Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint Investigation & Initial Certification Report

Assisted Living Program: **Complaint Intake #: 16196**

Ms. Sandy Heller, Administrator
Prairie Hills Assisted Living
173 E Rochester Rd
Ottumwa, IA 52501-1123

Date of Investigation:

March 6, 2008

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 and initial certification on-site visit was conducted at Prairie Hills Assisted Living on March 6, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* **–** A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	40
Current number of tenants with cognitive disorder:	0
Total Population:	**40**

Dementia Specific Program (DSP)* **–** Not applicable

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Tenant/Family Satisfaction Results – A community meeting was held with 32 tenants. Tenants stated the program was a nice place to live and staff are available when they are needed. The food is better than it has been and they now have a new cook. Hot foods are not always hot, but staff listens to their concerns and tries to fix things when they can. Tenants would like to have more activities from the community, but they all agreed they have a good activities person. Tenants felt safe living at the program. Tenants stated they pay a lot for living there but also get a lot in return. Tenants stated they make their own decisions, are generally satisfied with the program and would recommend it to friends and family.

Accreditation Status – Not applicable

Program History – There are no substantiated Regulatory Insufficiencies this certification period.

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

A. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

Monitoring Observation: Tenant #1, an 89 year old, was admitted on 8-2-07 and has diagnoses of: Hypertension, Urinary Tract Infection (UTI), B-12 Deficiency, Incontinence and Diverticulitis. The program completed a health evaluation within 30-days on 9-2-07 but did not complete a cognitive evaluation within 30-days of admission. The tenant was admitted to the hospital on 11-7-07 for Pneumonia and returned to the program on 11-9-07. The program did not complete functional, cognitive and health evaluations to determine any modifications to needed services.

Tenant #2, an 86 year old, was admitted on 8-3-07 and has diagnoses of: Implemented Defibrillator, Insulin Dependent Diabetes Mellitus, Staph Cellulitis, Knee Prosthesis and Mild Dementia. The program completed initial functional, cognitive and health evaluations. A 30 day health evaluation was completed on 9-3-07; however a functional and cognitive evaluation were not completed within 30 days.

Tenant #3, a 95 year old, was admitted on 8-24-07 and has diagnoses of: Degenerative Joint Disease, Weight Loss and Leukemia. The program completed initial functional, cognitive and health evaluations but did not complete a cognitive evaluation within 30-days.

- Regulatory Insufficiency: The program did not complete a functional, cognitive and health evaluation within 30-days and, as needed, to determine the tenant's continued eligibility for the program and to determine any modifications to needed services. The evaluation shall be conducted by a health care professional or a human service professional. (25.23(2))

B. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

Monitoring Observation: Tenant #1's 30 day service plan was completed appropriately but was not supported by a cognitive evaluation. The tenant was hospitalized with pneumonia on 11-7-07 returning on 11-9-07, but the program did not complete an updated service plan when the tenant needed personal and health-related care.

Tenant #2's initial and updated service plan were completed appropriately, but the 30 day service plan was not supported by a completed functional and cognitive evaluations.

Tenant #3's initial and updated service plan were completed appropriately but the updated service plan was not supported by a completed cognitive evaluation.

- Regulatory Insufficiency: The program developed a service plan that was not based on the evaluations conducted in accordance with 25.23(1) and 25.23(2) and was not designed to meet the specific service needs of the tenant. (25.28(1))

C. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse

delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

Complaint Allegation: It is alleged Tenant #1 was given Levaquin four times daily instead of the daily dosage as ordered by the physician.

Monitoring Observation: Tenant #1 had a physician's order dated 12-7-07 for Levaquin, 750 milligrams (mg), first dose now, one tablet by mouth daily times seven doses. The order was transcribed to the December 2007 Medication Administration Record (MAR) as follows: Levaquin, 750 mg. three times daily (tid), one tablet by mouth daily. One dose was given on 12-7-07 and two doses were given daily on 12-8-07 through 12-10-07. The Registered Nurse (RN), stated in a written document, Tenant #1 was sent to the emergency room (ER) on 12-10-07 due to an unsteady gait. The tenant returned later in the day with an order discontinuing the Levaquin medication. The RN stated she had written the physician's order incorrectly in the MAR. On 12-12-07 the RN completed a "Pharmacy Error Reporting Form" and indicated she had made a medication error on Tenant #1's Levaquin order. The RN did not correctly transcribe the physician's order to the MAR: subsequently, the tenant was given the medication incorrectly.

Complaint Allegation: It is alleged Tenant #2 had complaints of having trouble seeing and reading and had been receiving four pills daily and was now receiving five pills daily. The RN fills the tenant medication planner and it was found the tenant was receiving twice the amount of Glipizide medication on a daily basis.

Monitoring Observation: The program sets up Tenant #2's medications, provides reminders, and observes the tenant taking his/her medication. The MAR for February 2008 indicated the program records showed the date and time in which reminders and observations were given. Staff did not have a current medication list to compare the number of medications given to the actual number of medications listed on the medication list. The RN, in a written statement, indicated the tenant's pharmacy filled a prescription labeled Glipizide, incorrectly, with Amaryl, 4mg. This medication was in addition to an already filled order of Glipizide, 5mg. On 2-15-08 the tenant reportedly brought to the RN's attention the additional medication. The RN completed a medication count and determined the tenant received an additional four doses of Amaryl 4mg. The RN immediately contacted the pharmacist that filled the prescription, who in turn contacted the tenant's physician. The RN also contacted the tenant's physician who told the RN to monitor the tenant's blood sugars. The RN completed a pharmacy error reporting form and indicated Glipizide was incorrectly dispensed. The program did not cross reference medications received from the pharmacy with the physician's order for medications. The program did not did not have a current medication list to compare the number of medications given to the actual number of medications listed on the medication list.

During the course of the recertification, the following information was obtained:

Monitoring Observation: Medication documentation indicated medications were not charted as given. A review of the March 2008 MAR indicated the following:

Tenant #5	Klor-Con, 10meq ER, 1 tablet by mouth daily.	3-1-08 – not documented as given

Tenant #5	Fluticasone Propionate/Salmate, Ihale 1 dose, twice daily.	3-1-08 – not documented as given at 8:00 a.m.
Tenant #5	Lasix, 20mg tablet, 1 tab by mouth every a.m. and at noon.	3-1-08 – both times not documented as given.
Tenant #5	Micronase, 5mg tablet, 1 tablet by mouth every morning and 2 tablets at bedtime.	3-1-08 – the a.m. dose was not documented as given.
Tenant #5	Metoprolol, 50mg tablet, 1 tablet twice daily.	3-1-08 – a.m. dose not documented as given.
Tenant #5	Warfarin Sodium, 4mg tablet, 1 tablet by mouth daily	3-1-08 – not documented as given.
Tenant #6	Glycolax Powder, 17gm. in 8oz of fluid by mouth.	3-1-08 & 3-5-08 – documented as refused with no explanation given.
Tenant #7	Amlodipine Besylate, 5mg tablet daily.	3-2-08 – 3-4-08 – not documented as given
Tenant #7	Levaquin, 500mg, 1 tablet daily times 5 days.	3-1-08 – 3-4-08 – not documented as given
Tenant #7	Finasteride, 5mg tablet, 1 tablet every morning.	3-2-08 – 3-4-08 – not documented as given
Tenant #7	Therapeutic M Vitamin, one tablet every morning.	3-2-08 – 3-4-08 – not documented as given
Tenant #7	Timolol, 0.5% gel/solution, instill 1 drop in each eye daily.	3-2-08 – 3-4-08 – not documented as given
Tenant #7	Cosopt Eye Drops, 1 drop in left eye, twice daily.	3-2-08 – 3-3-08 – not documented as given. 3-4-08 – not documented as given at 8:00 a.m.

- Regulatory Insufficiency: The program did not consistently follow an acceptable medication protocol by ensuring the nurse followed the regimen prescribed by the physician by exercising professional judgment in accordance with minimum standards of nursing practice as defined in the rules.(IAC 655-Chapter 6.2(5)e)

D. 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]

Monitoring Observation: Tenants #1, #2 and #3's files indicated the program did not consistently complete a 90-day nurse review.

- Regulatory Insufficiency: The program did not consistently complete, every 90-days, each tenant receiving program-administered prescription medications for adverse reactions to program-administered medications and make appropriate interventions or referral, and ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (25.30(1))

Dated this 10th day of April, 2008.