IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

May 12, 2009

Complaint #22385- I
#22386-M

Shelley Wicks, Administrator
Leland Smith Assisted Living
309 Ovesen Drive
Wilton, IA 52778-9605

RE: Incident Investigation Report, Leland Smith Assisted Living, Wilton, IA

Dear Ms. Wicks:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Incident Investigation Report dated March 17, 18 & 19, 2009. 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 Insufficiencies. 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 Incident & Complaint Investigation Report

Assisted Living Program:

Incident Intake #: 22385-I
22386-M

Shelley Wicks, Administrator
Leland Smith Assisted Living
309 Ovesen Drive
Wilton, IA 52778-9605

Date of Incident Investigation:

March 17, 18 & 19, 2009

Monitor(s):

Hal Chase, RN BSN MPH
Stephanie Cummins, 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 an Incident 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:

An on-site visit was conducted at Leland Smith Assisted Living on March 17, 18 and 19, 2009. 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:	18
Current number of tenants with cognitive disorder:	3
Total Population:	21

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 have been no substantiated complaints this certification period.

Incident Investigation – The 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)]

Incident Allegation #22385-I: It was reported that two tenants had falls with injuries.

Monitoring Observation: Tenant #1, an 86 year old, was admitted on 7-6-06 and diagnoses include: Neuropathy, Aortic Valve Replacement, Osteoarthritis, Hypertension (HTN) and Left Breast Cancer. According to an Incident/Accident Report dated 11-2-08, the tenant reported he/she went to turn sideways on the couch and slid off the cushion and landed on his/her knees. According to the report, the tenant had no injuries noted at that time and denied pain. Nurse's Notes dated 11-16-08 at 4:30 a.m., indicate the tenant complained of right knee pain and stated when he/she stood up he/she heard a crack. The notes stated, "it hurts x100 if I put wt on it" and indicated the tenant did not have pain when off the knee. Notes dated 11-16-08 at 8:15 a.m., indicated the tenant complained of right knee pain and declined to go to the hospital. Notes dated 11-28-08 at 7:33 a.m., indicated the tenant complained of right knee pain and the tenant's family was taking him/her to the doctor. According to hospital after care instructions dated 11-28-08, the tenant was diagnosed with a right knee sprain and was to apply an ace wrap when up, continue use of the walker and bear weight as tolerated. Evaluations were not completed, as needed.

Tenant #2, a 90 year old, was admitted on 6-1-08 with diagnoses of: Atrial Fibrillation, HTN, Hypothyroidism, Osteoporosis, Decreased T4, Hyperparthyroidism, History of Hysterectomy and History of Cholecystectomy. An incident report dated 9-26-08 indicated the tenant had difficulty ambulating and called for assistance with three staff assisting the tenant back to his/her apartment. On 9-27-08 staff noted a slight blue discoloration of the right ankle, no edema was noted; however, the tenant refused to come to meals. Nurse's notes of 9-27-08 through 10-5-08 indicated the tenant had difficulty ambulating, requested standby assistance with ambulation and would elevate his/her ankle. On 10-5-08 it was noted the tenant's right ankle was reddened, swollen, bruised and the tenant was complaining of stiffness. On 10-10-08 the tenant was seen by a physician and was diagnosed with a distal fibula break of the right ankle. A splint was applied with orders to return for a follow-up visit on 10-24-08. Nurse's notes of 11-13-08 indicated a clear fluid was weeping from the left lower leg (LLL) and there was redness. On 11-14-08 Telfa, with Kling wrap, was applied to the left lower leg and edema was noted with redness above a small opened area on the front of the leg. The program did not complete a functional, cognitive and health evaluation to determine if there were any modifications to services needed.

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

Monitoring Observation: Tenant #4, a 93 year old, was admitted on 8-29-08, with diagnoses of: Dementia, Anxiety, Depression, Gastroesophageal Reflux Disease (GERD), Hypothyroidism, Anemia and Osteoporosis. Nurse's notes of 1-7-09 through 1-31-09 indicated at least 10 incidents including: being incontinent of bowel and bladder, in "terrible" pain, yelling and crying because his/her legs were hurting, having a bloody nose, a report from his/her spouse the tenant could not stand and was crying and yelling,

needing assistance with ambulation and staff finding the tenant on the floor on at least two separate occasions. Nurse's notes of 1-27-09 indicated staff found the tenant on the floor with a re-opened skin tear of the right elbow. Each incident was recorded by a Licensed Practical Nurse (LPN) but the tenant was not always assessed to determine the tenant's current status. The program did not complete functional, cognitive and health evaluations to determine any modifications to services needed.

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

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

Incident Allegation #22385-I: It was reported two tenants had falls with injuries.

Monitoring Observation: Tenant #1 reported he/she went to turn sideways on the couch and slid off the cushion and landed on his/her knees. According to the report, the tenant had no injuries noted at that time and denied pain. Nurse's Notes dated 11-16-08 at 4:30 a.m., indicate the tenant complained of right knee pain and stated when he/she stood up he/she heard a crack. The notes stated, "it hurts x100 if I put wt on it" and indicated the tenant did not have pain when off the knee. Notes dated 11-16-08 at 8:15 a.m., indicated the tenant complained of right knee pain and declined to go to the hospital. Notes dated 11-28-08 at 7:33 a.m., indicated the tenant complained of right knee pain and the tenant's family was taking him/her to the doctor. According to hospital after care instructions dated 11-28-08, the tenant was diagnosed with a right knee sprain and was to apply an ace wrap when up, continue use of the walker and bear weight as tolerated. The service plan was not updated, as needed.

Tenant #2's file revealed an incident report dated 9-26-08 which indicated the tenant had difficulty ambulating and called for assistance and three staff assisted the tenant back to his/her apartment. On 9-27-08 staff noted a slight blue discoloration of the right ankle with no edema but the tenant refused to come to meals. Nurse's notes of 9-27-08 through 10-5-08 indicated the tenant had difficulty ambulating, requested standby assistance with ambulation and would elevate his/her ankle. On 10-5-08 it was noted the tenant's right ankle was reddened, swollen and bruised and the tenant was complaining of stiffness. On 10-10-08 the tenant was seen by a physician and was diagnosed with a distal fibula break of the right ankle. A splint was applied with orders to return for a follow-up visit on 10-24-08. Nurse's notes of 11-13-08 indicated a clear fluid was weeping from the left lower leg (LLL) and there was redness. On 11-14-08 Telfa, with Kling wrap, was applied to the left lower leg and edema was noted with redness above a small opened area on the front of the leg. The program did not update the tenant's service plan when changes were needed and did not include identified needs and requests for assistance.

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

Monitoring Observation: Tenant #4's service plan of 11-25-08 indicated the tenant was continent of bowel and bladder, was independent with toileting and did not list interventions related to chronic pain of legs or pain management. Nurse's notes of 1-7-

09 through 1-31-09 indicated at least 10 incidents including; being incontinent of bowel and bladder, being in "terrible" pain, yelling and crying because his/her legs were hurting, having a bloody nose, a report from his/her spouse that the tenant could not stand and was crying and yelling, the tenant was needing assistance with ambulation and staff finding the tenant on the floor on at least two separate occasions. Nurse's notes of 1-27-09 indicated staff found the tenant on the floor with a re-opened skin tear of the right elbow. The program did not update the tenant's service plan when changes were needed and did not include identified needs and requests for assistance.

- Regulatory Insufficiency: The program did not update the service plan 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, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. (25.28(3))

- Regulatory Insufficiency: The program did not individualize the service plan and did not indicate, at a minimum, the tenant's identified needs and the tenant's requests for assistance and expected outcomes. (25.28(4)a)

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]

Incident Allegation #22385-I: It was reported Tenant #3 & #5 had missing medications.

Monitoring Observation: Tenant #5 passed away on 12-21-2006.

Tenant #3, an 85 year old, was admitted on 7-2-08 and diagnoses include: Atrial Fibrillation, Coronary Artery Disease (CAD), Macular Degeneration, Gout and Stasisdermatitis. The tenant scored 30/30 on the Mini Mental Status Exam (MMSE). According to physician orders dated 6-27-08, the doctor ordered Hydrocodone 5 mg/APAP 500 mg, one tablet every four to six hours, as needed (PRN), for pain. On 7-8-08 the physician ordered that all PRN medications could be at the tenant's bedside, including the Hydrocodone. On 8-27-08 the physician ordered Hydrocodone 5/500, one tablet every a.m. and Hydrocodone 5/500, one every day, PRN. On 9-10-08 a physician's order stated the tenant may get one Vicodin in the a.m. and the rest are to be kept at the nurse's station, locked up, to take PRN.

The tenant was interviewed and stated previously he/she kept the Hydrocodone in the medicine cabinet in his/her bathroom and was independent with the medication. The tenant stated he/she would refill the Hydrocodone and would get 60 tablets which would last 30 days. According to the tenant, in very late August, 2008 or early September, 2008, the tenant noticed the pill bottle was down and it was one week after it was filled. The tenant stated he/she counted the pills and had 18 left at that time. The tenant stated he/she could not have taken more than 10 pills in that week. The tenant stated that after this was discovered, the doctor ordered one Hydrocodone in the medication planner every a.m. and if the tenant requested more during the day he/she could ask for the medication that was to be kept in the nurse's office.

According to a statement dated 9-8-08 from the pharmacist, he was contacted by the tenant and the tenant reported there were too few Hydrocodone in the vial. The pharmacist indicated there were 60 tablets refilled on 8-27-08 and there were 16 in the vial returned to the pharmacy. The pharmacist contacted the tenant and the tenant stated that he/she was only taking the medication twice daily and did not abuse it. The pharmacist contacted the tenant's physician and the doctor said diversion is happening somewhere, whether the tenant was taking more than prescribed or if someone is stealing them.

Complaint Allegation #22386-M: It is alleged the program RN destroyed Tenant #4's Hydrocodone but the Administrator found a bottle containing 41 tablets of Hydrocodone belonging to the tenant.

Monitoring Observation: Tenant #4's narcotic count sheet with a beginning date of 1-13-09 indicated there were 75 tablets of Hydrocodone/APAP, 2.5mg/500mg tablets, with the last Hydrocodone given, on 1-27-09. The narcotic count sheet dated 1-26-09 indicated a local pharmacy delivered 150 Hydrocodone/APAP, 2.5mg/500mg tablets, to the program on the same day. An entry of 1-28-09 indicated 24 Hydrocodone/APAP tablets were placed in a medication "med minder," leaving 126 Hydrocodone tablets. An entry of 2-3-09 indicated Staff #2, registered nurse (RN) and Staff #1, LPN, "wasted all Hydrocodone down the toilet." The program reported to the Department on 3-6-09 that 41 Hydrocodone/APAP, 2.5mg/500mg tablets, were found in Tenant #4's initial prescription bottle dated 1-13-09. The pharmacist who initially filled the Hydrocodone confirmed tablets in the prescription bottle were Hydrocodone 2.5mg/500mg.

- Regulatory Insufficiency: The program did not consistently provide the administration of medications 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 medication 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 (a), 655-6.2 (5) (e) (152)

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]

Incident Allegation: It was reported two tenants had falls with injuries.

Monitoring Observation: Tenant #1 reported he/she went to turn sideways on the couch and slid off the cushion and landed on his/her knees, according to an Incident/Accident Report dated 11-2-08. According to the report, the tenant had no injuries noted at that time and denied pain. Nurse's Notes dated 11-16-08 at 4:30 a.m., indicate the tenant complained of right knee pain and stated when he/she stood up he/she heard a crack. The notes indicated the tenant did not have pain when off the knee and stated "it hurts x100 if I put wt on it." Notes dated 11-16-08 at 8:15 a.m., indicated the tenant complained of right knee pain and declined to go to the hospital. Notes dated 11-28-08 at 7:33 a.m., indicated the tenant complained of right knee pain and the tenant's family was taking him/her to the doctor. According to hospital after care instructions dated 11-28-08, the

tenant was diagnosed with a right knee sprain and was to apply an ace wrap when up, continue use of the walker and bear weight as tolerated. Nurse review was completed on 11-14-08, post hospitalization; however, nurse review was not completed, as needed.

Tenant #2's file revealed an incident report of 9-26-08 which indicated the tenant had difficulty ambulating and called for assistance and three staff assisted the tenant back to his/her apartment. On 9-27-08 staff noted a slight blue discoloration of the right ankle with no edema but the tenant refused to come to meals. Nurse's notes of 9-27-08 through 10-5-08 indicated the tenant had difficulty ambulating, requested standby assistance with ambulation and would elevate his/her ankle. On 10-5-08 it was noted the tenant's right ankle was reddened, swollen and bruised and the tenant was complaining of stiffness. On 10-10-08 the tenant was seen by a physician and was diagnosed with a distal fibula break of the right ankle. A splint was applied with orders to return for a follow-up visit on 10-24-08. Nurse's notes of 11-13-08 indicated a clear fluid was weeping from the left lower leg (LLL) and there was redness. On 11-14-08 Telfa, with Kling wrap, was applied to the left lower leg and edema was noted with redness above a small opened area on the front of the leg. The program did not assess and document the health status when there were changes in health status.

Tenant #4's nurse's notes dated 1-7-09 through 1-31-09 indicated at least 10 incidents including; being incontinent of bowel and bladder, being in "terrible" pain, yelling and crying because his/her legs were hurting, having a bloody nose, a report from his/her spouse that the tenant could not stand and was crying and yelling, needing assistance with ambulation and staff finding the tenant on the floor on at least two separate occasions. Nurse's notes of 1-27-09 indicated staff found the tenant on the floor with a re-opened skin tear of the right elbow. The program did not consistently assess and document health status when there were changes in the tenant's health status.

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

E. 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]

Incident Allegation #22385-I: It was reported staff were verbally abusive towards tenants.

Monitoring Observation: Eight tenants were interviewed. A tenant reported he/she had been treated well except from Staff #1. The tenant reported Staff #1 was not appropriate in September, 2008. Staff #1 stated she could not lift anyone over 200 pounds as she had a bad back, no insurance and had financial hardships.

A tenant asked Staff #3 to wipe between his/her toes as the tenant's toes were crippled. According to the tenant, Staff #3 told the tenant he/she was not the only person in the building, there was too much to do and the tenant was selfish. The tenant reported this happened months ago and occurred one time.

A tenant reported Staff #1 told him/her he/she had to come down to the table for meals or he/she would have to go to a nursing home and pay more.

A tenant reported when he/she was admitted Staff #1 was abrupt one time and since then, he/she had gotten to know the staff and did not have issues.

Four other tenants were interviewed and did not report any concerns with staff.

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

Incident Allegation #22385-I: It was reported Staff# 1 refused to come in and administer as needed medication, as requested by the tenant. It was reported the tenant cried and screamed until another staff came in and administered the medication.

Monitoring Observation: Tenant #4's physician order dated 1-13-09 indicated administration of Hydrocodone/APAP 2.5mg/500mg, one tablet to be given four times daily and one tablet, as needed, in the middle of the night. Staff #4, a personal care attendant (PCA), not trained to administer medications, indicated she had called Staff #1, a LPN, around 4:00 a.m. on 1-27-09, reporting Tenant #4 was asking for Lorazepam or Hydrocodone as the tenant was in pain and could not sleep. Staff #1, LPN, indicated she would not come in and give the tenant Hydrocodone as it would "screw up" the tenant's morning medications, including the tenant's scheduled Hydrocodone. Staff #4 told the tenant he/she would have to wait until Staff #5, LPN, came in at 6:00 a.m. The tenant began to cry and yell. Staff #5, LPN, arrived at the program at 6:00 a.m., as scheduled, and gave a PRN dose of Lorazepam and Hydrocodone. Staff #5 confirmed Staff #4's statement of Staff #1's refusal to come to the program despite being on-call. Staff #1 stated she did not come in when called at 2:00 a.m. because the tenant had Hydrocodone at 10:30p.m. on 1-26-09. A Medication Administration Record (MAR) dated 1-26-09 indicated the tenant received a scheduled 9:00 p.m. dose of Hydrocodone with no other dose of Hydrocodone given. The narcotic count sheet for PRN Hydrocodone beginning 1-26-09 through 1-27-09 indicated no PRN Hydrocodone was given.

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

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

Incident Allegation #22385-I: It was reported Staff# 1 refused to come in and administer, as needed, medication as requested by the tenant. It was reported the tenant cried and screamed until another staff came in and administered the medication.

Monitoring Observation: Staff #4, a PCA, not trained to administer medications, indicated she had called Staff #1, a LPN, around 4:00 a.m. on 1-27-09, reporting that Tenant #4 was asking for Lorazepam or Hydrocodone as the tenant was in pain and could not sleep. Staff #1, a LPN, indicated she would not come in and give the tenant Hydrocodone as it would "screw up" the tenant's morning medications, including the tenant's scheduled Hydrocodone. Staff #4 told the tenant he/she would have to wait until Staff #5, a LPN, came in at 6:00 a.m. The tenant began to cry and yell. Staff #5, a LPN,

arrived at the program at 6:00 a.m., as scheduled, and gave a PRN dose of Lorazepam and Hydrocodone. Staff #5 confirmed Staff #4's statement of Staff #1's refusal to come to the program despite being on-call. Staff #1 stated she did not come in when called at 2:00 a.m. because the tenant had Hydrocodone at 10:30p.m. on 1-26-09. The MAR dated 1-26-09 indicated the tenant received a scheduled 9:00 p.m. dose of Hydrocodone with no other dose of Hydrocodone given. The narcotic count sheet for PRN Hydrocodone beginning 1-26-09 through 1-27-09 indicated no PRN Hydrocodone was given.

- Regulatory Insufficiency: The program did not consistently provide provisions to ensure, to the greatest extent possible, health, safety and well-being and appropriate treatment of tenants (231C.3(a))

Dated this 12th day of May, 2009