days for resource coordination/referral, assistance in decision-making, support in following medical recommendations/orders, emotional support to address/intervene with symptoms of depression/anxiety, address/intervene in isolating behaviors and tenant advocacy were ordered. According to a Home Health Certification and Plan of Care document (certification period 12-6-15 to 2-3-16), Tenant #6 wore Oxygen continuously at 3.0 liters per nasal cannula, was diabetic but did not check Tenant #6's blood glucose. Staff brought Tenant #6 the evening meal but many nights Tenant #6 refused. Encouragement was given to Tenant #6 to eat meals and drink plenty of fluids. The document also indicated medications/treatments including	A 083		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 083	Continued From page 28 the following: Aquaphilic daily, Proventil two puffs, inhale every four hours as needed and Spirvia 18 mcg once daily. According to a Home Health Certification and Plan of Care document (certification period 12-6-15 to 2-3-16), Tenant #6 had a history of urinary tract infections (UTIs) (none recently). Encouragement was given to eat meals and drink plenty of fluids. According to a Physician Interim Orders document dated 12-15-15, Tenant #6 was sent to the ER on 12-14-15 and was discharged on 12-14-15 with a new order for Cephalexin 500 mg, one capsule by mouth twice daily (14 doses) for a UTI. According to a Patient Communication Note dated 12-15-15, Tenant #6 had a couple of doses of Cephalexin and was feeling better. Tenant #6 did not have chest pain, fever or pain or burning with urination. The service plan was most recently signed on 1-8-16. The service plan was not updated as needed and did not reflect social worker visits regarding addressing and intervening with depression/anxiety and isolating behaviors, significant weight loss and refusal of doctor appointments. It also did not reflect Tenant #6 was diabetic but not check Tenant #6's blood glucose, the refusal of the evening meal and encouragement to eat and drink plenty of fluids. The service plan did not reflect the use of the following medication/treatments: Aquaphilic, Proventil, Spirvia and Oxygen continuously. The service plan was not updated as needed and did not reflect the needs of Tenant #6. 7. According to the Program's Service Plan Agreement, if the designated service provider determined that a tenant needed personal or health-related care, the service plan would be	A 083		

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A 083	Continued From page 29 updated within 30 days of occupancy and as needed by not less than annually. If a significant change triggered the review and update of the service plan the updated service plan would be signed and dated by a multidisciplinary team of no fewer than three individuals, including a health care professional and other staff appropriate to meet the needs of the tenant, in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and with the tenant's legal representative, if applicable.	A 083		
A 086	481-69.26(3)a Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant ' s occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on review of tenant files and review of Program documents the Program failed to provide signatures by all parties when a significant change triggered the review and update of the service plan for two of six tenant files reviewed (Tenants #2 and #4). Two tenants had significant changes that triggered an update of the service plans and the service plans were not signed by the tenants	A 086		

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A 086	Continued From page 30 (Recertification) 1. Tenant #2, an 89 year old, was admitted on 8-29-13 and diagnoses included: congestive heart failure with chronic atrial fibrillation, peripheral artery disease, type 2 diabetes mellitus, weakness, sleep apnea, chronic renal disease/insufficiency, hypernatremia and history of alcohol abuse. Tenant #2 was discharged on 10-31-15. The service plan was signed by a health care professional on 10-20-15, 10-22-15 and 10-26-15; however, Tenant #2 last signed the service plan on 9-28-15. Tenant #2 did not sign the service plan with the initiation of services and services held due to fleas. The service plan was not signed by Tenant #2 when significant changes occurred and the service plan was updated. 2. Tenant #4, a 77 year old, was admitted on 5-7-15 and diagnoses included: chronic obstructive pulmonary disease, paralysis, diastolic heart failure and coronary atherosclerosis. Tenant #4 received Hospice services. The service plan was updated on 1-8-16 and reflected Tenant #4 received Hospice cares and services were discontinued including: bathing, dressing, verbal medication reminder and general assessment. The service plan was last signed by Tenant #4 on 4-22-15. A health care professional signed the service plan on 1-8-16; however, Tenant #4 did not sign the service plan with the discontinuation of dialysis and initiation of Hospice services. The service plan was not signed by Tenant #4 when a significant change occurred and the service plan was updated.	A 086		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 086	Continued From page 31 3. According to the Program's Service Plan Agreement, if the designated service provider determined that a tenant needed personal or health-related care, the service plan would be updated within 30 days of occupancy and as needed but not less than annually. If a significant change triggered the review and update of the service plan the updated service plan would be signed and dated by a multidisciplinary team of no fewer than three individuals, including a health care professional and other staff appropriate to meet the needs of the tenant, in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and with the tenant's legal representative, if applicable.	A 086		

THE ROSE OF WATERLOO

PLAN OF CORRECTION

For complaint/recertification report from investigation by DIA January 11-25, 2016

Regulatory Insufficiency: Dependent adult abuse Iowa Code 235B. 16.5.b
A person required to report cases of dependent adult abuse pursuant to section 235B.3 other than a physician whose professional practice does not regularly involve providing primary health to adults, shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment or self-employment which involves the examination, attending, counseling or treatment of adults on a regular basis. Within one month of initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person's employer or, if self-employed, from the department. The person shall complete at least two hours of additional dependent adult abuse identification and reporting training every five hours.

Elements detailing how the Program will correct the insufficiency:
Service provider is obtaining the necessary video to provide adequate training for all employees.

What measures will be taken to ensure the problem does not recur:
Requirements are tracked in employee's files and in the computer to ensure all required training is completed on time.

How the Program plans to monitor performance to ensure compliance:
Employee files are reviewed monthly to ensure all required training is completed on time.

The date by which the regulatory insufficiency will be corrected:
Service provider will obtain the video by 2/15/16 and all employees of The Rose will be trained by 3/1/16.

Regulatory Insufficiency: Tenant Rights 481-67.3(2)
To receive care, treatment and services which are adequate and appropriate.

Elements detailing how the program will correct the insufficiency:
Service provider policy is being revised by 3/1/16 to ensure proper services are provided to client as needed without any breaks in services.

What measures will be taken to ensure the problem does not recur:
Company policy is being updated and will note that aides will wear disposable gowns/booties/etc if a bug problem is suspected. Services will not be put on hold during this time.

How the Program plans to monitor performance to ensure compliance:
Client charts will be reviewed daily and staff communication notes will be reviewed daily to ensure all clients are receiving needed services.

The date by which the regulatory insufficiency will be corrected:
Company policy will be updated by 3/1/16

Regulatory Insufficiency: Staffing 481-67.9(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: (a) The program's newly hired registered nurse shall within 60 days of beginning employment s the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated.

Elements detailing how the program will correct the insufficiency:
Nurse will review all skills associated with cares on clients at The Rose with all employees employed by the service provider.

What measures will be taken to ensure the problem does not recur:
Proper training will be provided to current and future registered nurses in charge of the assisted living program at The Rose.

How the Program plans to monitor performance to ensure compliance:
A copy of the aides skills testing will be kept in the nurse's office and will be monitored every 6 months to ensure proper training is up to date.

The date by which the regulatory insufficiency will be corrected:
Nurse delegations will be completed with all staff by 3/15/16

Regulatory Insufficiency: Evaluation of Tenant 481-69.22(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.

Elements detailing how the program will correct the insufficiency:
Nurse will review all charts daily to ensure all significant cognitive, functional or health changes have been noted and signed.

What measures will be taken to ensure the problem does not recur:
Tenant's files will be reviewed daily with a quarterly clinical chart review done to ensure proper documentation was completed as needed and required.

How the Program plans to monitor performance to ensure compliance:
Quarterly clinical chart reviews will be done to ensure compliance. The clinical chart review is a peer review which consists of an audit of clinical note content, appropriate assessments, and review of the service plan.

The date by which the regulatory insufficiency will be corrected:
All charts will be reviewed and updated by 3/15/16 with daily reviews to follow.

Regulatory Insufficiency: Service Plans 481-69.26(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.

Elements detailing how the Program will correct the insufficiency:
Tenant's files will be reviewed daily with changes made as needed and signatures obtained when needed. A clinical chart review will be performed quarterly which will consist of an audit of clinical note content, appropriate assessments and review of the service plan.

What measures will be taken to ensure the problem does not recur:
Nurse will review and update tenant files daily to ensure changes are recorded and signatures are obtained when needed.

How the Program plans to monitor performance to ensure compliance:
A clinical chart review will be performed quarterly which will consist of an audit of clinical note content, appropriate assessments and review of the service plan.

The date by which the regulatory insufficiency will be corrected:
The service plans will be looked at daily and all will be updated by 3/15/16

Regulatory Insufficiency: Service Plans 481-69.26(3)
When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.

Elements detailing how the Program will correct the insufficiency:
The nurse will ensure that the service plan will be signed within 48 hours of a significant change.

What measures will be taken to ensure the problem does not recur:
Nurse will review and update tenant files daily to ensure changes are recorded and signatures are obtained when needed.

How the Program plans to monitor performance to ensure compliance:
Quarterly clinical chart reviews will be done to ensure compliance. The clinical chart review is a peer review which consists of an audit of clinical note content, appropriate assessments, and review of the service plan.

The date by which the regulatory insufficiency will be corrected:
The service plans will be looked at daily and all will be updated with necessary signatures by 3/15/16.

1800 Commercial Street
Waterloo, IA 50702

ABLE
PEST CONTROL

Ph. (319) 291-7200
Ph. 1-800-369-2847
Fax (319) 291-2118

INVOICE: 1013992
DATE: 10/28/15
ORDER: 1013992

[103986]
The Rose of Waterloo
Craig Bell
421 Oak Ave
Waterloo, IA 50703-3401

[103986] 319-232-6061
The Rose of Waterloo
Craig Bell
421 Oak Ave
Waterloo, IA 50703-3401

10/28/15 09:00 AM

02/01/16

MCS	MON COM SERVICE	$105.00

SUBTOTAL	$105.00
TAX	$7.35
TOTAL	$112.35

Date: 10/27/15 03:40 PM
System Date: 10/27/15

1800 Commercial Street
Waterloo, IA 50702

Aable/Terminix of NE Iowa
PEST CONTROL

Notes Review Report

Page:
User: DEB B

Ph. (319) 291-7200
Ph. 1-800-369-2847
Fax (319) 291-2118

Starting:		Ending:					
Note Date:	[10/28/15]	Note Date:	[10/28/15]	Add User:	[All]	Location:	[All]
Add Date:	[All]	Add Date:	[All]	Update User:	[All]	Bill-To:	[All]
Update Date:	[All]	Update Date:	[All]	Note Code:	[CC1]	Branch:	[All]
Sorted by:	[Note Date, Note Date]			Search For:	[]	Include:	[Both]

Note	Add User Add Date	Update User Update Date	Note Date Note Time	Source	Code
Location: [103986] The Rose of Waterloo/Craig Bell	DEB B	MARIA	10/28/15		CC1
421 Oak Ave Waterloo, IA 50703-3401 319-232-6061	10/26/15	10/26/15	09:00AM		
10/26 apt#225 for fleas on 10/28 10/26/2015-- Confirmed with Cedric for monthly service on Wed 10/28/2015 with techs arriving between 9 and 9:30am. CH					