IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

August 29, 2008

Complaint Intake: #14752-R1
#15394-R1

Mr. Gary Troth, Administrator
Northern Hills
4002 Teton Trace
Sioux City, IA 51104

RE: I. Final Complaint Investigation Revisit Report – #14752-R1 and #15394-R1
II. Civil Penalty
III. Hearings and Appeals
IV. Conclusion

Dear Mr. Troth:

I. Final Complaint Investigation Revisit Report – Northern Hills, Sioux City, IA

Enclosed is the **Final Complaint Investigation Revisit Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2007) and Iowa Administrative Code, chapters 321—25, pertaining to assisted living programs and 321—26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. The Final Report notes the **Regulatory Insufficiencies,** as defined in the areas of: Evaluation of Tenant, Service Plan, Medications, Nurse Review, and Other.

DIA is accepting the Plan of Correction (POC) following the program's submission of additional information.

II. Civil Penalty

If no appeal is requested within 30 days of receipt of this **Final Complaint Investigation Revisit Report,** the civil penalty obligation, in the amount of three thousand ($3,000.00) dollars, is required.

III. Hearings/Appeals

The Program may appeal the DIA decision in accordance to 321 IAC 26.4, within 30 days of notice, by submitting a request for appeal to the DIA. Hearings will be held pursuant to 481 IAC Chapter 10. If the program appeals, the civil penalty will be suspended, pending appeal. If the program does not appeal, the fine is due within 30 days of notice.

IV. Conclusion

Northern Hills is being assessed a $3000 civil money penalty. The Plan of Correction that was submitted is accepted. DIA may revisit the program to confirm compliance in fulfilling the POC's corrective measures. If the program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

If you have any questions in regard to these matters, please contact me at (515) 281-5077.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #: 14752-R1, 15394-R1**

Gary Troth, Administrator
Northern Hills
4002 Teton Trace
Sioux City, Iowa 51104

Date of Investigation:

June 24, 2008

Monitor(s):

Michael Streepy, RN
Hal 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 revisit on-site was conducted at Northern Hills on June 24, 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:	53
Current number of tenants with cognitive disorder:	3
Total Population:	56

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.**

Accreditation Status – Not applicable.

Program History – There were substantiated complaints in the areas of Evaluation of Tenant, Service Plan, Medications, Nurse Review, and Record Checks.

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)]

The program received a regulatory insufficiency during the December 2007 visit related to not consistently completing functional, cognitive and health evaluations as needed and annually to determine the tenants continued eligibility for the program and to determine any modifications to services needed for Tenants #1, #2, #3, #7, #8, #9, #10 and #12.

Tenants #3, #7 and #12 had been discharged from the program prior to the revisit.

Monitoring Observation: Tenant #2, a 90 year old, was admitted to the program 09-06-04 with diagnoses including: Status Post Right Cerebral Vascular Accident with Spastic Hemiparesis, Hypercholesterolemia, Hypertension, and Macular Degeneration. The tenant scored a nine on the Mental Status Questionnaire (MSQ) indicating no or mild impairment dated 11-29-07. A review of the tenant's file indicates evaluations were completed appropriately.

Tenant #8, an 86 year old, was admitted to the program 06-11-01 with diagnoses including: Chronic Obstructive Pulmonary Disease and Left Hip Degenerative Osteoarthritis. The tenant scored 11 on the MSQ indicating no cognitive decline. Review of nurse's notes, dated 05-01-08 reveal a return to self administration of medication with no documentation of functional, health or cognitive evaluations.

Tenant #9, a 95 year old, was admitted on 7-6-01 with diagnoses including: Status Post Shingles, Muscular Atrophy and Gout. Annual functional, cognitive and health evaluations were completed on 12-26-07. Resident care notes of 1-19-08 indicated the tenant was hospitalized with an admitting diagnosis of Bronchitis. The tenant returned to the program on 1-23-08. Resident care notes of 2-5-08 indicated the tenant was sent to the emergency room to be evaluated for lethargy. Resident care notes of 2-6-08 indicated the tenant was admitted to Hospice due to Dementia and clinical decline. Resident care notes of 4-30-08 indicated the tenant was discharged from Hospice. The program did not complete a functional, cognitive and health evaluation with a change in health status when the tenant returned from the hospital on 1-23-08, when the tenant returned from being seen in the emergency room of a local hospital on 2-5-08 and when the tenant was admitted to Hospice on 2-6-08. The program completed a functional and health evaluation on 5-2-08 but did not complete a cognitive evaluation.

Tenant #10, a 77 year old, was admitted to the program 11-01-06 with diagnoses including: Syncope, Atherosclerotic Heart Disease, Hypertension, B-12 Deficiency, Hypercholesterolemia and Depression. Nurse's notes dated 03-03-08 revealed tenant was found sitting on the bedroom floor. The tenant stated he/she fell and hit his/her head. The tenant complained of knee pain and was sent to the hospital, returning with a physician's order for a knee immobilizer for 1 week to be removed three times daily for range of motion and to start physical and occupational therapy. Nurse's notes dated 04-17-08 state the tenant was walking better with assistance of cane only. Nurse's notes of 05-25-08 reveal the tenant had increased confusion and was transported to the hospital for evaluation and returned with an order to follow up with

the physician in three to four days. The record contained no documentation of functional, health or cognitive evaluations.

Tenant #12, an 86 year old, was admitted on 4-20-05 with diagnoses including: Cardiomyopathy and HTN. Annual functional, cognitive and health evaluations were completed on 1-14-08. The tenant died on 2-21-08.

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

Monitoring Observation: Tenant #5, a 90 year old, was admitted to the program 11-30-02 with diagnoses including: Chronic Obstructive Pulmonary Disease and Hypertension. The tenant scored an 8 on the Mental Status Questionnaire (MSQ) indicating moderately advanced impairment dated November, 2007. Review of the nurse's notes dated 02-08-08 reveal the tenant complaining of not feeling well with oxygen saturation of 85% on room air. Physician orders for DuoNeb treatment four times daily and as needed, Amantidine 100 milligrams daily for five days and Levaquin 250 milligrams daily for five days were noted in the nurse's notes. Nurse's notes of 03-26-08 reveal the tenant unable to stay awake at the noon meal. The tenant was taken to the emergency room and returned with physician orders to discontinue Doxazocin and obtain laboratory studies. The record contained no documentation of functional, health or cognitive evaluations.

Tenant #13, a 92 year old, was admitted on 6-4-05 with diagnoses including: HTN, Macular Degeneration, Asthma, History of Edema, Post Bronchitis, History of Upper Respiratory Infection, Recurrent Urinary Tract Infection (UTI), Heard of Hearing (HOH) and Cellulitis. Annual functional and health evaluations were completed on 3-5-08; however, a cognitive evaluation was not completed.

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

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

The program received a regulatory insufficiency during the December 2007 visit related to not consistently developing service plans based on evaluations and conducted in accordance with 25.23(1) and 25.23(2) and designed to meet the specific needs of the tenant for tenants #3, #7 and #12.

The program received a regulatory insufficiency during the December 2007 visit related to not consistently updating the service plan when a tenant needs personal or health related care, within 30 days of occupancy and as needed, but not less than annually, by a multidisciplinary team consisting of three staff for tenants #2, #5, #6, #7, #8, #9, #10 and #12.

Tenants #3, #6, and #7 had been discharged from the program prior to the revisit. Tenant #12 died on 2-21-08.

- Monitoring Observation: Tenant #2 had a service plan updated 06-06-08 with no documentation that a cognitive evaluation had been completed. The service plan lacked signatures by the tenant, a health professional and two other staff.

  Tenant #8's service plan updated on 06-10-08, lacked signatures by the tenant and one other staff.

  Tenant #9's service plan was not updated annually and when the tenant was admitted to Hospice on 2-6-08. The program did not have a hospice care plan and did not coordinate care between hospice and the program. The tenant was discharged from Hospice on 4-30-08. The program completed a service plan update on 5-2-08, but lacked signatures of the tenant or tenant's legal representative and three staff.

  Tenant #10's nurse's notes dated 03-03-08 reveal the tenant was found sitting on the bedroom floor. The tenant stated he/she fell and hit his/her head. The tenant complained of knee pain and was sent to the hospital, returning with a physician's order for a knee immobilizer for one week to be removed three times daily for range of motion and to start physical and occupational therapy. The service plan was not updated with the change in condition and did not reflect the service needs of the tenant. Nurse's notes dated 04-17-08 state the tenant was walking better with the assistance of a cane only. The service plan was not updated to reflect the changes or service needs of the tenant.

  Tenant #12's annual service plan was updated on 10-31-07 but was not signed by the tenant, the tenant's legal representative or by three staff. The tenant died on 2-21-08.

- Regulatory Insufficiency: The program did not consistently ensure a service plan would be developed for each tenant based on the evaluations in accordance with 25.23(1) and 25.23(2), and would be designed to meet the specific needs of the individual tenant. (25.28(1))

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

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]

The program received a regulatory insufficiency during the December 2007 visit related to not consistently documenting medications the program agreed to administer for Tenants #1, #2, #4, #10, #12, #15, #16, #17, #18, #19 and #20. The program received a regulatory insufficiency related to not ensuring the medications were labeled and maintained in accordance with label instructions and state and federal laws for Tenants #2 and #10.

Tenants #3, #6, #7, #11, #13 and #14 had been discharged from the program prior to the revisit. Tenant #4 died on 12-2-07 and Tenant #12 died on 2-21-08.

- Monitoring Observation: Tenant #15 through #20 MARs for January through June 23, 2008 indicated medications were administered according to applied standard.

  Tenant #1's April 2008 Medication Administration Record (MAR) revealed medication errors on 04-13-08 for the 8 a.m. dose of Sertraline 25 milligrams and Metformin 500 milligrams not signed as given and with no explanation. The MAR for 04-13-08 revealed the 8 a.m. dosages of Levothyroxine 125 micrograms, Atenolol 25 milligrams, Amlodipine Besylate 10 milligrams, Nifedipine 60 milligrams, Lisinopril 20 milligrams, Vitamin B-12, Calcium 600 milligrams and a multivitamin not signed out as given with no explanation. The MAR for 04-18-08 revealed the 8 p.m. dose of Lipitor 20 milligrams and the 5 p.m. doses of Glyburide 2.5 milligrams and Metformin 500 milligrams not signed as given with no documented explanation.

  Tenant #5's April 2008 MAR revealed medication errors on 04-02 and 04-04 with the Duo Nebulizer treatment scheduled for 8 a.m. and 12 p.m. and 04-11 the 12 p.m. dose not signed as given with no explanation.

  Tenant #8's April 2008 MAR revealed medication error of 04-18 with the 5 p.m. dosage of Calcium 500 milligrams, the 8 p.m. dose of Carvedilol 12.5 milligrams, and Non ASA medication 325 milligrams at night not signed as given with no documented explanation.

  Tenant #10's April 2008 MAR revealed medication errors of 04-16 through 4-18, 4-20 through 4-27 and 4-30 and 4-31 with the 8 a.m. dose of Ranitidine 150 milligrams daily not signed as given with no documented explanation. The MAR also reveals Gabapentin 300 milligrams was not signed as given at the 2 p.m. and 8 p.m. times on 04-14-08 and the 8 p.m. dose on 04-18-08 with no documented explanation.

- Regulatory Insufficiency: The program did not consistently ensure documentation of any medication the program had agreed to administer and store. (25.29(2)b))

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]

The program received a regulatory insufficiency during the December 2007 visit related to not consistently providing a registered nurse to monitor, at least every 90 days, or after a change in condition, each tenant receiving program administered medications for adverse reactions and to make appropriate interventions or referral for Tenants #8 and #9.

- Monitoring Observation: Tenants #3, #6, #7, and #13 had been discharged from the program prior to the revisit. Tenant #4 died on 12-2-07 and Tenant #12 died on 2-21-08.

  Review of Tenants #3, #6 and #12 files indicated the program did not complete a 90-day nurse review as stated in their plan of correction.

Tenant #2's nurse's notes dated 05-18-08 indicated the tenant notified staff of a syncopal episode and a complaint of nervousness. The record contained no documentation of nurse review.

Tenant #5's nurse's notes dated 02-08-08 reveal the tenant complaining of not feeling well with oxygen saturation of 85% on room air. Physician orders for DuoNeb treatment four times daily and as needed, Amantidine 100 milligrams daily for five days and Levaquin 250 milligrams daily for five days were noted in the nurse's notes. Nurse's notes of 03-26-08 reveal the tenant unable to stay awake at the noon meal. The tenant was taken to the emergency room and returned with physician orders to discontinue Doxazocin and obtain laboratory studies. The record contained no documentation of nurse review.

Tenant #8's nurse's notes, dated 05-01-08, reveals a return to self administration of medication. The record contained no documentation of nurse review.

Tenant #9's file indicated the program did not complete a nurse review when the tenant returned to the program for a hospitalization on 1-23-08, when the tenant returned from being seen in the emergency room for lethargy on 2-5-08, when the tenant returned from seeing the physician on 2-6-08 with an order to admit to hospice and when the tenant was discharged from hospice on 4-30-08.

Tenant #13's resident care notes indicated the tenant was started on antibiotic therapy for an Upper Respiratory Infection. Resident care notes of 3-27-08 indicated the tenant was started on antibiotic therapy for ten days. The program did not complete a nurse review with a change in health status.

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

Tenant #10's nurse's notes dated 03-03-08 reveal the tenant was found on sitting on the bedroom floor. The tenant stated he/she fell and hit his/her head. The tenant complained of knee pain and was sent to the hospital, returning with a physician's order for a knee immobilizer for one week to be removed three times daily for range of motion and start physical and occupational therapy. Nurse's notes dated 04-17-08 state the tenant walking better with assistance of cane only. Nurse's notes of 05-25-08 reveal the tenant had increased confusion, transported to the hospital for evaluation and returned with an order to follow up with the physician in three to four days. The record contained no documentation of nurse review. Review of the tenant record reveals the last 90 day nurse review of health status was completed 01-24-08.

- Regulatory Insufficiency: The program did not consistently ensure that when the program administers prescription medications or provides professional directed or health related care, a registered nurse would be provided to monitor at least every 90 days, or after a change in condition, each tenant receiving program administered prescription medications for adverse reactions to program administered medications and make appropriate interventions and referral, and ensure that the prescription medications orders are current and administered consistent with such orders. (25.30(1))

- Regulatory Insufficiency: The program did not consistently ensure a registered nurse would be provided to assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress of previous recommendations at least every 90 days or if there are changes in health status. (25.30(3))

E. Record Checks - The program conducts applicable employee record checks. [Iowa Code section 135C.33(5)]

During the course of the complaint investigation of complaints #14752 & #15394 in December 2007, the program received a regulatory insufficiency related to not consistently ensuring background checks were completed on each employee prior to hire for Staff #3.

- Monitoring Observation: Record checks for five personnel hired since the investigation revealed background checks were completed as required.

- Regulatory Insufficiency: None noted.

F. Other – The provisions of this section address the program's noncompliance with other applicable statutory and administrative rule requirements.

Monitoring Observation: During the course of the complaint investigation, a review of the Plan of Correction submitted by the program on 1-31-08, in response to complaints #14752 and #15394, was reviewed and it was determined the program did not completely implement the Plan of Correction.

- Regulatory Insufficiency: The program did not completely implement the Plan of Correction submitted. (26.2(6)(a))

Dated this 14th day of July, 2008.