IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

November 30, 2010

Mr. Ron Perry, Administrator
Fox Run Assisted Living
3121 MacIneery Drive
Council Bluffs, IA 51501

RE: Final Recertification & Complaint Investigation Report – Fox Run Assisted Living, Council Bluffs, IA

Dear Mr. Perry:

Enclosed is the **Final Recertification & Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has completed the review of your Plan of Correction (POC) in response to the Preliminary Recertification & Complaint Investigation Report. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0193** with effective dates of **July 1, 2010** through **June 30, 2012.**

If you have any questions in regard to this certification, please contact me at 515/281-5721.

Sincerely,

Tamara Halvorson

Tamara Halvorson
ASB Certification Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Mr. Ron Perry, Administrator
Fox Run Assisted Living
3121 Mac Ineery Drive
Council Bluffs, IA 51501

Complaint Intake #: 29598-C
30397-C

Date of Investigation:

October 25, 2010

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. IAC r. 481-67.10(5). 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 481 IAC chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Fox Run Assisted Living on October 25, 2010. 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 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS:	12
Current number of tenants without cognitive disorder:	50
Total Population:	62

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Tenant/Family Satisfaction Results – A community meeting was held with 37 tenants. Tenants liked living at the program and enjoyed the privacy of having their own apartments. Housekeeping services were adequate and the building and grounds were well maintained. Nursing services were available when needed, staff were well trained and responded within 10 minutes of being called. Tenants felt safe and made their own decisions. Tenants reported meals were served on time, food quality was good and a variety of fruits and vegetables were offered. Tenants stated a selection of activities were offered and the Activity Director was "fabulous." Tenants were generally satisfied with the program and would recommend it to friends and family.

Program History – The program received no regulatory insufficiencies during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

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

A. Evaluation of Tenant

Complaint Allegation #29598-C: It is alleged a tenant had a large bruise on his/her back and the program did not document how the tenant got the bruise. There has been additional bruises on the tenant's arm and it appeared the bruises were caused from a fall. The tenant had fallen again and a bump and skin tear was found on the elbow. The tenant went to the hospital and the tenant's elbow was dislocated. The tenant reported there were a couple of instances when he/she had fallen and needed assistance getting up from the toilet. Staff knew when the tenant fell but weren't documenting the falls.

- Monitoring Observation: Five tenant files were reviewed. Tenant #1passed away on 7-8-10. The tenant, a 93 year old, was admitted on 6-15-10 and had diagnoses of: Hypertension (HTN), Gastro Esophageal Reflux Disease (GERD), Dementia and Chronic Ischemic Heart Disease. Functional, cognitive and health evaluations were completed on 6-14-10. Prior to admission, the tenant had been hospitalized. Instructions for post hospital care dated 6-14-10 indicated the tenant needed assistance with ambulation.

  A functional evaluation of 6-14-10 revealed the tenant was independent with ambulation and transfer. An incident report of 6-26-10 revealed the tenant lost his/her balance and fell. The tenant's physician and family were notified. Resident care notes of 6-30-20 revealed the tenant was unable to lift his/her left arm. Physician communication note of 6-30-10 revealed the tenant complained of upper arm hurting and a bruise was seen. Resident care notes of 7-1-10 revealed the tenant was weak and unsteady. Notes of the same date but separate entry revealed the tenant went to a hospital emergency room for an arm contusion. Notes of the same date but separate entry revealed the tenant's left arm sustained a contusion. The tenant returned with orders to wear a sling and perform range of motion exercises three times daily. Notes of 7-7-10 revealed the tenant's physician indicated the tenant could see him if the tenant continued to complain of left upper arm pain. Notes of the same date but separate entry revealed the tenant had passed a blood clot and was oozing bloody drainage from the rectum. Notes of the same date but separate entry revealed the tenant was unresponsive to verbal stimuli and was transferred to a local hospital emergency room. The tenant was later admitted. The tenant passed away on 7-8-10.

  The program did not complete functional, cognitive and health evaluations with a significant change in health status related to the tenant's fall of 6-26-10 and subsequent complaints of left arm pain, skin tear and contusion to the left arm, the use of a sling, range of motion exercises three times daily and the inability to lift his/her left arm.

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

- Monitoring Observation: Tenant #2 passed away on 8-3-10. The tenant, an 80 year old, was admitted on 4-27-09 and had diagnoses of: GERD, History of an Umbilical Hernia, Chronic Renal Failure, History of Urinary Tract Infections, Hyperlipidemia, Hypothyroidism, Morbid Obesity, Soteoarthritis and Dementia. The tenant was staged at five on the Global Deterioration Scale which indicated moderately severe cognitive decline.

Functional, cognitive and health evaluations were completed on 4-27-10, 4-25-10 and 4-27-10 respectively. Physician communication of 4-29-10 through 7-19-10 revealed the tenant had fallen or was found on the floor on three separate occasions, had increased edema in both ankles, a hospitalization of 5-14-10 to 5-17-10 with an admitting diagnosis of Cellulitis and an order for physical therapy and home health services on 5-17-10. Physician communication of 6-7-10 revealed a 20 pound weight loss between May and June 2010 and a 19.5 pound weight loss between 6-7-10 and 6-16-10.

A physician's order of 7-13-10 revealed the tenant could go to a long term skilled nursing facility. Resident care notes of 7-20-10 revealed the tenant went to his/her primary physician for a history and physical at the request of local nursing facility, but the tenant remained at the program. Notes of the same date but separate entry revealed the tenant's physician order a hospice evaluation with a diagnosis of Failure to Thrive. Physician's communication of 7-20-10 revealed an order to evaluate for hospice care. On 7-20-10 a hospice evaluation was completed and the tenant was admitted to hospice. A hospice care plan was initiated on 7-21-10 and a hospice aide assignment was initiated on 7-22-10 to provide assistance with activities of daily living (ADLs).

The program did not complete functional, cognitive and health evaluations with a change in health status beginning 4-29-10 when the tenant fell and through the admission to hospice on 7-20-10.

Tenant #3, an 88 year old, was admitted on 3-18-08 and had diagnoses of: Atherosclerotic Heart Disease, Hypothyroidism, Congestive Heart Failure, Sleep Apnea and Bilateral Left Extremity Edema. The tenant was staged at four on the GDS which indicated moderate cognitive decline. Functional evaluation of 3-17-10 revealed the tenant was independent with ambulation. Cognitive and health evaluations were completed on 3-17-10.

Resident care notes of 9-12-10 revealed the tenant was taken to the hospital as the tenant was shaky. Resident care notes of 9-13-10 revealed the tenant was admitted to the hospital for Pneumonia. Notes of 9-16-10 revealed the tenant did not have Pneumonia but had a blood infection and Bronchitis. Notes of the same date but separate entry revealed the tenant returned to the program. Hospital discharge instructions included stand by assist with ambulation. Notes of 9-18-10 revealed the tenant was "very" confused and anxious last night. Notes of 9-24-10 revealed the tenant stated he/she had passed out, had fallen and hit his/her head on the corner of a wall and was complaining of right shoulder pain. The tenant was taken to a local hospital emergency room to be evaluated. Notes of the same date but separate entry revealed the tenant had a laceration above the right eye. Resident care notes of 9-26-10 indicated the tenant fell 9-25-10 in the dining room when he/she was trying to pick something up. The tenant sustained a skin tear on the left elbow. Physician communication of 9-27-10 revealed an order for physical therapy evaluation and treatment as the tenant had unsteady balance, need for strengthening and the use of his/her walker.

The program did not complete functional, cognitive and health evaluations with a significant change in the tenant's health status beginning 9-16-10 through 9-27-10 when the tenant was hospitalized, fell and sustained a head injury, had increased confusion and anxiety and an order for physical therapy related to an unsteady balance.

Tenant #5, an 85 year old, was admitted on 3-1-10 and had diagnoses of: Dementia, Incontinence, Depression, HTN and Sudden Death related to Heart Blockage. The tenant was staged at five on the GDS which indicated moderately severe cognitive decline. Functional, cognitive and health evaluations were completed on 9-23-10 following a hospitalization and admission to hospice.

Resident care notes of 9-24-10 revealed the tenant was very anxious, fearful, grasped staff's hand and stated "Don't leave me alone," when staff was in the tenant's apartment. Notes of 9-28-10 revealed the tenant lost his/her balance and fell when attempting to use the bedside commode. Notes of 10-2-10 through 10-10-10 revealed the tenant fell or was found on the floor on at least four times. Notes of 10-12-10 revealed the hospice RN was notified of the tenant's agitation and increased anxiety. Notes of 10-19-10 stated bed and chair alarms were used to alert staff and prevent the tenant from falling

The program did not complete functional, cognitive and health evaluations with a significant change in health status as evidenced by the tenant's increased anxiety, not wanting to be left alone and increased falls.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Service Plan

- Monitoring Observation: Five tenant files were reviewed.

Tenant #1's service plan of 3-17-10 revealed the tenant was independent with ambulation and transfer. An incident report of 6-26-10 revealed the tenant lost his/her balance and fell. The tenant's physician and family were notified. Resident care notes of 6-30-20 revealed the tenant was unable to lift his/her left arm. Physician communication note of 6-30-10 revealed the tenant complained of upper arm hurting and a bruise was seen. Resident care notes of 7-1-10 revealed the tenant was weak and unsteady. On 7-1-10 the tenant went to a hospital emergency room for an arm contusion. Notes of 7-7-10 revealed the tenant's physician indicated the tenant could see him/her if needed if the tenant continued to complain of left upper arm pain. Notes of the same date but separate entry revealed the tenant had passed a blood clot and was oozing bloody drainage from the rectum. Notes of the same date but

separate entry revealed the tenant was unresponsive to verbal stimuli and was transferred to a local hospital emergency room. The tenant was later admitted. The tenant passed away on 7-8-10.

The program did not update the tenant's service plan with a significant change as evidenced by a fall on 6-26-10 and subsequent complaints of left arm pain, inability to lift his/her left arm, a emergency room visit for an arm contusion and increased weakness and being unsteady.

Tenant #2's physician communication of 4-29-10 through 7-19-10 revealed the tenant had fallen or was found on the floor on three separate occasions and had increased edema in both ankles. The tenant was hospitalized 5-14-10 through 5-17-10 with an admitting diagnosis of Cellulitis and an order for physical therapy and home health services on 5-17-10. Physician communication of 6-7-10 revealed a 20 pound weight loss between May and June 2010 and a 19.5 pound weight loss between 6-7-10 and 6-16-10.

A physician's order of 7-13-10 revealed the tenant could go to a long term skilled nursing facility. Resident care notes of 7-20-10 revealed the tenant went to his/her primary physician for a history and physical at the request of local nursing facility, but the tenant remained at the program. Notes of the same date but separate entry revealed the tenant's physician order a hospice evaluation with a diagnosis of Failure to Thrive. Physician's communication of 7-20-10 revealed an order to evaluate for hospice care. On 7-20-10 a hospice evaluation was completed and the tenant was admitted to hospice. A hospice care plan was initiated on 7-21-10 and a hospice aide assignment was initiated on 7-22-10 to provide assistance with activities of daily living (ADLs).

The program did not update the tenant's service plan with a significant change as evidenced by increased falls, physical therapy, home health services, interventions related to a new diagnosis of Cellulitis and hospice services.

Tenant #3's service plan of 3-17-10 revealed the tenant was independent with ambulation and transfer. Resident care notes of 9-12-10 revealed the tenant was taken to the hospital as the tenant was shaky. Notes of 9-13-10 revealed the tenant was admitted to the hospital for Pneumonia. Notes of 9-16-10 revealed the tenant did not have Pneumonia but had a blood infection and Bronchitis. Notes of the same date but separate entry revealed the tenant returned to the program. Hospital discharge instructions included stand by assist with ambulation. Notes of 9-18-10 revealed the tenant was "very" confused and anxious last night. Notes of 9-24-10 revealed the tenant stated he/she had passed out, had fallen and hit his/her head on the corner of a wall and was complaining of right shoulder pain. The tenant was taken to a local hospital emergency room to be evaluated. Notes of the same date but separate entry revealed the tenant had a laceration above the right eye. Notes of 9-26-10 indicated the tenant had fallen last night, 9-25-10 in the dining room when he/she was trying to pick something up. The tenant sustained a skin tear on the left elbow. Physician communication of 9-27-10 revealed an order or physical therapy evaluation and treatment as the tenant had unsteady balance, need for strengthening and the use of his/her walker.

The program did not update the tenant's service plan with a significant change as revealed in changes in health status as evidenced by a hospitalization and need for standby assistance, increased falls with sustained head injury and physical therapy for unsteady balance.

Tenant #5, an 85 year old, was admitted on 3-1-10 and had diagnoses of: Dementia, Incontinence, Depression, HTN and Sudden Death related to Heart Blockage. The tenant was staged at five on the GDS which indicated moderately severe cognitive decline. Functional, cognitive and health evaluations were completed on 9-23-10. Resident care notes of 9-14-10 through 9-17-10 revealed the tenant hospitalized for a Mild Heart Attack. Resident care notes of 9-19-10 revealed the tenant was not feeling well and was transported to a local hospital emergency room for evaluation but returned later in the day. Notes of the same date but separate entry revealed the tenant was "very" anxious and indicated he/she did not want to be left alone and was very shaky. Notes of 9-20-10 revealed the tenant remained anxious and did not want to be left alone. Notes of 9-22-10 revealed the tenant was admitted to hospice with an admitting diagnosis of Sudden Death related to Heart Blockage.

The program completed a service plan update on 9-23-10 related to the admission of hospice care but did not establish interventions requested by hospice related to alternation in physical and pain discomfort management, including medication management, alteration in cardiovascular and alteration in behavioral and emotional discomfort. Resident care notes of 9-24-10 revealed the tenant was very anxious, fearful and grasps staff's hand and stated "Don't leave me alone," when staff were in the tenant's apartment. Notes of 9-28-10 revealed the tenant lost his/her balance and fell to the floor when attempting to use the bedside commode. Notes of 10-2-10 through 10-10-10 revealed the tenant had fallen or was found on the floor on at least four separate occasions. Notes of 10-12-10 revealed the hospice RN was notified of the tenant's agitation and increased anxiety. Notes of 10-19-10 revealed the program received bed and chair alarms to alert staff and prevent the tenant from falls.

The program did not update the service plan with a significant change in health status as evidenced by increased anxiety, increased falls and the implementation hospice interventions and the use of bed and chair alarms.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3)

C. Medications

Complaint Allegation 30397-C: It is alleged staff gave a tenant an overdose of Morphine. Five milliliters of Morphine was given when the correct dosage was 0.25ml. The tenant had a seizure and nothing was done about it.

- Monitoring Observation: Tenant #2's physician order of 7-22-10 revealed an order for Roxanol (liquid morphine) 20mg/ml 0.25ml by mouth or sublingual every two hours as needed. Medication error incident report of 7-28-10 indicated Staff #1, a licensed practical nurse (LPN) administered 5ml of Roxanol to the tenant and not 0.25ml as ordered. Staff # 1 notified the on-call registered nurse (RN), the tenant's

physician and the tenant's family. The program completed an investigation of the medication incident and determined Staff #1 misread the order for Roxanol and gave 5ml instead of 0.25ml. The tenant was evaluated by Staff #1 and no signs of distressed was documented. On 7-29-10 Staff LPN #1 was counseled and given additional training on medication administration. Resident service notes of 7-30-10 revealed the hospice RN was notified and indicated adverse effects would have been noted or seen earlier of there were any. The hospice RN indicated the tenant was experiencing severe pain and they would be initiating and increase of Roxanol for pain. The program RN requested the hospice RN to evaluate the tenant as the tenant appeared to be deteriorating as the tenant's pain was increasing.

- Regulatory Insufficiency: None noted.

D. Food Service

- Monitoring Observation: Five staff personnel files were reviewed and indicated three of the five staff served or prepared food for tenants. Staff #6 was hired 9-16-10, Staff #7 was hired 6-24-10 and Staff #8 was hired 7-27-10. Personnel files lacked documentation of an orientation on sanitation and safe food handling prior to handling food.

- Regulatory Insufficiency: Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have an annual in-service training on food protection. (IAC r. 481-69.28(5))

E. Staffing

- Monitoring Observation: Five staff personnel files were reviewed and indicated three of the five staff provided personal and health related cares to tenants. Staff #6, Staff #7, Staff #8 lacked documentation they had demonstrated their competency of performing ADLs to the program RN.

- Regulatory Insufficiency: The program shall have training and staffing plans on file and shall maintain documentation of training received by program staff. (IAC r. 481-67.9(4))

Dated this 19th day of November, 2010.