IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED

Complaint Intake #: 44138-C
44147-C
42070-CR2

August 21, 2013

Ms. Christine Vasquez, Administrator
Walden Point Assisted Living
1200 4th Street
Des Moines, IA 50314

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION & COMPLAINT REVISIT REPORT - WALDEN POINT ASSISTED LIVING
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Vasquez:

I. Final Complaint/Incident Investigation & Complaint Revisit Report – Walden Point Assisted Living, Des Moines, IA

Enclosed is the **Final Complaint/Incident Investigation & Complaint Revisit Report ("Report")** issued by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **July 10, 11, 15 and 22, 2013.** The Report was amended regarding the ambulance service and the BrightStar RN. The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights, Nurse Review, Evaluation, Service Plans, Tenant Documents, Policies and Procedures, Medications, Staffing and Compliance with Plan of Correction.

Walden Point Assisted Living ("Program") is being assessed a **$3,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2).

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 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.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of Medications, Staffing, Policies and Procedures, Evaluation, Service Plans and Compliance with Plan of Correction.

The determination of a **$3,500 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Medications, Staffing, Policies and Procedures, Evaluation, Service Plans and Compliance with Plan of Correction. As the enclosed Report details, the Program failed to follow physician prescribed medication procedures and complete medication administration records. The Program failed to complete service plans to accurately reflect the needs of the tenants or the services staff were actually providing. Service Plans were not based on evaluations. The Program failed to complete evaluations with significant changes in condition and annually. The Program failed to document staff training. Staff were working independently with no knowledge of who to contact in case of emergency. The Program failed to follow their policy regarding incident reports.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.12(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 **two thousand two hundred seventy five dollars ($2,275)** within 30 days after the notice or service of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written 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 the notice or service of this demand letter.

IV. Conclusion

The Program is being assessed a **$3,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Plan of Correction (POC) submitted on August 16, 2013, has been reviewed and will constitute the final POC related to the on-site visit of July 10, 11, 15, and 22, 2013.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of notice or service 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,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Christine Vasquez, Administrator
Walden Point Assisted Living
1200 4th Street
Des Moines, IA 50314

Complaint/Incident Intake #: 44138-C
44147-C
42070-CR-2

Date of Complaint/Incident Investigation:

July 10, 11, 15, and 22, 2013

Monitor(s):

Maribeth Freland, RN
Lori Miner, RN BSN

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:	57
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	57
TOTAL census of Assisted Living Program	57

Program History – The program received regulatory insufficiencies in the areas of: Medications, Evaluation, Food Service and Staffing during the May 8, 2012 Recertification on-site. During the November 7, 2012 Complaint Investigation (41318-C) the program received a regulatory insufficiency in the area of Medications. The program received regulatory insufficiencies in the areas of: Medications, Policy and Procedures and Record Checks during the January 15, 2013 Complaint Investigation (42070-C). During the March 21, 2013 Revisit to Complaint 42070-CR-1, the program received regulatory insufficiencies in the areas of Medications, Policy and Procedures and Plan of Correction.

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

A. Tenant Rights

During the course of the investigation, the following was noted:

- Monitoring Observation: According to the Administrator, assisted living services had previously been provided to tenants through Mercy Home Health (Home Health). As of September 2012, Home Health no longer provided the 24-hour assisted living services to the tenants. A contractual agreement was reached at that time between the owner of Walden Point and BrightStar of Central Iowa to provide unskilled nursing services, as well as the amenities program including overnight onsite staff and an activities program. When BrightStar assumed the role of providing assisted living services, Home Health continued to see tenants who required skilled care, but provided services only as a home health agency. The previous contract between Walden Point and Mercy Home Health was severed on 10-1-12.

  According to the Administrator, Walden Point was continuing to negotiate a contract with Home Health to be an exclusive provider of skilled home health services within the Walden Point program. However, at the time of the onsite visit, the Administrator was unable to provide a copy of a written contractual agreement between Walden

Point and Home Health. According to the Mercy Home Health Administrator, the home health was strictly providing home health services. Home Health currently contracts with each tenant individually for the provision of services and bills such services directly to each tenant's third party payor. Mercy Home Health no longer shares any of the financial payment for services with Walden Point.

The program provided documentation of an Acknowledgement of On- Site Service Provider Requirements. The document indicated a tenant understood by choosing to live at Walden Point, Mercy Home Health was the onsite provider for home health care. Each tenant was required to sign the Acknowledgement prior to moving into Walden Point. According to the Walden Point Administrator, the choice was made by the tenant prior to admission to the program.

According to the program's Tenants Rights and Responsibilities document, each tenant had the right to select health and other skilled service providers for non-waiver covered services within the limits of applicable law.

The program did not have a contractual agreement any longer with Mercy Home Health; therefore, the home health agency was currently acting as an outside provider coming into the assisted living at the request of individual tenants. Mercy Home Health ceased acting as the program's on-site service provider on 10-1-13. BrightStar became the program's sole on-site provider of assisted living services on 10-1-12. Tenants were not given a choice in selecting a skilled home health provider.

- Regulatory Insufficiency: All tenants have the following rights: To associate and communicate privately and without restriction with persons and groups of the tenant's choice, including the tenant advocate, on the tenant's initiative or on the initiative of the persons or groups at any reasonable hour. (IAC r. 481-67.3(6))

B. Nurse Review

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #2, an 80 year-old, was admitted on 10-8-11 and had diagnoses of: Diabetes Type II, Gastroesophageal Reflux Disease, Hypertension (HTN), Alzheimer's Dementia, Chronic Obstructive Pulmonary Disease, and Macular Degeneration. Tenant #2 had eight errors on a cognitive ability assessment completed on 4-22-13 indicating moderate risk for cognitive decline.

  On 4-17-13, Tenant #2 was admitted to the hospital following two episodes within 24 hours of a low blood sugar reading of 30 or less. On 4-22-13 a physician's progress note documented Tenant #2 had a urinary tract infection, and protein-calorie malnutrition. The physician was concerned about Tenant #2's ability to self-administer medications and the need for a higher level of care. Documentation in the Walden Point/BrightStar clinical record did not clearly indicate Tenant #2's date of return to the program.

  A nurse review was completed on 5-20-13 which indicated no change in function, cognition, or health. According to the service plan dated 5-1-13, BrightStar staff

members assisted with medication administration. Tenant #2 received health-related cares. The nurse review did not assess and document Tenant #2's health status following changes within the previous 90 days, and did not monitor for adverse reactions to medications, did not ensure physician's orders were current, and did not ensure medications were given consistent with the orders. A 90-day nurse review was not completed by the BrightStar nurse.

Tenant #3, an 80 year-old, was admitted to the program on 6-13-08 with the diagnoses of: Arthritis, Asthma, Congestive Heart Failure, Hypertension, Diabetes, Atrial Fibrillation, Obesity and Legal Blindness. Tenant #3 answered all questions correctly on the Cognitive Ability Assessment completed on 6-13-13, indicating low risk for cognitive impairment. According to Tenant #3's service plan, dated 5-1-13, BrightStar staff members administered medications to Tenant #3.

Tenant #3's Nurse Review completed on 6-13-13 included a review of Tenant #3's health status but lacked documentation of the BrightStar nurse's review of Tenant #3's medications as required by regulation to identify any adverse reactions and to assure Tenant #3's medication list was up-to-date and being administered according to physician orders.

Tenant #4, a 69 year-old, was admitted on 5-29-12 and had a diagnosis of Diabetes and was on Anticoagulant Therapy. Tenant #4 answered all questions correctly on the Cognitive Ability Assessment dated 6-7-13. According to the service plan, BrightStar set up and administered medication for Tenant #4. A 90-day nurse review of health was completed on 6-7-13. The nurse review did not monitor for adverse reactions to medications, did not ensure physician's orders were current, and did not ensure medications were given consistent with the orders. Tenant #4 sustained a fall on 5-30-13 and on 6-3-13 was observed to have a have a one-inch by two-inch bump on the back of the head. The nurse review of 6-7-13 did not contain documentation of the condition of the head bump. A 90-day nurse review was not completed by the BrightStar nurse.

Tenant #6, a 77 year-old, was admitted on 4-9-10 and had diagnoses of: Diabetes Type II, Diabetic Neuropathy, Chronic Airway Obstruction, HTN, Depressive Disorder, and Morbid Obesity. Tenant #6 had four errors on the Cognitive Ability Assessment completed 6-20-13 which indicated low risk for cognitive impairment. According to the service plan dated 5-1-13, the program provided medication assistance. The 90-day nurse review of health was completed on 6-20-13. The nurse review did not monitor for adverse reactions to medications, did not ensure physician's orders were current, and did not ensure medications were given consistent with the orders. A 90-day nurse review was not completed by the BrightStar nurse.

Tenant #7, an 86 year-old, was admitted to the program on 12-30-09 with diagnoses of: Atrial Fibrillation and Diabetes. Tenant #7 answered all but four questions correctly on the Cognitive Ability Assessment completed on 6-20-13, indicating low risk for cognitive impairment. According to Tenant #7's service plan, BrightStar staff members administered medications to Tenant #7.

Tenant #7's Nurse Review completed on 6-20-13 included a review of Tenant #7's health status but lacked documentation of the BrightStar nurse's review of Tenant

#7's medications as required by regulation to identify any adverse reactions and to assure Tenant #7's medication list was up-to-date and being administered according to physician orders.

Tenant #11, an 86 year-old, was admitted to the program on 3-6-09 with diagnoses of: Congestive Heart Failure, Chronic Lower Leg Edema, Myalgia, Osteoarthrosis and Obesity. Tenant #11 answered all but two questions correctly on the Cognitive Ability Assessment completed on 6-3-13, indicating low risk for cognitive impairment. According to Tenant #11's service plan, BrightStar staff members administered medications to Tenant #11.

Tenant #11's Nurse Review completed on 6-3-13 included a review of Tenant #11's health status but lacked documentation of the BrightStar nurse's review of Tenant #11's medications as required by regulation to identify any adverse reactions and to assure Tenant #11's medication list was up-to-date and being administered according to physician orders.

Tenant #14, a 93 year old, was admitted to the program on 1-22-09 with diagnoses of: Atrial Fibrillation, Alzheimer's Disease and Chronic Kidney Disease. Tenant #14 answered all but four questions correctly on the Cognitive Ability Assessment completed on 6-21-13, indicating low risk for cognitive impairment. According to Tenant #14's service plan, BrightStar staff members administered medications to Tenant #14.

Tenant #14's Nurse Review completed on 4-19-13 included a review of Tenant #14's health status but lacked documentation of the BrightStar nurse's review of Tenant #14's medications as required by regulation to identify any adverse reactions and to assure Tenant #14's medication list was up-to-date and being administered according to physician orders.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To 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; and (IAC r. 481-69.27(1))

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

- Regulatory Insufficiency: 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. (IAC r. 481-69.27(3))

C. Evaluation

Complaint/Incident Allegation: It was alleged a tenant with a low blood sugar was not assessed and treated appropriately; skin conditions and injuries were not assessed and treated; and after falls, tenants were not monitored. (#44138-C)

- Monitoring Observation: The monitors reviewed the clinical records of 10 tenants, Tenants #1, #2, #3, #4, #6, #7, #8, #11, #12 and #14. The monitors identified no concerns related to evaluation for Tenants #1 and #7.

  Tenant #2 was hospitalized on 4-17-13 for two episodes of low blood sugar within 24 hours. Documentation in the Walden Point/BrightStar clinical record did not clearly document Tenant #2's return to the program. An unsigned note dated 4-22-13 indicated Tenant #2 was assessed to "recert to come back" to the program. The note indicated Tenant #2 was not sure of the ability to provide care for self. On 4-22-13 a physician's progress note documented Tenant #2 had a urinary tract infection, and protein-calorie malnutrition. The physician was concerned about Tenant #2's ability to self-administer medications, and the need for a higher level of care. A health evaluation was completed on 4-22-13 using a standardized form. The health form did not indicate an evaluation of the tenant related to the diagnoses of urinary tract infection and protein-calorie malnutrition. The functional evaluation form was part of the health form. The blanks were empty. An evaluation of function related to the ability to care for self or self-administer insulin was not completed. Evaluations were not completed with a significant change of condition.

  Tenant #3's Nurse Review/Functional Evaluation completed on 6-13-13 indicated Tenant #3 did not require assistance with diabetes management, including blood sugar testing. On 7-11-13 Staff #3, Direct Care Worker, administered Tenant #3's eye drops and assisted Tenant #3 with blood sugar testing. Staff #3 placed a lancet into Tenant #3's device and cocked the lancet device so it was ready to use. Staff #3 handed the lancet to Tenant #3. Tenant #3 was able to poke his/her own finger when testing the blood sugar but was unable to work the glucometer (machine used to read the blood for testing). Tenant #3 stated "I can't do it. I can't see." Staff #3 set up the glucometer and tested Tenant #3's blood with the machine without Tenant #3 participating at all. Staff #3 indicated she usually helps Tenant #3 with the use of the lancet and glucometer. Tenant #3's Health/Functional Evaluation did not accurately reflect Tenant #3's needs and did not match what staff members were doing for Tenant #3.

  An incident report dated 5-30-13 indicated on 5-30-13 Tenant #4 was outside sitting on a walker. Tenant #4 was independent with ambulation with the use of a wheeled walker. The wheels became unlocked and Tenant #4 rolled backwards and fell onto his/her back. A large bump was noted on the back of the head by the BrightStar staff. The BrightStar on-call nurse came to see Tenant #4. The Walden Point/BrightStar clinical record nursing notes documented the on-call nurse's assessment. Tenant #4 was sent to the emergency room because of a fall with a "knot" to the back of the head and Tenant #4 was on a blood thinner. According to the incident report, Tenant #4 returned to the program with an order to hold one dose of the blood thinner.

The nursing notes next documented a review of Tenant #4 on 6-3-13, four days after the fall occurred. Tenant #4 was observed to have a one-inch by two-inch bump on the back of the head. At that time, Tenant #4 was educated on what to report and to whom if the condition changed. After the initial review by the BrightStar on-call nurse, Tenant #4, who was on a blood thinner, was not evaluated for four days following a fall with an observed injury to the head. Evaluations were not completed with a change of condition.

Tenant #6 was observed during a medication pass on 7-11-13. Tenant #6 was to receive insulin via an insulin pen. Staff #1 took the insulin pen and the supplies from the locked cupboard in Tenant #6's apartment and handed the supplies to Tenant #6. Tenant #6 stated he/she had never put the insulin pen together before, referring to placing the needle on the syringe portion of the pen. Tenant #6 was observed to be missing portions of the thumb and index finger on the right hand, and was observed having some difficulty removing the needle from the packaging. Tenant #6 asked if the needle needed to be primed with two units of insulin. Staff #1 confirmed the dose for priming. Staff #1 stated Tenant #6 administered insulin independently. A health evaluation completed 6-20-13 by the BrightStar nurse indicated Tenant #6 had complaints about the right hand. The functional evaluation indicated Tenant #6 needed assistance with medication assistance but did not indicate Tenant #6 required assistance with diabetes management. An evaluation of Tenant #6's ability to prepare the insulin pen and self-administer insulin was not completed by the BrightStar nurse.

A nurse review was completed by BrightStar on 3-25-13 for Tenant #6. The review indicated Home Health was seeing Tenant #6 for a problem with left toe. The review did not contain any detail as to the problem with the left toe. The Home Health Certification and Plan of Care with certification dates of 1-22-13 to 3-22-13 indicated Tenant #6 had pain in a toe on the left foot, had been on several different antibiotics and was placed on a medication for gout. In an interview with Staff #4, she stated Tenant #6 complained of a broken toe, but it was "quite a while ago." Staff #4 stated there was no treatment for the broken toe. The Walden Point/BrightStar clinical record lacked documentation of an evaluation of Tenant #6's toe by the BrightStar nurse.

Tenant #8, an 83 year-old, was admitted to the program on 9-23-11 with the diagnoses of: Depression, Diabetes and Chronic Urinary Tract Infections. Tenant #8 answered all but four questions correctly on the Cognitive Ability Assessment completed on 6-26-13, indicating low risk for cognitive impairment. According to the service plan, dated 6-26-13, Tenant #8 was independent with housekeeping and laundry duties and independent with all activities of daily living. Tenant #8 ambulated independently and took his/her own medications.

On 6-5-13 Tenant #8 fell while outside, resulting in a 0.5 centimeter laceration to the back of the head. Tenant #8 returned to the program on 6-5-13 with no treatment to the head laceration. The BrightStar Registered Nurse (RN) performed a physical assessment the following day on 6-6-13 at 11:45 a.m. Tenant #8 denied dizziness, pain or blurred vision. During interview, the BrightStar RN reported Tenant #8's laceration did not require sutures or staples. The BrightStar RN directed Tenant #8 to notify the RN or direct care workers with any changes, dizziness or pain.

During interview Staff #4, Direct Care Worker, reported Tenant #8 had walked back and forth from Kwik Trip and fell when outside, resulting in a laceration to the back of his/her head. Tenant #8 was sent to the emergency room for evaluation and returned shortly thereafter holding a paper towel to the laceration. The laceration continued to bleed "a little" then stopped bleeding. The laceration did not require sutures. Tenant #8 was given a prescription for pain pills which he/she was able to take independently. The BrightStar RN had given direction to monitor Tenant #8. Tenant #8 had no further issues related to the laceration.

On 6-23-13 Tenant #8 began experiencing dizziness, shortness of breath and muscle cramps. Tenant #8 was sent to the emergency room and was admitted to the hospital with a diagnosis of pneumonia. Tenant #8 returned to the program on 6-25-13. On 6-26-13 Tenant #8 fell while inside, resulting in no injury. The BrightStar RN completed a nurse review addressing Tenant #8's falls and weakness due to the pneumonia, determining Tenant #8 would benefit from physical therapy services. Physical therapy services were initiated and the services were added to Tenant #8's service plan on 6-26-13. Tenant #8's clinical record included a cognitive evaluation completed on 6-26-13 but lacked a health and functional evaluation completed by the BrightStar RN despite the identification of Tenant #8's significant change.

Tenant #11's Health/Functional Evaluation completed on 6-3-13 indicated Tenant #11 had chronic edema to the lower extremities, requiring use of compression stockings. The evaluation indicated Tenant #11's skin on the lower extremities was intact. The evaluation indicated Tenant #11 did not require assistance with bathing, dressing and application/removal of compression stockings.

On 7-11-13, during medication administration observation, the monitor observed Staff #1, Direct Care Worker, apply Tenant #11's compression stockings. Tenant #11's legs appeared swollen and dry but with intact skin. Staff #1 applied over-the-counter lotion to Tenant #11's legs and applied the compression stockings to both legs. During interview, Tenant #11 reported the staff members routinely apply the over-the-counter lotion to his/her legs before applying the compression stockings.

During interview, Staff #4, Direct Care Worker, reported Tenant #11's family member purchased over-the-counter lotion to apply to Tenant #11's lower legs as needed. Staff #4 reported never being directed to apply the lotion but does so if Tenant #11 requests her to when applying Tenant #11's compression stockings. Tenant #11's service plan, dated 5-1-13, indicated Tenant #11 required the assistance of one person to shower. The service plan indicated the home health agency provided assistance with the shower. The service plan indicated Tenant #11 was independent with all grooming/hygiene needs but required assistance with putting on shoes, buttoning clothes and applying and removing compression stockings. The service plan directed BrightStar staff members to apply and remove the compression stockings twice daily.

Tenant #11's Health/Functional Evaluation did not accurately reflect Tenant #11's needs and did not match what staff members were doing for Tenant #11.

Tenant #12, a 92 year old, was admitted to the program on 9-26-11 with diagnoses of: Anemia; Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Tenant #12 attempted to complete the program's Cognitive Ability Assessment on 1-31-13 and 5-13-13 but, due to hearing difficulties was unable to complete the assessment. Tenant #12's clinical record lacked an evaluation as required by regulation.

Tenant #14's clinical record contained a health and functional evaluation, dated 4-16-09. Tenant #14's clinical record lacked any further health and functional evaluations after 4-16-09. During interview, the BrightStar RN reported he had looked through Tenant #14's clinical record, finding only the 4-16-09 health and functional evaluation with no documentation of any further evaluations after that time.

On 6-19-13 Tenant #14 began experiencing low peripheral oxygen levels. Tenant #14's physician ordered pulse oxygen level readings to be done each night. On 6-21-13 the BrightStar RN determined Tenant #14 had a change in health condition. Oxygen was initiated by Tenant #14's physician to be administered at bedtime for night time use. Tenant #14's clinical record contained a cognitive evaluation but lacked a health or functional evaluation at the time of Tenant #14's change in condition.

The program failed to complete an evaluation of Tenant #14's health and functional status at least annually and with a significant change of condition.

- Regulatory Insufficiency: 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. (IAC r. 481-69.22(2)

D. Service Plans

During the course of the investigation, the following was noted:

- Monitoring Observation: The clinical record for Tenant #2 was reviewed. Cognitive and basic health evaluations were conducted on 4-22-13, prior to discharge from the hospital for low blood sugar, urinary infection and protein-calorie malnutrition. A functional evaluation was not completed. The current service plan was dated 5-1-13 with an update on 6-10-13 to indicate physical therapy had been discontinued. The service plan indicated Tenant #2 utilized Home Health for bathing assistance, BrightStar staff assisted with medication administration, and provided tray assistance in the dining room. The service plan was not based on evaluations.

Tenant #2 was diabetic with a history of low blood sugars. The service plan did not identify Tenant #2 was diabetic or the physician-prescribed protocol for low blood sugar. The service plan indicated Tenant #2 required a device for mobility, but did not indicate what device was used, and whether or not Tenant #2 was independent in using the device. The service plan did not meet the identified needs of Tenant #2.

Tenant #3, an 80 year old, was admitted to the program on 6-13-08 with the diagnoses of: Arthritis; Asthma; Congestive Heart Failure; Hypertension; Diabetes; Atrial Fibrillation, Obesity and Legal Blindness. Tenant #3 answered all questions correctly on the Cognitive Ability Assessment completed on 6-13-13, indicating low risk for cognitive impairment. Tenant #3's Nurse Review/Functional Evaluation completed on 6-13-13 indicated Tenant #3 required assistance with medication administration.

Tenant #3's April, May, June and July 2013 MARs documented Tenant #3 was independent with administration of all oral medications and required staff member assistance with the administration of eye drops only. The MARs indicated staff members administered Tenant #3's eye drops twice daily but did not administer any oral medications.

Tenant #3's Consumer Directed Attendant Care (CDAC) notes for April, May and June 2013 documented staff members administered only eye drops to Tenant #3. The sheets lacked documentation of administration of any oral medications. The service plan, dated 5-1-13, directed staff members to administer oral medications three times daily.

The Nurse Review/Functional Evaluation completed on 6-13-13 indicated Tenant #3 did not require assistance with diabetes management, including blood sugar testing. On 7-11-13 Staff #3, Direct Care Worker, administered Tenant #3's eye drops and assisted Tenant #3 with blood sugar testing. Staff #3 placed a lancet into Tenant #3's device and cocked the lancet so it was ready to use. Staff #3 handed the lancet to Tenant #3. Tenant #3 was able to poke his/her own finger when testing the blood sugar but was unable to work the glucometer (machine used to read the blood for testing). Tenant #3 stated "I can't do it. I can't see." Staff #3 set up the glucometer and tested Tenant #3's blood with the machine without Tenant #3 participating at all. Staff #3 indicated she usually helps Tenant #3 with the use of the lancet and glucometer.

The service plan, dated 5-1-13, directed staff members to assist Tenant #3 with preparing his/her insulin pen and remind Tenant #3 to check his/her blood sugar with the glucometer.

Tenant #3's service plan did not accurately reflect Tenant #3's needs and did not match what staff members were doing for Tenant #3.

Tenant #4 sustained a fall on 5-30-13 which resulted in a bump to the head. Tenant #4 was on a blood thinner at the time of the fall, and one dose of the blood thinner was held after the fall. Nursing notes dated 6-3-13 indicated Tenant #4 was educated on what to report and to whom if the condition changed. The service plan was not

updated to indicate what was to be reported with a change of condition. Tenant #4 was voluntarily discharged on 7-6-13.

Tenant #6 was prescribed oxygen. Tenant #6 was also prescribed creams for a reddened perineum. A review of the service plan dated 5-1-13 did not indicate Tenant #6 required oxygen, nor perineal cares. The service plan did not meet the identified needs of Tenant #6.

Tenant #11's Health/Functional Evaluation completed on 6-3-13 indicated Tenant #11 had chronic edema to the lower extremities, requiring use of compression stockings. The evaluation indicated Tenant #11's skin on the lower extremities was intact.

On 7-11-13, during medication administration observation, the monitor observed Staff #1, Direct Care Worker, apply Tenant #11's compression stockings. Tenant #11's legs appeared swollen and dry but with intact skin. Staff #1 applied over the counter lotion to Tenant #11's both legs and applied the compression stockings to both legs. During interview, Tenant #11 reported the staff members routinely apply the over the counter lotion two his/her legs before applying the compression stockings.

During interview, Staff #4, Direct Care Worker, reported Tenant #11's family member purchased over the counter lotion to apply to Tenant #11's lower legs as needed. Staff #4 reported never being directed to apply the lotion but does so if Tenant #11 requests her to when applying Tenant #11's compression stockings. Tenant #11's service plan, dated 5-1-13, indicated Tenant #11 was independent with all grooming/hygiene needs. The service plan did not direct BrightStar staff members to apply the over the counter lotion to Tenant #11's legs.

Tenant #11's service plan did not accurately reflect Tenant #11's needs and did not match what staff members were doing for Tenant #11.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1)

E. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant exceeded criteria for retention at the program.

- Monitoring Observation: The monitors reviewed the clinical records of 10 tenants, Tenants #1, #2, #3, #4, #6, #7, #8, #11, #12 and #14. No issues related to criteria for retention were found with Tenants #1, #3, #4, #6, #7, #8, #11 and #14.

  Tenant #2 was hospitalized on 4-17-13 for two episodes of low blood sugar within 24 hours. Documentation in the Walden Point/BrightStar clinical record did not clearly

document Tenant #2's return to the program. An unsigned note dated 4-22-13 indicated Tenant #2 was assessed to "recert to come back" to the program. The note indicated Tenant #2 was not sure of the ability to provide care for self. On 4-22-13 a physician's progress note documented Tenant #2 had a urinary tract infection, and protein-calorie malnutrition. The physician was concerned about Tenant #2's ability to self-administer medications, and the need for a higher level of care. The current service plan dated 6-10-13 indicated Tenant #2 received assistance with medications and bathing, and was independent with grooming, dressing, transfers, toileting and eating. Tenant #2 did not exceed criteria for retention at the program.

Tenant #12's service plan, dated 5-1-13, Tenant #12 was independent with all activities of daily living but required medication administration assistance from BrightStar staff members. Tenant #12 was admitted to hospice services on 5-28-13. According to Tenant #12's service plan, dated 5-28-13, BrightStar staff members administered Tenant #12 nebulizer treatments four times daily. The service plan indicated hospice staff members assisted Tenant #12 with bathing twice a week and required assistance with dressing. The same service plan indicated Tenant #12 was independent with eating, toileting, transfers and ambulation.

Tenant #12's health condition began deteriorating throughout June 2013, requiring his/her transfer to a higher level of care on 7-1-13.

Staffing schedules given to all program staff at the start of each shift directed staff members to assist Tenant #12 with medication and a breathing treatment at 8:30 a.m., 12:30 p.m., 4:30 p.m. and 9:30 p.m.

During interview, Staff #3, Direct Care Worker, reported Tenant #12 was able to transfer and ambulate independently and required staff member assistance with bathing and dressing. Staff #3 reported Tenant #12 began to deteriorate, needing more assistance with activities of daily living, which required Tenant #12 to move to a nursing home.

During interview, Staff #4, Direct Care Worker, reported Tenant #12 was able to transfer and ambulate independently using a walker to and from meals and required staff member assistance with bathing, dressing and toileting. Staff #4 reported nebulizer treatments were administered four times daily to Tenant #12 and did not take much time to administer. Staff #4 reported Tenant #12 began to deteriorate, needing more assistance with activities of daily living, which required Tenant #12 to move to a nursing home.

Tenant #12 was transferred to a higher level of care by the program when his/her deterioration in health status and functional abilities reached a level of requiring more staff member assistance.

- Regulatory Insufficiency: None noted.

F. Tenant Documents

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1, a 90 year old, was admitted to the program on 11-12-10 with the diagnoses of: Anxiety; Hypertension and Osteoarthrosis. Tenant #1 died on 2-18-13 while hospitalized. Tenant #1 received home health services while residing at the program and was discharged from home health on 10-25-12. During interview, the Home Health Nurse reported Tenant #1 received only CDAC services and supervision of CDAC services from the home health agency. BrightStar began providing the CDAC services and supervision on 10-1-12. Tenant #1 was discharged from the home health agency at the end of the certification on 10-28-12.

  Tenant #1 fell, requiring hospitalization on 2-17-13. Tenant #1 died on 2-18-13 while hospitalized. The program could not present any documentation for Tenant #1 between 10-25-12 and 2-18-13 except three CDAC notes. During interview, the BrightStar Office Manager/Human Relations Personnel reported Tenant #1's assisted living clinical record was inadvertently sent to the hospital with Tenant #1 on 2-17-13. Tenant #1's clinical record was never returned to the program as the hospital was never able to recover the record.

  Upon the monitor's review of Tenant #1, the program presented a thinned clinical record that contained documentation through 8-23-12. The program also presented three CDAC notes, dated 2-7-13, 2-14-13 and 2-17-13. The note dated 2-17-13 documented Tenant #1 pushed his/her lifeline. Upon response to the call for assistance, Staff #5, Direct Care Worker, found Tenant #1 on the floor in pain. Staff #5 documented she contacted the registered nurse who gave direction to transfer Tenant #1 to the hospital.

  Tenant #1's clinical record lacked documentation of current health, functional and cognitive evaluations, nurse reviews, a current service plan, nurse progress notes from 8-23-12 to 2-17-13 and any documentation related to the 2-17-13 fall with hospitalization or Tenant #1's death the next day.

  Tenant #6 received physician prescribed oxygen. A review of the July CDAC sheet indicated staff members assisted with the oxygen. The oxygen, a physician-ordered task, was not on the Medication Administration Record (MAR).

  During the medication pass, Staff #1 was observed applying support stockings to Tenant #11. A review of the CDAC sheet indicated staff members assisted with the support stockings. The support stockings, a physician-ordered task, was not on the MAR.

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

- 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: All records shall be protected from loss, damage and unauthorized use. (IAC r. 481-69.25(3))

G. Activities

Complaint/Incident Allegation: It was alleged the program was not providing activities. (#44147-C)

- Monitoring Observation: The Walden Point Amenities Program Fee Agreement, a voluntary amenities program offered by the program, indicated a $225.00 per month fee was to be paid should tenants wish to receive the following services: access to overnight on-site staff member response to unscheduled needs between the hours of 9:00 p.m. and 7:00 a.m.; in-house 24-hour personal emergency response system that automatically identified the Tenant in distress and could be activated with one touch (Lifeline system); ongoing assistance in applying for and utilizing various subsidy programs; access to the activities program, which may have included such things as exercise classes, pet therapy, crafts, activities with children, music programs, bingo, social hour events, games and gardening.

  The Amenities Fee Agreement indicated that certain special events and/or outings such as trips, programs requiring admission fees and special dining outings could require an additional fee for those wishing to participate.

  The Activity Calendars for May, June and July 2013 included an average of 3 to 4 activities scheduled Monday through Friday and one activity scheduled on Saturdays and Sundays. The activities scheduled included coffee chats, exercises, crafts, games, bible studies, music events, ice cream socials, bingo, trivia, book clubs and movies with popcorn.

  On 7-10-13 upon initiation the on-site visit, the program Administrator reported a magic show had just ended prior to the monitors' entrance. The monitors observed group exercises occurring in the program's common dining area at approximately 1:30 p.m. on 7-11-13; observed tenants playing a board game at two different tables in the program's common dining area at approximately 1:30 p.m. on 7-15-13 and observed Bingo being played by multiple tenants in the program's common dining area at approximately 3:15 p.m. on 7-15-13. The reported and observed activities matched the activities scheduled for July 10, 11 and 15, 2013.

  The monitors interviewed four tenants (Tenants #3, #10, #15 and #16). All four tenants were cognitively intact and currently resided at the program.
  Tenant #3 reported no activities occurred during the month of September 2012 due to a change in providers. The program had three activity directors between September 2012 and July 2013. With each change in the activity director, the activities seemed to improve. The current Activity Director "has been working her ... off to try to do a good job. Change is hard for all of us but things (the provision of activities) have much improved."

Tenant #10 reported a variety of activities were offered by the program and he/she enjoyed attending the singing programs the most.

Tenant #15 reported the program offered plenty of activities. "They keep us plenty busy." Tenant #15 reported the activities offered by the program were age-appropriate, plentiful and addressed a variety of interests.

Tenant #16 reported the program offered a variety of age-appropriate activities to "keep us busy."

- Regulatory Insufficiency: None noted.

H. Policies and Procedures

The program received a regulatory insufficiency during the 1-15-13 complaint investigation (42070-C) and revisit of 3-21-13 related to the policy on incident reports not being followed.

- Monitoring Observation: The program was asked to provide incident reports for the last three months. Approximately 48 incident reports from 4-1 to 7-9-13 were given to the monitors. Incident reports documented medication errors and staff training related to medication errors. An incident report also documented an audit process was used.

  Approximately 35 incident reports were completed by Home Health. Home Health documented falls approximately 15 times when BrightStar staff responded to the lifeline, some of which were during evening and night time hours. Because Home Health no longer had a contract with Walden Point, BrightStar was the agency in charge at the time of the documented incidents.

  According to the Incident Reporting Policy, an incident report was to be prepared by the person in charge at the time of the incident and witness statements were to be obtained. BrightStar staff, which was in charge at the time of the incidents, did not complete reports documenting falls. BrightStar staff did not complete witness statements at the time of the falls. BrightStar did not follow the policy on the completion of incident reports.

  Tenant #1's clinical record contained a CDAC note, dated 2-17-13, which documented Tenant #1 pushed his/her lifeline. Upon response to the call for assistance, Staff #5, Direct Care Worker, found Tenant #1 on the floor in pain. Staff #5 documented she contacted the previous BrightStar registered nurse who gave direction to transfer Tenant #1 to the hospital. The program was unable to present an incident report documenting the circumstances surrounding Tenant #1's fall with subsequent hospitalization on 2-17-13.

  During interview, Staff #5 reported she had not filled out an incident report as she had never been told to do so. Staff #5 began working for the program on 2-5-13, 12 days

before the incident. BrightStar did not follow the policy on completion of incident reports.

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

I. Medications

The program received a regulatory insufficiency following the complaint investigation (42070-C) of 1-15-13 and the revisit of 3-21-13 related to direction for medication administration not written clearly, and medications not documented as given or according to the medication schedule.

It was alleged a tenant with a low blood sugar was not assessed and treated appropriately; skin conditions and injuries were not assessed and treated; and after falls, tenants were not monitored. (#44138-C)

- Monitoring Observation: The monitors observed Staff #1 and Staff #3, both Direct Care Workers, administering medications to 17 tenants on 7-11-13. Staff #1 and #3 both washed hands prior to and after tenant cares. Staff #1 and #3 used gloves appropriately. Medications were documented immediately after being given. Patches were dated and initialed. The monitors reviewed the Medication Administration Records (MARs) of tenants observed during the administration, noting the following:

  Tenant #6's July 2013 MAR contained a handwritten entry for two creams dated 7-6-13. The entry did not contain information as to where the creams were to be applied. The entry was not signed by a nurse.

  Tenant #13's June 2013 MAR lacked contained a "hole" for the night of 6-23-13.

  Tenant #17's June 2013 MAR documented Tenant #17's Omeprazole 40 milligrams (mg) was discontinued on 6-28-13. Tenant #17's July 2013 MAR continued to include Omeprazole 40 mg. even though the medication had been discontinued in June. As of July 11, 2013 the Omeprazole 40 mg order remained on the July 2013 MAR.

  The June MAR for Tenant #18 contained a "hole" for the morning of 6-7-13.

  The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #6, #7, #8, #11, #12 and #14.
  The BrightStar clinical notes were reviewed for Tenant #2. An entry dated 4-16-13 and timed 10:45 a.m. indicated BrightStar staff responded to the lifeline which had been activated by the Home Health Nurse. Home Health was seeing Tenant #2 for medication management and blood sugar control. According to the Administrator, part of the duties of the BrightStar staff was to respond to the lifeline. The notes documented Tenant #2's blood sugar was 29. The unsigned notes indicated the staff

member sat with Tenant #2 and gave Tenant #2 juice and glucose gel. The blood sugar rose to 81 in 25 minutes.

The Walden Point/BrightStar clinical record was reviewed for Tenant #2. The record contained standing orders for Tenant #2 which indicated if the blood sugar was less than 70, Tenant #2 was to have four glucose tablets or a snack of 15 grams of carbohydrates described as one-half cup juice or one cup milk. The blood sugar was to be re-checked in 15 minutes and to repeat the above steps if the blood sugar continued to be less than 70. If the blood sugar was less than 70 after two test results, the physician was to be notified.

A review of the April 2013 MAR was reviewed. The MAR contained a listing of glucose tablets, but there was no entry the tablets had been given. There was no listing on the MAR to indicate an equivalent dose of glucose gel and no entry to indicate the gel had been given. The documentation by BrightStar staff in the clinical notes did not indicate the physician-prescribed procedure for a low blood sugar was followed. There was no documentation the BrightStar nurse was notified of the event.

The clinical notes for Tenant #2 dated 4-17-13 and timed at 12:30 a.m. indicated a BrightStar staff member checked Tenant #2's blood sugar and got a low reading of 30. Notes documented Tenant #2 was given a cookie and juice. The Home Health Nurse was notified and according to the documentation, glucose gel was given. After a whole tube of gel was given, the blood sugar rose to 40 and Tenant #2 was described as "lethargic." According to the documentation by the BrightStar staff member, the Home Health Nurse called to check on Tenant #2 "we decided" a non-emergent ambulance was to be called. One hour after the blood sugar was first checked, the ambulance arrived and the blood sugar was 37. The clinical notes documented the ambulance staff administered a high dose of glucose through an intravenous line. The documentation by BrightStar staff in the clinical notes did not indicate the physician-prescribed procedure for low blood sugar was followed. There was no documentation the BrightStar nurse was notified of the event.

The clinical notes for Tenant #2 dated 6-27-13 and timed 1:00 a.m. indicated a BrightStar staff member checked Tenant #2's blood sugar and got a low reading of 66. Notes documented Tenant #2 was given juice and a roll. Home Health was contacted. The documentation by BrightStar staff in the clinical notes did not indicate the physician-prescribed procedure for low blood sugar was followed. There was no documentation the BrightStar nurse was notified of the event.

The medication cupboard for Tenant #6 was observed to contain the same standing orders as Tenant #2 for care in the event of low blood sugar. Clinical notes for Tenant #6 dated 6-12-13 indicated at 11:43 a.m., Tenant #6's blood sugar was 63 and three glucose tablets were given. Fifteen minutes later, the blood sugar was up to 128. A review of the June 2013 MAR contained an order for four glucose tablets as needed. There was no documentation that any glucose tablets were given on 6-12-13 to Tenant #6.

- Regulatory Insufficiency: When medications are administered traditionally by the program: (a) the administration of medications shall be provided by a registered

nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655---Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

J. Staffing

Complaint/Incident Allegation: It was alleged staff members were not trained to pass medications, including passing medications from a pill bottle, oxygen, and dialing insulin pens. It was alleged staff members called the wrong nurse in an emergent situation and a non-emergent ambulance was called. (44138-C).

Monitoring Observation: The monitors observed Staff #1 and Staff #3 administering medications to 17 tenants on 7-11-13. Staff #1 was observed applying support stockings to Tenant #11 during the medication pass. During the medication pass, Tenant #5 stated staff members usually dialed the insulin pen because Tenant #5 reported poor vision. Staff #1 did not prompt Tenant #5 to prime the needle prior to the administration of insulin through the pen and Tenant #5 did not prime the needle. Tenant #6 reported he/she had never put the insulin pen together. Tenant #6 asked Staff #1 about priming the needle prior to administration of insulin through the pen, and Staff #1 affirmed the need to prime the needle. Documentation indicated BrightStar staff members administered nebulizer treatments to Tenant #12.

Training records for BrightStar staff were reviewed. Staff #1 was hired 6-13-13 as a Direct Care Worker (DCW). Records dated 6-19-13 did not document training on the administration of oral medications, oxygen, nebulizer treatments, or insulin pens.

Staff #2 was hired 5-9-13 as a DCW. Records dated 5-14-13 did not document training on the administration of oral medications, oxygen, support stockings, nebulizer treatments or insulin pens.

Staff #3 was hired 6-3-13 as a DCW. Records dated 6-6-13 did not document training on the administration of oral medications, oxygen, support stockings, or insulin pens. The documentation sheet did not contain Staff #3's name, but was stapled by the program to Staff #3's orientation check list. The documentation sheet also indicated training on eye drops, ear drops and nose drops was done verbally.

Staff #4 was hired 2-12-12 as a DCW. Records dated 6-6-13 did not document training on the administration of oral medications, oxygen, support stockings, nebulizer treatments or insulin pens.

In an interview with the BrightStar RN on 7-11-13, he stated he did try to follow staff and observe medication passes and procedures but sometimes it was not possible. The BrightStar Nurse stated he did sit down with staff members to discuss procedures.

According to the BrightStar Nurse, some tenants self-administered insulin, required hand-over-hand assistance, or prompts to do the procedure correctly including priming the needle of an insulin syringe.

Staff training records lacked documentation of nurse-delegated training related to medications and treatments.

Tenant #1, a 90 year old, was admitted to the program on 11-12-10 with the diagnoses of: Anxiety; Hypertension and Osteoarthrosis. Tenant #1 died on 2-18-13 while hospitalized. Tenant #1 received home health services while residing at the program and was discharged from home health on 10-25-12. Tenant #1 fell, requiring hospitalization on 2-17-13. Tenant #1 died on 2-18-13 while hospitalized. The program could not present any documentation for Tenant #1 between 10-25-12 and 2-18-13 except three CDAC notes. During interview, the BrightStar Office Manager/Human Relations Personnel reported Tenant #1's assisted living clinical record was inadvertently sent to the hospital with Tenant #1 on 2-17-13. Tenant #1's clinical record was never returned to the program as the hospital was never able to recover the record.

Upon the monitor's review of Tenant #1, the program presented a thinned clinical record that contained documentation through 8-23-12. The program also presented three CDAC notes, dated 2-7-13, 2-14-13 and 2-17-13. The note dated 2-17-13 documented Tenant #1 pushed his/her lifeline. Upon response to the call for assistance, Staff #5, Direct Care Worker, found Tenant #1 on the floor in pain. Staff #5 documented she contacted the registered nurse who gave direction to transfer Tenant #1 to the hospital.

During interview, Staff #5 reported on 2-17-13 she had seen Tenant #1 ambulating down the hall. Tenant #1 entered his/her apartment. A short while later Tenant #1 pushed his/her lifeline. Staff #5 immediately responded, finding Tenant #1 lying on the floor. Tenant #1 reported he/she had been trying to go to the bath room, lost balance and fell. Tenant #1 reportedly denied injury or pain. Tenant #1 requested Staff #5 assist him/her to stand as Tenant #1 had to have a bowel movement. Staff #5 reported she had been told never to stand a tenant who had fallen independently due to safety issues. Staff #5 reported she had only worked for the program for less than two weeks and was unclear as to which nurse to call to report the injury and obtain direction on how to care for Tenant #1. Staff #5 made the decision to call the previous BrightStar RN who represented the assisted living provider. Staff #5 reported the previous BrightStar RN reported Tenant #1 was a patient of the home health not BrightStar; therefore, the home health RN should have been called to obtain direction "but just go ahead and call Frazier Ambulance Services". (Tenant #1 had not been a home health patient since 10-25-12) Staff #5 indicated she called the ambulance service and it took approximately 10 to 15 minutes to arrive to transport Tenant #1 to the emergency room. When the ambulance personnel arrived, Tenant #1 began complaining of arm discomfort.

Tenant #1 was transported to the hospital where he/she died early the following morning. Staff #5 reported she heard Tenant #1 died of a heart attack. Staff #5 reported Tenant #1 did not report chest pain or shortness of breath while at the program prior to transport. Staff #5 did not complete an incident report documenting the circumstances of Tenant #1's fall as she reported "no one had told me I was supposed to."

Staff #5 was working independently on 2-17-13 despite her lack of knowledge of who to contact in an emergent situation. Staff #5 had not been trained to fill out incident reports when falls or injuries occurred. As reported by Staff #5, the previous BrightStar RN did not know Tenant #1 was not being followed by home health between 10-25-12 and 2-17-13, giving Staff #5 inaccurate information as to who she should have called to receive direction.

In an emergency, staff was to call 911 in an emergency and then notify the nurse. The BrightStar RN stated staff members were to call Home Health if the tenant was a Home Health client. Otherwise, staff members were to call the BrightStar Nurse.

- 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))

K. Compliance with Plan of Correction

- Monitoring Observation: The program did not resolve the insufficiencies in the areas of medications and policies and procedures received during the 1-15-13 and 3-21-13 monitoring visit and revisit to Complaint Investigation #42070-C.

- Regulatory Insufficiency: The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. (IAC r. 481-67.10(8))