IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

September 5, 2008

Complaint #18831

Shelley Wicks, Administrator
West Liberty AL Residences
1000 N Miller St
West Liberty, IA 52776-1102

RE: Complaint Investigation Report, West Liberty Assisted Living Residences, West Liberty, IA

Dear Ms. Wicks:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated August 5, 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 #: 18831**

Shelley Wicks, Administrator
West Liberty AL Residences
1000 N Miller St
West Liberty, IA 52776-1102

Date of Investigation:

August 5, 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 West Liberty AL Residences on August 5, 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:	10
Current number of tenants with cognitive disorder:	0
Total Population:	10

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 Regulatory Insufficiencies in the areas of Evaluation of Tenant and Service Plan this certification period.

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

A. 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 nurse failed to order medications appropriately for Tenant #1. It was alleged the nurse set up medications incorrectly in March and May 12, 2008 for Tenant #1. There were no adverse effects due to this incident. It was alleged the program failed to have any medication error sheets completed to identify the problem. It was also alleged Tenant #2's medications were set up incorrectly, on three separate occasions, with no medication error sheets completed to identify the problem.

Monitoring Observation: Tenant #1, a 101 year old, was admitted on 2-8-08 and diagnoses include: Shortness of Breath, Chest Pain, Essential Hypertension (HTN), Hypothyroidism and Coronary Atherosclerosis.

Staff #1 stated medications have been available and there had been no issues with Tenant #1's medications. The nurse indicated there was one incident where Tenant #1's medications were not available. The nurse stated the tenant's medications arrived when the nurse was not at the program. The staff administering medications circled on the MAR that medications were not available; however, the nurse was not notified. This incident was documented in a medication error report. According to the medication error report, on 5-9-08, 5-10-08 and 5-11-08, Tenant #1's medication was not available from the pharmacy, it was ordered on 5-5-08; however, it was not added to the medication boxes when it arrived from the pharmacy. The tenant missed three evening doses and one morning dose of Metoprolol, 50 mg. The corrective action on the report stated nursing home staff will set up medications in medication boxes when they arrive or the nurse will be notified to set up the medications. The nurse indicated she was not aware of any other missed doses due to refilling issues. According to program records there were two medication error reports from March 2008 to the present time, both regarding Tenant #1's medication. One medication error report discussed above and the second medication error report involved Tenant #1's Metoprolol, 50 mg, that was not given on 6-13-08. According to the nurse and a review of incident reports there were no medication errors documented in March of 2008.

Tenant #1 was interviewed and indicated his/her medications were available and he/she was receiving the appropriate medications. A review of the tenant's MARs indicated medications were available and administered appropriately.

Tenant #2, an 85 year old, was admitted on 9-11-06/9-11-05(two different admission dates provided) and diagnoses include: HTN, Pacemaker, Arthritis, Atrial Fibrillation and Hyperlipidemia.

Staff #1 reported there were no issues brought to her regarding Tenant #2's medications not being set up appropriately. Staff #1 indicated the tenant received assistance with only medication set up and staff did not administer the tenant's medications. The nurse

indicated Tenant #2 reported to her last week, there was an issue with one medication in the planner; however, the tenant did not take the medication. The nurse indicated a medication error report was not filled out because the tenant did not take the medication. There were no medication error reports for this tenant. The nurse indicated medication error reports are filled out as soon as they are identified. Tenant #2 stated his/her medications were set up and he/she takes the medications independently. The tenant indicated his/her medications were set up appropriately and he/she did not have any concerns with medications. Review of the tenant's MARs indicated set up of medications was appropriately documented.

- 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).

B. 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 Tenant #5 receives Hospice care and on two separate occasions the program staff left the tenant alone without assistance. It was noted the tenant had a significant cough.

Monitoring Observation: Tenant #5, a 96 year old, was admitted on 10-24-06 and diagnoses include: HTN, Arthritis, Dementia and Terminal Laryngeal Cancer.

Tenant #5 was interviewed and indicated he/she was getting her needs met. The tenant did not have any concerns with staff and stated there was always staff available, including nights. The tenant stated he/she had never needed anyone at night. Staff #1 stated there was a monitor in the tenant's room to monitor coughing or choking. The monitor was kept in the kitchen during the day and was kept by staff at night. Staff #1 stated staff responded to the tenant appropriately and the tenant was never left unattended during a coughing episode. Staff #2 indicated the tenant was checked hourly and there was a monitor to monitor the tenant. The monitor was to monitor if the tenant had increased coughing or if something was different. Staff #2 indicated the tenant did not require 24 hour staffing. Staff #2 stated two weeks ago there was a caregiver (private duty) at night to make sure the tenant did not fall; however, that was discontinued. Staff #2 indicated the tenant was getting the services needed and there were no incidents where staff did not respond to choking or coughing. She stated she did not take the monitor with her on breaks. The nurse indicated the tenant was checked on hourly throughout the night and during the day, as needed; however, at least every couple of hours. The nurse indicated the monitor was put into place to promote rest without disturbing the tenant at night. The nurse indicated there had been staff in the building 24 hours a day since the tenant had been ill and the building had not been left unattended while the tenant was ill. The nurse indicated she was not sure if the monitor was on or off during breaks and staff automatically check on the tenant after breaks. The nurse indicated the tenant had a private caregiver, approximately four times; however, there were no problems and it was

discontinued. The nurse was not aware of any incidents were the tenant's needs were not being met. The nurse indicated the tenant did not require a staff with him/her at all times. Staff had not been directed by the program or by Hospice to have staff with the tenant at all times.

- Regulatory Insufficiency: None noted.

C. Structural requirements – The structure of the program shall be designed and operated to meet the needs of the tenants. The buildings and grounds shall be well-maintained, clean, safe and sanitary.

Complaint Allegation: It was alleged Tenant #4's shower had a significant amount of mold built up and that staff and the program failed to provide appropriate cleaning to remove the mold.

Monitoring Observation: Tenant #4, a 95 year old, was admitted on 3-30-06 and diagnoses include: HTN, Glaucoma and a History of a Urinary Tract Infection (UTI).

Tenant #4 was interviewed and did not report any issues or problems with mold. The tenant's bathroom and shower were viewed and the monitor did not observe any mold. The Environmental Services Supervisor was interviewed and indicated he had never heard of any issues with mold in the tenant's shower. The nurse indicated there was an issue with mold on the tenant's bathmat and staff cleaned it and bleached it; however, it did not destroy the mold and she replaced the tenant's bathmat. According to the nurse, the tenant did not voice any concerns or complaints and there were no health issues related to the bathmat. Staff #1 indicated the tenant's bathmat had stains on it and staff cleaned it and could not remove the stains, the bathmat was then replaced. Staff #2 stated she heard there was mold on the tenant's bathmat; however, she never observed the mold. Staff #2 stated the nurse bought a new bathmat for the tenant and indicated there was a quick response to the bathmat issue. Review of the tenant's files indicated there was no documentation of mold in the tenant's apartment.

- Regulatory Insufficiency: None noted.

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

Complaint Allegation: It was alleged the nurse placed a red mark of some kind on the stomach of Tenant #3 in March of 2008 that took approximately "1/5" weeks to disappear.

Monitoring Observation: Tenant #3, a 92 year old, was admitted on 4-26-06 and diagnoses include: HTN, Degenerative Joint Disease (DJD) and Gastroesophageal Reflux Disease (GERD). The tenant had normal cognitive function.

Tenant #3 indicated in an interview he/she had never had a red mark put on his/her body by the nurse or other staff. The nurse indicated in an interview she had never put a red mark on the stomach of the tenant. The nurse indicated in a statement, the tenant told a staff that the nurse took urine from his/her stomach and poked him/her in the stomach. The nurse talked to the tenant regarding this issue and the tenant

thought the nurse took urine from his/her stomach with a needle. The nurse assured the tenant this was not the case. The nurse stated she listened, with a stethoscope, to the tenant's stomach, that same day. Staff #1 and Staff #2 stated in interviews they had not seen the tenant with a red mark on his/her body. A review of the tenant's file indicated there was no documentation of a red mark on the tenant's stomach during the month of March, 2008.

- Regulatory Insufficiency: None noted.

Dated this 5th day of September, 2008.