IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 32683-C

February 21, 2011

Ms. Lisa Loring, Administrator
Ruthven Community Care Center AL
2701 Mitchell Street
Ruthven, IA 51358

RE: Final Complaint Investigation Report – Ruthven Community Care Center AL, Ruthven, IA

Dear Ms. Loring:

Enclosed is the **Final Complaint Investigation Report** from the on-site monitoring visit of February 8, 2011, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #: 32683-C**

Lisa Loring, Administrator
Ruthven Community Care Center Assisted Living
2701 Mitchell Street
Ruthven, IA 51358

Date of Investigation:

February 8, 2011

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 Ruthven Community Care Center Assisted Living on February 8, 2011. 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:	17
Current number of tenants with cognitive disorder:	0
Total Population:	17

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.**

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. Evaluation of Tenant

Complaint Allegation: It was alleged a tenant had increased problems with bloody stools. The tenant complained of being weak and feeling dizzy. The tenant was hospitalized with a diagnosis of Gastro Intestinal Bleeding and was given a blood transfusion.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1, an 87 year old, was admitted on 9-16-10 and had diagnoses of: History of Falls, Diabetes Mellitus II (DM II), Hypertension (HTN), Renal Insufficiency, Hyperlipidemia, Atherosclerosis, Iron Deficiency Anemia, Hearing Loss, Cerebral Vascular Accident (CVA), Osteoarthrosis, History of Malignant Neoplasm Cecum, Prostate Cancer and Coronary Artery Disease. The tenant scored two on a cognitive ability assessment on 10-5-10, which indicated normal cognition. Service plan of 10-5-10 indicated the tenant needed assistance with some activities of daily living (ADLs), but was independent with medication administration, including accu-checks and insulin injections.

  Resident log notes of 10-5-10 revealed staff responded to a pendent alert and found the tenant on the floor. A nurse review was completed and noted multiple skin tears to the extremities and provided wound care. The physician was notified and an order was received for a physical therapy evaluation and treatment. Functional, cognitive and health evaluations were completed 10-5-10 and the tenant's service plan was updated the same day and indicated the tenant needed assistance with some ADLs and was independent with medication administration.

  Resident log notes of 10-7-10 revealed the tenant complained of not feeling well and had refused dinner. Resident log notes following the above entry, but without a date, revealed evening staff reported the tenant initially declined supper, but later came to the dining room and asked when breakfast was to be served. The tenant had also complained his/her right leg didn't work. A nurse checked the tenant's pulse and blood sugar, which was 147ml/dl and jello and juice were given. Notes of 10-8-10 revealed the tenant reported he/she "didn't feel right." The tenant was alert and oriented to name, time and place. The nurse assisted with dressing the tenant and noted the tenant transferred "poorly." The tenant was unable to move his/her right leg. The tenant wasn't sure if he/she had taken his/her morning medications and insulin. A review of the tenant's medications revealed morning medications had been removed from the card they had been placed in, but seven Lasix tablets were missing. The physician was notified and an appointment was made for the same day.

  Notes of 10-8-10 revealed the tenant was admitted to the hospital for a Heart Attack, Urinary Retention and Pneumonia. Notes of 10-10-10 revealed hospital staff reported to the program the tenant had passed away.

  Tenant #2, an 84 year old, was admitted on 7-13-10 and had diagnoses of: History of Prostate Cancer, Peptic Ulcer Disease, Anal Fistula, Parkinson's Disease, Degenerative Joint Disease (DJD), Gastro Esophageal Reflux Disease (GERD), HTN, Insomnia and Constipation and Pain. A cognitive evaluation was completed on 1-28-11 and staged the tenant at three on the Global Deterioration Scale (GDS,) which indicated normal or mild cognitive decline.. Functional and health evaluations were

completed on 12-5-10 and a service plan of 12-5-10 indicated the tenant needed assistance with ADLs. Resident log notes of 12-28-10 revealed the tenant's lower legs were red and "rashy." Staff #1 stated she assisted the tenant with bathing and had put lotion on the tenant's feet when she noticed the tenant's legs were warm and red and it appeared the tenant had a rash. She stated she reported the tenant's condition to the program nurse. The nurse evaluated the tenant's legs and noted "slight pitting edema." A physician's appointment was made for the following day. Notes of 12-29-10 revealed the tenant's physician had diagnosed the tenant with Contact Dermatitis. Medication administration records (MARs) for December, 2010 revealed antibiotic therapy for seven days, steroidal treatment for five days and topical ointment application until healed. Notes of 12-30-10 revealed a nurse completed a nurse review related to the diagnosis of Contact Dermatitis and subsequent medication treatment.

Resident log notes of 1-14-11 revealed the program nurse noted the tenant had intact blisters on the bottom of both feet and yellowish drainage on the tenant's socks. The tenant's palms had intact blisters and a faint rash on the tenant's back, arms and feet. The tenant's physician was notified and an appointment was made for 1-17-11. Notes of 1-16-11 revealed staff reported the tenant needed two staff to assist with standing and pivot transfer, had right side weakness and was leaning to the right side. A nurse evaluated the tenant and the tenant was transferred to a local hospital emergency room. The tenant was admitted the same day to hospital for observation. On 1-19-11, the tenant was transferred to the adjacent nursing facility. On 1-28-11 the tenant transferred back to the program. Functional, cognitive and health evaluations were completed and the tenant's service plan was updated.

Tenant #3, an 88 year old, was admitted on 10-31-10 and had diagnoses of: HTN, Coronary Atherosclerosis, Esophageal Reflux Disease, Transient Cerebral Ischemia, Disorder of Kidney and Uretur, Hyperlipidemia, Peripheral Vascular Disease, Malignant Neoplasm of the Kidney, Diverticulitis, History of Migraines and Restless Leg Syndrome. Functional, cognitive and health evaluations were completed on 12-7-10 and 1-29-11. The cognitive evaluation completed on 1-29-11 indicated normal cognition. A service plan of 12-7-10 revealed the tenant was independent with ADLs, including medication administration.

Staff communication notes of 1-20-11 revealed the tenant complained of constipation. Staff encouraged the use of a stool softener to soften the tenant's stool. Resident log notes of 1-21-11 revealed the tenant had one semi-loose bowel movement with blood present. The tenant's rectal area was examined and one small external non-bleeding hemorrhoid was seen. The tenant reported a history of hemorrhoids, but reported he/she "never had blood like this." The tenant requested his/her physician be notified. The tenant was examined by an Advanced Registered Nurse Practitioner (ARNP.) The ARNP noted external and internal hemorrhoids with bleeding and ordered hemorrhoid suppositories daily for seven days, with a follow-up appointment on 2-1-11.

Resident log notes of 1-22-11 revealed the tenant reported blood was in his/her stool, but staff could not assess, as the tenant had flushed the toilet. Staff encouraged the tenant to call staff when the tenant had another bowel movement. Notes of 1-23-11 revealed the tenant did not report blood present in his/her stool. Staff communication

records of 1-25-11 revealed the tenant reported blood in his/her stool. The tenant requested an appointment with his/her physician for the following day. On 1-26-11, the physician's nurse notified the program the tenant had been admitted to the hospital with an admitting diagnosis of Gastro Intestinal bleeding. Notes of 1-27-11 revealed hospital staff reported the tenant's hemoglobin was 8.4g/dl, received two units of red packed blood cells and the tenant's hemoglobin was not 11.4g/dl. Resident log notes of 1-29-11 revealed the tenant returned to the program. Functional, cognitive and health evaluations were completed and the tenant's service plan was updated on 1-29-11.

The ARNP, who had seen the tenant on 1-21-11, was contacted by a monitor and reported she hadn't notified the program of lab results, which indicated low hemoglobin. The ARNP reported she had ordered Hemorrhoid suppositories with a follow-up appointment on 2-1-11. No additional orders were given.

- Regulatory Insufficiency: None noted.

B. Transportation

Complaint Allegation: It is alleged the program initially told a tenant he/she had to drive to a physician's appointment as the program's vehicle was not available. It wasn't until family called the program, requesting the program transport the tenant to a physician's appointment, that the program transported the tenant to the physician's appointment.

- Monitoring Observation: Program records indicated the program had a policy to provided transportation to tenants. Staff were to assist with scheduling and transportation as outlined in tenants service plans. Tenant #1 and #3's service plans revealed each tenant was the tenant was to find his/her own transportation to appointments and if unable to do so, the program would provide the transportation. A review of program records indicated the program transported the Tenant #3 to his/her physician's appointment the afternoon of 1-26-11.

- Regulatory Insufficiency: None noted.

Dated this 21st day of February, 2011