IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 44138-CR
42070-CR3

November 12, 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 REVISIT REPORT - WALDEN POINT ASSISTED LIVING
II. Reduction of Civil Penalty
III. Sanctions – Conditional Operation
IV. Appeals/Hearings
V. Conclusion

Dear Ms. Vasquez:

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

Enclosed is the **Final Complaint/Incident Investigation 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 **October 3, 7 and 8, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Nurse Review, Evaluations, Service Plans, Tenant Documents, Medications, Staffing and Compliance with Plan of Correction.

Walden Point Assisted Living ("Program") is being assessed a **$5,000 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, Evaluations, Tenant Documents, Service Plans, Nurse Review and Staffing.

The determination of a **$5,000 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Medications, Evaluations, Tenant Documents, Service Plans, Nurse Review and Staffing . As the enclosed Report details, the Program has been out of compliance since May 2012. Nurse Reviews, Evaluations, Service Plans and Medication Administration Records were not updated or completed. Program failed to document staff training. Program failed to follow their Plan of Correction.

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 **three thousand two hundred and fifty dollars ($3,250)** within 30 days after the notice or service of this demand letter.

III. Sanctions – Conditional Operation

Due to the Program's noncompliance and current Regulatory Insufficiencies, the Program's Conditional Certificate remains in effect as of **October 28, 2013.**

Previous sanctions include: No new admissions. Proof of staff training on rules, with emphasis on medications, by an outside agency for all direct care workers and nursing

staff within 60 days. The program will have 60 days from the date of receipt of preliminary report to complete the above training and provide proof of the training to the Department.

IV. 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.

V. Conclusion

The Program is being assessed a **$5,000 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 November 8, 2013, has been reviewed and will constitute the final POC related to the on-site visit of October 3, 7 and 8, 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 Revisit Report

Assisted Living Program:

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

Complaint/Incident Intake #:

44138-CR
42070-CR-3

Date of Complaint/Incident Investigation:

October 3, 7 and 8, 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:	58
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	58
TOTAL census of Assisted Living Program	58

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. During the July Complaint Investigation (44138-C, 44147-C, 42070-CR2), the program received regulatory insufficiencies in the areas of: Tenant Rights, Nurse Review, Evaluation, Service Plan, Tenant Documents, Policy and Procedure, Medications, Staffing 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 July 2013 on-site visit, the program received a regulatory insufficiency for failure to allow tenant autonomy when choosing an outside provider for home health services covered under Medicare and Medicaid.

- Monitoring Observation: The program provided documentation of a letter, titled Acknowledgement of On-Site Service Provider Requirements and dated 8-19-13. The program reported all tenants residing at Walden Point had received the Acknowledgement form. The Form indicated that by choosing to live at Walden Point, the tenant agreed to accept the provision Activities of Daily Living, Instrumental Activities of Daily Living and Consumer Directed Attendant Care from BrightStar Care. The Form indicated each tenant was afforded the autonomy to choose the provider of choice to provide any on-site home care services for any Medicare and Medicaid paid skilled services. The program reported an accompanying list of local outside certified home health providers was also given to each tenant.

The monitors reviewed the clinical records of seven tenants, Tenants #2, #3, #6, #7, #11, #15 and #19 to determine compliance with the notification. Tenant #2 signed the Acknowledgement form on 8-22-13, Tenant #3 signed the Acknowledgement form on 8-22-13, Tenant #6 signed the Acknowledgement form on 8-22-13, Tenant #7 signed the Acknowledgement form on 8-22-13, Tenant #11 signed the Acknowledgement form on 8-21-13, Tenant #15 signed the Acknowledgement form on 8-27-13 and Tenant #19 signed the Acknowledgment form on 8-22-13.

- Regulatory Insufficiency: None noted.

B. Nurse Review

During the 7-22-13 on-site visit, the program received a regulatory insufficiency related to the program on-site provider's (BrightStar Care) failure to review tenant medications at least every 90 days and with significant changes in condition to assure medication lists were up to date and accurate, to assure medications were administered according to physician's orders and to identify any adverse medication interactions for Tenants #2, #3, #4, #6, #7, #11 and #14. The program also received a regulatory insufficiency related to the program's failure to complete a nurse review with identified significant changes in health, functional or cognitive status for Tenant #2.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #2, #3, #6, #7, #11 and #14, with three additional record reviews related to nurse review for Tenants #8, #15 and #19. Tenant #4 no longer resided at the program. The monitors identified no concerns related to nurse review for Tenant #15.

  Tenant #2, an 80 year-old, was admitted on 10-8-11 and had diagnoses of: Insulin Dependent Diabetes, Hypertension (HTN), Dementia, Chronic Obstructive Pulmonary Disease (COPD) and Macular Degeneration. Tenant #2 scored a 3 on the Global Deterioration Scale (GDS) completed on 8-20-13, indicating mild cognitive decline.

  Tenant #2's clinical record contained a nurse review, completed by the program licensed practical nurse (LPN) and co-signed by the program registered nurse (RN), on 8-20-13. The nurse review addressed Tenant #2's current health status and medication assessment which included a review of Tenant #2's medications to assure the medication list was accurate and current, to assure all medications were administered according to physician's orders and to identify any adverse medication interactions.

  According to clinical notes, Tenant #2 experienced hypoglycemic (low blood sugar) episodes on 8-20-13, 8-31-13, 9-11-13, 9-16-13 and 9-18-13 with readings ranging from 61 to 69. The hypoglycemic episodes on 8-20-13, 8-31-13 and 9-18-13 required staff members to prepare food items high in sugar to bring the blood sugars back up to an acceptable level. The hypoglycemic episodes on 9-11-13 and 9-16-13 required staff members to administer glucose tablets according to physician ordered diabetic protocol. The program's nurse did not complete a nurse review addressing Tenant #2's changes in health condition following the five hypoglycemic episodes.

Tenant #3's clinical record was reviewed. Tenant #3's clinical record contained a nurse review, completed by the program LPN and co-signed by the program RN, on 8-21-13. The nurse review addressed Tenant #3's current health status and medication assessment which included a review of Tenant #3's medications to assure the medication list was accurate and current, to assure all medications were administered according to physician's orders and to identify any adverse medication interactions. Tenant #3 did not experience a change in health, functional or cognitive status since the 8-21-13 nurse review.

Tenant #6, a 77 year-old, was admitted on 4-9-10 and had a diagnosis of Diabetes, Cataract with Removal, Limited Mobility Right Hand due to Amputation/Partial Amputation of Fingers, and Overweight. A nurse review which included a medication review was completed on 8-21-13.

According to the nurse review of 8-21-13, Tenant #6 was scheduled to undergo Cataract surgery on the right eye on 8-30-13. According to the Medication Administration Record, Tenant #6 received several eye drops to the right eye during the first two weeks of September 2013. After the entry of 8-21-13, there was no documentation related to right eye surgery. A nurse review was not completed with a change of condition.

Clinical notes dated 9-19-13 and completed by a Certified Nursing Assistant (CNA) documented Tenant #6 was observed to have blood coming from the anus. The clinical notes documented the CNA completed a nurse communication form. A nurse review was not completed to assess Tenant #6's health status.

Tenant #7's clinical record was reviewed. Tenant #7's clinical record contained a nurse review, completed by the program LPN and co-signed by the program RN, on 8-21-13. The nurse review addressed Tenant #7's current health status and medication assessment which included a review of Tenant #7's medications to assure the medication list was accurate and current, to assure all medications were administered according to physician's orders and to identify any adverse medication interactions. Tenant #7 did not experience a change in health, functional or cognitive status since the 8-21-13 nurse review.

Tenant #8, an 83 year-old, was admitted on 9-23-11 and had diagnoses of Diabetes. A nurse review of 8-22-13, which included a medication review, indicated a medication planner was filled by the program staff and Tenant #8 took medications independently. The clinical record contained documentation dated 9-11-13 which indicated a home health agency was setting up medications. Documentation on the MAR indicated the home health nurse filled the medication planner. Beginning 9-12-13, the MAR documented program staff administered medications to Tenant #8. A nurse review was not completed when Tenant #8 went from independently taking medications to having program staff administer medications.

Tenant #11's clinical record was reviewed. Tenant #11's clinical record contained a nurse review, completed by the program LPN, on 8-22-13. The nurse review addressed Tenant #11's current health status and medication assessment which included a review of Tenant #11's medications to assure the medication list was

accurate and current, to assure all medications were administered according to physician's orders and to identify any adverse medication interactions. Tenant #11 did not experience a change in health, functional or cognitive status since the 8-22-13 nurse review.

Tenant #14's clinical record included a nurse review completed on 8-22-13 which included a medication review.

Tenant #14's clinical record contained a nurse review, completed by the LPN and co-signed by the program RN, on 8-22-13. The LPN completed a functional, cognitive, and health evaluation. The nurse review addressed Tenant #14's current health status and medication review.

Tenant #19, a 79 year-old, was admitted on 3-11-10 and had diagnoses of: Diabetes, HTN and Anxiety. A review of the clinical notes, MARs, and glucometer checks logs for Tenant #19 revealed the following:

Date/Time	Clinical record
8/5, 9 p.m.	Blood sugar (BS) 88, food given, BS 108 after 15 minutes (min)
8/10, 11:45 am	BS 63, Glucose tablets given, BS 67 after 15 min, food given, BS 76
8/15, 11:30 am	BS 62, Glucose tabs given, BS 70 after 15 min
8/15, 8:32 pm	BS 66, Glucose tabs given, BS 71 after 15 min
8/18, 11 am	BS 64, Glucose tabs given, BS 72 after 15 min
8/21, 11:15 am	BS 67, Glucose tabs given, BS 66, after 10 min, recheck at 11:40 am BS 105
8/21, 4:45 pm	BS 66, Glucose tabs given, BS 130 after 15 min
8/25, 4:32 pm	BS 63, Glucose tabs given, BS 75 after 10 min
8/26, 8:03 pm	BS 63, Glucose tabs given, BS 70 after 15 min, food given, BS 77, "drinking milk per nurse's request"
8/26, 11:30 am	BS 63, Glucose tabs given, BS 73
8/27, 11:30 am	BS 54, Glucose tabs given, BS 77
8/29, 11 am	BS 69, Glucose tabs given, BS 80 after 15 min
8/30, 11 am	BS 68, Glucose tabs given, BS 72 after 15 min
8/31, 11 am	BS 58, Glucose tabs given, BS 79 after 15 min
9/1, noon	BS 66, Glucose tabs given, BS 62, food given, BS 69, "drank a Red Bull," BS 126
9/3, 12:30 pm	Faxed copy of BS results to health care provider with notation low readings were patterned before lunch
9/3, 4:35 pm	BS 69, Glucose tabs given, BS 125 after 25 min
9/12, noon	New orders to decrease morning and evening insulin
9/14, bedtime	BS 60, food given, BS 89 after 15 min
9/15, bedtime	BS 70, Glucose tabs given, BS 74, food given, BS 77
9/18, 4 pm	New orders to decrease insulin following appointment with health care provider
9/21, bedtime	BS 64, Glucose tabs given, BS 82
9/22, morning	BS 68, food given, BS 95
9/26, morning	BS 71
9/28, 8:30 pm	BS 60, Glucose tabs given, BS 80

Clinical notes for Tenant #19 dated 9-3-13 indicated the LPN faxed a copy of the blood sugar results to the health care provider. The orders to decrease insulin were returned on 9-12. Tenant #19 had an appointment with the health care provider on 9-18-13 and insulin was decreased again.

Because the clinical record for Tenant #19 was not reviewed on a previous monitoring visit, the plan of correction indicated reviews would be completed by 9-22-13. A nurse review was completed as part of the plan of correction for Tenant #19 on 9-19-13. The nurse review completed by the program nurse indicated insulin was adjusted on 9-12 because of low blood sugars. The nurse review noted that chronic conditions were stable, even though the clinical notes and glucose log documented 14 episodes of low blood sugar that required intervention during the month of August 2013 and five episodes in September 2013 at the time of writing the review.

Tenant #19 had three episodes of low blood sugar that required intervention (9/21, 9/22, and 9/28/13) following a change in insulin dosage on 9-18-13. The program's nurse did not complete a nurse review addressing Tenant #2's changes in health condition following the three hypoglycemic episodes.

The plan of correction indicated the program would create an outside agency log, nurse communication forms, and summary transfer/discharge forms. The program provided those forms to the monitors.

- 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

The program received a regulatory insufficiency during the 7-22-13 complaint investigation (44138-C) related to the program's failure to complete an accurate health, functional and cognitive evaluations at least annually and upon identification of significant changes in tenant condition related to Tenants #2, #3, #4, #6, #8, #11, #12 and #14.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #2, #3, #6, #8, #11 and #14 and three additional record reviews related to evaluation for Tenants #7, #15 and #19. Tenants #4 and #12 no longer resided at the program. The monitors identified no evaluation concerns for Tenant #7.

  Tenant #2's clinical record included a health, functional and cognitive evaluation completed on 8-20-13 by the program LPN. The evaluations were accurate, reflected Tenant #2's needs and were consistent with what staff members were doing for Tenant #2. According to Tenant #2's clinical notes, Tenant #2 experienced hypoglycemic (low blood sugar) episodes on 8-20-13, 8-31-13, 9-11-13, 9-16-13 and 9-18-13 with readings ranging from 61 to 69 mg/dl. The hypoglycemic episodes on 8-20-13, 8-31-13 and 9-18-13 required staff members to prepare food items high in

sugar to bring the blood sugars back up to an acceptable level. The hypoglycemic episodes on 9-11-13 and 9-16-13 required staff members to administer glucose tablets according to physician ordered diabetic protocol. The program's RN did not complete the required health, functional or cognitive evaluation following Tenant #2's significant change in health condition as evidenced by the five hypoglycemic episodes.

Tenant #3's clinical record included health, functional and cognitive evaluations completed on 8-21-13 by the program LPN. The evaluations were accurate, reflected Tenant #3's needs and were consistent with what staff members were doing for Tenant #3. Tenant #3's clinical record did not document any significant change of health, functional or cognitive status after 8-21-13.

Tenant #6 had evaluations of function, cognition, and health completed on 8-21-13. The clinical notes did not contain documentation to indicate Tenant #6 had any changes of condition warranting repeated evaluations.

Tenant #8 had evaluations of function, cognition, and health completed on 8-22-13. The clinical notes did not contain documentation to indicate Tenant #8 had any changes of condition warranting repeated evaluations.

Tenant #11's clinical record included a health, functional and cognitive evaluation completed on 8-22-13 by the program LPN. The evaluations were accurate, reflected Tenant #11's needs and were consistent with what staff members were doing for Tenant #11. Tenant #11's clinical record did not document any significant change of health, functional or cognitive status after 8-22-13.

Tenant #14's clinical record included health, functional and cognitive evaluations completed on 8-22-13 by the program LPN. The evaluations reflected Tenant #14's needs and were consistent with what staff members were doing for Tenant #14. Tenant #14's clinical record did not document any significant change of health, functional or cognitive status after 8-22-13.

Tenant #15, an 86 year-old, was admitted on 2-22-13 and had diagnoses of: Diabetes, Coronary Artery Disease, HTN, Hyperlipidemia, and Pacemaker. Clinical notes dated 9-16-13 and timed at 2:30 p.m. by the LPN documented Tenant #15 had urinated in bed, was alert but confused with a temperature of 99.4 degrees. Tenant #15 also complained of left leg pain. The leg was tender to touch and was observed to have a raised area on the calf. The left leg was darker than the right. Tenant #15 was transported to the hospital.

Clinical notes of 9-24-13 documented a late entry for 9-23-13 at 4:00 p.m. The LPN documented a visit to the hospital to see Tenant #15 who was being discharged. A nurse review by the LPN documented a cognitive screening tool was completed; however, the tool was not part of the clinical record at the time of the onsite visit. The review also documented Tenant #15's ability to ambulate in the hospital room with some unsteadiness. The nurse review indicated Tenant #15 had been hospitalized for left leg cellulitis and was treated with antibiotics. The nurse review did not document the condition of the left leg.

Discharge instructions for Tenant #15 included a diagnosis of left leg cellulitis and instructions to ambulate with assistance. The discharge instructions also indicated Physical Therapy and Occupational Therapy were ordered.

Tenant #15's clinical notes documented the home health nurse made an on-call visit on 9-23-13 at 8:30 p.m. because Tenant #15 had returned from the hospital. The home health nurse documented she assessed the left leg by removing an elastic wrap, observed an open area on the shin. The home health nurse replaced the dressing and elastic wrap.

Evaluations of function, cognition, and health were not completed by the program's registered nurse with a change of condition following hospitalization, a person with Diabetes who was hospitalized for cellulitis and returned with a wound and orders for Physical Therapy.

Tenant #19's clinical notes, MARs, and glucometer checks logs revealed the following:

Date/Time	Clinical Notes
8/5, 9 p.m.	Blood sugar (BS) 88, food given, BS 108 after 15 minutes (min)
8/10, 11:45 am	BS 63, Glucose tablets given, BS 67 after 15 min, food given, BS 76
8/15, 11:30 am	BS 62, Glucose tabs given, BS 70 after 15 min
8/15, 8:32 pm	BS 66, Glucose tabs given, BS 71 after 15 min
8/18, 11 am	BS 64, Glucose tabs given, BS 72 after 15 min
8/21, 11:15 am	BS 67, Glucose tabs given, BS 66, after 10 min, recheck at 11:40 am BS 105
8/21, 4:45 pm	BS 66, Glucose tabs given, BS 130 after 15 min
8/25, 4:32 pm	BS 63, Glucose tabs given, BS 75 after 10 min
8/26, 8:03 pm	BS 63, Glucose tabs given, BS 70 after 15 min, food given, BS 77, "drinking milk per nurse's request"
8/26, 11:30 am	BS 63, Glucose tabs given, BS 73
8/27, 11:30 am	BS 54, Glucose tabs given, BS 77
8/29, 11 am	BS 69, Glucose tabs given, BS 80 after 15 min
8/30, 11 am	BS 68, Glucose tabs given, BS 72 after 15 min
8/31, 11 am	BS 58, Glucose tabs given, BS 79 after 15 min
9/1, noon	BS 66, Glucose tabs given, BS 62, food given, BS 69, "drank a Red Bull," BS 126
9/3, 12:30 pm	Faxed copy of BS results to health care provider with notation low readings were patterned before lunch
9/3, 4:35 pm	BS 69, Glucose tabs given, BS 125 after 25 min
9/3, 4:35 pm	BS 69, Glucose tabs given, BS 121 after 25 min
9/12, noon	New orders to decrease morning and evening insulin
9/14, bedtime	BS 60, food given, BS 89 after 15 min
9/15, bedtime	BS 70, Glucose tabs given, BS 74, food given, BS 77
9/18, 4 pm	New orders to decrease insulin following appointment with health care provider
9/21, bedtime	BS 64, Glucose tabs given, BS 82
9/22, morning	BS 68, food given, BS 95

9/26, morning	BS 71
9/28, 8:30 pm	BS 60, Glucose tabs given, BS 80

A nurse review was completed as part of the plan of correction on 9-19-13. The nurse review completed by the program indicated insulin was adjusted on 9-12 because of low blood sugars. The nurse review noted that chronic conditions were stable, even though the clinical notes and glucose log documented 14 episodes of low blood sugar that required intervention during the month of August 2013 and five episodes in September 2013 at the time of writing the review.

Clinical notes for Tenant #19 dated 8-5-13, timed 9:00 p.m., and completed by the LPN documented Tenant #19's blood sugar was 66. The LPN documented Tenant #19 was not shaking or sweating, and speech was clear.

According to the Clinical Notes for Tenant #19 dated 9-28-13 and timed 8:30 p.m. a staff member checked the blood sugar level and found it to be 60. Glucose tablets were given. Tenant #19 began to choke. The staff member then observed Tenant #19's speech was slurred, Tenant #19 was shaky and spilling juice, and was "losing footing." According to the notes, the staff member called the LPN who advised the staff member to wait 15 minutes and recheck the blood sugar, even though the symptoms were different than those observed by the LPN during the episode of low blood sugar on 8-5-13. The staff member noted the blood sugar level was 80 while she was on the phone. According to the notes, the LPN then directed the staff member to send Tenant #19 to the hospital.

On 9-28-13, the hospitalist documented Tenant #19 had weakness and gait difficulty. Tenant #19 was also noted to have garbled speech and could not follow commands. Blood pressure was documented as 182/65. Tenant #19 was identified by the hospitalist as having uncontrolled Diabetes, and was thought to have had a Stroke.

A neurologist also examined Tenant #19. The neurologist found Tenant #19's blood pressure to be 217/92 which was high. Tenant #19 had no speech, and did not follow complex commands, but was able to follow some simple commands. The visual fields may have been affected. Tenant #19 did not perform the shoulder shrug or finger-to-nose testing used to determine coordination and motor functioning. The neurologist was unable to assess Tenant #19's gait. The neurologist assessed Tenant #19 as having and Acute Left Hemisphere Ischemic Stroke manifesting with Aphasia. The neurologist planned to give the medication TPA, a clot-busting drug, stroke education, and rehabilitation. Tenant #19 was admitted to the intensive care unit (ICU).

After four days in the hospital, Tenant #19 returned to the program on 10-2-13 with changes to orders for insulin and a home discharge sheet for Stroke. The LPN completed evaluations of function, cognition, and health. The evaluations indicated Tenant #19 had returned with no limitations to movement and was able to respond to complete the cognitive screening evaluation.

Tenant #19 experienced a significant change of health condition, an ischemic stroke, resulting in hospitalization in an intensive care unit and treatment with a clot-busting

drug. Just prior to admission, program staff observed to be choking, had slurred speech, and was losing footing. The hospitalist determined Tenant #19 had uncontrolled Diabetes and Tenant #19 was sent back to the program with changes to insulin. A neurologist at the hospital found Tenant #19 to have no speech, did not follow complex commands and did not perform tasks requiring coordination. Tenant #19's condition changed again and Tenant #19 returned to the program. The program RN did not complete evaluations 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 7-22-13 on-site visit, the program received a regulatory insufficiency related to the program's failure to assure tenant service plans accurately reflected tenant individualized needs and to assure each service plan consistently reflected what staff members were doing for Tenants #2, #3, #4, #6 and #11. Tenant #4 no longer resided at the program.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #2, #3, #6 and #11 with five additional clinical record reviews related to service plans for Tenants #7, #8, #14, #15 and #18. The monitors identified no concerns related to service plans for Tenants #7 and #18.

  Tenant #2's clinical record included an updated service plan, completed by the program LPN on 8-20-13. The service plan accurately reflected Tenant #2's needs and was consistent with what staff members were doing for Tenant #2.

  Tenant #3's clinical record included an updated service plan, completed by the program LPN on 8-21-13. The service plan accurately reflected Tenant #3's needs and was consistent with what staff members were doing for Tenant #3.

  Evaluations and a nurse review were completed for Tenant #6 on 8-21-13. The nurse review indicated Tenant #6 had a history of redness to the groin, and indicated the condition was chronic. The health evaluation also indicated Tenant #6 had a history of redness to the groin and was Diabetic. The According to the September 2013 MAR, Tenant #6 was to have a cream applied to the perineal area twice a day as needed.

  The service plan dated 8-21-13 indicated Tenant #6 dribbled urine at times and did not always cleanse properly after toileting. Tenant #6 was to use a special toilet seat to aid in cleansing. The service plan did not identify the use of the cream twice a day

as needed, did not direct the staff members as to when the cream should be applied, and did not indicate observations of the skin staff members were to report to the nurse. The service plan did not meet the identified needs of Tenant #6.

Tenant #8's service plan dated 8-22-13 was reviewed. The service plan indicated Tenant #8 self-administered medication after program staff filled the medication planner. The clinical record contained documentation beginning 9-11-13, that a home health nurse filled the planner and program staff administered the medications.

The service plan dated 8-22-13 for Tenant #8, a Diabetic who was not on insulin, indicated the Blood Glucose protocol was in place. A review of the MAR for September 2013 did not indicate an order for glucose tablets and the clinical record lacked documentation of an order for the Blood Glucose protocol. The home health orders also lacked documentation of orders for the Blood Glucose protocol. The service plan did not meet the identified needs of Tenant #8. The program provided documentation of physician's orders for the Diabetic Protocol signed 10-7-13 which had a fax date of 10-3-13 and timed 7:38 p.m., the first day of the onsite visit.

Tenant #11's clinical record included an updated service plan, completed by the program LPN on 8-22-13. The service plan accurately reflected Tenant #11's needs and was consistent with what staff members were doing for Tenant #11.

The service plan for Tenant #14 dated 8-22-13 indicated BrightStar staff was providing medication assistance. The September 2013 MAR for Tenant #14 documented Tenant #14 self-administered a cream, a nasal spray, an antacid, and a muscle rub. The service plan did not identify Tenant #14 self-administered some of the medications. The service plan did not meet the identified needs of Tenant #14.

Tenant #15 was discharged from the hospital on 9-23-13 following treatment for left leg cellulitis. Tenant #15 returned with a wound on the left shin and orders for Physical Therapy. The service plan, dated 8-22-13, did not identify Tenant #15 had a shin wound, who was responsible for wound care, or Physical Therapy services. The service plan did not meet the identified needs of Tenant #15.

- 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. Tenant Documents

During the 7-22-13 on-site visit, the program received a regulatory insufficiency related to the program's failure to keep all tenant medical records safe and maintain all tenant medical records for a minimum of three years for Tenant #1. The program also received a regulatory insufficiency related to the program's failure to assure all physician ordered tasks were documented on tenant medication administration records (MARs) for Tenants #6 and #11. Tenant #1 no longer resided at the program.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #6 and #11 for physician ordered task documentation on MARs and seven additional clinical record reviews for Tenants #2, #3, #7, #8, #14, #15 and #19 for physician ordered task documentation on MARs. The program was able to provide all tenant medical records for the monitors when requested. The monitors found no missing tenant medical records during the on-site visit. The monitors identified no tenant document concerns for Tenants #2, #3, #8, #14 and #19.

  The MAR was reviewed for Tenant #6. Oxygen was listed on the September 2013 MAR.

  Tenant #7, a 77 year old, was admitted to the program on 12-30-09. Tenant #7 had diagnoses of: Non Insulin Dependent Diabetes, COPD, HTN and History of Stroke. Tenant #7 answered all but two questions correctly on the program's Cognitive Ability Assessment completed on 8-21-13, indicating very mild cognitive impairment. Tenant #7 received physician prescribed diabetic protocol on 8-20-13 requiring the administration of glucose tablets with hypoglycemic episodes identified by blood glucose levels less than 70 mg/dl. Tenant #7's September 2013 MAR lacked documentation of the physician's order for glucose tablets with hypoglycemic episodes. The diabetic protocol, a physician-ordered task, was not on the September 2013 MAR.

  Tenant #11, an 87 year old, was admitted to the program on 3-4-11. Tenant #11 had diagnoses of Dementia, HTN, Osteoarthritis, Anxiety, Depression and Edema. Tenant #11 answered all questions correctly on the Cognitive Ability Assessment completed on 8-22-13, indicating no cognitive impairment. Tenant #11 received physician prescribed edema wear to assist with swelling in the extremities. Tenant #11's September 2013 MAR lacked documentation of the physician's order for edema wear. The edema wear, a physician-ordered task, was not on the September 2013 MAR.

  The September 2013 MAR for Tenant #15 was reviewed. The MAR contained an entry for the application and removal of support stockings. The program provided documentation from a 1-8-13 visit with a physician that the physician was aware Tenant #15 was using a support stocking, but the program was unable to provide a physician's order for the support stockings. The program did not have a physician's order for a task listed 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))

F. Policies and Procedures

The program received a regulatory insufficiency during the 1-15-13 complaint investigation (42070-C), during the 3-21-13 revisit (42070-CR) and at the 7-22-13 revisit

(42070-CR2) related to the program's failure to follow the policy on incident report completion.

- Monitoring Observation: The program was asked to provide incident reports completed for tenant unusual occurrences during August and September 2013. 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, completed all incident reports and witness statements. All incident reports were completed according to the program's policy.

- Regulatory Insufficiency: None noted.

G. Medications

The program received a regulatory insufficiency during the 1-15-13 complaint investigation (42070-C), during the 3-21-13 revisit (42070-CR) and at the 7-22-13 complaint investigation (44138-C)/revisit (42070-CR2) related to the program's failure to keep clear, concise medication administration records, failure to document medications on the MARs as given according to physician orders and according to the identified schedule for administration.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #2, #3, #6, #7, #8, #11, #14, #15 and #19 for medication issues. The monitors identified no medication issues for Tenants #3 and #11.

  Tenant #2 received physician prescribed diabetic protocol on 8-21-13 requiring the administration of glucose tablets with hypoglycemic episodes identified by blood glucose levels less than 70 mg/dl. Tenant #2's September 2013 MAR included documentation of the physician's order for glucose tablets with hypoglycemic episodes. According to Tenant #2's clinical notes, Tenant #2 required the administration of glucose tablets on 9-11-13 for a blood glucose reading of 69 mg/dl and on 9-16-13 for a blood glucose reading of 66 mg/dl. The September 2013 MARs lacked documentation of the administration of the glucose tablets on 9-11-13 and 9-16-13. The MARs did include the physician's order for the glucose tablets; however, staff members had not documented the glucose tablets as given on 9-11-13 and 9-16-13.

  The September 2013 MAR was reviewed for Tenant #6. There were two sets of MAR's for September. One documented medications administered from September 1 through 11th with documentation on the 12th, 13th, and 25th. The other documented medications administered from the 12th through the 30th of September. Medications were double-documented on the 12th, 13th, and 25th. Documentation for AM (morning) medications on 9-25-13 was documented as 22 medications given on the sheet documenting medications for the first half the month and 21 medications given on the sheet documenting medications for the last half the month.

  Tenant #6's MAR for the first half the month indicated Clobetasol was discontinued; although there was no documentation of time, date, or signature with the

discontinuation. The Clobetasol was not discontinued on the MAR for the second half of September 2013.

According to the September MAR for Tenant #6, all eye drops related to the Cataract surgery were completed by 9-21-13. The number of medications documented was not consistent when taking into account the varying schedule of the glucose checks.

Tenant #6's Medication Administration Record for September 2013 contained a listing of three different eye drops; Ketorlac, Vigamox, and Prednisolone. The entries were handwritten but did not notation of time, date, or signature.

Tenant #7 took oral medications and inhalant medications. Staff members documented the number of medications actually taken by Tenant #7 during each medication administration, documented the number of medications administered in the slot on the MAR for morning and evening medications and placed their initials in the same slot. Tenant #7's September 2013 MAR indicated he/she took two puffs of one inhalant medication in the morning and in the evening, 12 morning oral medications daily, one morning oral medication every other day, one morning oral medication only on Fridays and four evening oral medications daily.

Tenant #7's clinical record did not document any medication discontinuations or additions during the month of September 2013. The clinical record documented one change in dosage of Coumadin from 5 mg daily to 4 mg daily on 9-16-13. The change in the Coumadin dosage would not have affected the number of medications administered daily.

When totaled, the number of medications administered both orally and inhalant combined, would have been 14 medications on odd days in the mornings, 13 medications on even days in the mornings and 5 medications every evening. An additional medication would have been added on every Friday (9-6, 13, 20, and 27-13).

Tenant #7's September 2013 MAR documented the following:

The 9-3-13, 9-5-13, 9-7-13 and 9-29-13 (odd mornings) slots documented only 13 medications were administered by staff members. Tenant #7's clinical record lacked documentation indicating the program nurse clarified the discrepancy between the number of medications physician-ordered to be administered on odd days and the number of medications documented as administered on the above stated days.

The 9-16-13, 9-18-13 and 9-24-13 (even mornings) slots documented 14 medications were administered by staff members. Tenant #7's clinical record lacked documentation indicating the program nurse clarified the discrepancy between the number of medications physician-ordered to be administered on even days and the actual number of medications documented as administered on the above stated days.

The 9-6-13, 9-13-13, 9-20-13 and 9-27-13 (Friday mornings) documented 21, 22 or 23 medications were administered by staff members instead of either 14 or 15 depending on the even or odd day of the month. Tenant #7's clinical record lacked documentation indicating the program nurse clarified the discrepancy between the

number of medications physician-ordered to be administered on even days and the actual number of medications documented as administered on the above stated days.

The evening slots on 9-16-13, 9-17-13, 9-28-13, 9-29-13 and 9-30-13 documented only 4 medications as administered by staff members. Tenant #7's clinical record lacked documentation indicating the program nurse clarified the discrepancy between the number of medications physician-ordered to be administered on even days and the actual number of medications documented as administered on the above stated days.

The September MAR for Tenant #8 was reviewed. The program began to administer medications to Tenant #8 on 9-12-13. The MAR did not document any additions or deletions to the medications. The documentation of the number of medications given varied from seven to nine.

The August MAR for Tenant #8 indicated it was updated on 8-22-13. Tylenol 650 milligrams (mg) were discontinued, and Tylenol 500 mg and Glipizide were added. The handwritten changes did not all contain notation of time, date, or signature.

Tenant #14, a 93 year-old, was admitted on 1-22-09 and had diagnoses of: Atrial Fibrillation and Anemia. The September 2013 MAR was reviewed. The MAR had a notation which indicated the MAR was reprinted for clarity on 9-20-13. Levofloxacin was added to the MAR, but lacked documentation of time, date, and signature. Coumadin 3 mg was discontinued on 9-27-13, but lacked the signature of a nurse. Coumadin 2.5 mg was added but lacked documentation of time, date, and signature of the person making changes to the MAR. The number of medications documented was not consistent when taking into account the changes in the Coumadin and the addition of Levofloxacin.

Tenant #15 had a Diabetic Protocol order form signed by a health care provider on 8-30-13. The order was noted on 9-1-13. A review of the September 2013 MAR did not contain an entry for four glucose tablets as needed. The MAR was not updated with new medication orders.

Clinical notes for Tenant #15 were reviewed. The notes contained entries on 9-5 and 9-16-13 indicated staff members administered glucose tablets in response to a low blood sugar. The administration of the glucose tablets as ordered by the health-care provider were not documented on the September 2013 MAR.

Documentation in the clinical notes, back sides of MARs, and glucometer checks logs indicated Tenant #19 had five episodes of low blood sugar with glucose tablets given (9/1, 9/3, 9/15, 9/21, 9/28) during September 2013.

There were three separate MARs for September 2013, each updated with new orders. Documentation was found for 9-3-13, but lacked documentation for the four other days identified as days Tenant #19 received glucose tablets.

- 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 certified and noncertified staff in accordance with subrule 67.9(4).

(IAC r. 481-67.5(6)(a))

H. Staffing

The program received a regulatory insufficiency during the 7-22-13 complaint investigation (44138-C) related to the program's failure to maintain documentation of the program's delegating nurse's teaching, shadowing and observing direct care workers in service planned tasks which relate to tenant medical or nursing needs for Staff #1, #2, #3 and #4 and failure to assure all staff members were trained on emergency procedures and familiar with how to reach the on-call nurse who is responsible for the program for Tenant #1 and Staff #5. Tenant #1 no longer resided at the program. Staff #2, #3, #4 and #5 no longer worked at the program.

- Monitoring Observation: The program reported they no longer included Mercy Home Care, an outside provider, in the on-call schedules. All staff members were to report to the identified program nurse on-call when having questions or in emergent situations. A copy of the on-call schedule was being kept in the employee charting station and was available for staff members to refer to readily.

  The program identified tenants currently residing in the building who required staff members to assist with or administer the following: oral medication administration, inhalant medication administration, topical medication administration, administration of eye drops, oxygen administration, application of compression stockings or edema wear, preparing an insulin pen for administration, hand over hand administration of insulin using an insulin pen and blood glucose testing assistance using a glucometer.

  The monitors reviewed the personnel file of Staff #1, finding documentation of a nurse training and observing a return demonstration to determine competency with all tasks assigned to program tenants which relate to medical or nursing needs.

  The monitors reviewed the personnel files of seven additional personnel files for Staff #6, #7, #8, #9, #10, #11 and #12, all Direct Care Workers (DCW). The monitors identified no concerns related to nurse delegation for Staff #12.

  Staff #6 was hired on 5-20-13 and currently provided direct care independently to program tenants. Staff #6's personnel file lacked documentation of training and observation of return demonstration of a task to determine competency with the tasks for administration of eye drops, inhalant medication administration, oxygen administration, application of compression stockings or edema wear, preparing an insulin pen for administration, hand over hand administration of insulin using an insulin pen and blood glucose testing assistance using a glucometer.

  Staff #7 was hired on 7-3-12 and currently provided direct care independently to program tenants. Staff #7's personnel file included training but lacked documentation of observation of return demonstration of a task to determine competency with the tasks for administration of eye drops, administration of topical medications, oxygen administration and application of compression stockings or edema wear.

  During interview, Staff #7 reported the program LPN had trained her on the administration of eye drops but had never actually observed a return demonstration to

determine competency. The LPN had also reportedly trained Staff #7 on the administration of inhalant medications but had never actually observed a return demonstration to determine competency.

Staff #8 was hired on 5-20-13 and currently provided direct care independently to program tenants. Staff #8's personnel file lacked documentation of training and observation of return demonstration of a task to determine competency with the tasks for oral medication administration, inhalant medication administration, topical medication administration, administration of eye drops, oxygen administration, application of compression stockings or edema wear, preparing an insulin pen for administration, hand over hand administration of insulin using an insulin pen and blood glucose testing assistance using a glucometer.

Staff #9 was hired on 8-23-13 and currently provided direct care independently to program tenants. Staff #9's personnel file lacked documentation of training and observation of return demonstration of a task to determine competency with the tasks for oral medication administration, inhalant medication administration, topical medication administration, administration of eye drops, oxygen administration, application of compression stockings or edema wear, preparing an insulin pen for administration, hand over hand administration of insulin using an insulin pen and blood glucose testing assistance using a glucometer.

Staff #10 was hired on 9-19-13 and currently provided direct care independently to program tenants. Staff #10's personnel file lacked documentation of training and observation of return demonstration of a task to determine competency with the tasks for oral medication administration, inhalant medication administration, topical medication administration, administration of eye drops, oxygen administration, application of compression stockings or edema wear, preparing an insulin pen for administration, hand over hand administration of insulin using an insulin pen and blood glucose testing assistance using a glucometer.

Staff #11 was hired on 10-15-12 and currently provided direct care to program tenants. Staff #11's personnel file included documentation of training but lacked documentation of observation of return demonstration of a task to determine competency with the tasks for oral medication administration, inhalant medication administration, topical medication administration, administration of eye drops, application of compression stockings or edema wear, preparing an insulin pen for administration and hand over hand administration of insulin using an insulin pen.

During interview, Staff #13, DCW, reported he was trained by a nurse and had a nurse observe him administer oral medications administration only. All other tenant care tasks were trained and observed by other DCWs at the program.

Staff training records for Staff #6, #7, #8, #9, #10 and #11 lacked documentation of completed nurse-delegation for tasks related to tenant medical or nursing needs.

The MAR and the log for blood sugar checks was reviewed for Tenant #6. There was no documentation Tenant #6 was given or required glucose tablets per protocol for low blood sugar.

The clinical notes were reviewed for Tenant #8. There was no documentation Tenant #8 was given or required glucose tablets per protocol for low blood sugar.

The clinical notes were reviewed for Tenant #15. On 9-5 and 9-16-13 entries indicated staff members administered glucose tablets in response to a low blood sugar. Both indicated staff members repeated blood sugar checks within 15 to 20 minutes; the blood sugar was found to be above the level required for further administration of glucose tablets.

- 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))

I. Compliance with Plan of Correction

- Monitoring Observation: The program did not resolve the insufficiency in the area of Medications received during the 1-15-13 complaint investigation (42070-C), during the 3-21-13 revisit (42070-CR) and at the 7-22-13 complaint investigation (44138-C)/revisit (42070-CR2). The program did not resolve the insufficiencies in the areas of Nurse Review, Evaluations, Service Plan and Tenant Documents received during the course of the 7-22-13 on-site visit. The program did not resolve the insufficiencies in the area of Staffing received during the 7-22-13 complaint investigation (44138-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))