IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint/Incident Intake #: 40184-I
40159-C
40187-C

October 5, 2012

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

RE: I. Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Standard Certification
V. Conclusion

Dear Mr. Hunter:

I. Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report – Legacy Gardens (Program), Iowa City, IA

Enclosed is the **Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapter 481—67 and 481—69. The Report notes the Regulatory Insufficiencies in the area(s) of: Policies and Procedures, Tenant Rights, Medications, Staffing, Tenant Documents, Service Plans and Nurse Review.

Legacy Gardens is being assessed a $3500 civil penalty pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC 67.12(3)(a)(1)(2). The Program failed to comply with regulatory requirements. The non-compliance resulted in imminent danger or a substantial

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report

Assisted Living Program:

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

Complaint/Incident Intake #: 40184-I
40159-C
40187-C

Date of Complaint/Incident Investigation & Monitoring Visit:

August 23, 27, 28, 29, 30, 2012 & September 6, 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:	5
Number of tenants with cognitive disorder:	25
Total Population of Program at time of on-site	30
TOTAL census of Assisted Living Program	30

Tenant/Family Satisfaction Results – Interviews were conducted with two family members and one tenant. They said the building was clean and staff cleaned all the time. Anything needed was taken care of immediately. Staff was described as pretty good and wonderful; never a harsh word was said. Tenants were treated with compassion by staff and a nurse was either on duty or available by cell phone at all times. Family members were notified of tenant changes. Breakfast was described as great although the rolls were hard to cut. Lots of macaroni, pasta and turkey were served. A family member stated the tenant didn't like the food, was a picky eater, yet had gained weight since moving to the Program. A family member stated although there were a lot of activities, some tenants were resistant to participate in them. A tenant enjoyed a bus ride every week with a family member. The family members said they felt the Program was safe. A family member said the Director of Nursing (DON) was outstanding. No suggestions for improvements were made. The monitors observed a variety of activities throughout the day.

Program History – The Program did not receive any regulatory insufficiencies during this certification period.

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

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas:

A. Policies and Procedures

Complaint/Incident Allegation #40159-C: It was alleged narcotics were not counted.

Monitoring Observation: According to the Program's Narcotic Count Policy, all narcotics were to be counted at every change of shift by both the departing and oncoming medication administering Registered Nurses (RNs)/Licensed Practical Nurses (LPNs)/Certified Medication Aides (CMAs)/Oral Medication Techs (OMTs)/Medication Managers. Narcotics were also to be counted whenever a change of RN/LPN/CMA/OMT/Medication Manager occurred in the middle of the shift. The

Controlled Drugs Count Record was to be signed by both persons counting. Each Controlled Drug Administration Record for each narcotic was to be initialed by both counting persons, dated and timed in the verification column. Narcotics were to be signed out at the time they were administered by the administering RN/LPN/CMA/OMT/Medication Manager on the Controlled Drug Administration Record and appropriate medication sheet.

Staff #2 said the process for counting narcotics included two medication managers or one medication manager and a nurse counting medications before and at the end of each shift. Staff #3 said staff got another medication aide or a nurse and both count and sign. This process was completed one time per shift; she tried to do so at the beginning of the shift, but needed a nurse or medication aide and overnight staff was not medication aides. If she counted at the beginning of the shift, she didn't count at the end of the shift. According to the DON, narcotics should be counted at the beginning and end of each shift.

A monitor witnessed a narcotic count being performed on 8-27-12 between the day shift medication manager and oncoming evening nurse at 3:10 p.m. The narcotic record for Tenant #17 was signed and the count was correct.

Controlled Drug Inventory Sheets for two tenants (Tenants #1 and #17) were reviewed. The records indicated staff did not complete narcotic counts according to the Program's Narcotic Count Policy.

A review of the narcotic record for Tenant #1 reflected inconsistency in signing at shift change. Between 7-24-12 at 3:00 p.m. through 7-31-12 at 7:00 a.m., there were 11 entries where medications were counted and not administered at those times. Based on three entries per day, minus three (one count proceeded the timeframe and two occurred after the timeframe) there needed to be a total of 21 entries. The narcotic medication was not counted at shift change by oncoming and departing staff per the Program's policy.

A review of the narcotic record for Tenant #17 reflected inconsistency in signing at shift change. Between 7-12-12 and 8-28-12, there were 33 entries where medications were counted and not administered at those times. If narcotic counts were conducted at the beginning and end of each shift, based on three entries per day, there needed to be a total of 144 entries. The narcotic medication was not counted at shift change by oncoming and departing staff per the Program's policy.

Review of the Program's Narcotic Count Policy and Controlled Drug Inventory sheets indicated the Program did not count and document narcotics according to the Program's policy.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)

B. Tenant Rights

Complaint/Incident Allegation #40159-C: It was alleged a tenant had a Do Not Resuscitate (DNR) order that was not signed by a physician and a tenant was resuscitated.

- Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16). The files reviewed consistently had Cardio Pulmonary Resuscitation (CPR) status designated and the order was signed by a physician. Tenant #2's Clinical Notes indicated CPR was initiated due to the DNR form not being signed by the physician.

  Tenant #2, a 90 year old, was admitted on 8-28-11 and diagnoses include: Dementia, Coronary Artery Disease, Osteoarthritis and Hypercholesteromia. Tenant #2 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #2 was discharged from the Program on 7-22-12.

  According to an Explanation of CPR/NO CPR form, each tenant must chose a CPR or NO CPR status. If CPR status was chosen or the form was not completed and the tenant was found without a heart rate and not breathing, the Program staff would immediately call 911. If NO CPR status was chosen, appropriate comfort measures would be provided and if the tenant or responsible party requested, the tenant may be transferred to the hospital. The form in Tenant #2's file was signed by the guardian and the attending physician and NO CPR was indicated. The form was signed by the guardian on 8-23-11 and signed by the attending physician on 8-25-11.

  According to Clinical Notes dated 7-22-12 (entry for 7-21-12 at 11:00 a.m.), Tenant #2 was noted to be slouched down in a chair with chin to chest and notable right sided slump. Tenant #2 was not easily aroused, would not respond immediately to voice, and when aroused appeared very lethargic. Tenant #2's clothing was drenched in sweat, speech was jumbled (per usual at times), no facial drooping, grips were equal and strong, pupils were equal and reactive to light and vitals were obtained. Tenant #2 was assisted to stand with two staff and was able to bear weight per usual. Tenant #2 was noted to drag the left foot. Notes dated 7-22-12 at 1:25 p.m. (entry for 7-21-12 at 11:30 a.m.) indicated a call was made to Tenant #2's guardian regarding a change in condition. Tenant #2's guardian returned a call to the Program and the change of condition at 11:00 a.m. was explained to the guardian. Since 11:00 a.m. Tenant #2's condition had improved. Tenant #2's speech was clear, Tenant #2 was noted to ambulate independently without dragging the left foot (per usual). Tenant #2 continued to be very tired but would not lie down. The guardian decided Tenant #2 would be best kept at the Program versus going to urgent care for an evaluation. According to Clinical Notes dated 7-22-12 at 7:02 p.m. (entry for 7-21-12 at 8:07 p.m.), Tenant #2 was noted to be restless and was unable to lie still. Tenant #2 had complaints of abdominal pain, bowel sounds were active in all four quads and vitals were obtained. A call was placed to Tenant #2's guardian and the guardian was asked again if the guardian wanted Tenant #2 taken in for an evaluation or monitored at the Program. The guardian preferred to keep Tenant #2 at the Program and requested a call if symptoms worsened. Clinical Notes dated 7-22-12 at 7:28 p.m. (entry for 7-21-12 at 8:45 p.m.) indicated Tenant #2 continued to have abdominal pain and was assisted to the bathroom. A digital rectal exam was performed by a nurse and a hard formed stool was just inside the rectum. Tenant #2 was able to pass a large stool with

nurse assistance. Abdominal discomfort was relieved and Tenant #2 was up ambulating in the hallway per usual. The guardian was updated regarding Tenant #2's relief of stomach discomfort. Clinical Notes dated 7-22-12 at 9:24 p.m. (entry for 7-21-12 at 10:30 p.m.) indicated Tenant #2 was assisted to bed, denied stomach discomfort and appeared tired but comfortable. Clinical Notes dated 7-22-12 at 9:25 p.m. (entry for 7-21-12 at 7:10 a.m.) indicated Tenant #2 was sleeping comfortably in bed with no signs or symptoms of discomfort. Clinical Notes dated 7-22-12 at 10:10 p.m. (entry for 7-22-12 at 7:43 a.m.) indicated a nurse was summoned to Tenant #2's apartment by staff who stated Tenant #2 had dark red bloody substance on Tenant #2's lip. Upon entering the apartment, Tenant #2 was noted to have a small amount of dark red bloody substance running down the right side of the face and did not appear to be breathing. No breath sounds and no heart beat were found and 911 was called immediately. Clinical Notes indicated a DNR form, face sheet and all necessary forms obtained by staff. A nurse remained with Tenant #2, notified the guardian that Tenant #2 had expired and 911 was called. Clinical Notes dated 7-22-12 at 10:32 p.m. (entry for 7-22-12 at 7:44 a.m.) indicated the first responders arrived and began CPR. After a few minutes a pulse was evident and Tenant #2 was transported to a local emergency room (ER). According to Clinical Notes dated 7-22-12 at 11:17 p.m. (entry for 7-22-12 at 7:55 a.m.), a call was placed to inform the guardian the DNR papers were not signed by the physician therefore the paramedic was required to initiate CPR. They were able to obtain a pulse and Tenant #2 was transported to a local ER. Clinical Notes dated 7-22-12 at 11:21 p.m. (entry for 7-22-12 at 9:14 p.m.) indicated the ER nurse called and requested DNR papers, face sheet and Medication Administration Record (MAR) to be faxed and also stated that Tenant #2 expired at 9:14 a.m.

The Corporate Nurse said on Sunday morning she received a call from staff who said Tenant #2 had died. Staff called 911 and family before calling the Corporate Nurse. Staff told her the DNR form was not signed by the physician. The Corporate Nurse told staff if it was not signed by a physician it was not an active order and Tenant #2 was a full code. First responders (911) arrived and were able to get a pulse and Tenant #2 was sent to the hospital. The Corporate Nurse instructed staff to call the family back and staff had already done so. The Corporate Nurse said the family was pleased with the care, was not upset but said Tenant #2 would not have wanted it.

Staff #2 said resuscitation status was listed on the front of the tenant chart and was in the emergency book that was kept in each medication room. Staff #3 said resuscitation status was on the face sheets located in the medication room. The DON said the resuscitation status was listed in the emergency contact book. The ED said the resuscitation status was listed in a binder in the nurse's area on both sides of the building.

At the time Tenant #2's file was reviewed, a DNR form was found signed by the physician and by the guardian, which indicated NO CPR. Clinical Notes indicated CPR was initiated due to the DNR form not being signed by the physician. Tenant #2 was resuscitated despite a signed form to not resuscitate. Tenant #2 did not receive care, treatment and services regarding end of life choices which were adequate and appropriate.

- Regulatory Insufficiency: All tenants have the following rights: To receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

C. Medications

Complaint/Incident Allegation #40159-C: It was alleged medications were crushed that could not be crushed.

- Monitoring Observation: According to the Crushing Medications Policy, it was the policy of the Program to crush medications as ordered by the physician. Prior to crushing any medications, the pharmacist must assess for safety to be crushed and shall be documented on the MAR. Medication tablets may be crushed or capsules emptied out when a tenant had difficulty swallowing. The guidelines used when crushing medications included: the tenant's MAR must indicate the necessity for crushing the medication, long-acting or enteric coated medications may not be crushed without a physician's order, medications should be crushed in paper cups to prevent contact between the drug and the crushing device and crushed medications should be given with applesauce or some other soft foods or liquids to ensure that the tenant received the entire dose ordered.

  Staff #2 said she was not aware of any medications being crushed that should not be crushed. She said there were not a lot of crushed medications and those that needed to be crushed had a physician's order to crush. Staff #3 said she was not aware of any medications being crushed that should not be crushed. The DON said there were not any medications being crushed that should not be and there were orders to crush the medications. The ED did not identify any concerns with medications being crushed that should not be crushed.

  During the medication passes no medications were crushed. A notation of the ability to crush a medication was observed on the MARs.

  The Program had a policy on Crushing Medications and followed the policy as indicated. Observation of medication crushing directions was noted on the MARs during medication passes.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #40159-C: It was alleged CMAs were giving narcotics.

- Monitoring Observation: According to the Program's Narcotic Count Policy, all narcotics were to be counted at every change of shift by both the departing and oncoming medication administering RNs/ LPNs/CMAs/OMTs/Medication Managers. Narcotics were also to be counted whenever a change of RN/LPN/CMA/OMT/Medication Manager occurred in the middle of the shift. The Controlled Drugs Count Record was to be signed by both persons counting and signed in the appropriate place. Each Controlled Drug Administration Record for each narcotic was to be initialed by both counting persons, dated and timed in the verification column. Narcotics were to be signed out at the time they were

administered by the administering RN/LPN/CMA/OMT/Medication Manager on the Controlled Drug Administration Record and appropriate medication sheet.

The DON said CMAs administered narcotics. A review of nurse delegations reflected training on narcotic administration and narcotic counts. Nurse delegations were completed for Staff #1, #2 and #5.

During the observed medications passes, no narcotics were administered.

According to the Narcotic Count Policy, CMAs were listed as one of the staff to administer and count narcotics. The DON verified CMAs administered narcotics and nurse delegations were provided related to the task. IAC Chapters 67 and 69 did not prohibit CMAs from administering narcotics.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #40159-C: It was alleged as needed medications were not offered and CMAs did not know what as needed medications were for.

Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16). There were no issues identified in the files regarding the lack of as needed medications offered for those tenants that had as needed medications prescribed.

Staff #2 said as needed medications were offered appropriately. A medication manager would notice if behaviors or anxiety were present and a tenant would need an as needed medication. Staff #2 said staff passing medications knew what as needed medications were for and if not they would ask a nurse. Staff #3 said staff did offer as needed medications appropriately. Staff #3 said she would hope everyone knew what the as needed medications were for and if not there were medication books in the medication room. The DON said more education could always be given to staff regarding as needed medications and when to give and when not to give. The DON said she would think the staff passing medications would know what the as needed medications were for and if not, they should ask. The ED said staff offered as needed medications appropriately, knew what as needed medications were for and staff was trained.

Review of tenant files and interviews did not identify any issues with lack of as needed medications being offered.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #40159-C: It was alleged pudding that was used to administer medications was not kept cold after opening.

Monitoring Observation: Staff #2 said pudding was labeled by the kitchen and then labeled and dated by the medication staff. Pudding was signed, dated and timed when staff got it. She preferred not to use it after two hours. The same container of pudding or yogurt was used for a medication pass, but a different spoon and cup was

used to serve it. Staff #3 said pudding was used for Tenant #7's medication pass at 9:00 a.m. The pudding was dated and timed. She scooped out what was needed and left the rest in the refrigerator. The DON said the pudding needed to be removed from the medication cart every six hours. It should be covered, dated, timed and initialed. The ED said pudding or yogurt was kept in the refrigerator with date. The pudding could be out for three to four hours without growth.

During the medication pass on 8-27-12 at 8:40 a.m., a container of pudding was observed on the top of the medication cart. The pudding container had been opened and was dated 8-27-12. During a medication pass on 8-27-12 at 2:50 p.m. the pudding was not on the top of the medication cart. Staff #1 was asked about the pudding and she stated she had disposed of it prior to the end of her shift. Observation of a container of pudding retrieved from the refrigerator indicated "Keep Refrigerated" on the label.

Interviews indicated inconsistent practice regarding use of food products for medication administration that were labeled "Keep Refrigerated." 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.

Complaint/Incident Allegation #40159-C: It was alleged medications were not ordered on time and a tenant did not receive the prescribed dose of medication because a sufficient amount of the medication was not available.

Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16).

Tenant #5, a 76 year old, was admitted on 6-27-11 and diagnoses include: Alzheimer's/Dementia. Tenant #5 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Review of MARs indicated medications were consistently available.

Tenant #10, a 77 year old, was admitted on 6-6-12 and diagnoses include: Dementia, Hypertension (HTN), Deep Vein Thrombosis and Osteoporosis. Tenant #10 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Review of MARs indicated medications were consistently available.

Staff #2 said if a new medication was ordered it was started that night or the next day. Staff #3, the DON and the ED said medications were ordered in a timely manner when there were medication changes.

Review of tenant files and interviews indicated medications were consistently available.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #40159-C: It was alleged medications were not dated.

Monitoring Observation: The refrigerators located in both locked medication rooms were inspected. A review of the refrigerator contents on 8-27-12 at 3:00 p.m. revealed insulin pens were boxed and labeled with Tenant #17's name. Staff #2 said only one tenant used insulin pens. She knew the pen with the top off had been opened but was not labeled or timed. She stated the pens were good for 30 days. Staff #3 said she didn't know if insulin pens were dated when used because she didn't give insulin because only the nurses administered insulin. She did know that Tenant #17 had insulin pens in the refrigerator. The DON said she was not aware that anyone dated the insulin pens as they were good for 45 days and they would be cycled through before that time.

On 8-27-12 at 3:20 p.m., Staff #2 was asked to show a monitor Tenant #10's medication vials. A vial of Octreotide Acetate was taken from the refrigerator. It was inside a plastic prescription bottle with a small slip of paper in the bottom that was dated 8-11-12. The label on the vial said to discard 14 days after opening. The vial was still being used on 8-27-12 which was 16 days after the vial had been opened. At 4:20 p.m. the DON and a monitor searched the refrigerator for additional vials. One unopened vial of the medication was found in the refrigerator. The DON stated she would immediately dispose of the expired vial of medication. A review of the medication vial on 8-28-12 at 11:20 a.m. reflected a vial of Octreotide Acetate had been opened and was dated and timed on the box and on the bottle that reflected the date opened and also indicated the discard date.

Medication was not appropriately labeled and Tenant #10 received expired medication.

Complaint/Incident Allegation #40159-C: It was alleged medication orders were not changed and a tenant had a medication change and the medication change was not followed up on.

- Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16). Tenant #4 had a medication change that was not reflected on the MAR.

  Tenant #4, a 90 year old, was admitted on 6-22-11 and diagnoses include: Alzheimer's Disease, Constipation, Gastro Esophageal Reflux Disease (GERD), HTN, Pain and Stroke. Tenant #4 was staged at a six on the GDS, which indicated severe cognitive impairment. According to a fax to the physician dated 5-14-12, Tenant #4's family member said the neurologist suggested Namenda be discontinued and in 30 days Aricept be discontinued. According to a physician order dated 6-1-12, continue Aricept and restart Namenda 5 mg twice daily for two weeks and then increase to 10 mg twice daily. A fax to the physician dated 7-7-12 indicated Tenant #4's family member questioned why Tenant #4 was on Namenda and not on Aricept. The physician indicated on 7-10-12, Tenant #4 was supposed to be on Aricept but if not, start 5 mg for one month and then 10 mg daily.

  Clinical Notes dated 6-1-12 at 3:33 p.m. indicated new orders were received to restart Namenda at 5 mg for two weeks and then increase to 10 mg. The physician also

ordered to continue Aricept; however, the continuation of Aricept was not documented in Clinical Notes when the order was received for both the Aricept and Namenda.

The order for Aricept 5 mg by mouth daily for one month was on the July 2012 MARs with a 7-10-12 order date and a 7-11-12 start date. The August 2012 MARs reflected Aricept 5 mg by mouth daily until 8-11-12 and then Aricept 10 mg with a 8-12-12 start date.

On 6-1-12 the physician ordered to continue Aricept and start Namenda at 5 mg for two weeks and then increase to 10 mg twice daily. The Aricept continuation was not reflected in Clinical Notes or on the MAR. The medication was ordered again on 7-10-12 and reflected on both the July 2012 and August 2012 MARs.

A medication order was not reflected on MARs for Tenant #4.

Complaint/Incident Allegation #40159-C: It was alleged a tenant had multiple falls and had not been receiving medication. It was alleged a tenant fell after a medication change that was ordered but not done and the tenant sustained a fracture.

- Monitoring Observation: Tenant #6, a 68 year old, was admitted on 2-1-12 and diagnoses include: Diabetes Mellitus, Alcohol Abuse, Hyperlipidemia, HTN, Peripheral Neuropathy and Tobacco Abuse. According to a Medication Error Report dated 8-28-12, Tenant #6 had Vitamin B12 1000 mcg intramuscular (IM) once a month ordered. The medication order was entered incorrectly in the system which resulted in it not appearing on the MAR correctly and not being administered. There was no actual effect of the error made on Tenant #6. The physician was notified and Tenant #6 was notified. Precautions to prevent a similar error included to review the proper way to enter injections into the system. The date of the error was noted as 3-23-12. According to Clinical Notes dated 8-28-12 (entry for 8-27-12), a nurse review was completed.

  The service plan reflected the B12 injections. The MARs did not reflect the Vitamin B12 injections had been administered, once per month as ordered.

  According to a fax to the physician dated 8-27-12, it was noted Tenant #6 had an order for B12 which was to be given monthly. It was noted Tenant #6 had not received the medication since March. A request was made to restart the medication. It was noted Tenant #6 had no side effects from not receiving the medication. The physician ordered to restart B12 at 1000 mcg IM monthly. Clinical Notes were reviewed and did not identify any falls for Tenant #6.

  Tenant #7, a 79 year old, was admitted on 1-31-11 and diagnoses included: Dementia, Parkinson's Disease and Hypothyroid. Tenant #7 was staged at a five on the GDS, which indicated moderately severe cognitive decline. According to a Medication Error Report dated 7-19-12, the date of the error was 12-7-11 at 12:15 p.m. and the medication was Vitamin B12 1000 mcg injection once monthly. On 12-7-11 an order was entered incorrectly, which resulted in the injection not being administered from January to April (four doses total). The error was a transcription error, according to the report. The physician and family were notified.

According to a fax to the physician dated 7-19-12, it was noted that related to a computer error Tenant #7 did not receive the B12 injections for the months of January through April. The dose was to be 1000 mcg monthly. No adverse reactions were noted. MARs from December 2011 through April 2012 did not reflect the order for the B12 or the administration of the medication as ordered. MARs from May 2012 through August 2012 reflected the order for B12 and also reflected the medication was administered as ordered. Clinical Notes reflected Tenant #7 had falls during the time Tenant #7 did not receive B12 as ordered and also when Tenant #7 received the B12 as ordered. Fall interventions were listed on Tenant #7's service plan.

Tenant #11, a 94 year old, was admitted on 5-10-11 and diagnoses include: Dementia, HTN, Osteoporosis and Hyperlipidemia. Tenant #11 was staged at a five on the GDS, which indicated moderately severe cognitive decline. According to Clinical Notes dated 7-9-12, Tenant #11 was started on Zoloft 50 mg on 7-6-12 and then had four falls causing skin tears and a need to be seen in the ER. No new orders were given and it was requested Tenant #11 see Tenant #11's personal care physician (PCP). Tenant #11 saw a PCP on 7-9-12 and new orders were received as follows: discontinue Lisinopril and check blood pressure twice daily, redress upper extremity wounds, obtain urine for culture, cath specimen for urinalysis, order physical therapy (PT) to evaluate and treat, assure Sertraline (Zoloft) was every HS, and lower the mattress to the floor. The August 2012 MAR reflected Zoloft 50 mg tab by mouth at bedtime at 8:00 p.m., first date given was 7-10-12 for depression. The MARs were completed appropriately without exception. Tenant #11's file did not reflect any evidence of any fractures. The DON said Tenant #11 had not had any fractures.

Tenant #11 received medications as ordered. Tenant #6 and Tenant #7 did not receive B12 injections as ordered.

Monitoring Observation: During the medication pass on 8-27-12 at 11:00 a.m., Staff #1 combined Tenant #15's Risperidone Oral liquid 0.25 ml and K Cl Oral 10% solution 22.5 ml. The medications were mixed together in a liquid medication cup and then added to juice. The MAR did not indicate that the medications could be combined. When asked, Staff #1 said she had verbally been told the two medications could be mixed together in water. A call to a pharmacy revealed that there were no contraindications in combining these two medications with juice or water. The Program addressed the situation immediately by adding directions on the MAR that stated the medications could be combined.

During a walk through on 8-30-12 at 10:14 a.m., a medication cart was observed to be unattended and unlocked. At 10:17 a.m., Staff #2 walked past the medication cart and was notified by a monitor the cart was unlocked. Staff #2 said she had been passing medications and then realized she had to do 10:00 a.m. checks so she left the cart. During the time the cart was left unattended, a monitor observed one tenant sitting at a dining room table and two other tenants walking in the common areas of the unit, passing the medication cart. The medication cart was located in a central area between the dining room and the living room.

Tenant #1 was ordered Morphine Sulfate (Roxanol) 5 mg/0.25 ml sublingual (SL) every one hour as needed for pain and dyspnea. The July 2012 MAR reflected an

order for Roxanol 5 mg which was to be given in liquid form of 0.25 ml SL every hour as needed for pain and dyspnea. The order date was 7-23-12. A photocopy of the box of Morphine Sulfate Oral Solution was obtained. The prescription label on the box indicated Tenant #1 was ordered Morphine Sulfate take 0.25 to 1 ml (5-20 mg) every two hours as needed for pain. The Controlled Drug Inventory Sheet for Tenant #1 reflected the medication was Morphine Sulfate 100 mg/5 ml (20 mg/ml) take 0.25 to 1 ml (5 to 20 mg) every two hours as needed for pain. The prescription label on the box and the medication listed on the Controlled Drug Inventory Sheet reflected Morphine Sulfate take 0.25 to 1 ml every two hours for pain. The order and the MAR reflected Morphine Sulfate 0.25 ml every hour for pain and dyspnea. The prescription label on the box and Controlled Drug Inventory Sheet did not match the physician order and the MAR.

A review of MARs indicated the effectiveness of as needed medications were not consistently charted and held or refused medications did not consistently have an explanation. The table below represents examples.

Tenant #1	Roxanol 5 mg which was to be given in liquid form of 0.25 ml SL every hour as needed for pain and dyspnea	On 7-27-12 at 4:11 p.m. the MAR reflected Roxanol was administered. A document indicated a PRN med was given at 4:12 p.m., no medication was identified but it was given for moderate pain all over. No effectiveness was charted.
Tenant #1	Roxanol 5 mg which was to be given in liquid form of 0.25 ml SL every hour as needed for pain and dyspnea	On 7-27-12 at 7:02 p.m. the MAR reflected Roxanol was administered. A document indicated a PRN med was given at 7:02 p.m.; no medication was identified but it was given for severe aching pain/discomfort all over. No effectiveness was charted.
Tenant #1	Roxanol 5 mg which was to be given in liquid form of 0.25 ml SL every hour as needed for pain and dyspnea	On 7-29-12 at 3:59 a.m. the MAR reflected Roxanol was administered. A document indicated a PRN med was given at 4:02 a.m., no medication was identified but it was given for pain to relax and comfort. No effectiveness was charted.
Tenant #10	Sandostatin 0.15 ml	On 7-19-12 at 8:00 p.m.

	subcutaneously (SQ) twice daily at 8:00 a.m. and 8:00 p.m.	charted as either held or refused; no explanation provided
Tenant #10	Sandostatin 0.15 ml SQ twice daily at 8:00 a.m. and 8:00 p.m.	On 7-27-12 at 8:00 a.m. charted as either held or refused; no explanation provided

- Regulatory Insufficiency: When medications are administered traditionally by the program: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

D. Staffing

Complaint/Incident Allegation #40159-C: It was alleged many tenants were not receiving oral care. It was alleged a tenant had an order to use an electric toothbrush and it was unopened and unused.

- Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16). Tenant #10 had an order for an electric toothbrush.

  Tenant #10's file was reviewed. A Physician Visit Form dated 6-28-12 indicated Fluoride Mouth Rinse weekly (once weekly) and a rotary toothbrush, brush up on gum tissue and needed to return for more restorative work. The Fluoride Mouth Rinse to be swished and spit was added to the MARs. The service plan was updated on 6-29-12 and indicated Tenant #10 was independent with oral care; however, staff needed to make sure Tenant #10 was completing the task two times per day as well as using the rotary toothbrush.

  On 8-27-12 at 3:20 p.m., a review of a medication cart revealed Tenant #10's electric toothbrush. The toothbrush was not in a package and had been used. Staff #2 said the toothbrush had been used that morning. Mouthwash was observed in the treatment drawer for Tenant #10.

  Staff #2, #3, the DON and ED said oral hygiene was being completed. Interviews were conducted with two family members and one tenant. They did not identify any concerns with cares or services.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #40159-C: It was alleged several tenants were not being toileted and not given perineal care.

- Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16). The files reviewed reflected varying levels of toileting assistance needed.

Tenant #6's file was reviewed. The service plan updated was on 5-10-12 and reflected Tenant #6 required assistance of one for toileting. The toileting schedule was every two hours and as needed. Tenant #6 wore protective undergarments.

Tenant #8, a 91 year old, was admitted on 8-3-10 and diagnoses include: Alzheimer's Dementia, Osteoporosis and Hyperlipidemia. Tenant #8 was staged at a five on the GDS, which indicated moderately severe cognitive decline. The service plan was updated on 8-2-12 and reflected Tenant #8 required cues, reminders or oversight for toileting and needed assistance with perineal care. Staff was to monitor toilet and flush as needed.

Tenant #13, an 87 year old, was admitted on 2-23-12 and diagnoses include: Dementia and L1 fracture. Tenant #13 was staged at a four on the GDS, which indicated moderate cognitive decline. According to the Nurse Review completed on 6-15-12, Tenant #13 went to the restroom independently.

Staff #2, #3, the DON and the ED said perineal care and toileting was being completed. Interviews were conducted with two family members and one tenant. They did not identify any concerns with cares or services.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #40187-C: It was alleged a tenant received an overdose of a medication.

Complaint/Incident Allegation #40184-I: It was reported by the Program, a tenant received an overdose of medication, a reversal drug was refused by the tenant's legal representative and the tenant returned to baseline status prior to the overdose. The Program reported days later, the tenant died at a Hospice unit at a local hospital.

- Monitoring Observation: Tenant #1, a 61 year old, was admitted on 5-25-11 with a diagnosis of Dementia. Tenant #1 was staged at a seven on the GDS, which indicated very severe cognitive decline. Tenant #1 received Hospice services and was a DNR. Tenant #1 received medication administration assistance from the Program. Tenant #1 had an enacted legal representative. Tenant #1 was discharged on 8-1-12.

  According to Clinical Notes dated 7-23-12, Tenant #1 went to the hospital on 7-19-12 related to decrease in condition and returned to the Program on 7-23-12. A change of condition evaluation was completed related to nurse review and decline in condition. A new service plan was also completed and task sheets were initiated. According to Clinical Notes, a meeting was held with a Hospice Nurse and Tenant #1's legal representative. With the decline in Tenant #1's health, comfort measures would be provided. Review of Tenant #1's file indicated evaluations and service plans were updated as needed with change in condition.

  According to an Incident Investigation Report, on 7-30-12, Staff #4, an LPN, called the Corporate Nurse at 7:36 p.m. and reported she had made a big mistake. Staff #4 told the Corporate Nurse that she needed to give Tenant #1 Morphine. She read the

MAR, drew 5 ml, and administered the medication, came back to sign it off on the narcotic sheet and realized all other staff gave 0.25 ml. She then read the order again and realized the order read to give 5 mg which was to be administered in liquid form and the dose was to be 0.25 ml. The Corporate Nurse told Staff #4 to get vitals and monitor breathing of Tenant #1 and to stay by Tenant #1's side until she arrived. The DON, ED and Assistant Executive Director were all made aware of the situation and all staff was en route to the Program. The DON called the Hospice Nurse and she gave the direction that they could do the following: Tenant #1 could be sent to the ER or give Tenant #1 Narcan. Tenant #1's legal representative was called several times and could not be reached. Another family member was contacted and was told of the situation, overdose and potential outcome of possible death related to the respiratory system being suppressed. The family member did not want Tenant #1 sent to the ER and did not want Narcan administered. The DON spoke with the Hospice Nurse who had spoken with Tenant #1's legal representative who also wanted no treatment. The Hospice Nurse was updated and was asked to be onsite with the Narcan in case the family had a change of mind. The local police department was called and came to conduct an investigation. On 7-31-12 at 4:00 p.m. Tenant #1 was showing no signs of adverse reaction to the Morphine dosage. Tenant #1 was responsive and was at baseline status prior to the 5 ml dosage of Morphine.

Tenant #1's legal representative signed a document on 7-30-12 that indicated the legal representative was aware of the potential adverse reactions of the drug, Morphine Sulfate, and that if not reversed, could lead to the death of Tenant #1. The document was signed by Tenant #1's legal representative, the ED and the DON.

Clinical Notes dated 7-31-12 indicated Staff #4 called the Corporate Nurse and indicated she made a big mistake. Staff #4 told the Corporate Nurse Tenant #1's spouse was "pressuring" her to give Tenant #1 Morphine and she gave 5 ml instead of 0.25 ml. The DON called into the Program to talk with Tenant #1's spouse, staff was unclear that the person was not the spouse but a family friend. Vitals were taken and cares were provided throughout the night. At 6:58 a.m. respirations were 6-10 per minute and were no longer labored, pulse was 72 and regular and extremities were warm to touch and no mottling was noted. The physician advised medications could be restarted as ordered and stated the Morphine should have been out of Tenant #1's system. Tenant #1 became more alert, was tearful and responded when attempting to swab out the mouth. Tenant #1's legal representative was given an update on Tenant #1. Clinical Notes dated 8-1-12 indicated Tenant #1's legal representative reported Tenant #1 was going to be transferred to a Hospice unit at a local hospital. The legal representative said it had nothing to do with the situation. At 1:10 p.m. Tenant #1 was transferred to a Hospice unit. According to Clinical Notes dated 8-7-12 (entry for 8-4-12) it was reported Tenant #1 had died.

Staff #4 was interviewed. She said she had come to the Program from the other Assisted Living Program (ALP) on the campus to administer injections. She worked originally at the other ALP on the campus and in the last month was at the Program more. She said initially she would come to the Program to administer insulin and cancer medication injections. On the day of the incident, she said she worked 7 a.m. at the other ALP on the campus and at about 7:30 p.m. came to the Program and one staff was late leaving. The staff gave Staff #4 the bottle of Roxanol. Staff #4 said a person she believed was Tenant #1's spouse requested pain medication for Tenant #1.

Staff #4 looked at the MAR, measured it to 5 ml, put in the syringe and gave it to Tenant #1. After Tenant #1 took the medication, Staff #4 went to the narcotic sheet and realized she had made a mistake. She called the DON and the Corporate Nurse. The Corporate Nurse told her to call Hospice, monitor vitals and not to leave Tenant #1. The DON, Corporate Nurse, ED and Hospice Nurse arrived at the Program. She recalled everything that happened to them, left around 9:00 p.m. or 9:30 p.m. and went home. At about 11:00 p.m. or 11:30 p.m. she met with police and told them what happened. She said she was working a 16 hour shift and was supposed to work until 11:00 p.m. She had given Tenant #1 Tylenol a week or two prior. She had never given the medication (Morphine Sulfate) before. She said the Tylenol was the first liquid medication she had given and the Morphine Sulfate was the second time she had given any liquid medication. Staff #4 was an LPN and was used to assisting with insulin injections and had been shown injections. After the incident, the six medication rights training and training on administration of oral solutions was completed. She said at times the Program was short staffed and she felt more comfortable after more training was provided.

According to the Corporate Nurse, she was called in the evening about 8:00 p.m. by Staff #4 saying she had made a big mistake. Staff #4 said she had gone to the Program to help with medications. Tenant #1 needed an as needed dose of Morphine. Staff #4 said she gave Tenant #1 5 ml and then went to sign the narcotics sheet and noticed everyone else had given 0.25 ml. The Corporate Nurse told Staff #4 to page Hospice right away and to contact the legal representative. She further advised her to monitor Tenant #1's breathing and vitals and the Corporate Nurse would head there. The DON called Hospice and Hospice said they could get Narcan so the legal representative was called. Staff was unable to reach the legal representative so the next family member in line was called. The family member did not want the Narcan administered and was certain the legal representative would not want Narcan given. When the Corporate Nurse arrived at the Program, the Hospice Nurse was at Tenant #1's bedside talking to the legal representative via telephone. It was explained to the legal representative the extent of the overdose. The legal representative signed a statement indicating refusal of the Narcan. The police department was notified, a police officer arrived and stayed for 12 hours per the Medical Examiner's direction. The police officer left around 7:00 a.m. Throughout the night the Corporate Nurse watched Tenant #1's breathing, repositioned Tenant #1 and made sure Tenant #1 was comfortable. About 3:00 a.m. or 4:00 a.m., Tenant #1 started to return to normal. The Corporate Nurse said she left the Program between 5:00 a.m. and 6:00 a.m. The Corporate Nurse said the DON informed her Tenant #1 was back to baseline around 7:00 a.m.

According to the DON, she received a call from the ED who had been called by Staff #4 who reported she had given a medication and then realized it was the wrong dose. She immediately headed to the Program while calling Hospice and trying to call Tenant #1's legal representative. She reached the next family member in line who contacted the legal representative. Once she arrived at the Program, she immediately went to Tenant #1's room. Staff #4 was in the room obtaining vitals. The DON immediately took over the care of Tenant #1 for the rest of the night. She assessed and checked vitals, respirations were one to two minutes for about 30 minutes and then steadily the vitals returned to baseline. The DON left the Program between 8:30 a.m. and 9:30 a.m. and Tenant #1 was opening eyes and returned back to baseline.

The DON stated she completed the online notification to the Department later that afternoon. Re-education of staff was completed on the use of syringes and how to draw up medication. Effective immediately, she had Hospice pre-draw all injection medications.

The Hospice Nurse said she was paged, called back and was informed by the DON a staff had given Tenant #1 5 ml of Morphine. The Hospice Nurse went to the Program. There was a staff with Tenant #1 when she arrived, taking vitals. The Hospice Nurse obtained vitals and they were fairly unremarkable. She said Tenant #1 was in the final days before the medication overdose occurred. She contacted the physician covering for Tenant #1's primary physician. She said the Medical Director was also contacted, which served as a second physician to the primary. Tenant #1's legal representative did not want Narcan administered or to have Tenant #1 sent to the hospital. The prescription for Narcan was filled in case it was needed. The DON stayed throughout the night. The Hospice Nurse said Tenant #1 seemed comfortable and there was someone with Tenant #1 at all times.

The ED said he received a telephone call from the Corporate Nurse and was told Tenant #1 had received a major overdose. The ED was on the phone with the nurses on the way to the Program. The ED saw Tenant #1 immediately. He said family and Hospice was contacted. He talked to Staff #4 and she said she read the box, drew the medication and was nervous because there was family in the apartment. She looked at the narcotic sheet and saw 0.25 ml and called a nurse immediately. Hospice and the physician were contacted and a reversal drug could be administered. The legal representative came in right away and did not want the reversal drug. The local police department was notified. Tenant #1 was turned every 30 minutes. At about 6:15 a.m. or 6:30 a.m., Tenant #1 was bright eyed and became very agitated. Police saw Tenant #1 was awake and alert. The physician approved medications to be given that morning.

According to an Incident Investigation Report, it was concluded Staff #4 failed to identify the correct dose of medication as properly described on the MAR, resulting in an improper dosage. The Program notified the Department and the Iowa Board of Nursing. The follow up included an in-service on the administration of medication and the rights of medication administration for all staff. Morphine, Ativan and Haldol syringes would be prepared in advance and counted at the end of each shift.

Medication Error and Incident Reports were completed related to the overdose of Morphine Sulfate. The Program notified the Department appropriately.

A document indicated Staff #4 and the DON reviewed information regarding medication administration including reading labels, six rights and checking them three times prior to administration, syringes and syringe markings, medication equations, medications of high alert and protocol if unsure of how to administer medication and or question of medication dose.

According to an addendum to the Program's self report, the unofficial cause of Tenant #1's death was Alzheimer's Disease, natural causes and the death certificate had not yet been completed.

The Staffing policy indicated it was the policy of the Program to maintain competent staff at all times who were able to implement the accident, fire safety and emergency procedures. The management company ensured all personnel employed by the Program received training appropriate to tasks and target population. The determination of how nursing staff would be scheduled would be assessed according to what medications needed to be given on a particular shift, tenant numbers and the level of care tenants needed at a given time.

There was not a sufficient number of trained staff available at all times to fully meet tenants' identified needs.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

E. Criteria for Admission and Retention

Complaint/Incident Allegation #40159-C: It was alleged there were tenants who had behaviors with other tenants.

- Monitoring Observation: Incident reports and Clinical Notes were reviewed and identified behaviors between several tenants including Tenant #3, #5, #12, #13 and #14.

Tenant #3, a 78 year old, was admitted on 7-31-11 and diagnoses include: Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, HTN, Hard of Hearing and Arthritis. Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #3's service plan was updated on 7-20-12 and reflected interventions related to behaviors. Tenant #3 was discharged from the Program on 8-17-12.

Tenant #5's file was reviewed. Tenant #5's service plan was updated on 7-11-12 and reflected interventions related to issues with other tenants.

According to Incident Reports, on 7-18-12 staff ran around the corner and heard Tenant #5 yelling "stop." When staff arrived Tenant #3 had Tenant #5 by the arms and slammed Tenant #5 against the wall. Both Tenant #3 and Tenant #5 were angry. Tenant #3 had coffee on Tenant #3's shoe and it was all over the floor. Tenant #5 had the cup in Tenant #5's hand. Staff stepped between them and was able to get Tenant #3 to let go of Tenant #5. Tenant #3 had a skin tear on right arm with a bruise. Tenant #5 had red marks on both arms where Tenant #3 had grabbed Tenant #5. Tenant #5 reported Tenant #5 did nothing but walked past Tenant #3 with a cup of coffee and Tenant #3 came after Tenant #5. Tenant #3 reported Tenant #3 did nothing. Ice was applied to Tenant #5's arm and staff cleaned and bandaged Tenant #3's arm.

According to Tenant #3's Clinical Notes, dated 7-19-12 (entry for 7-18-12), Tenant #3 was taken to the ER by family. A verbal immediate move out was issued for Tenant #3. Tenant #3 returned from the ER with orders to start Risperdal 0.25 mg twice daily. Checks every 15 minutes and arrangements for one to one supervision were discussed with family. Clinical Notes dated 7-20-12 indicated a formal 30 day notice was sent via certified mail.

According to Incident Reports, on 8-8-12 Tenant #5 said Tenant #3 grabbed Tenant #5's arms and pointed to the inner elbow area. Tenant #5 did not have any bruises or marks on the inner elbow area. Tenant #3 had a large skin tear on Tenant #3's arm and was bleeding. Tenant #3 said Tenant #3 got cut working.

According to Tenant #3's Clinical Notes, on 8-9-12 Tenant #3 was moved to the other side of the Program to a new apartment. Tenant #3 was oriented to the new apartment. Clinical Notes dated 8-17-12 indicated Tenant #3 left the Program permanently.

Tenant #12, an 89 year old, admitted on 1-10-12 and diagnoses include: Dementia, Vitamin B12 Deficiency, HTN and Syncopol Episode. Tenant #12 was staged at a five on the GDS, which indicated moderately severe cognitive decline.

Tenant #13's file was reviewed. According to Tenant #13's Clinical Notes from 7-13-12 to 8-27-12, Tenant #13 had one incident with Tenant #3. No other incidents with other tenants were documented.

Tenant #14, a 79 year old, was admitted on 7-12-12 and diagnoses include: Memory Loss, Polymyalgia Rheumatica, HTN, Trans Ischemic Attack, Cardiomyopathy, Hyperlipidemia and Gout. Tenant #14 was staged at a five on the GDS, which indicated moderately severe cognitive decline. A service plan dated 7-23-12 was updated to include a mood and behavior intervention.

According to an Incident Report dated 7-28-12, Tenant #12 was standing in the bathroom doorway with fist up stating, "I will hit ...again." Tenant #14 was present. According to Tenant #12's Clinical Notes dated 7-30-12 (a late entry for 7-28-12), Tenant #12 was in bed after taking a shower when Tenant #14 tried to enter the room. Tenant #12 got out of bed and was found by Tenant #14 in the bathroom doorway stating "I will hit ... again." No injuries were noted for either tenant. A nurse implemented half hour checks and the family and physician were notified. According to Tenant #12's Clinical Notes dated 8-22-12 for a 90 day evaluation nurse review, Tenant #12 showed no negative behaviors and was cooperative. According to Tenant #12's Clinical Notes dated 8-24-12, Tenant #12 only had one situation of agitation in the last 90 days. Tenant #12 did not exceed level of care.

According to an Incident Report dated 7-21-12 at 8:45 a.m., Tenant #14 was swinging a cane at a staff and made derogatory comments. A nurse, family member and physician were notified. According to an Incident Report dated 7-21-12 at 10:00 a.m., staff was walking with Tenant #14 who pointed a cane at Tenants #3 and #12 and made a threatening statement. Tenant #14 was redirected away from other tenants, 15 minute checks and one to one supervision was provided to prevent a more serious incident from occurring.

Tenants #5, #12, #13 and #14 did not exceed level of care. Tenant #3 was discharged from the Program on 8-17-12.

Staff #2, the DON and the ED did not identify any tenants who exceeded level of care.

Tenant files reviewed and incident reports indicated there had been some behaviors between tenants. Service plans provided interventions related to behaviors and one tenant was discharged. Review of tenant files and interviews did not identify any current tenants that exceeded the level of care.

- Regulatory Insufficiency: None noted.

F. Tenant Documents

Monitoring Observation: Tenant #1's file was reviewed. According to Clinical Notes dated 7-23-12, Tenant #1 went to the hospital on 7-19-12 related to decrease in condition and returned on 7-23-12. A change of condition evaluation was completed related to nurse review and decline in condition. A new service plan was also completed and task sheets were initiated. The task sheets were not consistently completed. On 7-26-12, repositioning every two hours, toileting every two hours and providing perineal care as needed with incontinence at 6:00 a.m. was not documented as completed. On 8-1-12 from 12:00 a.m. through 7:00 a.m. there was no documentation of cares. The task sheet reflected OOF (out of facility); however Tenant #1 did not leave the Program until 1:10 p.m. when Tenant #1 was taken to a Hospice unit. The tasks on the morning of 8-1-12 from 12:00 a.m. through 7:00 a.m. were not documented as completed. Cares were documented at 8:00 a.m., 10:00 a.m. and 12:00 (a.m. sic) p.m. and then OOF was charted when Tenant #1 left the Program. Service plans were updated as needed with changes. Task sheets were initiated and the remainder of the days the task sheets were used Tenant #1's cares were consistently documented as completed.

A task sheet was initiated for Tenant #1; however, the cares were not consistently documented as completed.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care was required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs). (IAC r. 481-69.25(1)(q))

G. Service Plans

- Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16).

Tenant #7's file was reviewed. According to Clinical Notes dated 5-3-12, Tenant #7 was admitted to a local hospital with a diagnosis of a Urinary Tract Infection. The hospital discharge orders indicated to evaluate for outpatient PT. The discharge orders were noted on 5-3-12. Clinical Notes dated 5-10-12 indicated Tenant #7 was going to be evaluated by PT and treatment as appropriate. The service plan was not updated as needed and did not reflect PT services.

Tenant #11's file was reviewed. According to a Program correspondence dated 8-6-12 from Tenant #11's PT provider, PT services were completed on 8-6-12 due to Tenant #11 reaching maximum/prior level. Tenant #11 ambulated independently without a walker. According to a Nurse Review completed on 8-13-12, a change of condition was noted due to Tenant #11's discharge from PT on 8-6-12. A service plan completed on 8-15-12 was not updated to reflect the discontinuation of PT services.

Tenant #12's file was reviewed. According to Clinical Notes dated 8-14-12, Tenant #12 had a change of condition due to returning to the Program after a hospital stay. On 8-15-12, Tenant #12's physician was notified requesting an order for a walker and PT services due to Tenant #12 being a little unsteady on feet with a cane. According to a physician's order dated 8-15-12, the physician ordered a walker and PT to evaluate and treat due to unsteadiness. Tenant #12's service plan was not updated to reflect the use of a walker or the order for PT services.

Tenant files reviewed indicated service plans were not updated as needed to reflect changes including PT services.

- Regulatory Insufficiency: 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 does not exist, the program may after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan. (IAC r. 481-69.26(3)(a))

H. Nurse Review

Complaint/Incident Allegation #40159-C: It was alleged a tenant had an order for daily baths and it was not being completed as ordered.

- Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16). Tenant #9 had an order for bathing.

  Tenant #9, an 89 year old, was admitted on 1-7-10 and diagnoses include: HTN, Dementia, Possible GERD, Constipation, Cellulitis on the Right Foot and Anemia. Tenant #9 was staged at a six on the GDS, which indicated severe decline. According to a Physician Visit Form dated 6-21-12, a new order for daily baths with post bowel movement (BM) cleaning and hygiene was ordered. Desitin ointment daily after cleaning was also ordered. The orders were noted on 6-22-12. A fax was sent to the physician dated 6-22-12 and clarification was requested in regards to the orders from

6-21-12. There was an inquiry as to if Tenant #9 was to receive a full shower each day or a partial bath each day and perform perineal care after each BM. The response was baths and perineal care as ordered. The order was noted on 6-22-12. According to a fax sent to the physician dated 8-29-12, a telephone order was received from the office and as a clarification the order from 6-22-12 read, bathing as ordered and perineal care as ordered.

According to Tenant #9's June, July and August 2012 MARs, Desitin Barrier Cream topical to perineal area after each toileting a.m. and p.m. shift was consistently documented as completed. The daily baths that were physician ordered and BM cleaning and hygiene were not reflected on the MARs.

The service plan reflected Tenant #9 required assistance with bathing and was to have two whirlpools per week. Tenant #9's service plan was updated on 8-27-12 and reflected staff could give Tenant #9 a bath as needed when incontinent of BM and if staff were unable to get BM cleaned up adequately. Staff completed perineal care after Tenant #9 was incontinent of BM.

Staff #2, #3, the DON and the ED said baths and perineal care were being provided. Interviews were conducted with two family members and one tenant. They did not identify any concerns with cares or services.

Tenant #9's physician's order for daily baths and perineal care after each BM was noted; however, was not put on the MARs. Physician orders were not ensured to be current for tenants who received health care professional-directed care.

- Regulatory Insufficiency: 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 ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program. (IAC r. 481-69.27(2))

I. Life Safety

Complaint/Incident Allegation #40159-C: It was alleged window and door alarms were not checked.

- Monitoring Observation: According to the Program's Door and Window Alarms Policy, all door and window alarms were responded to within three minutes to ensure tenant safety. The policy did not reference any scheduled or required maintenance checks for the door and window alarms.

  A door and a window from each side of the building were tested and functioned appropriately at the time they were checked. The monitors were in the building five days and were throughout the building and traveled through various doors. The doors the monitors went through appeared to be functioning appropriately at the time of investigation.

Staff #2, #3, the DON and the ED said the door alarms and window alarms functioned properly. Staff #2 was not aware of the maintenance process and the DON said alarm checks were not completed routinely. The ED said there were no scheduled checks of the doors and alarms; however, staff went through the doors constantly and the doors were always checked. The ED said there had been no issues.

The Program's policy did not address scheduled and documented checks of door and window alarms. Per observations, interviews and a check of window and door alarms there were no issues identified with the door and window alarms.

- Regulatory Insufficiency: None noted.