IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED

Complaint Intake #: 41577-C
41700-C

March 19, 2013

Ms. Shirley Givant, LPN Administrator/Owner
Country Haven Guest Homes, LTD
2490 Prairie View Avenue
Winterset, IA 50273

RE: I. Amended Final Complaint/Incident Investigation Report
II. Sanction – Revocation of Certificate
III. Appeals/Hearings
IV. Reduction of Civil Penalty
V. Conclusion

Dear Ms. Givant:

I. Amended Final Complaint/Incident Investigation Report – Country Haven Guest Homes, LTD (Program), Winterset, IA

Enclosed is the **Amended Final Complaint/Incident Investigation Report ("Final Report")** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69. The Final Report was amended to change the date of admission for Tenant #7 from 8-27-12 to 8-27-07, based on the program's documentation. The Final Report notes Regulatory Insufficiencies in the area(s) of: Program Reporting to Department, Medications, Staffing, Evaluation, Structural Requirements, Tenant Documents, Nurse Review and Food Services.

Country Haven Guest Homes, LTD (Program) is being assessed a $5,000 civil penalty pursuant to Iowa Code section 231C.14(1)(a) and (b) and 481 IAC 67.12(3)(a)(1) and (2).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.12(3)(a)(1), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.12(3)(a)(2), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

The Final Report reflects that the program failed to comply with regulatory requirements which have been cited previously by the Department. The Program's continued failure (or refusal) to comply with regulatory requirements within the prescribed time frame established has a direct relationship to the health, safety, or security of tenants. The Final Report reflects repeated Regulatory Insufficiencies in the areas of Staffing and Evaluations.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

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

In this case, the determination of a $5,000 civil penalty is based upon repeated regulatory insufficiencies in the areas of Staffing and Evaluations, and based upon noncompliance with numerous life safety code issues, including the lack of a required sprinkler system.

II. Sanction – Revocation of Certificate

As reflected in the Preliminary Report, the Program failed to comprehensively follow the regulations in IAC chapters 481—67 and 481—69. Due to the Program's noncompliance, current Regulatory Insufficiencies, and the findings of the on-site monitoring visit of November 20, 21 and 26, 2012, the Program was placed on a Conditional Certificate, effective December 11, 2012.

On March 13, 2013, a Complaint and Affidavit was filed in the Iowa District Court in and for Madison County, accusing Shirley Givant, Owner/Administrator, of the crime of theft by misappropriation.

Based on the foregoing, a Notice of Revocation is being issued by the Department. Please see the Notice of Revocation for additional information.

III. Appeal Rights

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

Appeal of the Notice of Revocation is as provided in Iowa Code section 231C.11.

IV. Reduction of Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of three thousand two hundred and fifty dollars ($3,250) within 30 business days after the receipt of this demand letter.

V. Conclusion

The Program is being assessed a $5,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plans of Correction (POC) submitted on January 13, 2013 and March 18, 2013, have been reviewed and will constitute the final POC related to the on-site visit of November 20, 21 and 26, 2012.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the Final Report, the Program may do so within 30 days of this letter.

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

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Cc: Shayla McCormally, Attorney

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

Assisted Living Program:

Shirley Givant, LPN Administrator/Owner
Country Haven Guest Homes, LTD
2490 Prairie View Ave.
Winterset, Iowa 50273

Complaint/Incident Intake #:

41577-C
41700-C

Date of Complaint/Incident Investigation:

November 20, 21 and 26, 2012

Monitor(s):

Maribeth Freland RN
Joyce Kix RN

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.

General Population Program	
Number of tenants without cognitive disorder:	6
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	9
TOTAL census of Assisted Living Program	9

Program History – The program received regulatory insufficiencies in the areas of: Evaluation, Service Plan, Staffing, Non Reporting to the Department, Food Service and Program Initiated Involuntary Transfer during the March 6, 2012 Recertification visit. The program received a regulatory insufficiency in the area of Tenant Rights during the October 8, 2012, Complaint Investigation (40998-I).

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

A. Program Reporting to the Department

Complaint/Incident Allegation: 41577-C: It was alleged a tenant, who was known to stockpile medications, took an overdose of medication in a suspected attempt to commit suicide.

- Monitoring Observation: The program Administrator/Owner, who is also a licensed practical nurse (LPN), reported the program had provided care to only one tenant who had attempted suicide, Tenant #1. Review of Tenant #1's file revealed the following:

  Tenant #1, a 76 year old, was admitted to the program on 10-11-07 with the diagnoses of: rheumatoid arthritis, glaucoma and mental illness. Tenant #1 scored a 2 on the Global Deterioration Scale (GDS) completed on 5-8-09, indicating very mild cognitive decline with forgetfulness. Tenant #1 required assistance with bathing and medication administration.

  Tenant #1's clinical record included nurse's notes that documented the following:

  a. On 4-16-09 the LPN/Administrator documented Tenant #1 was noted to appear to be sleeping more most days, going back to bed after breakfast and sleeping until noon.

b. On 4-16-09 staff members found prescription medications hidden in Tenant #1's apartment.
c. On 6-12-09 Tenant #1 complained of unhappiness with care received at the program.
d. On 6-12-09 staff members found prescription medications hidden under Tenant #1's tongue after medication administration.
e. On 6-22-09 the LPN/Administrator told Tenant #1 he/she needed to find another residence. The notice was given verbally but never in writing. (Tenant #1 did not move out of the program as requested.)
f. On 7-25-09 the LPN/Administrator documented Tenant #1 continued to sleep until noon most days. Tenant #1 had been less demanding in the previous three weeks and mood had improved.
g. On 8-28-09 the LPN/Administrator documented Tenant #1 had requested to remain living at the program. The LPN/Administrator documented Tenant #1 could remain living at the program as long as Tenant #1 quit complaining to others, quit hiding medications in his/her hand or under the tongue during medication administration and quit hiding medications in his/her apartment. The LPN/Administrator did not do this in writing.) Tenant #1 agreed to the stipulations.
h. On 10-26-09 staff members found Tylenol hidden in Tenant #1's hand after medication administration.
i. On 11-23-09 the LPN/Administrator documented Tenant #1 had not been sleeping well at night and had periods of complaints related to not being happy with the care received at the program.
j. On 1-5-10 Tenant #1 continued to complain about not sleeping well at night.
k. On 1-28-10 staff members found Tenant #1 "passed out" at the breakfast table. Tenant #1 was transported to the emergency room via ambulance. Tenant #1 did not return to the program.

During interview, the LPN/Administrator reported Tenant #1 was "terribly mentally disturbed". The LPN indicated Tenant #1 continually attempted to stock pile medications in his/her apartment with the suspected intent to commit suicide. The LPN reported Tenant #1 was diagnosed with a medication overdose on 1-28-10; therefore, Tenant #1 was not allowed to return to the program "as we just couldn't keep up with the hiding of the medications." The LPN/Administrator reported she had not reported Tenant #1's suicide attempt to the Department of Inspections and Appeals as required by regulation.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available when a tenant attempts suicide, regardless of injury. (IAC r. 481-67.4(5))

B. Medications

Complaint/Incident Allegation: 41577-C: It was alleged medications were left unlocked and accessible to unauthorized persons. 41577-C: It was alleged medications were not being set up correctly by the nurse, requiring an unlicensed staff member to set up the medications.

- Monitoring Observation: Upon entrance into the program, the monitors noted all tenant medications to be locked in an upper wall cupboard located in the kitchen area. The cupboard was locked. Staff #1, a certified medical assistant (CMA), removed a key hanging on the side of the locked cupboard containing the medications and unlocked the cupboard. Staff #1 locked the cupboard and returned the key to the side of the cupboard and left the area. The key hung at a height of approximately five feet. The kitchen door was open to the main living space used by program tenants. Throughout the day on 11-20-12, the monitor observed the cupboard containing tenant medication continued to be locked, the key continued to hang on the side of the cupboard and observed no staff members present in the immediate area of the cupboard. Multiple tenants were seated or walking around in the main living space. The monitor manipulated the lock on the medication cupboard with her fingers finding the lock was easily manipulated by turning the entire lock without the use of a key to unlock the cupboard. The program often had only one staff member present in the building on each shift.

  The kitchen area was observed open, accessible to tenants and unsupervised by staff members. Tenant medications were unsecured as the key to unlock the medication cupboard was hanging on the side of the cupboard, visible and accessible to unauthorized persons and the lock itself could be manipulated easily to unlock the cupboard without the use of a key.

  The LPN/Administrator reported all tenant medications are set up by herself or by Staff #1, CMA. A CMA is permitted to set medications up into a medication planner after teaching by a nurse, nurse observation of a return demonstration of the task by the CMA and determination of competency by the nurse completed delegation. Staff #1's personnel file lacked any documentation of such teaching, observation or delegation. The LPN/Administrator reported the medications are removed from the prepackaged unit dose containers delivered from the pharmacy and placed in a medication planner so that staff members administering the medications to tenants on a daily basis have less chance of making an error during medication administration. The medications for the week of the on-site visit had already been set up in the medication planners; therefore, the monitor was unable to observe the set up for errors.

  When reviewing the clinical records of Tenants #4, #5 and #6, the monitors noted the LPN/Administrator had placed her initials as the person administering the medications on the July, August, September and October 2012 Medication Administration Records (MARs). The MARs were initialed by the LPN on each shift, every day of the month during these months. When initially asked if she had actually administered the medications on each of the days, the LPN responded "I'm here a lot."

  During interview, Staff #1, CMA, reported she had been employed for two years and worked the day shift five days per week. Staff #1 reported she administered medications to tenants five days weekly during the day shift. Staff #1 reported she did not know she was to initial the MARs after administering tenant medications until approximately three weeks prior to the on-site visit. Staff #1 reported she routinely administered the medications but the LPN/Administrator initialed the slots on MARs as administering the medications.

During interview, Staff #2, Universal Worker (UW), reported she had been employed for approximately one month and worked day shift two days per week and every other weekend from 3:00 p.m. to 8:00 p.m. Staff #2 reported she administered tenant medications routinely when working the weekend shifts. Staff #2 reported she had worked the previous weekend and administered medications. Staff #2 reported she had never initialed tenant MARs after administering medications as she had never been instructed to. Staff #2 believed the LPN/Administrator initialed the MARs as needed. The 5:00 p.m. medication slots from the previous weekend were initialed by the LPN/Administrator and not Staff #2 who had administered the medications.

Tenant #4, #5 and #6's MARs for November 2012 contained the initials of Staff #1 five days per week for administration of the 8:00 a.m. and 12 noon medications. The 8:00 a.m. and 12 noon medications two days per week, the 5:00 p.m. medications seven days per week and the bedtime medications seven days per week had all been initialed by the LPN/Administrator.

After revealing Staff #1 and #2's interview content, the LPN/Administrator admitted that she had been initialing the MARs to indicate medication administration even though she was not present in the building when the medications were administered and admitted the medications were usually administered by a direct care staff member who did not initial the MARs. The LPN/Administrator indicated she believed because she set up each medication in a planner for staff members to administer she could initial the medications as administered.

During interview, the program registered nurse (RN) reported she transcribed all of the programs MARs. The RN indicated she used the previous months MARs and any new physician's orders to update the upcoming months MARs. During review of the clinical records, the monitors identified the following medication errors:

a. On 10-22-12 staff members did not administer Tenant #8's new 8:00 a.m. medication (unnamed) as the box containing the medication was not identified with a tenant name.
b. Tenant #4's October and November 2012 MARs included an order for Tylenol 325 milligram (mg) two tablets to be given at bedtime. Tenant #5's clinical record included a physician's order on a hospital discharge, dated 12-8-11, which documented Tenant #4's Tylenol dosage to be 500 mg tablets. The RN did not clarify the discrepancy with the physician at the time of the order. The RN continued to place the previous dosage of 325 mg on the MARS for the months after the discharge order. Tenant #4's clinical record lacked any further physician orders changing the dosage of Tylenol after the 12-8-11 order.
c. Tenant #4's October and November 2012 MARs indicated the physician ordered Tylenol 325 mg one tablet to be given as needed for pain. The MAR did not indicate the approved frequency of as needed Tylenol. The MAR also included an order for Tenant #4 to take Tylenol 325 mg two tablets daily at bedtime. According to documentation located in the program's communication book, staff members administered Tenant #4's Tylenol to Tenant #4 per the tenant's request at 11:30 p.m. for pain on 10-23-12, 10-25-1210-28-12, 10-29-12,, 10-30-12, 11-1-12 and 11-2-12. Staff members documented giving Tenant #4 Tylenol two tablets when the order allowed administration of one tablet on all of the above stated

dates. On 11-3-12, Staff #6, UW/medication manager, documented noting Tenant #4 was only to receive one Tylenol tablet instead of two tablets when giving on an as needed basis. Staff #6 documented this in the program's communication book. On 11-5-12, a staff member documented giving Tenant #4 Tylenol 325 mg two tablets per Tenant #4's request for pain. Later in the documentation, the staff member documented she had just read Staff #6's documentation, noting her medication error previously in the shift.

d. On 10-30-12, a staff member documented receiving a prescription bottle of Coumadin from Tenant #5. The staff member documented leaving the bottle of pills on the table in the program's kitchen instead of locking the medication up in the cupboard.
e. On 11-1-12, a staff member documented receiving a prescription bottle of an unidentified medication. The staff member documented leaving the bottle of pills on the table in the program's kitchen instead of locking the medication up in the cupboard.
f. Tenant #3 had a physician's order to have staff members monitor the tenant's blood sugar and document the results prior to administering Tenant #3's insulin. On 11-12-12, Staff #3, CNA, documented having no testing strips available; therefore, Staff #3 did not test Tenant #3's blood sugar as ordered by the physician prior to administration of his/her insulin. The staff member administered 16 units of insulin.
g. Tenant #5's November 2012 MAR contained an order for Omega 3 Fish Oil 1000 mg three times daily. Tenant #5's clinical record contained a physician's order via hospital discharge orders, dated 11-12-12, changing Tenant #5's Omega 3 Fish Oil to Omega 3-6-9 once daily. The MARs had not been updated with the change in physician's orders. Staff members continued to administer the fish oil three times daily from 11-13-12 through 11-20-12.

- Regulatory Insufficiency: When medications are administered traditionally by the program, medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. (IAC r. 481-67.5(6) b)

- Regulatory Insufficiency: The program shall maintain a list of each tenant's medications and document the medications administered. (IAC r. 481-67.5(6) c)

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

C. Staffing

Complaint/Incident Allegation: 41700-C: It was alleged a program employee had taken over the finances of a tenant. The employee took the tenant's money after the tenant died without having reported legal authority to do so. 41577-C: It was alleged a staff member transferred a tenant using a mechanical lift without using two staff members as recommended by the manufacturer of the lift, thereby placing the tenant at risk for injury.

41577-C: It was alleged staff members were not trained appropriately and often were required to make medical decisions without the supervision of a nurse.

- Monitoring Observation: Upon initiation of the on-site visit, the program's LPN/Administrator reported she had managed the funds of one tenant, Tenant #7. The LPN/Administrator reported Tenant #7 had no family, was not related by blood or adoption to the LPN/Administrator but had requested the LPN/Administrator "take over things" as the tenant had recently been hospitalized and felt he/she needed to put something in place. The LPN/Administrator presented the monitor with a form titled Veteran's Affairs Advance Directive: Durable Power of Attorney for Health Care and Living Will. The document had been signed by Tenant #7, the LPN/Administrator and two witnesses on 12-28-08.

  Tenant #7, a 78 year old, was admitted to the program on 8-27-07 with the diagnosis of Dementia. The program Administrator was unable to locate Tenant #7's clinical record for monitor review. The LPN/Administrator reported Tenant #7 was cognitively intact until October 2010, when Tenant #7 had a heart attack and was admitted to hospice services, dying on 1-19-11. The LPN/Administrator reported she took over Tenant #7's finances, arranging for Veteran's Administration checks and social security checks to be direct deposited into a checking account set up by the LPN/Administrator. The LPN/Administrator took care of all of Tenant #7's finances, writing checks on the account. When Tenant #7 died, the LPN/Administrator paid all final bills, wrote a check to herself for $400.00 to make funeral arrangements for Tenant #7 and closed out the account approximately one year after Tenant #7's death. The LPN/Administrator took approximately $6900.00 from the account on 1-27-12, indicating she was "paying herself" for services rendered while Tenant #7 was alive. The LPN/Administrator reported "Tenant #7 willed the money to me." The LPN verified she did not have any legal papers naming her as a Power of Attorney (POA) or as a representative payee; however, concurred she had taken over Tenant #7's finances without the legal papers. The LPN/Administrator indicated she was unaware of the regulatory prohibition against her being acting on the behalf of a tenant of the program unless blood related.

  Tenant #6, a 99 year old, was admitted to the program on 4-20-11 with diagnoses of: End Stage Adult Failure to Thrive, Arthritis and Severe Contractures of the Legs. Tenant #6 scored a 2 on the GDS completed on 5-30-12, indicating very mild cognitive decline. On 6-21-12, Tenant #6 was admitted to hospice services. Tenant #6 was no longer able to bear weight during transfers due to the severe contractures. The hospice delivered a mechanical lift to the program for use in transferring Tenant #6 from the bed to chair and chair to bed. The mechanical lift manufacturers recommend use of the lift using two staff members for tenant safety. The program only had one staff member routinely working at one time. Staff members transferred Tenant #6 using the mechanical lift with one staff member completing the transfer without assistance for four days. On 6-24-12, Tenant #6 slipped from the sling on the mechanical lift while being assisted with the transfer by only one staff member, falling to the floor. Tenant #6 did not experience any injuries during the fall. On 6-25-12, the staff member reported she felt uncomfortable transferring Tenant #6 alone. The LPN/Administrator requested Tenant #6 move from the program due to the unsafe transfers. Tenant #6 was discharged from the program on 6-27-12. The

manufacturer's recommendations were not followed, resulting in Tenant #6 falling from the mechanical lift during an improper transfer.

Tenant #4, an 88 year old, was admitted to the program on 1-16-10 with diagnoses of: Stroke, Arthritis, HTN and History of Urinary Tract Infections. Tenant #4 scored a 2 on the GDS completed on 5-30-12, indicating very mild cognitive decline. Tenant #4's clinical record included documentation of an evaluation of Tenant #4's health, functional and cognitive status on 10-22-11. Tenant #4's clinical record indicated Tenant #4 was hospitalized in late November 2011 and diagnosed with a pleural effusion. Tenant #4 returned to the program on 11-28-11. The clinical record indicated Tenant #4 was hospitalized in mid- December 2011 and diagnosed with fluid of unknown etiology accumulating in the lungs. Tenant #4 returned to the program on 12-14-11 with a chest tube attached to a Jackson Pratt bulb. Physician's orders directed staff members to empty the bulb and change the dressing around the chest tube site daily or every other day. The physician's order did not clarify what type of dressing or indicate a procedure for the dressing change. The LPN/Administrator noted the order at 5:00 p.m. on 12-14-11 and the program RN noted the order on 12-22-11. The chest tube was removed on 1-12-12 and a permanent chest drain shunt was placed surgically on 1-16-12. On 1-31-12, the RN documented Tenant #4's granddaughter had written out instructions on how to care for Tenant #4's drain shunt. The granddaughter reported the program staff members were to empty the shunt tube daily and perform a dressing change to the site twice weekly. The RN did not contact the physician to obtain orders to drain the shunt and did not clarify the procedures to follow in changing the dressing to the site.

Tenant #4's clinical record indicated Tenant #4 had a permanent chest tube/shunt placed in January 2012. The program RN and LPN/Administrator reported the direct care workers who are CMAs, UWs and CNAs were generally responsible for draining the shunt daily and completing a sterile dressing change to the chest tube/shunt site twice weekly. The program did not maintain documentation on a MAR or treatment administration record (TAR). The program staff members documented the date and amount drained from the chest tube/shunt on lined notebook paper. The notebook papers were kept folded and placed in a corner on Tenant #4's bathroom countertop. The current notebook paper was kept taped to Tenant #4's bathroom mirror. Staff members did not sign or initial when draining the shunt. The program did not have any legal documentation to be kept in Tenant #4's clinical record of the draining of the chest tube/shunt.

The program kept no legal documentation of staff members' completion of the twice weekly sterile dressing change to Tenant #4's chest tube/shunt site. Staff members did not initial or sign any type of documentation when completing the task.

The program failed to maintain physician's orders for Tenant #4's shunt draining and sterile dressing change. The program failed to maintain documentation of staff member completion of Tenant #4's shunt draining and sterile dressing change, including signatures or initials of those performing each procedure.

During the onsite visit, Tenant #4 currently had a chest tube/shunt that required draining daily and required a sterile dressing to be changed to the chest tube site twice weekly following bathing. Tenant #4 had the chest tube inserted in December 2011

and a chest tube shunt placed in January 2012. The LPN/Administrator and the RN both reported the program's CMA, UW's and CNA's independently drained the chest tube/shunt and changed the sterile dressing to the chest tube site.

Tenant #6 had a pressure sore on the coccyx, requiring wound care. The LPN/Administrator reported the program's CMA, UW's and CNA's independently performed the wound care to the pressure sore area.

Staff #1, CMA, had a hire date of 12-9-10. Staff #1's personnel file lacked documentation of training to perform medication administration, medication planner set up, chest tube/shunt draining, sterile dressing changes to a chest tube site and pressure sore wound care by an RN or LPN; documentation of an RN or LPN's observation of a return demonstration for each task performed by Staff #1; and documentation of delegation of each task to be performed independently by an RN or LPN. Staff #1 had been performing chest tube/shunt draining and sterile dressing changes to a chest tube site independently since December 2011, medication administration independently since hire, medication planner set up independently for approximately three weeks and performed pressure sore wound care independently in the past while employed at the program.

Staff #2, UW, had a hire date of 10-23-12. Staff #2's personnel file lacked documentation of training to perform medication administration, chest tube/shunt draining and sterile dressing changes to a chest tube site by an RN or LPN; documentation of an RN or LPN's observation of a return demonstration for each task performed by Staff #2; and documentation of delegation of each task to be performed independently by an RN or LPN. Staff #2 had been performing medication administration, chest tube/shunt draining and sterile dressing changes to a chest tube site independently since date of hire.

Staff #3, CNA, had a hire date of 5-2-09. Staff #3's personnel file lacked documentation of training to perform chest tube/shunt draining, sterile dressing changes to a chest tube site and pressure sore wound care by an RN or LPN; documentation of an RN or LPN's observation of a return demonstration for each task performed by Staff #3; and documentation of delegation of each task to be performed independently by an RN or LPN. Staff #3 performed chest tube/shunt draining and sterile dressing changes to a chest tube site independently from December 2011 to the her termination date of 10-31-12 performed pressure sore wound care independently in the past while employed at the program.

Staff #4, UW, had a hire date of 9-27-12. Staff #4's personnel file lacked documentation of training to perform medication administration, chest tube/shunt draining and sterile dressing changes to a chest tube site by an RN or LPN; documentation of an RN or LPN's observation of a return demonstration for each task performed by Staff #4; and documentation of delegation of each task to be performed independently by an RN or LPN. Staff #4 had been performing medication administration, chest tube/shunt draining and sterile dressing changes to a chest tube site independently since date of hire.

Staff #5, CNA, had a hire date of 11-1-12. Staff #5's personnel file lacked documentation of training to perform medication administration, chest tube/shunt

draining and sterile dressing changes to a chest tube site by an RN or LPN; documentation of an RN or LPN's observation of a return demonstration for each task performed by Staff #5; and documentation of delegation of each task to be performed independently by an RN or LPN. Staff #5 had been performing medication administration, chest tube/shunt draining and sterile dressing changes to a chest tube site independently since date of hire.

The program was cited during the March 2012 recertification monitoring visit for not having at least one nurse completing the required delegating nurse training. The RN subsequently attended the training on 4-17-12. Following the training, the RN indicated she had not completed any training related to the state rules regarding delegation with the LPN/Administrator; however, the RN indicated she turned over all delegation responsibilities to the LPN/Administrator. Review of personnel records showed the LPN/Administrator had not been delegating direct care workers according to state rules. The RN did not provide supervision of this task and was not aware the documentation related to delegation was not completed or maintained.

- 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))

- Regulatory Insufficiency: All programs employing a new delegating nurse after January 1, 2010, shall require the delegating nurse within six months of hire to complete an assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living. A minimum of one delegating nurse from each program must complete the training. If there are multiple delegating nurses and only one delegating nurse completes the training, the delegating nurse who completes the training shall train the other delegating nurses in the Iowa rules and laws on assisted living. As of January 1, 2011, all programs shall have a minimum of one delegating nurse who had completed the training described in this subrule. (IAC r. 481-69.29(6))

- Regulatory Insufficiency: A staff member shall not be designated as attorney-in-fact, guardian, conservator, or representative payee for a tenant unless the staff member is related to the tenant by blood, marriage, or adoption. (IAC r. 481-67.9(6))

- Regulatory Insufficiency: Any nursing services shall be provided in accordance with Iowa Code chapter 152 and 655- Chapter 6. (IAC r. 481-67.9(5))

D. Evaluation

Complaint/Incident Allegation: 41577-C: It was alleged two tenants experienced changes in health status and did not receive an evaluation by a nurse in a timely manner, resulting in delayed medical evaluation.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5 and #6, finding no concerns with evaluations completed for Tenants #1, #2 and #3.

Tenant #4's clinical record indicated Tenant #4 was hospitalized in late November 2011 and diagnosed with a pleural effusion. Tenant #4 returned to the program on 11-28-11. The clinical record indicated Tenant #4 was hospitalized in mid-December 2011 and diagnosed with fluid of unknown etiology accumulating in the lungs. Tenant #4 returned to the program on 12-14-11 with a chest tube attached to a Jackson Pratt bulb. Physician's orders directed staff members to empty the bulb and change the dressing around the chest tube site daily or every other day. The physician's order did not clarify what type of dressing or indicate a procedure for the dressing change. The LPN/Administrator noted the order at 5:00 p.m. on 12-14-11 and the program RN noted the order on 12-22-11. The chest tube was removed on 1-12-12 and a permanent chest drain shunt was placed surgically on 1-16-12. On 1-31-12, the RN documented Tenant #4's granddaughter had written out instructions on how to care for Tenant #4's drain shunt. The granddaughter reported the program staff members were to empty the shunt tube daily and perform a dressing change to the site twice weekly. The RN did not contact the physician to obtain orders to drain the shunt and did not clarify the procedures to follow in changing the dressing to the site. Tenant #4's clinical record contained documentation of an evaluation of Tenant #4's health, functional and cognitive status, completed by the program RN on 5-30-12. The record lacked any other evaluations between 10-22-11 and 5-30-12, despite the changes in Tenant #4's health status in November and December 2011.

Tenant #4 began experiencing swelling in both legs with increasing pain to the legs on 10-29-12. Tenant #4 requested Tylenol for leg pain on a fairly routine basis from 10-29-12 to 11-5-12. The communication book documented Tenant #4's increased pain, taut legs and frequent waking during the night. The communication book documented banter between staff members related to who should be called to take Tenant #4 for medical evaluation of the edema and increased pain. Tenant #4 was eventually taken to see the physician on 11-5-12, returning with a diagnosis of edema with minor cellulites to the lower extremities. The physician ordered an increase in Lasix, a diuretic, to 40 mg daily for four days and initiated an antibiotic. Tenant #4's clinical record lacked documentation of an evaluation completed by the LPN or the RN related to Tenant #4's increased edema or cellulites either before the physician visit or following the visit.

Tenant #5, a 94 year old, was admitted to the program on 8-10-11 with the diagnoses of: Chronic Obstructive Pulmonary Disease (COPD), Gout, Atrial Fibrillation and Benign Prostatic Hypertrophy. Tenant #5 scored a 1 on the GDS completed on 4-12-12, indicating very mild cognitive decline with forgetfulness. Tenant #5 was independent with grooming, dressing and toileting. Tenant #5 was mostly continent of urine and bowel movements. Tenant #5 began experiencing loose involuntary stools requiring staff member assistance to clean up the mess multiple times a day from 11-6-12 to 11-14-12. Tenant #5's clinical record lacked documentation of an evaluation of Tenant #5's health, functional and cognitive status following the change in Tenant #5's functional abilities. The clinical record lacked any documentation in the clinical record by the LPN or the RN addressing the loose involuntary stools.

The LPN and RN did not evaluate Tenant #4 or #5 when changes in health or functional status occurred.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall 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 with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

E. Structural Requirements

Complaint/Incident Allegation: 41577-C: It was alleged the program did not meet all structural requirements and lied to inspectors about structural issues.

- Monitoring Observation: (See attached State Fire Marshal Survey Results)

- Regulatory Insufficiency: The structure in which a program is housed shall be built, at a minimum, of Type V (111) construction as provided in Section 22.3.1.3.3 and Sections 6.2.2 of NFPA 101, Life Safety Code, 2003 edition, published by the National Fire Protection Association, 1 Batterymarch Park, Quincy Massachusetts 02169-7471, or as required in administrative rules promulgated by the state fire marshal. (IAC r. 481-69.35(1) e.)

F. Criteria for admission and retention of tenants

Complaint/Incident Allegation: 41577-C: It was alleged the program allowed a tenant to remain at the program despite multiple elopement attempts.

- Monitoring Observation: During interview, the LPN/Administrator and Staff #1, CMA, reported having only on tenant, Tenant #3, who would routinely exit seek and attempted to elope from the program on multiple occasions. Tenant #3 no longer resided at the program. Tenant #3, a 73 year old, was admitted to the program on 11-20-11 with the diagnoses of: Dementia, Hypertension (HTN) and Prostate Cancer. Tenant #3 scored a 5 on the GDS completed on 11-20-11, indicating moderately severe cognitive decline. Tenant #3's clinical record included documentation of Tenant #3's exit seeking behaviors and multiple attempts to leave the program without assistance. Staff #1, CMA, reported Tenant #3 would open the front door, sounding the alarm. Staff members would respond when the alarm sounding, find Tenant #3 either in the process of exiting the building or find Tenant #3 in the program's parking lot. Both the LPN/Administrator and Staff #1 reported Tenant #3 did not ever get off of the program's property. Tenant #3's legal representative was asked to move Tenant #3 to another residence due to Tenant #3's continued exit seeking and elopement attempts. Tenant #3 moved from the program on 12-4-11 to a higher level of care. Tenant #3's elopement attempts and involuntary discharge were investigated during the March 2012 recertification monitoring visit, resulting in a regulatory insufficiency related to the involuntary transfer.

The program requested Tenant #3 transfer to a higher level of care following Tenant #3's repeated exit seeking behaviors and multiple elopement attempts. The Department of Inspections and Appeals had already investigated the concerns reported by the complainant at a previous on-site visit.

- Regulatory Insufficiency: None noted.

G. Tenant Rights

Complaint/Incident Allegation: 41577-C: It was alleged the program administration did not follow tenant representative directives.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5 and #6. Tenants #1, #2, #3 had guardians or durable powers of attorney for health care decisions (DPOA) and each guardian or DPOA was actively involved in decision-making. Tenant #4 had a POA for financial matters and a DPOA assigned. The POA was activated, handling all of Tenant #4's financial matters. Tenant #4 was not cognitively impaired and did not experience health related issues that prevented Tenant #4 from making his/her own decisions for health care; therefore, Tenant #4's assignment of the DPOA would not have yet been activated. Tenant #4's POA was involved in financial decision making matters as needed. Tenant #4 would have made all health care decisions and daily decision making on his/her own. Tenants #5 and #6 were cognitively intact and did not have an activated legal representative.

- Regulatory Insufficiency: None noted.

During the investigation, the following information was identified:

H. Tenant Documents

- Monitoring Observation: According to the program's list of past tenants, Tenant #7 was admitted to the program on 8-27-07 and died on 1-1-19-11. The monitors requested to review Tenant #7's clinical record. The LPN/Administrator reported she had looked for Tenant #7's clinical record and was unable to locate the entire record. The LPN could locate a copy of Tenant #7's face sheet, a copy of Tenant #7's death certificate and multiple financial documents. The monitors allowed the LPN/Administrator two full days to locate the record; however, the LPN did not locate Tenant #7's clinical record prior to the exit of the on-site visit. The monitor visited the hospice who had provided services to Tenant #7 during the last three months of his/her life and reviewed the hospices' clinical record to ascertain information related to Tenant #7's health, functional and cognitive status during his/her residence at the program.

  Tenant #4's clinical record indicated Tenant #4 was hospitalized in late November 2011 and diagnosed with a pleural effusion. Tenant #4 returned to the program on 11-28-11. The clinical record indicated Tenant #4 was hospitalized in mid-December 2011 and diagnosed with fluid of unknown etiology accumulating in the lungs. Tenant #4 returned to the program on 12-14-11 with a chest tube attached to a

Jackson Pratt bulb. Physician's orders directed staff members to empty the bulb and change the dressing around the chest tube site daily or every other day. The physician's order did not clarify what type of dressing or indicate a procedure for the dressing change. The LPN/Administrator noted the order at 5:00 p.m. on 12-14-11 and the program RN noted the order on 12-22-11. The chest tube was removed on 1-12-12 and a permanent chest drain shunt was placed surgically on 1-16-12. On 1-31-12, the RN documented Tenant #4's granddaughter had written out instructions on how to care for Tenant #4's drain shunt. The granddaughter reported the program staff members were to empty the shunt tube daily and perform a dressing change to the site twice weekly. The RN did not contact the physician to obtain orders to drain the shunt and did not clarify the procedures to follow in changing the dressing to the site.

Tenant #4's clinical record indicated Tenant #4 had a permanent chest tube/shunt placed in January 2012. The program RN and LPN/Administrator reported the direct care workers who are CMAs, UWs and CNAs were generally responsible for draining the shunt daily and completing a sterile dressing change to the chest tube/shunt site twice weekly. The program did not maintain documentation on a MAR or treatment administration record (TAR). The program staff members documented the date and amount drained from the chest tube/shunt on lined notebook paper. The notebook papers were kept folded and placed in a corner on Tenant #4's bathroom countertop. The current piece of notebook paper was kept taped to Tenant #4's bathroom mirror. Staff members did not sign or initial when draining the shunt. The program did not have any legal documentation to be kept in Tenant #4's clinical record of the draining of the chest tube/shunt.

The program kept no legal documentation of staff members completion of the twice weekly sterile dressing change to Tenant #4's chest tube/shunt site. Staff members did not initial or sign any type of documentation when completing the task.

The program failed to maintain physician's orders for Tenant #4's shunt draining and sterile dressing change. The program failed to maintain documentation of staff member completion of Tenant #4's shunt draining and sterile dressing change, including signatures or initials of those performing each procedure.

- Regulatory Insufficiency: The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. (IAC r. 481-69.25(2)

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include, when any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception. (IAC r. 481-69.25(1) i.)

I. Nurse Review

- Monitoring Observation: Tenant #4's clinical record included documentation of an evaluation of Tenant #4's health, functional and cognitive status on 10-22-11. The clinical record indicated Tenant #4 was hospitalized in late November 2011 and diagnosed with a pleural effusion. Tenant #4 returned to the program on 11-28-11. The clinical record indicated Tenant #4 was hospitalized in mid- December 2011 and diagnosed with fluid of unknown etiology accumulating in the lungs. Tenant #4 returned to the program on 12-14-11 with a chest tube attached to a Jackson Pratt bulb. Physician's orders directed staff members to empty the bulb and change the dressing around the chest tube site daily or every other day. The physician's order did not clarify what type of dressing or indicate a procedure for the dressing change. The LPN/Administrator noted the order at 5:00 p.m. on 12-14-11 and the program RN noted the order on 12-22-11. The chest tube was removed on 1-12-12 and a permanent chest drain shunt was placed surgically on 1-16-12. On 1-31-12, the RN documented Tenant #4's granddaughter had written out instructions on how to care for Tenant #4's drain shunt. The granddaughter reported the program staff members were to empty the shunt tube daily and perform a dressing change to the site twice weekly. The RN did not contact the physician to obtain orders to drain the shunt and did not clarify the procedures to follow in changing the dressing to the site. Tenant #4's clinical record lacked documentation of nurse reviews addressing Tenant #4's changes in health status in November and December 2011.

  Tenant #4 began experiencing swelling in both legs with increasing pain to the legs on 10-29-12. Tenant #4 requested Tylenol for leg pain on a fairly routine basis from 10-29-12 to 11-5-12. The communication book documented Tenant #4's increased pain, taut legs and frequent waking during the night. The communication book documented banter between staff members related to who should be called to take Tenant #4 for medical evaluation of the edema and increased pain. Tenant #4 was eventually taken to see the physician on 11-5-12, returning with a diagnosis of edema with minor cellulites to the lower extremities. The physician ordered an increase in Lasix to 40 mg daily for four days and initiated an antibiotic. Tenant #4's clinical record lacked documentation of a nurse review completed by the LPN or the RN related to Tenant #4's increased edema or cellulites either before the physician visit or following the visit.

  Tenant #5, a 94 year old, was admitted to the program on 8-10-11 with the diagnoses of: Chronic Obstructive Pulmonary Disease (COPD), Gout, Atrial Fibrillation and Benign Prostatic Hypertrophy. Tenant #5 scored a 1 on the GDS completed on 4-12-12, indicating very mild cognitive decline with forgetfulness. Tenant #5 was independent with grooming, dressing and toileting. Tenant #5 was mostly continent of urine and bowel movements. Tenant #5 began experiencing loose involuntary stools requiring staff member assistance to clean up the mess multiple times a day from 11-6-12 to 11-14-12. Tenant #5's clinical record lacked documentation of a nurse review following the noted changes in Tenant #5's health status and functional abilities. The clinical record lacked any documentation in the clinical record by the LPN or the RN addressing the loose involuntary stools.

  The LPN and RN did not obtain physician's orders for Tenant #4's chest tube care, did not complete nurse reviews for Tenant #4 or #5 when changes in health or functional status occurred and did not assure each tenant received timely medical evaluation .

- Regulatory Insufficiency: 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 monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r. 481-69.27(1))

J. Food Service

- Monitoring Observation: The LPN/Administrator reported all direct care workers prepare and serve meals to program tenants.

  Staff #1, CMA, had a hire date of 12-9-10. Staff #1's personnel file contained documentation of food safety and sanitation orientation training on 12-16-10. The file lacked any documentation of food safety and sanitation training during 2011 or 2012. Staff #1 currently prepared and served tenant meals. During interview, Staff #1 reported she had not attended an in-service related to food safety and sanitation in the past year.

  Staff #2, UW, had a hire date of 10-23-12. Staff #2's personnel file lacked any documentation of food safety and sanitation orientation training. Staff #2 currently prepared and served tenant meals. During interview, Staff #2 reported she had not attended an in-service related to food safety and sanitation since her hire date.

  Staff #3, certified nursing assistant (CNA), had a hire date of 5-2-09 and a termination date of 10-29-12. Staff #3's personnel file contained documentation of food safety and sanitation orientation training on 5-7-09. The file lacked any documentation of food safety and sanitation training during 2010, 2011 or 2012.

  Staff #4, UW, had a hire date of 9-27-12. Staff #4's personnel file lacked documentation of food safety and sanitation orientation training. Staff #4 currently prepared and served tenant meals.

  Staff #5, CNA, had a hire date of 11/1/12. Staff #5's personnel file lacked documentation of food safety and sanitation orientation training. Staff #5 currently prepared and served tenant meals.

- Regulatory Insufficiency: Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have an annual in-service training on food protection. (IAC r. 481-69.28 (5))