IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

October 16, 2008

Complaint #19028-M
19142-C

Deanna Fisher, Administrator
Cedars of Madrid
600 North Kennedy
Madrid, IA 50156

RE: Complaint Investigation Report, Cedars of Madrid, Madrid, IA

Dear Ms. Fisher:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated September 2, 2008. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary. The Final report is enclosed for your information

We appreciate your prompt action in correcting the Regulatory Insufficiencies. If you have questions, please contact me at 515-281-5721.

Sincerely,

Tamara Halvorson

Tamara Halvorson
ASB Lead Certification Coordinator
Adult Services Bureau

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

Assisted Living Program:

Complaint Intake #: 19028-M
19143-C

Deanna Fisher, Administrator
Cedars of Madrid Homes Assisted Living
600 North Kennedy Avenue
Madrid, IA 50156

Date of Investigation:

August 25, 2008

Monitor(s):

Hal L. 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 on-site visit was conducted at Cedars of Madrid Homes Assisted Living on August 25, 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:	30
Current number of tenants with cognitive disorder:	0
Total Population:	30

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 serves 5 or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale (GDS):	8
Total Population:	8

***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 in the area of Medications during this certification period.

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 complaint investigations, the following information was obtained.

- Monitoring Observation: Tenant #5, a 92 year old, was admitted on 5-26-08 and has diagnoses of: Alzheimer's Disease, History of Cancer, Hypertension (HTN), and History of a Fractured Clavicle. The tenant scored a four – five on the Gobal Deterioration Scale (GDS) on 7-31-08, which indicated moderate to moderately severe cognitive decline. Nurse's notes of 6-30-08 indicated the tenant fell outside the building on 6-27-08, was seen in an emergency room of a local hospital on 6-28-08 and was diagnosed with a closed fracture of the right forearm. Nurse's notes of the same entry indicated emergency room discharge instructions included application of an ice pack every two to three hours. The tenant's son requested staff to assist the tenant with personal cares as needed. The program did not complete a functional, cognitive and health evaluation when the tenant returned on 6-28-08 with a change in health status.

- 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 any modifications to the 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]

During the course of the complaint investigations, the following information was obtained.

- Monitoring Observation: Tenant #5's service plan was not updated until 6-30-08 despite a change in health status on 6-28-08 related to a right forearm fracture and the need for additional assistance with ADLs and physician ordered treatment.

- Regulatory Insufficiency: The program did not consistently update a tenant's service plan when a tenant needs personal or health related care as needed to meet the needs of the tenant. (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]

Complaint Allegation #19143: It is alleged the program did not implement Tenant #7's hospital discharge orders.

- Monitoring Observation: Tenant #7, an 81 year old, was admitted on 6-21-05 and has diagnoses of: Post Coronary Artery Bypass Graft, History of Mitral Valve Replacement, HTN, Diabetes Mellitus II, History of Cerebral Vascular Accident, and Third Degree Heart Block with Pacemaker, Anxiety and Depression. Nurse's notes of 7-21-08 indicated the tenant was admitted to the hospital on 7-19-08, returning to the program on 7-20-08. Hospital discharge orders of 7-20-08 included Lisinopril 10 mg daily and Glipizide 10 mg twice daily. Medication Administration Records for July, 2008 indicated both medications were not started until 7-22-08. The Registered Nurse (RN) stated medications were not started on Sunday, 7-20-08 or Monday, 7-21-08.

Complaint Allegation # 19028: It is alleged Tenant #1 and Tenant #2's medications were missing.

- Monitoring Observation: Tenant #1, a 97 year old, was admitted on 5-17-07 and has diagnoses of: History of Right Hip Fracture Open Reduction Internal Fixation, HTN, Atrial Fibrillation, Chronic Pain, Constipation, Insomnia, Syncope, History of Left Rib Fracture, Osteoarthritis, Hypothyroidism and History of Renal Insufficiency. An investigation conducted by the program on 7-21-08 indicated two Vicodin tablets were missing from the tenant's dose cassette on 7-13-08. Program's medication notes, which accounts for each Vicodin given, indicated on 7-13-08 at 2:00 a.m. there were eight tablets available. On 7-13-08 at 4:00 p.m. there were five tablets available which indicated there were two tablets not accounted for. Staff #1 stated, in a prepared statement, that she had taken one of the tablets from the tenant's cassette.

  Tenant #2, a 69 year old, was admitted on 2-5-07 and has diagnoses of: Alzheimer's Disease, Dementia, History of Weight Loss, Fatigue, Tobacco Abuse, History of Right Wrist Fracture, History of Nephrectomy and History of Right Rotator Cuff Repair. The tenant scored a four – five on the GDS on 5-6-08, which indicated moderate to moderately severe cognitive decline. An investigation conducted by the program on 7-21-08 indicated the 7-19-08 evening dose of Seroquel was missing from the tenant's cassette. The tenant's Medication Administration Records (MARs) for 7-19-08 dose of Seroquel was given. The program's investigation indicated staff used an available spare in the cassette to give the tenant. There was no evidence medication was taken by staff.

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

- Monitoring Observation: The program's internal investigation indicated Staff #1 stated she had taken a Vicodin tablet from Tenant #6's dose cassette.

  Tenant #6, an 83 year old, was admitted on 9-21-07 and has diagnoses of: Hypercholesterolemia, HTN, Stasis Dermatitis, Arthritis, Hyperuricemia, Macular Degeneration, Anemia, Gout and History of Deep Vein Thrombosis of the Left Leg. The tenant scored a four – five on the GDS on 10-10-07, which indicated moderate to moderately severe cognitive decline. Program's medication notes, which accounts for each Vicodin given, indicated on 6-29-08 at 10:20 a.m. 12 tablets were available. On 6-29-08 at 11:30 a.m. medication notes indicated 10 tablets were available indicating two tablets were missing.

- 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 the rules. 25.29(2)a, 655-6.2(5)e(152).

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 # 19028: It is alleged money was taken from Tenant #3 and Tenant #4 by staff.

- Monitoring Observation: Tenant #3, a 71 year old, was admitted on 7-11-08 and has diagnoses of: Overweight, History of Failure to Thrive, Dementia with Behavior Disorder, History of Chronic Pain Syndrome, HTN, Rheumatoid Arthritis, Generalized Muscle Weakness, Osteoporosis, Abnormal Gait, History of Schizophrenia, Vitamin Deficiency, Hypopotassemia, Asthma, Pes Planus and History of Osteopenia. An investigation conducted by the program on 7-21-08 indicated the tenant reported $55.00 was taken from a lock box located on the kitchen table. There is no conclusion as to how the money came up missing.

  Tenant #4, a 77 year old, was admitted on 11-4-06 and has diagnoses of: Arthritis, Osteoporosis, Neuropathy, Gastro Esophageal Reflux Disease, Fatigue, Hyperlipidemia, History of Hypokalemia, History of Dyspenia, History of Coronary Artery Disease, History of Diverticulosis, History of Elevated Blood Sugars, History of Vaginal Prolapse, History of Back Pain, History of Chronic Cough, History of Vertigo and a History of Depression. An investigation conducted by the program on 7-21-08 indicated the tenant reported $100.00 was taken from his/her purse. Staff #1 stated she had taken $60.00 to $90.00 from the tenant's purse when the tenant was at supper. Staff #1 was terminated on 7-21-08.

- Regulatory Insufficiency: The program did not consistently provide sufficiently trained staff at all times to fully meet the tenant's identified needs (25.23(1))

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]

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

- Monitoring Observation: Tenant #5's nurse's notes of 6-30-08 indicated the tenant fell outside the building on 6-27-08, was seen in an emergency room of a local hospital on 6- 28-08 and was diagnosed with a closed fracture of the right forearm. Nurse's notes of the same entry indicated emergency room discharge instructions included to apply an ice pack every two to three hours. The tenant's son requested staff to assist the tenant with personal cares as needed. The program did not complete a nurse review until 6-30-08 and not when a change in health status occurred.

- Regulatory Insufficiency: The program did not assess and document the health status of each tenant, make recommendations and referrals as appropriate if there is a change in health status. (25.30 (3))

Dated this 2nd day of September 2008.