IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

May 27, 2008

Complaint # 16615

Jennifer Christenson, RN, MNHP, Director
Country House
900 W 46th Street
Davenport, IA 52806-4362

RE: Final Complaint Investigation Report, Country House, Davenport, IA

Dear Ms. Christenson:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated March 25, 2008. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary.

We appreciate your prompt action in correcting the Regulatory Insufficiencies. If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

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

Assisted Living Program: **Complaint Intake #: 16615**

Jennifer Christenson, RN, MNHP, Director
Country House
900 W 46th Street
Davenport, IA 52806-4362

Date of Investigation:

March 25, 2008

Monitor(s):

Stephanie Cummins, SW MA

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 Country House on March 25, 2008. 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:	30
Current number of tenants without cognitive disorder:	1
Total Population:	31

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

Accreditation Status – Not applicable.

Program History – There were substantiated Regulatory Insufficiencies this certification period in the areas of: Medications, Nurse Review, Staffing and Life Safety.

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)]

During the course of the investigation, the following information was obtained.

Monitoring Observation: Three tenant files were reviewed.

Tenant #1, a 76 year old, was admitted on 11-9-07 and diagnoses include: Dementia and Behavioral Problems. The tenant was staged at 6.1 on the Global Deterioration Scale (GDS)/Brief Cognitive Rating Scale (BCRS), which indicated severe cognitive decline. The tenant died on 3-21-08. The tenant was admitted to Hospice on 2-28-08, according to nurse's notes. A functional evaluation was not completed at that time. A cognitive evaluation was completed on 3-5-08. According to nurse's notes, the tenant had a fall or was found on the floor on a least two occasions in March and nurse's notes from 3-18-08 to 3-20-08 indicated the tenant had increased lethargy, difficulty with ambulation, increased pain and increased care needs. Cognitive, health and functional evaluations were not completed, as needed.

Tenant #3, a75 year old, was admitted on 6-28-07 and diagnoses include: Dementia (Alzheimer's type) Hypercholesterolemia and Hyperlipidemia. The tenant was staged at a six on the GDS/BCRS, which indicated severe cognitive decline. According to nurse's notes on 3-6-08 the tenant was found on the floor with an injury. According to nurse's notes on 3-8-08 the tenant was found on the floor and started having a "seizure x 2." Functional and cognitive evaluations were not completed as needed.

Tenant #4, an 87 year old, was admitted on 12-17-07 with a diagnosis of Dementia. The tenant was staged at a 5.1 on the GDS/BCRS, which indicated moderately severe cognitive decline. Incident reports and nurse's notes indicated the tenant had falls or was found on the ground and attempted elopements. On 1-30-08, the tenant eloped and was brought back to the program by a neighbor. Cognitive, health and functional evaluations were not completed, as needed.

- Regulatory Insufficiency: The program did not consistently evaluate each tenant's functional, cognitive and health status within 30 days of occupancy and as needed, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any modifications to the services needed. The evaluation shall be conducted by a health or 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]

During the course of the investigation, the following information was obtained.

Monitoring Observation: Three tenant files were reviewed.

Tenant #1 was admitted to Hospice on 2-28-08. The tenant's service plan was updated on 2-27-08; however, it was not signed by the nurse, two staff and the tenant when the update occurred. The service plan updated was not based on evaluations. According to nurse's notes the tenant had a fall or was found on floor on at least two occasions in March and nurse's notes from 3-18-08 to 3-20-08 indicated the tenant had increased lethargy, difficult with ambulation, increased pain and increased care needs. The service plan was not updated, as needed, and did not reflect the needs of the tenant.

Tenant #3 was found on the floor with an injury, according to nurse's notes on 3-6-08. According to nurse's notes on 3-8-08, the tenant was found on the floor and started having a "seizure x 2." The service plan was updated on 3-8-08, which stated staff were to monitor the tenant closely post seizure. The service plan update was not signed by the nurse, two staff and the tenant and it was not based on evaluations.

Tenant #4 had falls or was found on the ground and attempted elopements, according to incident reports and nurse's notes. On 1-30-08 the tenant eloped and was brought back to the program by a neighbor. The service plan was not updated, as needed, and did not reflect the needs of the tenant.

- Regulatory Insufficiency: The program did not consistently update a tenant's service plan when a tenant needs personal or health related care, as needed, by a multidisciplinary team that consists of no fewer than three individuals, including a health professional and other staff appropriate to meet the needs of the tenant, in consultation with the tenant and at the tenant's request with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative (25.28(3))

- Regulatory Insufficiency: The program did not consistently develop service plans that identified needs and the tenants' requests for assistance and expected outcomes. (25.28(4)a)

- Regulatory Insufficiency: The program did not consistently develop service plans for each tenant based on the evaluations conducted in accordance with 25.23(1) and 25.23(2), and designed to meet the specific services needs of the individual 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 was alleged narcotics were not kept behind two locks. Tenant #2's Lorazepam was kept in an unlocked refrigerator in the room with the staff time clock.

Monitoring Observation: The monitor observed Tenant #2's Lorazepam was in a locked box in the refrigerator in the locked medication room on side A of the program. The Director stated Tenant #1's Lorzepam was brought in by Hospice and was put in the unlocked refrigerator from Saturday night to Monday morning. The Director checked and there were no missed doses when it was discovered. The medication was moved to

the medication room and was locked in the refrigerator in the locked medication room. Staff #3 stated Tenant #2's Lorazepam liquid was stored in the time clock room in a locked box in the refrigerator; however, she was not 100% sure.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged missing medications were not reported. It was alleged there was no documentation regarding missing narcotics. The Director indicated the medications were wasted and there was no documentation signed by two staff to support wasted medications.

Monitoring Observation: The Director and interviews with Staff #1, #2, #3 and #4 indicated there no missing medications. Review of the, as needed, medication sheets indicated they were not consistently signed by two staff at the beginning and end of each shift. The Controlled Drug Receipt Record/Disposition Forms that were reviewed indicated reconciled counts. Staff #1 stated two staff flush a narcotic down to waste it and it is signed on the MAR and explained on the back that the medication was wasted. Staff #2 stated one person washed the narcotic down the drain and she would write on the MAR refused and let a supervisor know. Staff #3 indicated two staff sign when wasting a narcotic and she would sign on the, as needed (PRN), medication sheet that it was wasted. Staff #4 stated that to dispose of a narcotic she would flush it or crush it and she would do that by herself. The Director stated two staff flushes a narcotic to waste it and record it as wasted in the PRN medication book with two staff signing.

Complaint Allegation: It was alleged often tenants do not have their PRN medications and staff often forget to order medications. It was alleged if families complain enough, the PRN medications might eventually arrive at the program. It was alleged Tenant #1 was very agitated before a fall on 3-9-08; however, he/she did not have the PRN medication for agitation as the medication was not at the program. It was alleged Tenant #1 fell in the courtyard on 3-9-08 suffering a scrape to the tenant's leg.

Monitoring Observation: According to a Hospice note dated 3-9-08, it was reported to the Hospice Registered Nurse (RN), Tenant #1 fell in the courtyard and skinned his/her right shin. The Licensed Practical Nurse (LPN) provided a statement that indicated Tenant #1's Alprazolam was reordered and was used until 1-31-08 with the last dose given at 8:00 a.m. on 1-31-08. On 1-31-08 a new order for Haldol, 1-2mg by mouth or IM, 2-4 hours, PRN, was received. The Alprazolam was not discontinued and was not reordered due to the Haldol order. The Hospice Death Event Record did not indicate any Alprazolam medication was disposed. The Director indicated the Alprazolam medication was not destroyed by the Hospice nurse upon the tenant's death because there was no medication left. A Hospice nurse noted on 3-14-08, that the tenant had increased anxiousness and was moving constantly and she discussed these issues with the Director. The Director stated to the Hospice nurse, the Haldol was on hold at that time and the tenant did have a PRN Xanax. The Hospice nurse indicated there was no nurse intervention at that time. According to the Director, on 3-14-08 she spoke with the Hospice nurse regarding why Haldol had not been administered. The Director indicated the medication was not given due the condition decline and the Hospice nurse used the wording "hold."

Staff #1, Staff #2, Staff #3 and Staff #4 stated, as needed medications were available and the LPN ordered the medications. The Director stated the incident mentioned above was the only PRN medication that had been brought to her attention. The Director stated if families supply medications the medications may be late.

During the course of the investigation, the following information was obtained.

Monitoring Observation: A medication pass was observed. Tenant #5 was ordered Senna-Gen NF, 8.6 mg tablet, two tablets by mouth, three times daily. The MAR indicated there was no record the medication was administered on 3-5-08; however, the medication was not in the bubblepack. The medication remained in the bubblepack on 3-12-08; however, the medication was signed as given.

- Regulatory Insufficiency: The administration of medications shall be provided by an Iowa-licensed registered nurse or advanced registered nurse practitioner registered in Iowa or the authorized agent in accordance with 655—subrule 6.2(5) and 655—subrule 6.3(1) and Iowa Code chapter 155A and in executing the medical regimen as prescribed by the physician, the registered nurse shall exercise professional judgment in accordance with minimum standards of nursing practice as defined in these rules: 25.29(2)a, 655-6.2(5)e(152).

- Regulatory Insufficiency: The program did not consistently provide nursing services in accordance with Iowa Code chapter 152 and 655-Chapter 6. (25.33(6))

D. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation: It was alleged management staff told program staff not to call about falls that occurred at night and to wait until the next day to contact administrative staff. It was alleged Tenant #3 fell on 3-8-08 at 2:00 a.m., and received a small laceration from hitting his/her head on the dresser. The staff had to wait until 7:00 a.m. to contact the nursing director. It was alleged Tenant #1 was sent to the Emergency Room (ER) for evaluation and returned to the program, after which, the tenant had two seizures although there was no history of seizures. It was alleged that waiting for five hours before being sent to the ER was not appropriate for someone with a potential head trauma.

Monitoring Observation: Interviews with the Director and Staff #1, #2, #3 and #4 indicated staff were never told not to call administrative staff regarding falls. Staff #1 stated she would call the nurse if there was a wound or blood and that whoever witnessed the fall assessed the tenant. Staff #2 stated she would call the nurse if there was a serious or even if there was a not so serious injury. Staff #4 stated she would call the nurse for a bruise or abrasion and if there was a serious injury she would call 911. The Director stated she wanted to be called regarding falls when there is a head injury or apparent change in appetite or behavior. The Director stated she had not given staff stipulations on when to call. A review of incident reports for the past three months indicated nurse notification was not consistently documented. According to an incident report dated 3-6-08 at 4:30 a.m., Tenant #3 fell in his/her bedroom, was found lying across the bed and was bleeding. The incident report stated the tenant's spouse was notified at 6:30 a.m. The notation by the LPN on the incident report was documented at 11:30 a.m. Nurse's

notes dated 3-6-08 at 11:30 a.m. indicated the tenant was found bleeding from an abrasion on the forehead and a small laceration, and had a hematoma on the right side of the forehead at 4:30 a.m. The tenant went to the physician's office at 8:30 a.m. and returned on 3-6-08. Nurse's notes dated 3-8-08 at 7:05 a.m. indicated the tenant was found sitting on the floor, having missed the chair. The tenant had no injury to the head; however, immediately the tenant started "having seizure x 2." The tenant was taken to the hospital and returned on 3-8-08. An incident report was not provided for this incident or fall. A time was not provided in the nurse's notes when the tenant was found on the floor; however, the nurse's note was timed at 7:05 a.m. The Director made the entry that occurred at 7:05 a.m.

- Regulatory Insufficiency: The program did not consistently provide sufficient trained staff available at all times to fully meet the tenants' identified needs. (25.33(1))

Complaint Allegation: It was alleged several tenants have tried to climb the fences to get out of the courtyard. Several other tenants have fallen.

Monitoring Observation: Staff #1, #2, #3 and #4 indicated staff was sufficient to meet the needs of the tenants. Staff #1, #2, and #3 indicated Tenant #4 had eloped at one time. Staff #1, #2, #3 and #4 indicated there had been no injuries in the courtyard. Review of Tenant #4's nurse's notes indicated the tenant attempted to climb the fences on 12-17-07 and 12-18-07, after the tenant was admitted. The tenant eloped on 1-30-08 and was brought back to the program by a neighbor.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged staff who were not medication certified have access to the medications as there are other keys on the medication key ring.

Monitoring Observation: The Director and interviews with Staff #1, #2, #3 and #4 indicated staff have access to the medication room and cabinet if they do not pass medications. According to the Director and Staff # 1, #2, #3 and #4 there were no adverse outcomes related to staff access to medications.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged management staff told staff not to call on the weekends if tenants did not have their medications.

Monitoring Observation: The Director and Staff #1, #2, #3, #4 indicated staff were never told not to call administrative staff regarding lack of medications.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged staff did everything from cleaning to providing care to cooking. It was alleged staff did not always wash their hands appropriately between clean and dirty tasks.

Monitoring Observation: Interviews with Staff #1, #2, #3 and #4 and monitor observation indicated appropriate sanitation was practiced.

- Regulatory Insufficiency: None noted.

E. Exit Door Alarm System – A dementia-specific program shall have an operating alarm system connected to each exit door. [25.37(2)]

Complaint Allegation: It was alleged the doors to the courtyard were neither alarmed nor locked.

Monitoring Observation: The monitor observed doors that entered into the secured courtyard were not alarmed. Doors leading into a secure enclosure that does not lead directly to a public way or parking lot are not considered exit doors and therefore, are not required to be alarmed.

- Regulatory Insufficiency: None noted.

Dated this 27th day of May, 2008.