Iowa Department of Inspections and Appeals
Assisted Living Program
(Amended) Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 12485**

Ms. Cathy Berner, Administrator
Continental at St. Joseph's
19999 St. Joseph's Drive
Centerville, IA 52544

Date of Investigation:

November 1, 2005

Monitor(s):

Hal L. Chase, RN BSN MPH

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Continental at St. Joseph's on November 1, 2005. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* **–** A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	7
Current number of tenants without cognitive disorder:	38
Total Population:	45

***These are the census numbers represented by the program to be applicable.**

Accreditation Status – Not applicable.

Complaint History – There were substantiated complaints in the areas of Occupancy Agreement, Service Plan, Exclusion of Tenants and Medications during this certification period.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Criteria for exclusion of tenants - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

Complaint Allegation: It is alleged the program does not initiate transfer for tenants who require a higher level of care than the program is allowed to provide under regulation.

- Monitoring Observation: On October 7, 2005, the program sent a letter to the Department of Inspection and Appeals (DIA) detailing an altercation between Tenant #1 and Tenant #2, in which Tenant #2 sustained injuries. The letter also described a medication error caused when Tenant #1's son, who was setting up the tenant's medication, omitted a prescribed medication without the program's knowledge. Following the incident between the two tenants, Tenant #1's son told the program he omitted the medication from the medication planner.

  Three incidents were reported between Tenant #1 and Tenant #2. The first two incidents resulted in no injury to either one. The third incident, which occurred on October 6, 2005, resulted in Tenant #2 falling and breaking a hip. During the third incident, Tenant #1 allegedly pushed Tenant #2, resulting in Tenant #2 falling and breaking a hip. Copies of the reports were requested, but the program failed to provide them.

  Tenant #1 was admitted to the program on July 1, 2005. On July 26, 2005, the program met with the tenant's son to discuss concerns of inappropriate behavior exhibited by the tenant. The son requested a medical evaluation. On July 26, 2005, the program requested medication to treat the aggression exhibited. The tenant's physician ordered Seroquel 25mg twice daily. This order was revised on July 27, 2006, for Seoquel 25mg at bedtime. Nurse's notes of October 6, 2005, state the manager, LPN, and charge nurse were called to the Memory Care Unit and found Tenant #2 on the floor. Nurse's notes state Tenant #1 had pushed Tenant #2 to the floor. Nurse's notes of the same day state Tenant #1's son was notified of the incident and the tenant's physician was called to request a psychiatric evaluation of Tenant #1. Outpatient psychiatric visits are ongoing every two months.

  Four of five direct care staff, who work primarily in the Memory Care Unit, report Tenant #2, "being mean" to tenants and staff, making "derogatory statements about other tenants," and "likes to instigate stuff." Four of five direct care staff report overhearing Tenant #1 tell Tenant #2 not to come near him/her. Staff reports Tenant #2 telling them he/she was going to make Tenant #1 speak to him/her because Tenant #1 wouldn't speak to him/her. One direct care staff reports "they both go at it," referring to Tenant #1 and Tenant #2. Five of five direct care staff report there has not been any inappropriate behavior of Tenant #1 since the altercation between both tenants. Tenant #2 is currently not living at the program, but will be returning at an unknown date.

  A review of each tenant's service plans indicates interventions are in place to reduce or inhibit inappropriate behavior toward each other. Five direct care staff interviewed report feeling confident the interventions will work.

- Regulatory Insufficiency: The program did not transfer a tenant who exhibited aggressive behavior.

  In response to the preliminary identification of Tenant #1 exceeding occupancy criteria, the program provided input that the tenant, subsequent to the on-site by DIA, applied for and was granted a conditional medical waiver.

B. Nurse Review - Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. [321 IAC 25.30]

During the course of the investigation, it was found the program's Registered Nurse (RN) did not ensure that medications ordered are current and administered consistent with such orders.

- Monitoring Observation: The program submitted a letter to DIA describing an altercation between two tenants and an omission of medication prescribed by a tenant's physician. A review of four tenant files, interviews with the RN, the program administrator who is an LPN and administers medications, and medication aides reeal the program allows family to set up medications in medication planners without the program knowing what medications are placed into medication planners. Program staff administer medications and initial the time given, with no knowledge if medications in the medication planner are correct. Medication Administration Records (MARs) only record the time medications are given and do not list each medication ordered. Staff who administer medications do not know what medications they are giving, the number of capsules ordered, and if there are any medications missing. The RN has no oversight or knowledge of what medications are set up by families. The program actively takes orders from physicians indicating the program will administer medications as ordered.

  Tenant #1 had an omission of Seroquel 25mg to be given at bedtime, which was ordered by the tenant's physician on July 27, 2005. The program requested medication from the physician as the tenant " was having daily episodes of outbursts of foul language directed towards staff and tenants." The tenant's son requested a medication evaluation to be done to consider a mild sedative or other appropriate medication." On July 27, 2005, the tenant's son requested a change in the order of Seroquel 25mg to be given at bedtime. The physician agreed and wrote an order to the program. Tenant #1 had an altercation with another tenant on October 6, 2005. The tenant's son was notified of the altercation at which time he told program staff he omitted the Seroquel ordered on July 27, 2005, due to fear of potential side effects, and did not tell staff of the omission until October 6, 2005. On October 7, 2005 the program asked the physician for an order to discontinue the Seroquel, since the son did not want Tenant #1 on Seroquel. On October 20, 2005 the program received a telephone order to change Seroquel 25mg p.o. bid to daily at h.s. The program continues to allow the tenant' son to continue setting up medications in the tenant's medication planner. The RN states she is not responsible for medications set up by family members and is only responsible for staff to give each tenant the medications.

- Regulatory Insufficiency: The RN did not monitor, at least every 90 days, each tenant receiving program-administered prescription medications for adverse reactions

to program-administered medications, make appropriate interventions, and ensure that the prescription medications orders are administered consistent with such orders.

Dated this 14th day of November, 2005