IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

November 18, 2008

Complaint Intake: #19359-C
19544-C
Incident Intake: #19778-I

K'lee Lathum, Administrator
Shores at Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, IA 50327-0921

RE: I. Final Complaint & Incident Investigation Report–#19359-C, 19544-C and 19778-I
II. Civil Penalty
III. Hearings and Appeals
IV. Conclusion

Dear Ms. Lathum:

I. Final Complaint & Incident Investigation Report – Shores at Pleasant Hill Assisted Living, Pleasant Hill, IA.

Enclosed is the **Final Complaint & Incident Investigation 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 Insufficiency,** as defined in the area of Medications.

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

While effective immediately, the program may appeal these sanctions by filing an appeal within 30 days of issuance of this letter

II. Civil Penalty

If no appeal is requested within 30 days of receipt of this Final Complaint Investigation Report the civil penalty obligation, in the amount of five hundred ($500.00) 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

Shores at Pleasant Hill Assisted Living is being assessed a $500.00 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

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

K'lee Lathum, Administrator
Shores at Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, IA 50327-0921

Complaint Intake #: 19359-C
19544-C
19778-I

Date of Investigation:

September 24 and 25, 2008

Monitor(s):

Lincoln Newsom, RN
Michael Streepy, RN

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 and incident investigation on-site visit was conducted at Shores at Pleasant Hill on September 24 and 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:	25
Current number of tenants with cognitive disorder:	5
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 holds itself out as providing specialized care in a dedicated setting:	8
Current number of tenants without cognitive disorder:	4
Total Population:	12

***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 was a substantiated regulatory insufficiency in the area of Staffing during 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: Complaint # 19359-C allege the Director of Nursing (DON) was double dosing a tenant with a diabetic medication which began with "GLY" and for the first six days in July it was given twice daily The error was marked out to look like it was only given once daily and a copy of the Medication Administration Record's (MAR's) was made and filled in. The original with the white out was very noticeable and was removed. It was unclear if the family or the tenant's physician were notified of the error.

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 1-20-07 with diagnoses of: Parkinson's, Hypertension (HTN), Diabetes and Depression. The tenant had a Brief Cognitive Rating Scale completed on 9-12-08 staging the tenant at a 4 6, indicating moderate cognitive decline, with marked impairment which is readily evidenced clinically The tenant resides in the dementia unit. A physician order dated 5-23-08 indicated the tenant was to have Glimepiride 2mg (generic for Amaryl) increased to 4mg daily; the physician order was noted on 5-28-08. A review of the tenant's MAR's from May 28 through June 2, 2008 indicated the tenant was receiving Amaryl 2mg. Further review of the MAR for the month of June 2008 indicated the following: Amaryl 2mg by mouth daily and Glimepiride 2mg tab take two daily for diabetes (4mg daily). The MAR documents on June 3, 4, 6, 8 and 11, 2008, indicated the tenant received both the 2mg and 4mg dose daily for a total of 6mg, not the prescribed dose of 4mg. On the June MAR for Amaryl there is a notation to discontinue the dose dated 6-5-08; however, the medication continued to be given on June 6, 8 and 11, 2008.

  A review of July's MAR indicated there was a possible medication error from July 1 thru July 8, 2008; however, the MAR appears to have been altered as to not to reflect the error on the July MAR. The MAR from July 1 thru July 8 does not contain ink signatures (initials) of those giving medications, but instead are photo copied signatures (initials) for that time period. From July 9, 2008 the signatures (initials) are in ink. In an interview with the DON and the programs part-time Registered Nurse, both stated they had never altered a MAR to conceal an error in documentation. The DON was asked for the original MAR for the month of July and she indicated the one she provided was the original. A review of the tenant's documented blood sugars for the months of May, June and July do not indicate any true fluctuations in blood sugars.

- Regulatory Insufficiency: The program prevented or interfered with or attempted to impede in any way any duly authorized representative of the Department of Inspections and Appeals in the lawful enforcement of this chapter or of the rules adopted pursuant to this chapter As used in this subsection, "lawful enforcement" includes but is not limited to· Examining any relevant records of an assisted living program and preserving evidence of any violation of this chapter or of the rules adopted pursuant to this chapter (231C.14(3)(b and c))

Complaint Allegation: Complaint # 19359-C and 19544-C allege if the medication administration sheets were checked there would be medication errors found. The MARs are not initialed that medications are administered as ordered.

- Monitoring Observation: Tenant #1's MAR's for the months of May, July and August 2008 indicate the tenant will perform his/her own blood sugar test in the morning and staff is to document the results daily. There were at least four instances during this period which indicate staff did not document the blood sugar reading. MARs for the months of June, July and August 2008, indicated the tenant is to get Cetaphil Cream to the body twice daily for dry skin. There were at least 35 instances in which the tenant either did not get the medication or that it was not documented as being given.

Incident Allegation #19778-I: The program reported an incident on 09-09-08 that a tenant had 26 doses of Oxybutrin ER (Ditropan) missing on 09-05-08. The medication was kept in the locked medication cart. The program searched without success for the missing medication.

- Monitoring Observation: Review of program investigative notes revealed the program had not found the missing medications. Interviews with 6 staff persons who had worked in the program memory unit from the second shift 09-04-08 through the shift the medication was discovered as missing on 09-05-08 revealed none of the staff were able to account for the missing medications. The investigation did not develop a suspect related to possible theft of the missing medications. An interview with the program Registered Nurse revealed no resolution to the investigation of the missing medication.

- 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).

Complaint Allegation: Complaint # 19544-C alleges medication errors are not reported to residents, family or doctors.

- Monitoring Observation: Tenant #2, a 91 year old, was admitted on 2-16-08 with diagnoses of: Depression, HTN and Hard of Hearing. A Global Deterioration Scale was completed on 8-1-08, staging the tenant at a four, indicating moderate cognitive decline. The tenant resides in the Dementia Unit. Health Profile Notes dated 5-22-08, indicate the tenant received the following medications in error in the morning: Calcium D 500mg one tab, Diltiazem 240mg one tab, Namenda 10mg one tab, Detrol LA 4mg one tab, Digoxin 0 125mg one tab and Senokot one tab and the physician and family were notified. In an interview with the DON, she stated when serious medication errors occur she calls the physician and the tenants Durable Power of Attorney or Power of Attorney of record, and medication error reports are completed.

- Regulatory Insufficiency: None noted.

Complaint Allegation: Complaint # 19544-C alleges medication errors are not documented and tracked by the nurse.

- Monitoring Observation: In an interview with the DON and the part time RN, they stated medication error reports are completed. Staff are spoken to and re-educated on medication administration policy and practices. A review of seven staff files indicated the program did complete a record of corrective action for medication error documentation.

- Regulatory Insufficiency: None noted.

Complaint Allegation: Complaint # 19544-C alleges medications that are missed are left in bubble packs.

- Monitoring Observation: Tenant #3, an 80 year old, was admitted on 6-11-07 with diagnoses of: Dementia, HTN, Diabetes and Stroke. A GDS was completed on 1-17-07 scoring the tenant a three, which indicates mild cognitive decline. The tenant resides in the dementia unit. September's bubble pack was checked and it was discovered the tenant's Namenda 10mg remained in the pack; however, it had been signed as given on the MAR's. A review of 238 bubble packs revealed this to be the only medication remaining for the month of September 2008.

- Regulatory Insufficiency: None noted.

Dated this 18th day of November, 2008.