IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

July 28, 2008

Complaint #17505

Ms. Stacey Struble, Administrator
Prairie Hills of Independence
505 Enterprise Drive SW
Independence, IA 50644-9603

RE: Complaint Investigation Report, Prairie Hills of Independence, Independence, IA

Dear Ms. Struble:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated June 19, 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,

Tamara Nalvorson
fo

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 #: 17505**

Stacey Struble, Administrator
Prairie Hills at Independence
505 Enterprise Drive SW
Independence, IA 50644-9603

Date of Investigation:

May 20, 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 Prairie Hills Independence on May 20, 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:	35
Current number of tenants with cognitive disorder:	1
Total Population:	36

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:	10
Current number of tenants without cognitive disorder:	8
Total Population:	18

***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 have been no substantiated Regulatory Insufficiencies this certification period, starting February 15, 2008.

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 77 year old, was admitted 1-9-08 and diagnoses include: Hyperlipidemia, Hypertension (HTN), Atrial Fibrillation, Osteoporosis, Cognitive Decline and Trigeminal Nerve Syndrome. The tenant was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. The tenant resided in the dementia unit. A medication error was discovered on 4-5-08. According to the report, the tenant received Gabapentin, 600 mg, three times daily, for four days, despite the medication being discontinued on 3-14-08. Health and functional evaluations were updated on 4-4-08, 5-2-08, 5-5-08, 5-8-08, 5-12-08 and 5-19-08. A cognitive evaluation was only completed on 4-4-08, 5-5-08 and 5-19-08. A toileting sheet for the tenant indicated staff were to document toileting every two hours while the tenant is awake. Health and functional evaluations did not reflect the need for two hour toileting and evaluations were not completed, as needed.

Tenant #3, an 88 year old, was admitted on 9-5-06 and diagnoses include: Alzheimer's Disease and Anxiety. The tenant was staged at a three on the GDS, which indicated mild cognitive decline. The tenant resided in the dementia unit. According to a document from the Administrator, Tenant #3 had increasing levels of care issues. Frequent conversations with the family were held regarding increased needs, reviewing services and service plans and meeting the needs of others at the program. Evaluations were last completed on 2-25-08. Evaluations were not completed, as needed.

- Regulatory Insufficiency: The program did not consistently evaluate each tenants' functional, cognitive and health status as needed to determine the tenants' continued eligibility for the program and to determine any modifications to the services needed. (25.23(2))

B. Program Initiated Involuntary Transfer – Program initiates the involuntary transfer of a tenant and the action is not a result of a monitoring evaluation or complaint investigation by DIA. [321 IAC 25.26(1)]

Complaint Allegation: It was alleged on 4-5-08 that the Administrator told the Power of Attorney/Durable Power of Attorney (POA/DPOA) that her parents were being discharged because they no longer qualified for Assisted Living Services. Tenant #2 is on dialysis and the program was trying to get rid of him/her.

Monitoring Observation: The Administrator indicated in an interview that Tenant #1 and Tenant #2 were not given a written 30 day notice for transfer. The Administrator indicated she discussed generally, with family, the potential need for a higher level of care at one time, due to the complicated medical management and multiple physicians

involved. According to Administrator's notes dated 4-5-08, the Administrator stated the POA/DPOA needed to look for a higher level of care that could safely manage medications, as Tenant #1 had more than 10 medication changes in one month. The Administrator indicated the issues with Tenant #1's medications had leveled off, there had been an improvement with medications, there were no concerns with Tenant #2's care, Tenant #2 was appropriate for this level of care and since that conversation there had been no other conversations regarding the transfer issue. On one occasion, family initiated a conversation regarding alternative placement. A statement from the Administrator indicated Tenant #3 and Tenant #4 had increasing level of care issues, there were frequent conversations with family regarding the increased needs, reviewing services, service plans and meeting the needs of others at the program. When the administrator was asked which Tenants required a higher level of care and could be potential future discharges, Tenants #1 and #2 were not included in the list.

- Regulatory Insufficiency: None noted.

C. 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.

A medication error in regard to Tenant #1 was discovered on 4-5-08. According to the medication error report, the tenant received Gabapentin, 600 mg, three times daily for four days, despite the medication being discontinued on 3-14-08. The tenant moved to the dementia unit on 4-4-08, the service plan was not updated, as needed. A toileting sheet for the tenant indicated staff were to document toileting every two hours while the tenant was awake. The service plan did not indicated two hour toileting. The service plan was not updated, as needed, and did not reflect the needs of tenant.

Tenant #3 had increasing level of care issues, according to the Administrator. There were frequent conversations with the family regarding the increased needs, reviews of services and service plans and meeting the needs of others at the program, according to a document from the Administrator. The service plan was last updated on 3-18-08. The service plan was not updated, as needed.

- Regulatory Insufficiency: The program did not consistently develop service plans for tenants, as needed, when a tenant needs personal care or health-related care, by a multidisciplinary team that consists of no fewer than three individuals, including a health care professional and other staff appropriate to the meet the needs of the tenant, in consultation with 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 meet the identified needs of the tenants. (25.28(4)a)

D. 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 the following occurred in regard to Tenant #1's medications. On 3-14-08 Gabapentin was stopped and Lyrica was started; however, the program made an error and increased the dose of the Gabapentin to 600 mg three times per day and it was not discontinued until 3-18-08. The tenant received both Lyrica and Gabapentin from 3-14-08 to 3-18-08. The tenant was hallucinating and confused on 4-1-08, Trileptal was started on 4-1-08 and the Gabapentin was restarted but should not have been. On 4-3-08 the Trileptal was stopped. On 4-4-08 the program realized the problem with the Gabapentin that had occurred in March and April. The POA instructed the program to hold the Trileptal and the program refused; however, the Gabapentin was stopped. The program failed to honor the directives of the POA about the medication regimen.

Monitoring Observation: According to admission orders and the March 2008 MARs, Tenant #1 had an order for Gabapentin 300 mg by mouth twice daily. On 3-4-08 a fax to the tenant's physician indicated the tenant was having a significant amount of face pain and the program inquired about an increase in Gabapentin. Gabapentin, 300/300/600 mg for one week was ordered, followed by Gabapentin 600/300/600 mg for one week and then Gabapentin 600 mg, three times daily. The Gabapentin, 300 mg twice daily, was discontinued on the MAR on 3-4-08. On 3-14-08 Gabapentin was discontinued and Lyrica, 75 mg by mouth, twice daily, increasing up to two by mouth twice daily, as needed, was ordered. The last recorded administered dose of Gabapentin for the month of March, 2008 was on 3-14-08 at 0800. The order to discontinue Gabapentin was noted on 3-14-08 at 1520. Lyrica was added to the MAR and the first dose was administered at 2200 on 3-14-08.

According to a Medication Error Report dated 4-1-08 to 4-4-08, Tenant #1 received Gabapentin, 600 mg three times daily, after the medication was discontinued on 3-14-08. The report indicated the pharmacy sent out the Gabapentin with the monthly medications and the medication was given for four days. The medication was then pulled from the medication drawer and discontinued from the April, 2008 MAR. According to the form, teaching was done with the Licensed Practical Nurse (LPN). The physician was notified on 4-7-08 at 1133 and there was no negative outcome to the tenant. The report also stated the family was aware of the situation. The Administrator indicated in an interview that the error was discovered by the family and she was notified on 4-5-08. The physician was notified on Monday, 4-7-08, as the error was noticed on a Saturday. The Administrator's notes indicated on 4-4-08 at 1940, the tenant's DPOA for healthcare requested Trileptal not to be re-started as the physician ordered. The Administrator informed the family medications would be administered, as ordered, and the family should call the physician or the on call physician to obtain an order to discontinue the Trileptal. The Administrator received a message on 4-4-08 at 2040 from the DPOA requesting that the medications not be given however; no physician order was received. On 4-5-08 at 1030 the Administrator's notes indicated the DPOA was aware Trileptal was to be given and the DPOA requested the Administrator call the physician for an order to change the medications. On 4-5-08 at 1040 the Administrator received a verbal order from the physician to stop the Trileptal and the Gabapentin and if the Tenant's pain resumed to start the Trileptal. The medication was not held per the DPOA's request.

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

A review of Tenant #1's MAR for March, 2008 indicated the Tenant was to have Hydrocodone/Apap, 500 mg tablet, one tablet by mouth every six hours, as needed. This was transcribed on the March, 2008 MAR, twice. A dose was signed on 3-11-08 in each place on the MAR; however, different initials appear for both doses. The dose is not signed out on the back of the MAR.

A review of MARs indicated medications were not appropriately documented or not administered as noted below:

Tenant #5	Check pulse and blood pressure daily.	5-9-08 and 5-14-08, not signed or not completed.
Tenant #6	Zymar, one drop to both eyes four times daily for four days.	5-3-08 at 1200 and 5-4-08 at 1200 not signed or not administered.
Tenant #6	Zolpidem, 5 mg by mouth at bedtime.	5-3-08 was not signed or not administered.
Tenant #6	EC ASA, 81 mg by mouth, daily.	5-4-08 and 5-9-08 was not signed or not administered.
Tenant #7	Potassium CR, 20 MEQ by mouth, once daily.	5-7-08 was not signed or not administered.
Tenant #7	Levothyroxine Sodium, 200 mg by mouth daily.	5-7-08 was not signed or not administered.
Tenant #7	Atenolol, 100 mg by mouth, once daily.	5-7-08 was not signed or not administered.
Tenant #7	Furosemide, 40 mg by mouth, daily.	5-7-08 was not signed or not administered.
Tenant #7	Namenda, 10 mg by mouth, twice daily.	5-7-08 was not signed or not administered.
Tenant #7	Alprazolam, .25 mg by mouth, twice daily.	5-7-08 was not signed or not administered.

- 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))

E. 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]

Complaint Allegation: It was alleged the following incidents occurred with Tenant #1's medications. On 3-14-08 Gabapentin was stopped and Lyrica was started; however, the program made an error and increased the Gabapentin dose to 600 mg, three times per day

and it was not discontinued until 3-18-08. The tenant received both Lyrica and Gabapentin from 3-14-08 to 3-18-08. The tenant was hallucinating and confused on 4-1-08 and Trileptal was started and the Gabapentin was restarted, but should not have been.

Monitoring Observation: According to admission orders and the March, 2008 MAR, Tenant #1 had an order for Gabapentin, 300 mg by mouth, twice daily. On 3-4-08 a fax to the tenant's physician indicated the tenant was having a significant amount of face pain and a request was made to increase the Gabapentin. Gabapentin was ordered for 300/300/600 mg, for one week followed by Gabapentin, 600/300/600 mg for one week and then Gabapentin, 600 mg, three times daily. The Gabapentin, 300 mg twice daily, was discontinued on the MAR on 3-4-08. On 3-14-08 Gabapentin was discontinued and Lyrica, 75 mg by mouth, twice daily, increasing to two by mouth, twice daily, as needed, was ordered. The last recorded administered dose of Gabapentin, for the month of March 2008, was on 3-14-08 at 0800. The order to discontinue the Gabapentin was noted on 3-14-08 at 1520. The Lyrica was put on the MAR and the first dose was administered at 2200 on 3-14-08.

According to a Medication Error Report, from 4-1-08 to 4-4-08, Tenant #1 received Gabapentin, 600 mg, three times daily, after the medication was discontinued on 3-14-08. The report indicated the pharmacy sent out the Gabapentin with the Tenant's monthly medications and the medication was given for four days. The medication was then pulled from the medication drawer and discontinued from the April, 2008 MAR.

- Regulatory Insufficiency: The program did not consistently monitor, at least every 90 days, or after a change in condition, each tenant receiving program administered prescription medications for adverse reactions, make appropriate interventions or referrals and ensure that the prescription medications orders are current and that the prescription medications are administered consistent with such orders. (25.30(1))

- Regulatory Insufficiency: The program did not consistently ensure the health care professional's orders for tenants receiving health care professional-directed care from the program are current. (25.30(2))

Dated this 28th day of July, 2008.