IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #:
50041-IRV2
53410-IRV
53862-IRV
53865-IRV
57595-C

February 25, 2016

Mr. Nicholas Lensch, Manager
Courtyard Estates at Hawthorne Crossing
601 Hawthorne Crossing Drive SE
Bondurant, IA 50035

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

Dear Mr. Lensch:

I. Final Complaint Investigation, Recertification Revisit and Complaint/Incident Investigation Revisit Report – Courtyard Estates at Hawthorne Crossing, Bondurant, IA

Enclosed is the **Final Complaint Investigation, Recertification Revisit and Complaint/Incident Investigation Revisit 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 **February 9 - 16, 2016.** The Report notes Regulatory Insufficiencies in the area(s) of: Program Policies and Procedures, Tenant Rights, Medications, Exit Interview, Final Report and POC and Nurse Review.

The following insufficiencies cited in the 7-22-15 report WERE NOT substantiated during Revisit #2.

1. Policies and Procedures: The Program was previously cited related to staff not following door alarm procedures. During the onsite visit, door alarms were set off on two occasions and staff responded appropriately.

2. Policies and Procedures: The Program was previously cited related to staff not following procedures for the administration of eye drops. During the onsite visit, multiple medication passes were observed with different staff members. No tenants received eye drops and therefore it could not be determined the staff performed the task inappropriately. The Program continued to have difficulty in the area of Policy and Procedure and received a regulatory insufficiency for that as detailed in the report.

3. Evaluation of Tenant: The Program was previously cited for not completing evaluations with changes of condition. Previously Tenant #1, #5, and #7 were cited. Tenants #1 and #7 were no longer at the Program. Nine tenant files including Tenant #5 were reviewed. One tenant, #17 did not have evaluations completed with a change of condition.

4. Criteria for Admission and Retention: Previously Tenant #1 was cited and per the plan of correction a waiver was obtained from the Department. Tenant #1 passed away and was no longer at the Program. Based on file review, interview, and observation, no other tenants were identified during the onsite visit as exceeding criteria for admission and retention.

5. Tenant Documents: Previously Tenants #1, #5, #8, and #12 were identified as not having documented visual checks as identified on the service plan. Tenants #1 and #8 were no longer at the Program. Nine tenant files were reviewed including Tenants #5 and #12. Tenant #12's service plan continued to identify 32 times per shift visual checks while the task sheet required eight times per shift visual checks. Per interview and observation, Tenant #12 was no longer aggressive, which had prompted the 32 times per shift checks.

6. Service plans: Previously Tenants #1, #5, #7, #10 and #12 were cited for having service plans that did not meet tenant needs. Tenants #1 and #7 were no longer at the Program. Nine tenant files were reviewed including Tenants #5, #10, and 12. No issues were identified with those tenants. Tenant #17 was identified as having a service plan that did not meet tenant needs.

7. Service plans: Previously Tenants #5, #8, and #12 were identified as having service plans that did not identify planned and spontaneous activities identified for persons with dementia. Tenant #8 was no longer at the Program. Service plans for Tenants #5 and #12 identified activities. A total of nine tenant files were reviewed; no problems were noted.

8. Nurse Review: Previously Tenants #1, #5, #6, were identified as not having nurse reviews to assess and document health status. Tenant #1 was no longer at the Program. Nine tenant files were reviewed including Tenants #5 and #6. This insufficiency was again identified. Please see the attached report for details.

9. Food Service: Previously the Program was cited for not following standards of the laws pertaining to food service. Meals were observed in the dining room of the dementia unit including breakfast, lunch, and dinner. No issues were identified related to food service.

10. Structural: Previously the Program was cited following an elopement which occurred because a gait was not properly locked. No elopements have occurred recently related to improper function of gaits, locks, or alarms. Staff was observed checking gaits and locks for security. No issues were identified related to Structural regulations.

    During the onsite visit an investigation was completed into Complaint #57595-C. The following allegations were not substantiated. Please see the attached report for issues identified during the onsite visit.

1. Allegation – Food Service: It was alleged staff don't always comply with procedures for maintaining food safety during food service as staff provide direct tenant care and serve food.
   Findings- Not Substantiated
   Comments –The monitors observed three meals. At each meal the staff was wearing aprons and used gloves appropriately. Staff was observed washing hands appropriately. Tenants were observed eating the food. There are no regulations related to the quality of the food.

2. Allegation – Staffing-There was one staff member for more than 20 tenants in the dementia unit. It was reported one tenant grabbed a wheelchair and dumped out the tenant sitting in the wheelchair.
   Findings – Not Substantiated
   Comments – It was confirmed that on one occasion a staff member worked alone in the dementia unit for the entire shift. In an interview with the staff member, she indicated all tasks were completed. There was no documentation tenants were harmed. The Program provided documentation staff stayed late or came in early to help cover shifts. The Program followed its staffing policy. During the days of the onsite visit, there were two staff members present on the day and evening shift, and one staff member on the night shift in the dementia unit, consistent with the staffing pattern identified by the Program.
   Interviews were conducted and files were reviewed. Details on the tenant/tenant interaction could not be confirmed. The Program was informed of the incident described so that the Program could make improvements in communication and documentation.

3. Allegation – Structure/Life Safety- It was alleged the Program did not have supplies to care for the skin wounds. It was alleged staff was taking supplies such as moist towelettes from one tenant to give to another.
   Findings – Not Substantiated
   Comments: Observations were made of the building and it appeared to be generally clean and safe. Typically, assisted living programs do not provide dressings and other medical supplies; tenants and/or families provide their own supplies. Staff members were not observed to take items from one tenant to give to another. No tenants were identified with current injuries requiring dressings.

4. Allegation – Activities-tenants have nothing to do
   Findings- Not Substantiated
   Comments – The Program provided documentation of an activity calendar and the activities were observed to be held as scheduled. Tenants were observed participating in the activities. Staff encouraged tenants to participate at the time of the activity. The Program met the regulations related to activities.

5. Allegation – Service Plans-It was alleged tenants required assistance with toileting, bathing, and oral care.
   Findings-Not substantiated
   Comments- The service plan is the tool the Program uses to communicate tenant needs to the staff. Nine tenant files were reviewed and the service plans identified those needs for each tenant.

Two allegations related to tenant rights and medications were substantiated and the details are in the attached report.

Courtyard Estates at Hawthorne Crossing ("Program") is being assessed a **$2,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

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

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

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

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

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

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

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

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

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of Nurse Review, Program Policies and Procedures and Exit Interview, Final Report and Plan of Correction.

The determination of a **$2,000 civil penalty** is based upon repeated in the area(s) of: Nurse Review, Program Policies and Procedures and Exit Interview, Final Report and Plan of Correction. As the enclosed Report details, the Program received a regulatory insufficiency in the area of Program Policies and Procedures in July, 2015 and February, 2016; a regulatory insufficiency in the area of Nurse Review in December, 2014, July, 2015 and February 2016 and a regulatory insufficiency for failure to follow their Plan of Correction in July, 2015 and February, 2016.

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 **one thousand three hundred dollars ($1,300)** 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 **$2,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

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

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

Sincerely,

Jim Friberg

Jim Friberg, Bureau Chief
Adult Services Bureau

Enclosure
cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

DEPARTMENT OF INSPECTIONS AND APPEALS

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	S0261	A. BUILDING: _____ B. WING _____	C 02/16/2016

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

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A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 22 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 24 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 23 Total Population of Program at time of on-site: 26 TOTAL census of Assisted Living Program: 50 This on-site included: a second revisit to 50041-I, a revisit to the Recertification, a revisit to 53410-I, a revisit to 53862-I, a revisit to 53865-I and a new Complaint investigation, 57595-C. During this investigation, the following areas were found to be in compliance: Evaluation of Tenant, Criteria for Admission/Retention, Tenant Documents, Service Plan, (included identified needs and activities for persons with dementia), Food Service, and Structural.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the	A 003		

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A 003	Continued From page 1 policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on observation, interview and procedure review, handwashing, medication administration, and use of the sharps container was not completed according to the Program's procedures. 1. Staff A was observed during a medication pass to Tenant #19 on 2-10-16 at 7:17 a.m. Staff A had applied gloves to administer oral medications. Staff A removed the gloves and used his bare hands to administer a nasal spray. Staff A left the apartment without washing his hands. On 2-10-16 at 8:00 a.m. Staff A entered Tenant #16's apartment and a blood sugar was checked. Staff A removed his gloves and proceeded to roll up the gloves and shred a paper towel and put them into a sharps container. Staff A reported the gloves and towel had blood on them. In order to get the items into the sharps container, Staff A used his finger to push the items into the container. The RN came into the apartment and stated gloves and paper towels did not go into a sharps container, and fingers should not be put into a sharps container. After administering pills, Staff A washed his hands but did not use soap. According to the hand washing procedure, soap was to be used. Staff A entered Tenant #20's apartment at 8:15 a.m. on 2-10-16 to obtain medications. Gloves	A 003		

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A 003	Continued From page 2 were applied. The gloves were removed and hands were not washed. Staff A left the apartment to go to the dining room to administer medications to Tenant #20. 2. On 2-10-16 at 10:57 a.m. Staff A and Staff E had completed toileting Tenant #17. Staff A and Staff E had applied gloves for the task and provided perineal care after toileting. Staff A and Staff E did not remove gloves or wash hands before leaving the bathroom. In an interview with the RN on 2-11-16 she stated handwashing was outlined in the eye drop procedure. Hands were to be washed prior to the use of gloves, and hands were to be washed once gloves were removed.	A 003		
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: Complaint #57595-C alleged tenants did not receive personal cares such as bathing and toileting. Based on observations and review of tenant documents, the Program did not ensure tenants received personal cares and services as directed by service plans. Tenants did not receive care, treatment and services which were adequate and	A 013		

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A 013	Continued From page 3 appropriate. 1. Tenant #14, a 91 year-old, was admitted on 7-3-13 and diagnoses included: unspecified dementia without behavioral disturbances, disease of upper respiratory tract, edema, sleep apnea, hypertension, arthritis and enlarged prostate. Tenant #14 was staged at a six on the GDS, which indicated severe cognitive decline. Tenant #14 resided in the dementia unit. Review of Tenant #14's service plan, dated 8-19-15, stated Tenant #14 required assistance to the toilet, peri care, and disposal of incontinence products four times a shift. Tenant #14 was observed on 2-9-16 from 4:20 p.m. to 7:25 p.m. During this time, no staff approached Tenant #14 to assist Tenant #14 with toileting. Review of tasks sheet indicated staff provided toilet assistance at 2:45 p.m., 6:11 p.m. and 10:08 p.m. The monitor did not observe staff provide the assistance to Tenant #14 at 6:11p.m as documented on the task sheet. Staff did not provide the four assists per shift as specified in Tenant #14's service plan. Observations on 2-10-16 from 7:09 a.m. to 10:40 a.m. revealed no staff approached Tenant #14 to assist Tenant #14 with toileting. Review of task sheets for the 6:00 p.m. to 2:00 p.m. shift indicated staff documented toilet assist at 7:59 a.m. The monitor did not observe staff who documented the task assist Tenant #14. Additional review of the task sheet indicated staff provided toilet assistance at 6:49 a.m., 7:59 a.m. and 11:10 a.m. Staff did not provide the four assists per shift as specified in Tenant #14's service plan. Staff D was interviewed on 2-10-16 at 4:10 a.m. and stated Tenant #14 was toileted at midnight and otherwise refused toileting. Staff D was observed at 5:33 a.m. in Tenant #14's apartment	A 013		

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A 013	Continued From page 4	A 013		

offering a shower. Staff D did not assist with toileting and did not check to see if Tenant #14 was wet.

The service plan for Tenant #14 documented Tenant #14 required showers twice a week. Task sheets for Tenant #14 were reviewed. There were no documented showers between 12-14 and 12-22-15. There were no documented showers between 1-18 and 1-27-16.

On 2-10-16 at 7:25 a.m. Tenant #14's bed was observed to have smears of feces on the sheets. At 11:30 a.m. Tenant #14's bed was observed to be made. The sheets with the smears of feces remained on the bed. The Manager was notified and stated it was not acceptable.

3. Tenant #17, a 74 year-old, was admitted on 4-1-12 and had diagnoses of: dementia, weight loss, hypertension, Parkinson's, and osteoarthritis. On 10-9-15 Tenant #17 was staged at six on the GDS which indicated severe cognitive decline. Tenant #17 resided in the dementia unit. Tenant #17 was admitted into hospice on 10-9-15 for Alzheimer's and weight loss.
At 10:20 a.m. on 2-10-16, a Wednesday, Staff A entered Tenant #17's apartment. Tenant #17 was laying across the bed in the same position the monitor observed at 5:12 a.m. Staff A was asked if Tenant #17 had received breakfast. Staff A reported he didn't usually work in the dementia unit but thought a hospice aide came daily to assist Tenant #17 with daily cares. Staff A did not think Tenant #17 went to the dining room for breakfast.
In an interview with the hospice nurse on 2-11-16 at 9:45 a.m., she stated hospice was no longer providing an aide daily and had stopped those

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A 013	Continued From page 5 services at the end of the previous week. Staff A reported Tenant #17 shared the apartment with another tenant and there was a common bathroom. The bathroom had a strong odor of feces; there were feces in the toilet and the toilet had not been flushed. At 10:26 a.m. Staff A used a wheelchair to transfer Tenant #17 from the bedroom to the bathroom. Staff A flushed the toilet, but the strong odor remained. At 10:37 a.m. Staff A was in the bathroom with Tenant #17 waiting for another staff member to assist with the transfer of Tenant #17 to the toilet. Staff A had broken the peel on a banana and was offering Tenant #17 the banana in the odor-filled bathroom while waiting for another staff member. Tenant #17's service plan dated 10-9-15 documented Tenant #17 needed assistance with grooming including putting toothpaste on a toothbrush and putting a hairbrush in Tenant #17'st hand. On 2-10-16 at 10:57 a.m. Staff A and Staff E had completed toileting Tenant #17. The Tenant's teeth and hair were not brushed. Toothbrushes in the bathroom identified by Staff E as belonging to Tenant #17 were dry and had not been used. On 2-10-16 at 3:49 p.m. Staff F was interviewed and stated Tenant #17 was showered. Staff F stated Tenant #17's teeth were not brushed with the shower. The toothbrushes in the bathroom remained dry. Tenant #17's service plan dated 10-9-15 documented Tenant #17 needed assistance with showers. The task sheets revealed the Program was completing showers on Monday, and hospice was completing showers on Wednesday and Friday. A review of the December 2015 and January 2016 task sheets did not contain documentation on any Monday that a shower was given. Hospice visit notes dated 1-13-16 and completed	A 013		

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A 013	Continued From page 6 by the hospice RN documented Tenant #17 was in bed resting when the hospice nurse arrived. Documentation included the hospice RN found Tenant #17's hands to be dirty with sweet potatoes served at lunch. The hospice RN cleaned Tenant #17's hands.	A 013		
A 036	481-67.5(6)a Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on tenant file review and observation, medications were not administered consistent with physician orders. 1. Tenant #16, an 81-year-old, was admitted on 11-30-12 and had diagnoses of: dementia, diabetes, hypertension, heart disease, and peripheral vascular disease. On 9-25-15 Tenant #16 was staged at four on the Global Deterioration Scale (GDS) which indicated	A 036		

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

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A 036	Continued From page 7 moderate cognitive decline. Tenant #16 resided in the dementia unit. During a medication pass on 2-10-16 a prescription bottle of antibiotic was observed in the locked medication box. The bottle contained tablets but Staff A was not observed taking any tablets from the bottle to administer. On 2-10-16 at 8:40 a.m. the RN confirmed there were a total of five tablets remaining in the bottle. The prescription bottle revealed one tablet was to be taken every 12 hours with meals until all tablets were taken. The bottle indicated 20 tablets were dispensed. The clinical record contained a hand-written note to the physician which indicated Tenant #16 had been to the physician's office and the antibiotic was ordered at one tablet twice a day for 10 days for an upper respiratory infection. A review of the medication administration record (MAR) for January 2016 documented the medication was started on 1-27-16. For January 2016, the MAR lacked documentation of the administration of three doses of medication. After reviewing the February 2016 MAR, a total of 18 doses of medication were documented as given. The total number of documented doses was not consistent with the five remaining tablets in the bottle. A nurse review was not completed to ensure the antibiotic was administered consistent with the orders. 2. Tenant #17, a 74 year-old, was admitted on 4-1-12 and had diagnoses of: dementia, weight loss, hypertension, Parkinson's, and osteoarthritis. On 10-9-15 Tenant #17 was staged at six on the GDS which indicated severe cognitive decline. Tenant #17 resided in the dementia unit. Tenant #17 was admitted into hospice on 10-9-15 for Alzheimer's and weight	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0261	A. BUILDING: _____ B. WING _____	C 02/16/2016

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

(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 036	Continued From page 8 loss. A physician's order dated 12-27-15 was written for Bactrim, an antibiotic, one tablet twice a day for 10 days. A review of the December 2015 medication administration record (MAR) revealed the medication was not started until the evening of 12-29-15. There were four doses of medication given in December. Although the medication was documented as given during the day shift in December, the January 2016 MAR documented the medication was not available for administration the first three days of January. The January MAR documented 12 doses were given. Tenant #17 did not receive the medication as prescribed.	A 036		
A 094	481-67.13(4) Exit Interview, Final Report and POC 481-67.13(17A,231C,85GA,SF394) Exit interview, final report, plan of correction. 67.13(4) Monitoring revisit. The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. This REQUIREMENT is not met as evidenced by: Based on a review of the Program's Plan of Correction, the Program did not correct the regulatory insufficiencies for Policies and	A 094		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COURTYARD ESTATES AT HAWTHORNE CRO	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

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A 094	Continued From page 9 Procedures and Nurse Review.	A 094		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(3) To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Based on record review was not completed with a change of condition to assess and document tenants' health status. 1. Tenant #16, an 81-year-old, was admitted on 11-30-12 and had diagnoses of: dementia, diabetes, hypertension, heart disease, and peripheral vascular disease. On 9-25-15 Tenant #16 was staged at four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. Tenant #17 resided in the dementia unit. Progress notes dated 1-27-16 documented Tenant #16 was started on an antibiotic for an upper respiratory infection. The progress notes lacked documentation of a nurse review after the completion of the antibiotic to assess and document the health status of Tenant #17 and to	A 096		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0261	A. BUILDING _____ B. WING _____	C 02/16/2016

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

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A 096	Continued From page 10 monitor progress following the completion of the antibiotic. 2. Tenant #17, a 74 year-old, was admitted on 4-1-12 and had diagnoses of: dementia, weight loss, hypertension, Parkinson's, and osteoarthritis. On 10-9-15 Tenant #17 was staged at six on the GDS which indicated severe cognitive decline. Tenant #17 resided in the dementia unit. Tenant #17 was admitted into hospice on 10-9-15 for Alzheimer's and weight loss. A progress note dated 12-27-15 documented Tenant #17 was found on the floor with a laceration to the forehead. Tenant #17 was sent to the hospital. Hospital notes documented Tenant #17 had a closed head injury and a facial laceration. A nurse review was not completed to assess and document the status of the head wound.	A 096		

Courtyard Estates @ Hawthorne Crossing
601 Hawthorne Crossing Dr. SE
Bondurant, IA 50035

Date: 02/26/2016

Complaint Intake #: 50041-IRV2, 53410-IRV, 53862-IRV, 53865-IRV, 57595-C

Plan of Correction (POC) Submitted For:
- February 6th-19th 2016
- Lori Miner, RN BSN

POC:

A. Policy and Procedures:

a. Regulatory Insufficiency: Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirement. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the report of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2231B,231C,231D))

i. **Program POC:**

1. With respect to Tenant #19, Tenant #20, and all tenants in the program, all tenants will be treated with consideration, respect, and full recognition of personal dignity and autonomy.

2. Staff A, was re-delegated on correct glove usage on 02/19/16. Staff A was also re-educated in medication administration which includes correct sharps disposal usage and nasal spray administration on 02/17/16.

3. All staff received education on handwashing, glove usage, oral hygiene, incontinent care, showers, gait belt usage, and medication administration on 02/19/16 from the Program Nurse.

4. The Program Nurse and/or Program LPN will perform monthly medication pass audits to ensure proper glove usage, handwashing, and medication administration beginning 03/01/16, semi-annual re-trainings on glove usage and handwashing, and annual re-trainings on medication administration.

B. Tenant Rights:

a. Regulatory Insufficiency: Tenant Rights. All Tenants have the following rights: The right to receive care, treatment, and services which are adequate and appropriate. (IAC r. 481-67.3 (2))

i. **Program POC:**

1. All staff received dementia training on 02/24/16. Training included review of toileting, showering and redirection of individuals with dementia.

2. With respect to Tenant #14, individualized service plan included contacting Tenant #14's spouse for assistance with showering. It has been updated effective 02/19/16, to include use of bed bath in a bag and rinse-less shampoo caps to ensure Tenant #14 proper hygiene and cleanliness if bathing is refused. A task has also been initiated for staff to check sheets daily for cleanliness.

3. With respect to Tenant #17, individualized service plan has been updated effective 02/18/16 to include if not participating in transfers to please call for assist and report to RN, and use of gait belt when ambulating.

4. Staff A was re-delegated on correct glove usage on 02/19/16. Staff A was also re-educated in medication administration which includes correct sharps disposal usage on 02/17/16.

5. All staff received education on handwashing, glove usage, oral hygiene, incontinent care, showers, gait belt usage, and medication administration on 02/19/16 from the Program Nurse.

6. The Program Nurse and/or Program LPN will perform monthly medication administration audits to ensure proper glove usage, handwashing, and medication administration beginning 03/01/16, semi-annual re-trainings on glove usage and handwashing, and annual re-trainings on all delegations including oral hygiene, incontinent care, showers, gait belt usage, and medication administration. Program LPN and or Program RN will be stationed in memory care routinely to observe cares, lead and provide education as needed.

C. **Medications:**

a. **Regulatory Insufficiency:** Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5 (6) When medications are administered traditionally by the program: the administration for medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and non-certified staff in accordance with sub rule 67.9(4) or a physician assistant in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant. IAC r. 481-67.5 (6)

i. **Program POC:**

1. With respect to Tenant #16, the physician was contacted on 02/16/16 and made aware of non-completion of antibiotic therapies. The physician replied on 02/19/16 and did not want to continue the use of the medication.
2. With Respect to Tenant #17, the physician was contacted on 02/10 and made aware of the non-compliance of the antibiotic therapies. The physician replied on 02/11 with the instructions to not complete.
3. All Universal Workers were counseled and re-delegated in medication administration and documentation on 02/19/16.
4. The Program Nurse and/or Program LPN will perform monthly medication pass audits to ensure proper glove usage, handwashing, and medication administration beginning 03/01/16, and annual re-training in all delegations including medication administration.
5. All staff received education on handwashing, glove usage, oral hygiene, incontinent care, showers, gait belt usage, and medication administration on 02/19/16 from the Program Nurse.

6. All staff received dementia training on 02/24/16. Training included review of toileting, showering and redirection of individuals with dementia.

D. Exit Interview, Final Report and POC:

a. Regulatory Insufficiency: Monitoring revisit. The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of plan of correction to determine compliance (IAC r. 481-67.13(4)).

1. The POC will be discussed routinely during our morning stand-up meetings with Community Manager, RN and Coordinator Staff. To ensure proper communication of compliance.
2. The Program Nurse and/or Program LPN will perform monthly medication pass audits to ensure proper glove usage, handwashing, and medication administration beginning 03/01/16, and annual re-training in all delegations including medication administration.
3. Nurse Reviews will be completed according to policy and procedure; follow-up with be tracked using a calendar entry and electronic reminders forwarded to community manager.
4.

b. 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 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 tenant's health status.

i. **Program POC:**

1. With respect to Tenant #16 the physician was contacted on 02/16/16 and made aware of non-completion of antibiotic therapies. The physician replied on 02/19/16 and did not

want to continue the use of the medication. A nurse review has been completed to reflect doctor's wishes.

2. With respect to Tenant #17 a full Change of Condition has been completed effective 02/18/16 to reflect changes of status.

3. Nurse reviews will be completed according to Policy and Procedure; follow-up will be tracked using a calendar entry and electronic reminders forwarded to manager.

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