IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

October 30, 2009

Complaint #24938-C
#24598-C

Kent Walton, Administrator
Promise House
1320 Litchfield Drive
Hiawatha, IA 52233-2343

RE: Complaint Investigation Report, Promise House, Hiawatha, IA

Dear Mr. Walton:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated August 25, 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 Insufficiency If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft

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:

Kent Walton, Administrator
Promise House
1320 Litchfield Drive
Hiawatha, IA 52233-2343

Complaint Intake #: 24938-C
24598-C

Date of Investigation:

August 25, 2009

Monitor(s):

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 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 Promise House on August 25, 2009. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition 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):	17
Current number of tenants without cognitive disorder:	0
Total Population:	17

***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 this certification period in the areas of: Evaluation of Tenants, Service Plans, Nurse Review, Staffing and Structural Requirements.

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

A. Criteria for exclusion of tenants - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

Complaint Allegation 24598-C: It was alleged a tenant made sexual comments towards another tenant. It was alleged tenants wandered into other tenants' apartments.

Monitoring Observation: Three staff and the nurse were interviewed. Staff #1, #2 and #3 and the nurse did not identify any tenants that were sexually inappropriate to other tenants or to staff, they indicated there were no outcomes related to tenants wandering and there were no tenants that exceeded the appropriate level of care. A review of three tenant files indicated none of the tenants exceeded the appropriate level of care.

- Regulatory Insufficiency: None noted.

B. 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 #24938-C & 24598-C: It was alleged a tenant was overmedicated.

Monitoring Observation: Below is a table that represents medications that were not documented as given or were not given. The table also included medications not administered per the physicians order.

Tenant #1	Docusate Sodium 100 mg, take two capsules by mouth once daily.	On 7-31-09, medication was not documented as administered or was not administered.
Tenant #1	Zolpidem, 5 mg tablet, one tablet by mouth at bedtime, as needed.	On 7-21-09 and 7-25-09, medication was not documented as administered on the front of the Medication Administration Record (MAR); however, it was documented on the back of the MAR as administered.
Tenant #1	Lorazepam, 1 mg tablet, by mouth every 8 hours, as needed.	On 7-26-09, medication was administered at 8:30 a.m. and 1:30 p.m. which was less than 8 hours between doses.
Tenant #1	Lorazepam, 1 mg tablet, by mouth every 8 hours, as needed.	On 7-26-09 at 8:30 a.m. and 1:30 p.m. medication was administered;

		however, only one dose of medication was documented on the front of the MARbut both doses were documented on the back of the MAR.
Tenant #1	Lorazepam, 1 mg tablet, by mouth every 8 hours, as needed.	On 7-30-09 medication administration was documented on the front of the MAR; however, was not documented on the back of the MAR.
Tenant #1	Hydrocodone/APAP, 7.5/500 tablet, take one tablet by mouth every four hours, as needed.	On 7-19-09 two doses of medication were signed out on the front of the MAR; however, only one dose was signed out on the back of the MAR.
Tenant #1	Hydrocodone/APAP, 7.5/500 tablet, take one tablet by mouth every four hours, as needed.	On 7-20-09 three doses of medication were signed out on the front of the MAR; however, only two doses were signed out on the back of the MAR.
Tenant #1	Hydrocodone/APAP, 7.5/500 tablet, take one tablet by mouth every four hours, as needed.	On 7-26-09 the medication was documented as administered on the front of the MAR; however, was not documented on the back of the MAR.
Tenant #1	Trazodone, 50 mg tablet, one tablet by mouth at bedtime.	On 8-3-09 the medication was not administered or was not documented as administered.
Tenant #1	Senna-Docusate Sodium, 8.6, two tablets by mouth every night at bedtime.	On 8-3-09 the medication was not administered or was not documented as administered.
Tenant #1	Zyprexa, 5 mg tablet, one by mouth at bedtime.	On 8-3-09 the medication was not administered or was not documented as administered.
Tenant #1	Gabapentin, 100 mg, one by mouth three times daily.	On 8-3-09 the MAR was initialed and circled; however, no explanation was given on the back of the MAR.
Tenant #1	Zolpidem, 5 mg tablet, take one tablet by mouth at bedtime, as needed.	On 8-2-09 medication was documented as given at 4:00 a.m. and 9:00 p.m.;

		however, the order is one tablet at bedtime, as needed.
Tenant #1	Lorazepam ,1 mg tablet, by mouth every 8 hours, as needed.	On 8-3-09 medication was documented as administered at 9:00 a.m. and 3:30 p.m. which was less than eight hours between doses.
Tenant #2	Lorazepam, .5 mg tablet, take one tablet by mouth every 4 hours, as needed.	On 7-5-09, 7-9-09, 7-12-09, 7-16-09, 7-26-09 and 7-29-09 the medication was documented as administered on the front of the MAR; however, it was not documented on the back of the MAR.

- 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)

C. 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 #24938-C & 24598-C: It was alleged a tenant did not receive appropriate care.

Monitoring Observation: Three staff and the nurse were interviewed. Staff #1, #2, #3 and the nurse stated the tenants were receiving cares. Three family member/legal representative interviews were held. They did not have any concerns regarding care needs.

- Regulatory Insufficiency: None noted.

Complaint Allegation #24938-C & 24598-C: It was alleged a staff was rude to visitors and may act in that way towards tenants when others were not around.

Monitoring Observation: Three staff and the nurse were interviewed. Staff #1, #2, #3 and the nurse stated staff had not been rude, impatient, inappropriate or aggressive with tenants. Three family member/legal representative interviews were held and there were no concerns regarding staffing. One family member stated staff were very kind, well trained and treated tenants with respect. The family stated he/she learned from staff.

Another family stated staff treated tenants with respect and the staff were very nice. The three family members/legal representatives stated they were welcome as visitors.

- 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 #24938: It was alleged a tenant was held against his/her wishes, expressed a desire to go home and did not require a dementia level of care.

Monitoring Observation: The Administrator was interviewed and indicated tenants were not held at the program against their will or wishes.

The nurse was interviewed and stated tenants were not held at the program against their wishes and tenant rights were upheld.

Tenant #1, a 75 year old, was admitted on 7-16-09 and diagnoses include: Brain Tumor Resection (6-29-09), Hypertension (HTN), Non-small cell Lung Cancer with Chemotherapy and Radiation, Peripheral Vascular Disease (PVD), Abdominal Aortic Aneurysm (AAA), Chronic Obstructive Pulmonary Disease (COPD) and Gastroesophageal Reflux Disease (GERD). The tenant was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive impairment. The nurse and the tenant's legal representative signed the occupancy agreement on 7-16-09. A statement dated 8-3-09 stated the tenant did not want the two individuals listed on the Durable Power of Attorney document to be his/her Power of Attorney.

Tenant #1's file was reviewed and according to the Physician Order Sheets, the tenant was to be admitted to an assisted living level of care on 7-16-09. On 7-16-09, the tenant's legal representative signed the lease agreement. Evaluations and the service plan were completed appropriately.

According to a progress note from the hospital dated 7-16-09, the tenant had been accepted to the program and the note stated that would be an "ideal facility" for the tenant because he/she would have his/her own living space and can go onto the grounds but is still in a locked unit for those with cognitive impairments. The note stated the tenant had a neuropsychology evaluation and the tenant was not capable of managing his/her own affairs and needed full-time supervision due to an impaired cognitive state and poor insight into deficits.

According to Neuropsychological Evaluation dated 7-15-09, the tenant's decision-making capacity had been severely compromised. The tenant did not have the cognitive capacity to independently make knowledgeable legal, financial, and medical decisions. The incapacity would include not being able to determine a place of residence and not being able to enter into contracts of any nature.

A statement dated 8-3-09 stated the tenant did not want the two individuals listed on the Durable Power of Attorney document to be his/her Power of Attorney. According to a fax to the tenant's doctor, on 8-4-09, the tenant left with family and did not return to the program.

- Regulatory Insufficiency: None noted.

Complaint Allegation #24598-C: It was alleged a tenant was left outside unattended.

Monitoring Observation: Three staff and the nurse were interviewed. Staff #1, #2, #3 and the nurse stated tenants were not left unattended in the enclosed secure courtyard area and had family or staff supervision. They stated tenants could go on other areas of the grounds if staff or family accompanied them. There have not been any elopements in the past three months and there have not been any harm related incidents in the courtyard area or other areas on the grounds.

- Regulatory Insufficiency: None noted.

Complaint Allegation #24598-C: It was alleged a tenant did not have access to a phone, was not allowed to have private discussions, that staff monitored conversations and that a tenant was not allowed to have visitors.

Monitoring Observation: According to the program's lease agreement, phone and cable services were not included or provided by the program. Staff #1, #2, and #3 were interviewed and stated there were no restrictions on tenant telephone use and the program had portable phones that were available for tenant use. The Administrator and nurse stated there were no restrictions on tenant telephone use. The nurse stated Tenant #1's family member brought in a cell phone and staff would charge the phone at night, as needed, in the medication room but the tenant had the phone the majority of the time. Tenant #1 used the program's portable phone too, and the phone was available whenever needed. The nurse stated if Tenant #1 was sleeping and received calls, staff did not wake up the tenant to talk. The nurse stated in regard to telephones in tenant rooms, family provides and pays for the phone service.

Staff #1, #2 and #3 and the nurse stated tenant conversations either by phone or in person were not monitored and tenant rights were upheld. Three family members/legal representatives were interviewed. They did not have concerns regarding tenant rights. They stated they were welcomed as visitors and there were no restrictions regarding visitors.

The Administrator was interviewed and stated some of Tenant #1's family was disruptive and negatively affected some of the tenants. The family arrived on Wednesday night and over the weekend the Administrator received constant calls regarding these visitors. The Administrator stated the visitors were going in and out of the doors without entering the code, staff reported tenants were agitated and the family was arguing at the program. He contacted all parties involved with the tenant, told the visitors that they were disruptive and in the best interest of the tenant, they were not allowed to return until they worked out the issues. He stated the tenant's rights were upheld throughout the process and that tenants were not held at the program against their will or wishes.

The nurse was interviewed and stated tenants were not held at the program against their wishes and tenant rights were upheld.

Another tenant's family member was interviewed and stated the tenant's family was upsetting to his/her spouse as they were in disagreement and were fighting in the hallway. The family member stated staff shielded the tenant from the fighting.

Three family members/legal representatives were interviewed and stated they did not have concerns regarding tenant rights, they had piece of mind with the tenants at the program and they were welcome as visitors.

- Regulatory Insufficiency: None noted.

Complaint Allegation #24598-C: It was alleged a tenant did not have eyeglass and had poor fitting dentures which made it difficult to eat.

Monitoring Observation: The nurse was interviewed and stated tenants had appropriate eyeglasses and dentures. Tenant #1 had eyeglasses and there was a discussion with a family member and the doctor about new eyeglasses. Due to radiation and the brain tumor it was too soon to get new glasses due to changes. The nurse stated the tenant did not complain about difficulty eating.

- Regulatory Insufficiency: None noted.

Dated this 19th day of October, 2009.