IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Complaint Intake #: 32040-C

January 11, 2011

Joni Fahrenkrog, Manager
Grand Haven Retirement Community
201 East Franklin Street
Eldridge, IA 52748

RE: Final Complaint Investigation Report, Grand Haven Retirement Community, Eldridge, Iowa

Dear Ms. Fahrenkrog:

Enclosed is the **Final 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 reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-5721.

Sincerely,

Tamara Halvorson

Tamara Halvorson
ASB Certification Coordinator
Adult Services Bureau

Enclosure

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

ADMINISTRATION
(515) 281-5457
FAX: (515) 242-6863

ADMINISTRATIVE HEARINGS
(515) 281-4843
FAX: (515) 281-4477

HEALTH FACILITIES
(515) 281-4115
FAX: (515) 242-5022

INVESTIGATIONS
(515) 281-5714
FAX: (515) 242-6507

Telephone Number for the Hearing Impaired: (515) 242-6515

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

Assisted Living Program: **Complaint Intake #: 32040-C**

Joni Fahrenkrog, Manager
Grand Haven Retirement Community
201 East Franklin Street
Eldridge, IA 52748

Date of Investigation:

December 8, 2010

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. 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 Grand Haven Retirement Community on December 8, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that does is not include a Dementia Specific unit, but may include have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	63
Current number of tenants with cognitive disorder:	2
Total Population of GPP:	65

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	9
Total Census of ALP:	74

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

Program History – There were no Regulatory Insufficiencies found 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. Criteria for Exclusion of Tenants

Complaint Allegation: It was alleged there was a tenant that was a two person lift and the tenant could not move independently.

- Monitoring Observation: Tenant #1, an 86 year old, was admitted on 4-28-10 with diagnoses of: History of Fall, Esophageal Reflux, History of Urinary Tract Infection (UTI) and Colostomy. The tenant's service plan indicated the tenant was an assist of one with transfers, used a wheelchair and had a history of falls. Staff used a gait belt for transfers and the tenant had physical therapy(PT)/ and occupational therapy (OT).

  The monitor observed the tenant transfer with one staff.

  The nurse stated the tenant was a one person transfer and could bear weight. The nurse did not identify any tenants that required a routine two person assist with transfers.

  Staff #1, #2, #3 and #4 did not identify any tenants that required a routine two person assist with transfers.

  Monitor observation, four staff interviews, an interview with the nurse and review of three tenant files indicated there were no tenants that exceeded the appropriate level of care.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged a tenant was totally dependent and often slept in the recliner in the dining room area.

- Monitoring Observation: Tenant #2, a 94 year old, was admitted on 8-4-07 with diagnoses of: Anxiety, Chronic Back Pain, Dementia, Arthritis and Sleep Apnea. The tenant was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The tenant resided in the dementia unit. The service plan indicated the tenant received staff assistance with activities of daily living (ADLs); however, the tenant also assisted with the cares. The service plan addressed the tenant slept up to 16 hours per day and enjoyed sitting in the chair in the lounge area with legs up on the ottoman. The tenant chilled easily and liked to be covered up with a blanket when sitting in the chair. The service plan indicated the tenant had a personal alarm.

  The monitor observed the tenant resting in the chair in the common area of the dementia unit covered up and with a personal alarm attached.

  The nurse stated there were no tenants that were totally dependent on staff for all cares. The nurse said the tenant participated with his/her cares. The nurse indicated at times, the tenant slept in the chair in the dining room area, per the tenant's choice. The tenant's family purchased the chair, according to the nurse. There were no

complaints from other tenants about the tenant sleeping in the chair. None of the tenant's cares were provided in the common areas.

Staff #1, #2, #3 and #4 stated there were no tenants that were totally dependent on staff for all cares. Staff #2, #3 and #4 stated the tenant participated with his/her cares. Staff #2, #3 and #4 stated at times the tenant slept in the chair in the dining room area per the tenant's choice. Staff stated there no complaints from other tenants and none of the tenant's cares were provided in the common areas.

Monitor observation, four staff interviews, an interview with the nurse and review of three tenant files indicated there were no tenants that exceeded the appropriate level of care.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint Allegation: It was alleged tenants received their medications three to four hours late.

- Monitoring Observation: A medication pass was observed and medications were administered appropriately and within the prescribed timeframe.

  The nurse reported medications were administered on time and were not give hours late.

  Staff #1, #2, #3 and #4 stated medications were administered on time and were not given hours late.

  Two tenants reported medications were administered on time.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: Medication Administration Records (MARs) for December 2010 were reviewed. The table below represents medications or treatments not documented as administered or completed.

Tenant #2	Isosorbide Mononitrate 60 mg ER tablet take one tablet by mouth daily	12-2-10 at 8:00 a.m.; initialed and circled; however, no explanation was provided
Tenant #2	MAPAP tablet 325 mg take two tablets by mouth daily	12-2-10 at 8:00 a.m.; initialed and circled; however, no explanation was provided
Tenant #2	Furosemide tablet 40 mg take one tablet by mouth daily	12-2-10 at 8:00 a.m.; initialed and circled; however, no explanation was provided
Tenant #2	Senna Plus tablet 8.6-50 mg take one tablet by mouth twice daily	12-2-10 at 8:00 a.m.; initialed and circled; however, no explanation was provided
Tenant #2	Vasolex Ointment apply twice daily to coccyx area	12-2-10 at 8:00 a.m.; initialed and circled; however, no explanation was provided
Tenant #2	Seroquel tablet 25 mg take one tablet twice daily	12-2-10 at 8:00 a.m.; initialed and circled; however, no explanation was provided
Tenant #5	Carbidopa-Levodopa tablet 25-100 mg take one & one-half tablets by mouth four times daily	12-3-10 at 9:00 p.m. not initialed
Tenant #6	Hearing aides to be locked in a drawer	12-5-10 at 7:00 a.m.; initialed and circled; however, no explanation on the back of the MAR

- Regulatory Insufficiency: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

C. Staffing

Complaint Allegation: It was alleged a tenant had a heating pad in bed and had burns on both feet. It was alleged the program would not treat the burns and staff were not allowed to chart on the burns.

- Monitoring Observation: Tenant #3, a 93 year old, was admitted on 11-1-10 and had a diagnosis of Dementia. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. The tenant resided in the dementia unit. According to notes dated 12-3-10, the tenant had a fluid filled blister on the back of the right heel that

was draining. The area was noted to be approximately three cm by three cm. The edge of the blister was open. The tenant's doctor and family member were notified. The nurse instructed staff to keep the tenant's heels off of the bed and to place a pillow above the ankles. The right great toe was noted to have less than one cm purple area. Staff were instructed to pull up covers over the tenant's feet to relieve pressure on the tenant's feet. On 12-5-10 staff reported to the on-call nurse that the tenant had two small open areas on the tenant's coccyx. The nurse assessed and observed the tenant two small open area less than one cm each at the top of the gluteal fold. The tenant's doctor was notified and orders were received. The doctor's orders included to clean heel wound with warm wash cloth, pat dry, and apply Xenaderm twice daily to affected area, discontinue when healed. Clean coccyx area with warm water, pat dry and apply Xenaderm to affected area, discontinue when healed. Keep heels off of bed surface, position pillow above heels, when the tenant was in bed to position to right hip for two hours then position to left hip, four times per shift. Position pillow behind the tenant's hip. Ensure twice a day between meals. These orders were reflected on the December 2010's MARs.

The nurse stated the tenant's family had brought in a heating device/blanket and staff notified the nurse of the device. The nurse had staff remove it immediately. The nurse stated there were no outcomes or burns related to the device. The tenant had a water blister that popped on its own and it was being treated at the time of the investigation. On 12-3-10 staff notified the nurse of the area and the nurse assessed. The tenant also had an area on the gluteal fold; however, neither the area on the gluteal fold nor on the heel were burns, according to the nurse. She stated she did not instruct staff not to chart on tenant issues.

Staff #1, #2, #3 and #4 did not identify any tenants had burns related to a heating pad or heating blanket. Staff #2, #3 and #4 said the tenant had a sore on his/her foot and it was being treated. Staff #2, #3 and #4 stated they were not instructed to not chart on the wound.

Review of the tenant's file indicated were was documentation of the tenant's wound.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged a tenant who could not stand fell and fractured his/her hip and died after the incident.

- Monitoring Observation: The program had previously reported Tenant #4 fell and fractured a hip. That incident was investigated on 11-29-10 and at that time no regulatory insufficiencies were given pertaining to that incident. The Manager indicated the tenant fell and was transferred to the hospital. On 11-30-10 the Manager was notified the tenant died on 11-29-10. The tenant did not return to the program after the fall.

- Regulatory Insufficiency: None noted.

Dated this 10th day of January 2011.