IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

August 8, 2008

Complaint #16984

Cindy Cason, Executive Director
Village Ridge
365 Marion Blvd
Marion, IA 52302-3139

RE: Complaint Investigation Report, Village Ridge, Marion, IA

Dear Ms. Cason:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated July 2, 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 Insufficiency. 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 #: 16984**

Cindy Cason, Executive Director
Village Ridge
365 Marion Blvd
Marion, IA 52302

Date of Investigation:

July 2, 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 Village Ridge on July 2, 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:	39
Current number of tenants with cognitive disorder:	0
Total Population:	39

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:	4
Total Population:	14

***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 no substantiated complaints during this certification period.

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

A. 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 on 3-29-08, the nurse left the program because she did not want to work a 16 hour shift. The nurse told Staff #1 to pass medications. It was alleged Staff #1 only had the in house medication course and this was expired.

Monitoring Observation: According to a program document, Staff #1 was a Medication Manager; however, a certificate of training was not found at the time of the investigation. Staff #1 indicated in an interview she was a Certified Nurses Aide (CNA). Staff #1 worked as needed and a program document indicated the staff worked 95 days from 8-1-06 to 7-2-08.

According to a program document, the general staffing patterns for the program included one medication administrator and two to three aides in the dementia unit on day and evening shift, one medication administrator and one aide in the general population (AL side) on day and evening shift and one staff in the general population and one to two staff in the dementia unit on the night shift.

According to a program document, staff that have been in-house trained, completed a medication manager course or Oral Medication Tech (OMT) course, Licensed Practical Nurse (LPN) or Registered Nurse (RN) were allowed to administer medications. The staff must also complete nurse delegation with the Director of Healthcare (DOH) and complete the required orientation according to a program document.

Review of scheduling sheets indicated Staff #1 worked on 3-29-08 on day and evening shifts. The Daily Assignment Sheet for 3-29-08 indicated Staff #1 worked as an aide in the dementia unit on day shift with no medication responsibilities. On the evening shift on 3-29-08, Staff #1 worked as an aide with medication responsibilities in the general population.

Review of medication error logs and reports indicated a medication error was not recorded for 3-29-08 when Staff #1 administered medications.

According to a program document, currently 13 tenants receive medications on the evening shift. The MARs were reviewed for 8 of the tenants and indicated medications were consistently administered on 3-29-08 on the evening shift.

Staff #1 was interviewed. Staff #1 stated the nurse had observed her administering medications. According to Staff #1 she had an in-house training on medication management at another program prior to employment with this program. Staff #1 indicated she had training from the DOH. Staff #1 indicated she rarely administered medications and was usually an aide in the dementia unit. Staff #1 could not recall the last time she administered medications at the program. Staff #1 stated the nurse had not left her or another staff to administer medications when she or other staff had

not been trained or not felt comfortable. Staff #1 stated she felt comfortable administering medications in the general population and dementia unit; however, she felt more comfortable administering medications in the dementia unit. If given a choice, Staff #1 stated she would rather administer medications in the dementia unit.

The DOH was interviewed. The DOH indicated staff do not administer medications without training from the nurse. The DOH stated she had not asked staff to administer medications when staff had not been trained or felt comfortable. The DOH indicated she had never left the program because she did not want to work an extended shift and have staff administer medications when they were not trained or not comfortable. The DOH stated there had not been any poor outcomes related to medication errors.

Staff #1 and #2 indicated there was sufficient staff to meet the needs of the tenants. Staff #1 and #2 stated none of the tenants had complained of lack of help. Staff #1 and #2 indicated the nurse had provided training related to tasks.

A medication pass was observed the day of the investigation and appropriate medication protocol was followed.

Review of nurse delegation documents indicated Staff #1, #7, and #8 did not have documented nurse delegated training. Staff #6, an LPN, had partial training given by another LPN, and not an RN. According to a program document since the first of May, 2008 the program had changed or moved three of the four front administrative offices. The move involved personnel files. The program also hired a new Business/Human Resources Manager and Marketing Coordinator. Due to the changes, there was some paperwork that the program was not able to find on the date of the investigation.

The program submitted additional information to the office on 7-3-08. Staff #1 provided a statement that indicated she had medication manager training with the DOH and in-house training with the DOH. Staff #7's statement indicated she was trained prior to working on the floor. Staff #8's statement indicated she had training earlier upon hire. The program submitted nurse delegated training for Staff #1, #7 and #8 dated 7-2-08 and 7-3-08.

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

Dated this 8th day of August, 2008.