IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 39674-C

September 12, 2012

Mr. Jim Hunter, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

RE: I. Final Complaint/Incident Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Mr. Hunter:

I. Final Complaint/Incident Investigation Report – Legacy Gardens, Iowa City, IA

Enclosed is the **Final Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69. The Report notes Regulatory Insufficiency in the area(s) of: Criteria for Admission and Retention.

Legacy Gardens ("Program") is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Program failed to comply with regulatory requirements. The non-compliance resulted in imminent danger or a substantial probability of resultant death or physical harm to a tenant. Tenant exceeded Level of Care, was physically aggressive to tenants and staff, grabbing tenant's and staff's wrists, pushing staff, hitting with silverware and swinging.

II. Civil Penalty

If, within 30 days of the receipt 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 481–67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of three hundred twenty five dollars ($325) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on September 6, 2012, has been reviewed and will constitute the final POC related to the on-site visit of July 12, 17 and 18, 2012. The Request for Reconsideration has been denied. Tenant #4 exceeded level of care as evidenced by staff interviews, review of incident reports and documentation found in the tenant's file.

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 within 30 days of this letter.

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

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program: **Complaint/Incident Intake #:** 39674-C

Jim Hunter, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

Date of Complaint/Incident Investigation:

July 12, 17 & 18, 2012

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: *In preparing this report, the following information was considered:*

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	11
Number of tenants with cognitive disorder:	20
Total Population of Program at time of on-site	31
TOTAL census of Assisted Living Program	31

Program History – – The program received regulatory insufficiencies during the August 2011 on-site (35306-C, 35174-I) in the areas of Service Plan, Medications, Nurse Review, Staffing and Policy and Procedure. The program received a regulatory insufficiency in the area of Nurse Review during the January 4, 2012 Incident (36964-I) investigation.

Complaint/Incident Investigation - The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Tenant Rights

Complaint/Incident Allegation: It was alleged a staff member was forceful with a tenant and the tenant had bruises.

- Monitoring Observation: Four tenant files (Tenants #1, #2, #3 and #4) were reviewed. Per interviews and review of tenant files, Tenant #1 was identified as verbalizing an alleged situation regarding bruises to staff.

  Tenant #1, an 83 year old, was admitted on 6-14-11 and diagnoses include: Parkinson's, Atrial Fibrillation, Remote Anteroseptal Myocardial Infarction, Dementia, Hyperlipidemia and Hepatitis. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. A service plan completed on 4-20-12 indicated Tenant #1 was independent in ambulation with stand by assist as needed. Mobility devices used were a roller walker and wheelchair for long distances. The service plan indicated Tenant #1 was not oriented to person, place or time.

  According to Staff #6, when she worked on 6-16-12, she overheard Tenant #1 tell a staff member Tenant #1 had bruises on the forearm. Tenant #1 said it was a big guy with big hands and Tenant #1 didn't know if he meant to hurt Tenant #1 or if he just had big hands. Staff #6 waited until the next day to talk with Tenant #1. Staff #6 asked about any bruises and Tenant #1 said it happened about a week ago. Staff #6

said she didn't see any bruises but remembered a small oval red and peachy discoloration on Tenant #1's forearm but it was not purple. She immediately informed the Executive Director (ED) who called the Director of Nursing (DON). Staff #6 and the DON checked on Tenant #1. No bruises were observed on Tenant #1's arms. Tenant #1 said Tenant #1 had a bruise on the back, but observation of the back did not reveal any bruises. Staff #6 did not feel it was an abuse situation.

According to the DON, on 6-22-12, the ED called her to tell her Staff #6 reported to him Tenant #1 said a staff member had bruised Tenant #1. The DON immediately went to Tenant #1's room and asked if Tenant #1 felt Tenant #1 was in any danger. Tenant #1 said, no and asked why? The DON asked Tenant #1 if Tenant #1 felt scared and in any harm. Tenant #1 replied no and the DON then completed a head to toe skin assessment and no bruises were noted. At that time, the DON called Staff #6 to ask her to accompany the DON to Tenant #1's apartment to show the DON the bruises Staff #6 reported. Staff #6 accompanied the DON and during the skin reassessment said there were no bruises. The DON again asked Tenant #1 if Tenant #1 felt at harm and Tenant #1 replied "they just don't know how to treat an old..."

The ED said Staff #6 told him another employee hurt Tenant #1's arm but after talking with Tenant #1 there was no recall of the situation, no bruising or marks on the arm and Tenant #1 said the situation never happened. The ED said there was no bruising and no abuse in any way.

Tenant #1 was interviewed and said Tenant #1 had lived at the Program for a few months. Tenant #1 said some staff treated Tenant #1 well; like with anything there were different personalities. Tenant #1 said Tenant #1 did not feel safe at the Program because there was always something going on, like fire drills and people coming in and out. Tenant #1 said several months ago a staff member pushed Tenant #1 down which resulted in two broken legs. It was someone who worked at the Program and the staff member was let go the next day. Tenant #1 said it was a nice place and kept clean.

The DON said in December 2011 Tenant #1 lived at the Assisted Living Program on the campus, was independent in ambulation and had a fall. Tenant #1 was sent to the hospital and had a short stay. Tenant #1 had suffered a non-displaced pelvic fracture and was then transferred to the Program due to a decreased cognitive state. The DON stated Tenant #1 had not suffered any fractures while at the Program.

Staff #1, #2, #5, the DON and the ED stated incident reports were completed when bruises were noted on a tenant.

An Incident Report dated 6-11-12 indicated another tenant was standing in Tenant #1's doorway and motioned for staff to come over and asked for help. Upon entering Tenant #1's apartment, Tenant #1 was found on the floor. Staff called the nurse on duty. No visible injuries, bruises, abrasions or skin tears were noted. Tenant #1 was very confused and stated Tenant #1 had pain in the lower back. Clinical Notes dated 6-12-12 indicated no injury was noted from the fall. Tenant #1 showed confusion and had mild pain in the lower back. Tenant #1's family member declined wanting Tenant #1 to be seen and the doctor was made aware. Tenant #1's doctor ordered a

urine specimen to be obtained. Tenant #1 was diagnosed with a Urinary Tract Infection and an antibiotic was ordered for seven days.

Per a tenant interview, staff interviews, files audits, an interview with the DON and the ED, it could not be determined what or if something occurred with Tenant #1. No injuries were observed by the DON.

A review of Tenant #1's file did not reveal any documentation of the head to toe skin assessment. The DON said she did not document the situation because she did not observe any bruises. An incident report of the situation was not found. The DON said an incident report was not completed as she did not feel it was necessary. While a deviation from requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.

B. Program Reporting to the Department

Complaint/Incident Allegation: It was alleged a tenant left the building and it was not reported to the Department.

- Monitoring Observation: Incident reports for the last three months were reviewed. Per staff interviews, review of incident reports and file audits of four tenant files (Tenants #1, #2, #3 and #4) Tenant #3 and Tenant #4 were identified in incidents regarding leaving the building.

  Tenant #3, an 87 year old, was admitted on 8-16-11 and diagnoses include: Dementia, Lumbar Spinal Stenosis, Hypothyroidism, Hyperlipidemia and Osteoarthritis. Tenant #3 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #3 was discharged on 11-11-11.

  According to an Incident Report dated 10-22-11, Tenant #3 came into the lobby from the east side of the Program walking with a couple while chatting. The DON and ED were in the lobby talking and asked Tenant #3 where Tenant #3 was going. Tenant #3 replied "we are going up to see..." and then returned to the conversation with the couple. Tenant #3 and the couple exited the front door and continued walking towards the independent living building on the campus. The DON watched them walk until they were at the front door and then the DON went back to the east side to work. Approximately one and a half hours later the DON received a call from Tenant #3's spouse that Tenant #3 was at the apartment. The DON explained the situation and Tenant #3's spouse was very upset and the spouse would bring Tenant #3 back. Tenant #3's spouse expressed there were no other visitors with Tenant #3. Tenant #3 had moved from independent living to the Program and Tenant #3's spouse visited daily and occasionally would walk Tenant #3 to independent living. There were no visible changes and Tenant #3 was wearing proper clothing and shoes. Tenant #3 was observed leaving the building and was observed walking into the independent living building where Tenant #3's spouse resided. An incident report was completed.

The incident did not meet the definition of an elopement and did not require notification to the Department.

Tenant #4, a 78 year old, was admitted on 7-31-11 and diagnoses include: Alzheimer's Disease, Hypertension, Chronic Obstructive Pulmonary Disease, Hard of Hearing (HOH) and Arthritis. Tenant #4 was staged at a five on the GDS, which indicated moderately severe cognitive decline.

According to an Incident Report dated 5-2-12, from 3:40 to 4:20 p.m. Tenant #4 became agitated and began opening the southeast and northeast doors saying Tenant #4 was going home. Tenant #4 then went out of the east lobby door and towards the lobby entrance. Staff tried to convince Tenant #4 to stay and stood in front of the lobby door to block the exit. Other family members were leaving and unlocked the door and Tenant #4 became more determined to leave. Tenant #4 got angry toward staff and pushed them out of the way and made his/her way out of the door. The nurse was called and four nursing staff attempted to take Tenant #4 into the building. Tenant #4 refused activities and an attempt was made to distract Tenant #4 with ice cream. Tenant #4 was convinced to go back to the building for a coat. There were no injuries or visible changes and no complaints of pain. According to the Incident Report, staff was with Tenant #4 and observed Tenant #4 leaving the building. An incident report was completed. The incident did not meet the definition of an elopement and did not require notification to the Department.

The ED said if someone walked out the door and a staff member did not see them, it would be considered an elopement. An elopement would absolutely be reported to the Department. He said there was a time when he and the DON were working the 3 p.m. to 11 p.m. shift and Tenant #3 came into the lobby with two other visitors and said, "we are going up to..." Tenant #3 said they were going to the independent living building. The ED watched all three people walk to the building while visiting with each other. Later on Tenant #3's spouse called and said Tenant #3 was at the apartment and asked how Tenant #3 got there. No other situations like that occurred. The ED said Tenant #3 was not in harm's way.

Staff #1, #2 and #5 did not identify any tenants who had eloped. The Program provided a Missing Tenants policy.

Per incident reports, tenant file audits and staff interviews, Tenant #3 and Tenant #4 had incidents which involved leaving the building. According to incident reports and staff interviews, Tenant #3 and Tenant #4 did not leave the building without staff knowledge. Incident reports were completed related to the incidents and there was no harm or injuries identified. The incidents were not required to be reported to the Department as the tenants did not leave the building without staff knowledge.

- Regulatory Insufficiency: None noted.

C. Criteria for Admission and Retention

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #4's file was reviewed.

According to an Incident Report dated 5-2-12, Tenant #4 became agitated and began opening the southeast and northeast doors saying Tenant #4 was going home. Tenant #4 then went out of the east lobby door and towards the lobby entrance. Staff tried to convince Tenant #4 to stay and stood in front of the lobby door to block the exit. Other family members were leaving and unlocked the door and Tenant #4 became more determined to leave. Tenant #4 got angry toward staff and pushed them out of the way and made his/her way out of the door. The nurse was called and four nursing staff attempted to take Tenant #4 into the building. Tenant #4 refused activities and an attempt was made to distract Tenant #4 with ice cream. Tenant #4 was convinced to go back to the building for a coat. There were no injuries or visible changes and no complaints of pain.

Clinical Notes dated 5-3-12 indicated Tenant #4's family member was called and came in and an as needed medication was given. Tenant #4 calmed down and there were no further issues.

A fax to the physician indicated the date was 5-3-12 and notified the physician Tenant #4 had an episode where Tenant #4 went outside and staff had a difficult time getting Tenant #4 back inside and to please advise. The physician responded with a date of 7-12-12 and said the information was too distant and if Tenant #4's behaviors were an issue to arrange for a clinic evaluation. The fax back from the physician was noted on 7-13-12. Clinical Notes dated 7-13-12 indicated the physician faxed back related to the episode on 5-3-12 and stated Tenant #4 could be evaluated in the clinic. Geri psych had already given new orders related to the behaviors.

According to an Incident Report dated 5-6-12, Tenant #4 wanted to go outside and staff told Tenant #4 the door alarm would go off. Tenant #4 said Tenant #4 did not care and was leaving. Staff tried to redirect away from the door by offering coffee. Tenant #4 said Tenant #4 was getting the "hell" out of there and shoved staff back against the wall and went out the door.

Clinical Notes dated 5-7-12 indicated on 5-6-12 Tenant #4 was taken to the emergency room (ER) for evaluation because of increased agitation. Tenant #4 returned to the Program with a new order for Alprazolam 1 mg twice daily and 1 mg daily as needed, not to exceed 3 mg in a day. The service plan was reviewed and additional interventions were listed on the service plan.

According to Clinical Notes, on 5-8-12 an appointment was made for Tenant #4 at geri psych for 5-10-12. According to Clinical Notes, on 5-10-12 a new order was received to discontinue scheduled and as needed Xanax. Lorazepam 0.5 mg twice daily and Lorazepam 0.5mg by mouth daily as needed was ordered and Paxil was decreased from 40 mg to 30 mg.

According to an Incident Report dated 6-24-12, Tenant #4 was in the dining room for dinner when Tenant #4 became upset and began to grab silverware off the table. Staff called additional staff to help with behaviors and Tenant #4 became more violent, hitting with silverware and swinging. A nurse was called to help with Tenant #4 and took Tenant #4 out of the dining room.

Staff #3 said she was assisting tenants out to dinner when Staff #7 said Tenant #4 was getting aggressive so she went up to Tenant #4 and Tenant #4 swung silverware at her. Tenant #4 had a glass in one hand and about 12 pieces of silverware in the other hand. She asked Tenant #4 what was wrong, speaking loudly since Tenant #4 was HOH. Tenant #4 threw the silverware at another table. Staff #3 then asked Staff #7 to help when Tenant #4 grabbed Staff #7's arm.

Staff #4 came and removed Tenant #4 to calm Tenant #4 down. Tenant #4 held Staff #7's wrist for about six minutes. Staff #4 said she was called to the east side to help. When she opened the door she saw Tenant #4 standing with handfuls of silverware. Staff #4 saw two staff members trying to block and prevent Tenant #4 from hurting other tenants and trying to get the silverware from Tenant #4. Staff #4 said she walked up and told the other staff to walk away. Staff #4 looked at Tenant #4, motioned to Tenant #4 and said "come with me." Tenant #4 responded okay and followed Staff #4 to Tenant #4's apartment. Once Tenant #4 calmed down, Staff #4 put her hand out and Tenant #4 handed her the silverware.

According to an Incident Report dated 6-28-12, Tenant #4 followed Tenant #5 and Tenant #6 into an apartment. Tenant #5 yelled at Tenant #4 to get out and Tenant #4 just stood there and Tenant #5 put Tenant #5's fist up at Tenant #4 and then Tenant #4 grabbed both of Tenant #5's wrists. Both Tenant #4 and Tenant #5 had a few more words then another tenant lead Tenant #4 away towards a staff member. Tenant #4 did not have any injuries. Tenant #5 had pink areas around both of Tenant #5's wrists. Tenant #5 said it hurt a little.

Clinical Notes dated 7-6-12 indicated in the last week Tenant #4 had no behavior issues and had as needed medication one time. Tenant #4's family member suggested that a tenant of the opposite sex that resided next to Tenant #4 move apartments. As Tenant #4 thought the other tenant was Tenant #4's spouse and Tenant #4 was upset when Tenant #4 talked to the other tenant and there was no response. The DON told Tenant #4's family that the other tenant's legal representative would have to approve the trade and Tenant #4 might need to move if the other family did not want to move their loved one.

Clinical Notes dated 7-13-12 indicated that geri psych was contacted and medications were reviewed. A new order was received to increase Ativan to 0.5 mg three times daily. A device was provided to assist with Tenant #4 being HOH.

According to an Incident Report dated 7-13-12, Tenant #4 was in Tenant #7's apartment and Tenant #7 asked Tenant #4 to leave Tenant #7's apartment. Tenant #4 put Tenant #4's fist up and Tenant #7 put Tenant #7's fist up and in the process fell down. Tenant #4 and Tenant #7 did not have any injuries or complaints of pain.

According to Clinical Notes dated 7-13-12, Tenant #7's spouse witnessed the incident and said there was no physical contact. Tenant #4 did not have any injuries and was calm at the time of the assessment.

The service plan reflected interventions including if Tenant #4 became aggressive to step away, call for additional help, once help arrived to stand back and let additional

staff redirect. Offer a snack, allow Tenant #4 to share feelings, take to Tenant #4's apartment, take on a walk, engage in a simple card game or small puzzle. If interventions did not work then additional as needed medications may be given. Offer coffee, call Tenant #4's family member and let Tenant #4 talk to Tenant #4's family member on the phone or the family member would come in. If Tenant #4 was persistent about wanting to go out then staff could take Tenant #4 for a walk, if Tenant #4 wanted to go the courtyard Tenant #4 could do so and staff would check on Tenant #4 every 15 minutes. Staff should not gather around in multiples as it could make Tenant #4 more aggressive.

Incident reports and Clinical Notes indicated from 5-2-12 to 7-13-12 Tenant #4 had pushed staff out of the way to get out a door, Tenant #4 shoved staff against the wall, became violent and grabbed silverware off the table, grabbed Tenant #5's wrists after Tenant #5 raised Tenant #5's fist at Tenant #4. Tenant #5 had pink areas around the wrists. Tenant #4 raised Tenant #4's fist at Tenant #7 and Tenant #7 raised Tenant #7's fist and in the process fell down.

Interventions included as needed medication, an ER visit, medication adjustments with geri psych, a hearing device to help with hearing deficit and various interventions listed on the service plan.

Staff #1, #2 and #5 said staff was physically and verbally harmed by tenants and identified Tenant #4. Staff #1 said Tenant #4 holds arms back and swings at staff. Staff #2 said when Tenant #4 was agitated Tenant #4 grabbed staff. Staff #5 said Tenant #4 had grabbed a staff member's wrist.

The ED stated there were no issues with level of care with Tenant #4. There had been no injuries to tenants or staff. Tenant #4 was not a harm to self or others.

The DON said none of the tenants exceeded level of care. She said she had concerns about level of care regarding Tenant #4 due to Tenant #4's behaviors. She had added new interventions to the service plan on 7-13-12. Tenant #4 was HOH and a family member provided a hearing device. Tenant #4 had not had any physical contact with other tenants or with staff. Another dose of Ativan was added to Tenant #4's medications.

Tenant #4 was observed on 7-17-12. Tenant #4 ambulated independently and had a steady gait. Tenant #4 was asked Tenant #4's name and did not provide that information. Tenant #4 raised Tenant #4's right leg and kicked forward and said "Oh no I wouldn't do that." Tenant #4 appeared to do so in a joking manner. Tenant #4 interacted with another tenant with no issues observed.

An occupancy agreement was signed 7-30-11 by Tenant #4's legal representative. The occupancy agreement indicated the Admission and Retention Criteria.

The Program's Admission and Retention Requirements policy was reviewed. The policy indicated the Program shall not knowingly admit or retain a tenant who: was dangerous to self or other tenants or staff, including but not limited to a tenant who: despite intervention chronically elopes, was sexually or physically aggressive or

abusive, or displays unmanageable verbal abuse or aggression or displays behavior that places another tenant at risk.

Review of Tenant #4's file, staff interviews and review of incident reports indicated Tenant #4 exceeded the level of care.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: Is dangerous to self or other tenants or staff, including but not limited to a tenant who: Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression or Displays behavior that places another tenant at risk. (IAC r. 481-69.23(1)(c)(1-2))

D. Other

Complaint/Incident Allegation: It was alleged tenant supplies were not available as needed and staff was instructed to borrow supplies from another tenant.

- Monitoring Observation: A tour of the Program revealed two boxes of gloves (100 per box) were stored in the west medication room. One box of 10 super size protective undergarments and 16 protective pads were stored in the east medication room. In a nurse's office was one package of 26 protective undergarments, one box of gloves, two boxes of wipes, extra mattress protectors and a box of tissues. The DON office revealed five boxes of gloves (100 per box).

  Staff #1 said supplies were ordered by the tenant's family. If supplies were short, she called the family to order more. If hospice was in charge of supplies she would call them to order more. Staff #1 stated supplies were not available when needed because they were not ordered on time. Sometimes she would borrow a supply from someone else and then replace what was borrowed.

  Staff #2 said staff ordered supplies through the pharmacy or the family provided them. She said most of the time supplies were available when needed. They had not run out of supplies recently. If supplies did run out, she borrowed from another tenant and replaced what was borrowed when the supplies arrived. Staff #2 said she made a note of who she borrowed supplies from so she could replace them. She said she needed to borrow supplies about once a month.

  The DON said staff went from room to room and made a list of supplies that were needed and gave the list to the nurse and items were ordered from the pharmacy unless the family wanted to bring in supplies. Whenever staff noticed items were low they informed the nurse. The DON said supplies were available when needed. If supplies did run out, there was an on-call pharmacist who would deliver supplies or the medication aide could take supplies that were stored in the medication rooms or go to another building on campus to obtain supplies or call the family. The DON said it was rare that supplies were not available and she had never directed staff to take supplies from another tenant.

According to the ED, the Program supplied toilet paper and the family purchased tenant supplies either from the pharmacy or brought them in for the tenant. Staff reported when it was time for the family to bring in more supplies. The ED said staff did a good job of keeping on top of ordering supplies. The ED said supplies were available when needed. When supplies ran out the nurse was notified and supplies were reordered. If supplies were completely out there was a back up supply. He said extra gloves were in the kitchen and there were always extra protective undergarments. To his knowledge, staff was aware of the availability of extra supplies. He said it had never been reported to him that staff had run out of supplies. It was not the Program's policy to borrow supplies from another tenant and the ED did not want staff to borrow from another tenant.

A Supply Policy was available and stated the Program provided toilet paper and paper towels. If family did not prefer to bring in supplies, the items could be ordered from the pharmacy of choice of the family. Staff was to notify the nurse that the tenant needed items and they were to list the items needed. The nurse then filled out a form which was located in the pharmacy binder at the reception desk and the form was faxed to the pharmacy and supplies were delivered that evening.

A supply policy was available and a process was in place to provide supplies for all tenants. Extra supplies were observed to be available. Interviews with the ED and DON said supplies were available when needed. Although extra supplies were observed at the Program, staff interviews indicated staff had borrowed supplies and replaced the supplies. The borrowing of supplies did not appear too frequent; however, had occurred. While a deviation from requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.