IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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RODNEY A. ROBERTS, DIRECTOR

September 29, 2015

Ms. Kay Gabriel, Director
Village Terrace Assisted Living
302 Franklin Street
Keosauqua, IA 52565

RE: Final Recertification Monitoring Evaluation Report – Village Terrace Assisted Living, Keosauqua, IA

Dear Ms. Gabriel:

Enclosed is the **Final 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) chapters 481—67 and 481—69, following a survey by DIA on **September 16 & 17, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Medications, Staffing, Evaluation of Tenant, Service Plans, and Nurse Review.

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

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

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

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

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

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

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0174	A. BUILDING: _____ B. WING _____	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE TERRACE AL	302 FRANKLIN KEOSAUQUA, IA 52565

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 9 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 9 Total Population of Program at time of on-site: 9 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000		
A 038	481-67.5(6)c Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: c. The program shall maintain a list of each tenant ' s medications and document the medications administered. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, observation, staff interviews and review of Program documents the Program failed to accurately document the medications administered for three of three tenant files reviewed (Tenants #1, #2 and #3). Staff provided varying levels of assistance of medication administration to three tenants and	A 038		

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A 038	Continued From page 1 the documentation of the actual assistance with medications was not documented. 1. Tenant #1, a 94 year old, was admitted on 7-11-13 and diagnoses included: arthritis, anxiety, high cholesterol, hypothyroidism, hypertension and transient ischemic attack. According to a service plan dated 6-30-15, Program staff administered medications to Tenant #1. According to a medication list dated 9-16-15, Tenant #1 had Hydrocodone-Acetaminophen 5-325 milligram (mg) per tablet, take one tablet by mouth every eight hours as needed. According to observation of a medication pass on 9-16-15, Tenant #1's medications were set up in a medication planner and staff administered. The medication sheet where staff documented their initials indicated a.m., noon and p.m. medications were administered. The medication sheet did not reflect the as needed medication Hydrocodone-Acetaminophen every eight hours as needed for pain. According to an interview with Staff A, Tenant #1 received Hydrocodone in the medication planner twice a day. Tenant #1 had an order for as needed Hydrocodone-Acetaminophen. The medication was set up in a medication planner and per interview with Staff A was administered twice daily. The medication sheets reflected documentation of scheduled medication times such as a.m., noon and p.m. however, did not provide documentation of a medication that was ordered as needed. Medications administered by staff were not documented appropriately. 2. Tenant #2, a 104 year old, was admitted on	A 038		

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A 038	Continued From page 2 7-2-07 and diagnoses included: arthritis and fibromyalgia. According to a service plan dated 8-13-15, Program staff administered medications to Tenant #2. According to a medication list dated 9-2-15, Tenant #2 had Hydrocodone-Acetaminophen 10-325 mg per tablet, take one tablet by mouth every four hours as needed. Another medication list also dated 9-2-15 indicated Tenant #2 received Hydrocodone-Acetaminophen 10-325 mg, one tablet every six hours for pain (8 a.m., 2:00 p.m., 8:00 p.m. and 2:00 a.m.). According to an interview with the Chief Nursing Officer (CNO), Tenant #2's Hydrocodone-Acetaminophen was as needed. The September 2015 medication sheet reflected a.m., noon, 2:00 p.m , supper and bedtime (x 2) medication times. The August 2015 medication sheet reflected a.m., noon and p.m. medications. There was also a handwritten note at the bottom of the medication sheet that indicated pain medications at 2:00 p.m. and two pain medications before staff left. Staff A said before staff left for the end of the shift two Hydrocodone tablets were left in Tenant #2's apartment. One tablet for Tenant #2's bedtime dose at 8:00 p.m. in the kitchen and one dose in the bathroom so if at 2:00 a.m. Tenant #2 needed another dose Tenant #2 would have it. Staff A said Tenant #2 received the Hydrocodone at 8:00 a.m., 2:00 p.m. and then two doses were left, one for bedtime and one for 2:00 a.m. Staff A said they did it that way because they were not staffed after 6:30 p.m. According to Program documentation dated 8-28-15, Tenant #2 did not take the 8:00 p.m. pill the previous night. Staff was told to give it at 2:00	A 038		

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A 038	Continued From page 3 p.m. that day and there was an extra pill in the main medication tray. On 8-31-15 staff documented the 2:00 a.m. pill was still in Tenant #2's bathroom and it used for the 2:00 p.m. pill. Review of the August 2015 medication sheets indicated there were no initials for the two pain pills left at night on 8-27-15, the night Tenant #2 did not take the 8:00 p.m. dose. On 8-30-15 there were initials for the pain pills left at night; however, Program documentation indicated the dose left in the bathroom, the 2:00 a.m. pill, remained and was found on 8-31-15. Tenant #2 had an order for Hydrocodone-Acetaminophen. There were doses set up in the medication planner and staff administered it at 8:00 a.m. and 2:00 p.m. and then two doses were left for Tenant #2 to self administer, one pill at bedtime and one pill at 2:00 a.m. The medication sheets reflected documentation of scheduled medication times however, did not provide documentation of a medication that was ordered as needed. The medication sheets did not reflect staff left two doses in Tenant #2's apartment and Tenant #2 took those medications independently. Program documentation indicated Tenant #2 had not taken doses of the Hydrocodone-Acetaminophen that staff left in Tenant #2's apartment; however, it was not documented on the medication sheet. The medication was given at another medication time despite being dispensed the day before by staff, the medication was left in the Tenant #2's apartment and then administered the next day by the staff on duty. The medication sheets did not accurately reflect the administration of Tenant #2's Hydrocodone-Acetaminophen. Medications that were administered were not documented appropriately.	A 038		

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A 038	Continued From page 4 3. Tenant #3, an 89 year old, was admitted on 4-25-09 and diagnoses included: diabetes mellitus type II and cerebral vascular accident. According to Tenant #3's service plan dated 6-30-15, Tenant #3's insulin and blood sugars were supervised by staff and medications were set up by Tenant #3's family. Tenant #3's medication sheet for September 2015 indicated observe medications a.m., noon and p.m. According to an interview with Staff A, staff observed Tenant #3 take Tenant #3's blood sugars and documented the observation. Staff also observed Tenant #3 draw up Tenant #3's insulin and charted the observation. According to an interview with the Chief Nursing Officer (CNO), staff provided supervision of the administration of insulin and supervision of blood glucose monitoring. Staff did not assist Tenant #3 with the administration of oral medications. Review of the medication sheet indicated staff provided documentation of their initials for observation of a.m., noon and p.m. medications for Tenant #3. The task completed by staff was supervision of the self- administration of insulin and supervision of blood glucose checks. The medication sheet staff recorded their initials did not accurately document the medication administration assistance provided. 4. According to the Program's policy regarding medications, the following requirements should apply when medications were administered or stored by the Program including: medications would be set-up weekly in a seven day medication box by a registered nurse (RN). The RN would delegate to the staff daily dispensing of	A 038		

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A 038	Continued From page 5 medications. Staff would initial and date on the medication record after each tenant was dispensed medications.	A 038		
A 039	481-67.5(7) Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(7) Narcotics protocol shall be determined by the program ' s registered nurse. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews and review of Program documents the Program failed to have a narcotic protocol as determined by the Program's nurse and two tenants received narcotics administered by staff (Tenants #1 and #2). Two tenants received narcotic medications administered by staff and the Program did not have a narcotic protocol determined by the Program's nurse. 1. Tenant #1, a 94 year old, was admitted on 7-11-13 and diagnoses included: arthritis, anxiety, high cholesterol, hypothyroidism, hypertension and transient ischemic attack. According to a service plan dated 6-30-15, Program staff administered medications to Tenant #1. According to a medication list dated 9-16-15, Tenant #1 had Hydrocodone-Acetaminopen 5-325 milligram (mg), take one tablet by mouth every eight hours as needed. 2. Tenant #2, a 104 year old, was admitted on 7-2-07 and diagnoses included: arthritis and fibromyalgia. According to a service plan dated	A 039		

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A 039	Continued From page 6 8-13-15, Program staff administered medications to Tenant #2. According to a medication list dated 9-2-15, Tenant #2 had had an order for Hydrocodone-Acetaminophen 10-325 mg per tablet, take one tablet by mouth every four hours as needed. Another medication list also dated 9-2-15 indicated Tenant #2 received Hydrocodone-Acetaminophen 10-325 mg, one tablet every six hours for pain (8 a.m., 2:00 p.m., 8:00 p.m. and 2:00 a.m.). According to an interview with the Chief Nursing Officer (CNO), Tenant #2's Hydrocodone-Acetaminophen was as needed. 3. According to an interview with Staff A, staff administered narcotic medication to Tenants #1 and #2. Staff A said staff was going to start counting narcotic medication. 4. According to an interview with the CNO, Tenants #1 and #2 received narcotic medication. At the time of the recertification a narcotic policy was not developed; however, the Program would develop a policy for narcotics and it would include counting narcotics once a day at the end of the shift. There were no discrepancies with narcotics, according to the CNO. 5. A policy regarding narcotics was requested and at the time of the recertification a written policy and procedure for the administration of narcotics was not developed. 6. According to the Program's medication administration policy, the following requirements would apply when medications were administered or stored by the Program including: the Program should follow written policies and procedures for narcotic medication in accordance with Iowa chapter 155A.	A 039		

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A 061	481-67.9(4)d Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants ' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on review of staff files, staff interviews, review of staff files and review of Program documents the Program failed to provide staff training on service plan tasks for four of four staff files reviewed (Staff A, B, C and D). One tenant received routine assistance with supervision of self-administration of insulin and supervision of blood glucose checks. Four staff did not have nurse delegated training regarding these tasks. 1. Tenant #3, an 89 year old, was admitted on 4-25-09 and diagnoses included: diabetes mellitus type II and cerebral vascular accident. According to Tenant #3's service plan dated 6-30-15, Tenant #3's insulin and blood sugars were supervised by staff and medications were set up by Tenant #3's family. 2. Staff A, a resident assistant, did not have delegations for the supervision of	A 061		

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A 061	Continued From page 8 self-administration of insulin or supervision of blood glucose monitoring. Staff A did not have documented training on service plans tasks including the assistance provided with Tenant #3's insulin and blood glucose. 3. Staff B, a resident assistant, did not have delegations for the supervision of self-administration of insulin or supervision of blood glucose monitoring. Staff B did not have documented training on service plans tasks including the assistance provided with Tenant #3's insulin and blood glucose. 4. Staff C, a resident assistant/head cook, did not have delegations for the supervision of self-administration of insulin or supervision of blood glucose monitoring. Staff C did not have documented training on service plans tasks including the assistance provided with Tenant #3's insulin and blood glucose. 5. Staff D, a resident assistant/cook, did not have delegations for the supervision of self-administration of insulin or supervision of blood glucose monitoring. Staff D did not have documented training on service plans tasks including the assistance provided with Tenant #3's insulin and blood glucose. 6. According to an interview with Staff A, staff observed Tenant #3 take Tenant #3's blood sugars and documented the observation. Staff also observed Tenant #3 draw up Tenant #3's insulin and charted the observation. 7. According to an interview with the Chief Nursing Officer, staff provided supervision of Tenant #3's self-administration of insulin and blood glucose monitoring.	A 061		

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A 063	481-67.9(4)f Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This REQUIREMENT is not met as evidenced by: Based on observation, a staff interview, review of a staff file and review of Program documents the Program failed to provided services in accordance with the training provided regarding Staff A and the administration of medications administered to two tenants (Tenants #1 and #2). Staff A had documented nurse delegated training on medication administration. During the observation of the medication pass on 9-16-15 Staff A did not provide appropriate sanitation and documentation of medications. 1. Tenant #1, a 94 year old, was admitted on 7-11-13 and diagnoses included: arthritis, anxiety, high cholesterol, hypothyroidism, hypertension and transient ischemic attack. 2. Tenant #2, a 104 year old, was admitted on 7-2-07 and diagnoses included: arthritis and fibromyalgia. 3. Staff A, a resident assistant, had nurse delegated training on medication administration. 4. According to observation of the medication pass on 9-16-15, Staff A served lunch to the	A 063		

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A 063	Continued From page 10	A 063		

tenants and was wearing gloves. Staff A went to the medication room wearing gloves, touched the door handle to the room and the medication cabinet handle. Staff A took Tenant #2's medication from the medication planner and put the medication in a cup. Staff A documented the medication on the medication sheet prior to taking the medication to Tenant #2. Staff A took the medication to Tenant #2 in the dining room. Staff A went back to the medication room, touched the door handle, the medication cabinet handle and took Tenant #1's medication out of the medication planner and put it into a cup. Staff A documented the medication on the medication sheet prior to taking the medication to Tenant #1. Staff A touched the door handle on the way out of the medication room and opened Tenant #1's apartment door handle. Staff A then gave Tenant #1 the medication in a cup for Tenant #1 to consume. Staff A served food to the tenants, administered medications to Tenants #1 and #2 and touched surfaces including: the medication door handle, the medication cabinet handle, Tenant #1's apartment door and did not change gloves or provide any hand sanitation before beginning the medication administration pass or between the administration of medication to tenants. Staff A documented the administration of medications for Tenants #1 and #2 before the medication was administered to the tenants.

5. According to an interview with the Chief Nursing Officer (CNO), the expectations for medication administration was completed verbally with new staff and there was no documentation of the expectations. The CNO said the expectation regarding sanitation was staff washed their hands prior to administering medications and in between administering medications to tenants. The documentation of medication administered should

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A 063	Continued From page 11 occur after the tenant took the medications, according to the CNO.	A 063		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant ' s functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant ' s continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on review of tenant files and review of Program documents the Program failed to complete evaluations as needed with significant change for two of three tenant files reviewed (Tenants #1 and #2). Two tenants had significant changes and evaluations were not completed as needed. 1. Tenant #1, a 94 year old, was admitted on 7-11-13 and diagnoses included: arthritis, anxiety, high cholesterol, hypothyroidism, hypertension and transient ischemic attack.	A 037		

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A 037	Continued From page 12 According to a Progress Note dated 3-30-15, Tenant #1 was admitted to a hospital on 3-29-15 with pneumonia. According to a Progress Note dated 4-1-15, Tenant #1 returned from the hospital and the Program began to administer Tenant #1's medications. A cognitive evaluation was completed on 4-1-15 and the service plan was updated to reflect staff administered Tenant #1's medications for a one month trial. Health and functional evaluations were not completed as needed with a significant change after Tenant #1 was hospitalized for pneumonia, returned to the Program and the Program began administering Tenant #1's medications. Health and functional evaluations were not completed as needed. 2. Tenant #2, a 104 year old, was admitted on 7-2-07 and diagnoses included: arthritis and fibromyalgia. According to a Progress Note dated 8-4-15, Tenant #2 fell getting out of bed to go to the bathroom and had a cut on Tenant #2's lower lip, numerous skin tears and complained of left shoulder pain. Tenant #2 was taken to an emergency room and was transferred to another hospital for an orthopedic evaluation of the left shoulder. According to a Progress Note dated 8-14-15, Tenant #2 returned to the Program after an eight day stay in a private care unit at a hospital. The stay was for mobility and strengthening by physical therapy (PT). According to an interview with the Chief Nursing Officer, Tenant #2 had a dislocated shoulder. Cognitive and functional evaluations were completed and the service plan was updated. A health evaluation was not completed as needed with significant change after Tenant #2 fell, sustained injuries, went to a hospital, had an eight	A 037		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0174	A. BUILDING _____ B. WING _____	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE TERRACE AL	302 FRANKLIN KEOSAUQUA, IA 52565

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 037	Continued From page 13 day stay in a private care unit at a hospital, returned to the Program and received PT services. A health evaluation was not completed as needed. 3. According to the Program's policy regarding evaluations, each tenant would be evaluated within 30 days of occupancy, as needed with a change in condition but not less than annually to determine any modifications to needed services.	A 037		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant ' s identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on review of tenant files, a staff interview and review of Program documents the Program failed to develop service plans that identified the tenants' needs and preferences for assistance for two of three tenant files reviewed (Tenants #1 and #2). Service plans for two tenants did not identify the needs of the tenants and preferences for assistance including for falls and interventions related to falls, comments regarding not wanting to live, tenant self-administration of pain medication and private duty staff. 1. Tenant #1, a 94 year old, was admitted on 7-11-13 and diagnoses included: arthritis, anxiety, high cholesterol, hypothyroidism, hypertension and transient ischemic attack.	A 089		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0174	A. BUILDING. _____ B. WING _____	09/17/2015

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VILLAGE TERRACE AL	302 FRANKLIN KEOSAUQUA, IA 52565

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A 089	Continued From page 14 The service plan reflected Tenant #1 ambulated independently with a wheeled walker. Tenant #1 had a managed risk agreement for falls. The service plan did not reflect the managed risk agreement or that Tenant #1 had falls. The service plan dated 6-30-15 reflected under mental status that Tenant #1's mental status was normal for Tenant #1's age. According to a Progress Note dated 6-5-15, Tenant #1 was upset, left the dinner table and did not want the other tenants to see Tenant #1 crying. According to a Progress Note dated 6-9-15, staff reported Tenant #1 was out for meals but was not participating in activities. According to a Progress Note dated 6-22-15, Tenant #1 was having personal issues and was very upset. Tenant #1 was encouraged to talk with family/minister. According to Program documentation from 6-1-15 to 6-22-15, Tenant #1 was in a somewhat depressed state of mind, was very down, Tenant #1 expressed feelings of worthlessness, Tenant #1 did not want to come out for some activities, refused to take medications, made a comment regarding wanting to die and Tenant #1 would not get out of bed except to go to the bathroom. According to Program documentation dated 6-22-15, Tenant #1 went to an emergency room and left there against medical advice. A doctor called and wondered if they (staff) were aware they had a suicidal tenant and asked if the doors could be locked. The documentation indicated another doctor had reported Tenant #1 was going to jump in the river or walk out in front of a car. Program documentation from 7-1-15 to 7-22-15 indicated Tenant #1 was out of "steam" and asked staff to do Tenant #1's laundry and make the bed; Tenant #1 had shortness of breath, weakness and dealt with personal issues According to Program documentation dated	A 089		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0174	A. BUILDING _____ B. WING _____	09/17/2015

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VILLAGE TERRACE AL	302 FRANKLIN KEOSAUQUA, IA 52565

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A 089	Continued From page 15 8-30-15, Tenant #1 complained of Tenant #1's "usual" aches and pains and said some days it would be better if Tenant #1 could just lay down and die. According to an interview with Staff A, there was a time when Tenant #1 was unhappy and did not want to live anymore. Tenant #1 did not have a plan to harm Tenant #1, according to Staff A. The service plan did not reflect Tenant #1's comments regarding wanting to die, behavior and interventions related to the behavior. The service plan did not reflect the identified needs of Tenant #1. 2. Tenant #2, a 104 year old, was admitted on 7-2-07 and diagnoses included: arthritis and fibromyalgia. The service plan dated 8-13-15 reflected Program staff provided standby assistance with bathing as needed. According to an interview with Staff A, Tenant #2 received assistance with bathing from private duty staff. The service plan did not reflect Tenant #2 received assistance with bathing from a private duty staff. The service plan did not reflect the identified needs of Tenant #2. The service plan reflected medications were set up and administered by nursing staff. According to a medication list dated 9-2-15, Tenant #2 received Hydrocodone-Acetaminophen 10-325 mg per tablet. According to an interview with Staff A, before staff left for the end of the shift two Hydrocodone tablets were left in Tenant #2's apartment. One tablet for Tenant #2's bedtime dose at 8:00 p.m.	A 089		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0174	A. BUILDING: _____ B. WING _____	09/17/2015

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VILLAGE TERRACE AL	302 FRANKLIN KEOSAUQUA, IA 52565

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A 089	Continued From page 16 in the kitchen and one dose in the bathroom so if at 2:00 a.m. Tenant #2 needed another dose Tenant #2 would have it. The service plan did not reflect the direction to staff for the administration of Tenant #2's Hydrocodone-Acetaminophen including the two doses left nightly for Tenant #2 to self administer. The service plan did not reflect the identified needs of Tenant #2. 3. According to the Program's policy regarding service plans, the service plan would be individualized and would indicate: the tenant's identified needs and requests for assistance and expected outcomes.	A 089		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(3) To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Based on review of tenant files, a staff interview and review of Program documents the Program failed to assess and document the health status	A 096		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0174	A. BUILDING: _____ B. WING _____	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE TERRACE AL	302 FRANKLIN KEOSAUQUA, IA 52565

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A 096	Continued From page 17 of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there were changes in the tenant's health status if a tenant received personal or health-related care for three of three tenant files reviewed. (Tenants #1, #2 and #3). Three tenants received personal and health-related care and a nurse review was not completed every 90 days. 1. Tenant #1, a 94 year old, was admitted on 7-11-13 and diagnoses included: arthritis, anxiety, high cholesterol, hypothyroidism, hypertension and transient ischemic attack. According to the service plan dated 6-30-15, Tenant #1 received personal and health-related care. Review of Tenant #1's file indicated a 90 day nurse review was not documented. A nurse review was not completed every 90 days. 2. Tenant #2, a 104 year old, was admitted on 7-2-07 and diagnoses included: arthritis and fibromyalgia. According to the service plan dated 8-13-15, Tenant #2 received personal and health-related care. Review of Tenant #2's file indicated a 90 day nurse review was not documented. A nurse review was not completed every 90 days. 3. Tenant #3, an 89 year old, was admitted on 4-25-09 and diagnoses included: diabetes mellitus type II and cerebral vascular accident. According to the service plan dated 6-30-15, Tenant #3 received personal and health-related care. Review of Tenant #3's file indicated a 90 day nurse review was not documented. A nurse review was not completed every 90 days. 4. According to the Program's policy regarding	A 096		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 096	Continued From page 18 nurse review, a Program that administered prescription medications or provided health care professional-directed or health-related care would provide for a registered nurse to assess and document the health status of each tenant, make recommendations and referrals as appropriate and monitor progress on previous recommendations at least every 90 days or if there were changes in health status.	A 096		

AFFILIATED WITH UNIVERSITY OF IOWA HOSPITALS & CLINICS

Van Buren County Hospital

Simply Remarkable

Ray Brownsworth, Administrator/CEO
304 Franklin Street • Keosauqua, Iowa 52565
Phone: 319.293.3171 • www.vbch.org

October 9, 2015

Rose Boccella
Program Coordinator
Adult Services Bureau
Iowa Department of inspections and Appeals
Health Facilities Division
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

Ms. Boccella,

The following is Van Buren County Hospital's Plan of Correction for the regulatory insufficiencies received during a site visit on September 16 and 17, 2015 by Stephanie Covins,

Regulatory Insufficiency Tag # A 038 (IAC r. 481-67.5(6)c Medications

Plan of Correction: The medication administration record has been revised to reflect the varying levels of assistance:

V – Verify for standby assistance to verify a test number on insulin dosage for self – administration.
R – Reminder given to take self-administered medication
A – Those that are actually administered to tenants by RAs.

See Appendix A.

A PRN administration has been added to the revised MAR to reflect those PRN medications and the times they are administered and reason for giving the medication. See Appendix A.

All MARs will be audited at the end of the month for compliance. Resident Assistant staff will be educated about these changes on an individual basis and all training will be completed by October 17, 2015.* Implementation of the new MARs will also be completed by October 15, 2015. Each MAR is customized per tenant's individual needs.

*One Resident Assistant is on an extended vacation but will receive training upon return on October 19, 2015.

Regulatory Insufficiency Tag # A 039 (IAC r. 481-67.5(7) Medications

Plan of Correction: A narcotic policy has been developed. Narcotics are counted daily by an RN and Resident Assistant. The monthly count sheet is kept in the medication cabinet and will be audited monthly for compliance. This practice began on September 16, 2015. See Appendix B for policy.

Regulatory Insufficiency Tag # A 061 (IAC r. 481-67.9(4)d Staffing

Plan of Correction: The Nurse Delegation Skills sheet has been revised to reflect actual training of staff for specific tenant needs. All four Resident Assistants will receive training for supervision of insulin and blood sugars. Staff members trained to observe blood sugar recording and to observe dialing of an insulin pen for correct dosage as indicated by tenant. This training will be completed by October 17, 2015. One Resident Assistant is on an extended vacation but will receive training upon return on October 19, 2015. This will be audited monthly by the RN as an observed activity and noted on the MAR.

Regulatory Insufficiency Tag # A 063 (IAC r. 481-67.9(4)f Staffing

Plan of Correction: RA staff will be re-educated on the proper way to administer tenant medications. This training will include proper hand washing for medication administration, as well as, proper documentation of medication administration. See Appendix C for new revised delegation skills sheet. Re-training and education will be completed by October 17, 2015. One Resident Assistant is on an extended vacation but will receive training upon return on October 19, 2015. New delegation skills, if deemed appropriate for RAs, and training will be added as tenant needs are identified. This will be audited by the RN on a quarterly basis.

Regulatory Insufficiency Tag # A 037 (IAC r. 481-69-22(2) Evaluation of Tenant

Plan of Correction: When a Village Terrace resident is admitted to the hospital for care, and the patient has a significant change in status, then the RN will complete a health assessment, and functional and cognitive evaluations will also be completed with a significant change. If there is no significant change, a note will be made in tenant's chart. The Service Plan will also be reviewed to reflect tenant's changes or status quo. Tenant charts will be audited monthly for compliance by the RN.

Regulatory Insufficiency Tag # A 089 (IAC r. 481-69-26(4)a Service Plans

Plan of Correction: Each tenant's Service Plan is reviewed at least annually and when there is a change in the tenant's needs or health condition. Each Service Plan will be reviewed and revised to reflect tenant's identified needs and preferences for assistance. All Service Plans will be reviewed and revised, if needed, by October 17, 2015. This will be audited quarterly by the RN for compliance.

Regulatory Insufficiency Tag # A 096 (IAC r. 481-69-27(3) Nurse Review

Plan of Correction: Each tenant who received personal or health-related care and/or may have had a significant change in his/her condition will receive a 90-day evaluation. This 90-day evaluation will include review of current Service Plan, vital signs and observed condition (mental or physical) changes. See Appendix D for 90-day evaluation form. This will be audited quarterly by the RN for compliance.

Thank you for your review and consideration of this Plan of Correction.

Sincerely,

Kay Gabriel, RN, BSN.
Van Buren County Hospital
Village Terrace Assisted Living
304 Franklin Street
Keosauqua, IA 52565
319.293.3171
kay.gabriel@vbch.org

APPENDIX B

VAN BUREN COUNTY HOSPITAL
304 Franklin St.
Keosauqua, IA 52565

SUBJECT: **Narcotic Policy**	POLICY REFERENCE: **G 185**
SOURCE:	DATE EFFECTIVE. 10/15 DATE REVISED:
DEPARTMENT: **Village Terrace Assisted Living**	APPROVED BY_____ DATE_____

PURPOSE: To assist in security and accurate narcotic reconciliation.

POLICY: It is the policy of this facility to ensure the proper handling and tracking of controlled medications for tenants who receive staff assistance with medications.

PROCEDURE:

1. Resident's narcotics will be kept locked in the locked medication cabinet in the Village Terrace office.
2. When a resident requests a narcotic the resident assistant on duty will record the narcotic medication on the MAR under the PRN medication column with the time and reason for giving the medication.
3. If a PRN medication is not taken, the medication will be returned to the patient's own supply and reconciled at that time.
4. Controlled substances classified as Schedule II will be required to be reconciled near the end of each shift. The count will be done by the RA and a nurse.
5. Any discrepancies discovered will be reported to the RN supervisor. Failure to do so is grounds for termination.
6. If a discrepancy is found, the RN supervisor or hospital charge nurse will question the previous RA to attempt to reconcile the discrepancy.
7. A substantial discrepancy shall be defined as a variance of one or more tablets, capsules, patches, suppositories or liquid.
8. If after questioning the previous RA, there remains a discrepancy, the hospital CEO will be notified for further investigation and a SAM report will be completed.
9. Other reporting requirements will be followed according to state of Iowa requirements.
10. All expired, deteriorated, discontinued or unwanted controlled medications will be destroyed in a timely manner. Documentation on the narcotic count sheet will include the date of disposition, names and signatures of both staff (one of them will be a licensed person) who dispose of the medication and the method of disposition.

Name: Patient #1 Month/Year: _____ Drug Allergies _____

Date and initial after each medication distribution. For PRN meds list time and reason under Comments column.
Document the appropriate action: V=Standby assistance to verify a test number on insulin dosage for self administration.
R=Reminder given to take Self-Administered Med
A=Medications that are actually administered to tenants by Resident Assistants

Date	AM	Noon	PM	Bedtime	PRN med as needed		Exer	Appts	Meals	Laundry	AM Cares	PM Cares	Comments
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													

APPENDIX C

VILLAGE TERRACE RESIDENT ASSISTANT DELEGATION TRAINING

Name:_____

Date	Training Type	Return Demo	RN	Designee

90-DAY EVALUATIONS

NAME: _____ Apartment: _____

Date	B/P	RESP	PULSE	OBSERVED CHANGE IN MENTAL OR PHYSICAL CONDITION	SERVICE PLAN CHANGES NEEDED Yes/No