IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 32188-C

February 23, 2011

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

RE: I. Final Complaint Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Mr. Perry:

I. Final Complaint Investigation Report – Fox Run Assisted Living, Council Bluffs, IA

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. The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Service Plan and Medications. **Fox Run Assisted Living** ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

II. Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Jim Berkley** and remit the civil penalty assessed by check or money order in the amount of six hundred fifty ($650) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on February 10, 2011, has been reviewed and will constitute the final POC related to the on-site visit of January 4, 2011.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Jim Berkley, at 515/281-4116.

Sincerely,

Jim Berkley

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #: 32188-C**

Ron Perry, Administrator
Fox Run Assisted Living
3121 Macineery Drive
Council Bluffs, IA 51501

Date of Investigation:

January 4, 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 Fox Run Assisted Living on January 4, 2011. 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:	13
Current number of tenants without cognitive disorder:	50
Total Population:	63

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

Program History – During the October 25, 2010 Recertification and Complaint Investigation on-site, the program received regulatory insufficiencies in the areas of: Evaluation of Tenant, Food Service, Staffing and Service Plan.

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

A. Evaluation of Tenant

Complaint Allegation #32188-C: It was alleged a tenant was hospitalized for Hypokalemia, Alcoholism and Malnutrition. During hospitalization, staff and family found between 15 to 20 bottles of vodka and wine in the tenant's apartment. It was alleged the tenant refused to eat meals and refused assistance with bathing.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1, a 73 year old, was admitted on 12-29-09 and had diagnoses of: Parkinson's Disease, Diabetes Mellitus (DM) II, Hypertension (HTN), Hyperlipidemia and Hyperuricemia, Renal Failure and a History of Alcoholism. The tenant was staged at two on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. Functional and health evaluations were completed on 11-29-10 and indicated the tenant needed assistance with activities of daily living (ADLs), including bathing assistance, housekeeping and medication administration.

  On 9-2-10, the program notified the physician the tenant was a heavy drinker and recently had six one liter bottles of alcohol and a two gallon jug of wine delivered to the tenant. Resident care notes of 9-7-10 indicated the tenant's physician advised the tenant to limit alcoholic drinks to one per twenty-four hours. A managed risk agreement was initiated on 9-17-10, and addressed the tenant's refusal to take medication administered by the program, the hoarding of medication and the use of over-the-counter (OTC) medications. Physician medication orders of September 2010 included: Allopurinol, 300mg. once daily, Chlorthalidone, 25mg. once daily, Dicyclomine, 10mg. PRN, Tylenol PM, 500mg. PRN, Potassium Chloride 20meq. once daily, Prednisone 5mg. once daily, Ranitidine, 150mg. twice/day, Ropinirole Hydrochloride 0.5 mg. once daily and Cinvastatin 20 mg. once daily. On 9-22-10, the tenant's apartment was "very" dirty and fecal matter was seen, on the carpet, bed and floors. Staff requested, but the tenant refused housekeeping services.

  Resident care notes of 11-19-10 indicated the tenant called emergency medical services (EMS) and reported he/she couldn't get up from the floor and couldn't get any help. When EMS arrived, the tenant was sitting on the couch, partially dressed and appeared "intoxicated." On 12-2-10, the program gave the tenant a 30-day notice to improve living conditions in order to continue living at the program. The notice indicated housekeeping services, delivery of three meals daily, and a shower weekly. Staff would leave medications with the tenant and if the tenant hadn't taken the medications after one hour, staff would destroy the medications.

  Resident care notes of 12-13-10 indicated the program notified the physician the tenant had skin sores, his/her hair was falling out and the tenant had loose stools. The tenant had not taken his/her medications and the tenant had numerous OTC medications in the apartment. On 12-13-10, the physician reported the tenant's potassium was critical (2.2 meq per L.)and ordered the tenant transported to the hospital emergency room for intravenous therapy. The tenant was transported by family to a hospital emergency room and admitted to the hospital. Resident care notes of 12-30-10 indicated the tenant did not return to the program.

The program nurse stated the tenant refused medications and staff assistance with bathing the beginning of August 2010. The tenant didn't follow the objectives identified in the managed risk agreement of 9-17-10, and the 30 day notice to improve living conditions on 12-2-10. Alcohol bottles were not seen in the tenant's apartment and the tenant did not have a previous diagnosis or history of alcohol abuse. Staff LPN #1 stated sometime in August 2010 the tenant refused bathing, housekeeping and laundry services and would often refuse staff entry into his/her apartment. She knew the tenant had ordered alcohol, but never saw the tenant intoxicated. She was told by staff, bottles of alcohol were found in the tenant's apartment after the tenant had been hospitalized on 12-13-10. Staff #2 stated, beginning in August 2010, the tenant refused medications, bathing assistance, and laundry and housekeeping services. She stated staff were not given any additional interventions when the tenant refused medications and cares.

The program did not complete functional, cognitive and health evaluations with a change in health status as evidenced by the tenant's refusal to take medications, alcohol consumption, critical potassium level and the refusal of ADLs.

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

Tenant #2, a 94 year old, was admitted on 7-17-04 and had diagnoses of: Dementia, Arthritis, Thoracic Compression Fracture, Diverticulitis and Hyperlipidemia. The tenant was staged at four on the GDS which indicated moderate cognitive decline. Functional, cognitive and health evaluations were last completed on 7-12-10.

Resident care notes of 11-3-10 indicated the tenant was admitted to physical therapy (PT) related to right hip pain and poor endurance. An initial PT assessment on 11-5-10 indicated the tenant had impairments in strength, balance, safety awareness and activity tolerance. The tenant had right hip pain, low blood pressure and was "extremely dehydrated." The tenant complained of fatigue, general malaise and shortness of breath with standing or ambulation. The tenant complained of right hip pain with weight-bearing activity and rated his/her pain at seven out of ten.

The PT discharge assessment of 11-18-10 indicated the tenant was a fall risk secondary to poor safety awareness and decision making. The tenant was able to ambulate distances but was not willing to ambulate to meals due to hip pain. On 11-26-10, the tenant was found on the floor and complained of left hip pain. The tenant was transported to a hospital emergency room and was admitted with a left hip fracture. The tenant had not returned to the program.

The program did not complete functional, cognitive and health evaluations when a change in status occurred as documented in the initial PT assessment and PT discharge assessment, which indicated the tenant's continued risk for falls and continued hip pain resulting in the tenant's inability to ambulate.

Tenant #3, a 70 year old, was admitted on 9-27-10 and had diagnoses of: Dementia, Depression, HTN, Anxiety, and Parkinson's Disease, Coronary Artery Disease, and Gastro Esophageal Reflux Disease, Incontinence, Constipation, Anemia and a History of Falls. The tenant was staged at three on the GDS, which indicated mild cognitive decline.

Resident care notes of 10-3-10 indicated the tenant's urine was cloudy. On 10-4-10, the tenant's physician ordered a urinalysis culture and sensitivity and physical and occupational therapy. On 10-11-10, the tenant was diagnosed with a urinary tract infection (UTI) and was prescribed an antibiotic for five days. On 11-11-10, the tenant was sent to a hospital emergency room due to a fall and right hip pain. Notes of the same date but separate entry indicated the tenant was admitted to the hospital for a right broken hip, but on 11-12-10, family reported the tenant didn't fracture a hip. The tenant would remain in the hospital receive therapy. On 11-15-10, the tenant returned to the program. On 11-18-10, the tenant was not participating in transfers and the physician ordered the tenant be evaluated for PT.

Resident care notes of 11-19-10 indicated the tenant was admitted for PT. The tenant required "extensive" assistance from staff to get ready for PT. On 11-21-10, the tenant was found lying on the floor. On 11-23-10, the tenant called for assistance and was found sitting on the floor next to the bed. A nurse review of 11-30-10 indicated the tenant had increased periods of confusion. Physical therapy recommended the use of a bed side rail. On 12-2-10, the tenant refused to shower due to right upper leg pain and reported pain medication wasn't affective. On 12-16-10 it was reported the tenant had fallen on 12-6-10 and again on 12-12-10. On 12-20-10, the tenant was found on the floor. The tenant reported falling out of a wheel chair while trying to put on shoes. The tenant complained of right upper leg pain and reported it felt like his/her leg was broken. The tenant was evaluated by a local hospital emergency room and returned to the program the same day.

Resident care notes of 1-3-10 indicated the tenant had white patches on tongue. A physician ordered Nystatin swish and swallow-three times daily for 10 days, due to adverse reactions to antibiotic therapy for a UTI.

The program did not complete functional, cognitive and health evaluations when a change in status occurred as documented in the tenant's diagnosis of a UTI, falls, hospitalization for right hip pain, physical therapy, increased confusion, the use of bed side rails and adverse effects from antibiotic use.

- 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

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

- Monitoring Observation: Three tenant files were reviewed. Tenant #1's service plan of 1-26-10, indicated the program completed accu-checks, medication administration,

bathing assistance and housekeeping and laundry services. The tenant's service plan was updated on 11-29-10 and indicated the tenant had the right to refuse accu-checks. No other changes were noted from the service plan of 1-26-10.

On 9-2-10, the program notified the physician the tenant was a heavy drinker and recently had six one liter bottles of alcohol and a two gallon jug of wine delivered to the tenant. Resident care notes of 9-7-10 indicated the tenant's physician advised the tenant to limit alcoholic drinks to one per twenty-four hours.

A managed risk agreement was initiated on 9-17-10 and addressed the tenant's refusal to take medication administered by the program, the hoarding of medication and the use of OTC medications. Resident care notes of 9-22-10 indicated the tenant's apartment was "very" dirty and fecal matter was seen on the carpet, bed and floors. Staff requested to clean the tenant's apartment, but the tenant refused housekeeping services.

Resident care notes of 11-19-10 indicated the tenant called EMS and reported he/she couldn't get up from the floor and couldn't get any help. When EMS arrived, the tenant was sitting on the couch, partially dressed and appeared "intoxicated."

On 12-2-10, the program gave the tenant a 30-day notice to improve living conditions in order for the tenant to continue living at the program. The notice indicated housekeeping services, delivery of three meals daily, and a shower weekly. Staff were to leave medications and if the tenant refused medications, staff were to wait one hour and destroy the medication.

The nurse stated the tenant refused assistance with bathing, medications, and laundry and housekeeping services beginning of August 2010. The tenant didn't follow the objectives identified in the managed risk agreement of 9-17-10 and the 30 day notice to improve living conditions established on 12-2-10. Alcohol bottles were not in the open when staff were in the tenant's apartment. Staff LPN #1 stated sometime in August 2010 the tenant refused medications, bathing, housekeeping and laundry services and would often refuse staff entry into his/her apartment. She knew the tenant had ordered alcohol, but never saw the tenant intoxicated. She was told by staff bottles of alcohol were found in the tenant's apartment after the tenant had been hospitalized on 12-13-10. Staff #2 stated in August 2010 the tenant refused medications, bathing assistance, meals, and laundry and housekeeping services. Staff were not given any additional interventions when the tenant refused medications and cares.

The service plan of 1-26-10 wasn't updated with a change in health status and didn't include interventions related to the tenant's refusal of medications, the managed risk agreement on 9-17-10 and the tenant's alcohol consumption. The service plan of 11-29-10 wasn't supported by a cognitive evaluation and didn't include interventions related to the tenant's refusal of bathing assistance, changes in medication administration and housekeeping services.

Tenant #2's service plan of 7-12-10, indicated the tenant was independent with ambulation, was able to transfer safely and independently, and used a walker or electric scooter. Resident care notes of 11-3-10 indicated the tenant was admitted to

physical therapy related to right hip pain and poor endurance. An initial assessment completed by PT on 11-5-10, indicated the tenant had impairments in strength, balance, safety awareness and activity tolerance. The tenant had right hip pain, low blood pressure and was "extremely dehydrated." The tenant complained of fatigue, general malaise and was short of breath with standing or ambulation. The tenant complained of right hip pain with weight-bearing activity and rated the pain at seven out of ten.

The tenant's PT discharge assessment of 11-18-10 indicated the tenant was a fall risk secondary to poor safety awareness and decision making. The tenant was able to ambulate facility distances but was not willing to ambulate to meals due to hip pain. On 11-26-10, the tenant was found on the floor and complained of left hip pain. The tenant was transported to a hospital emergency room and was admitted with a left hip fracture. The tenant had not returned to the program.

The service plan of 7-12-10 wasn't updated with a change in health status and didn't include interventions related to the tenant's health status as documented in the initial PT assessment and PT discharge assessment which indicated the tenant was a fall risk, the tenant's continued hip pain resulting in the tenant's inability to ambulate.

Tenant #3's service plan of 9-27-10 and 10-27-10 indicated the tenant was incontinent, staff were to remind the tenant to toilet, to assist with transfers and assist with the use of a wheelchair.

Resident care notes of 10-3-10 indicated the tenant's urine was cloudy. On 10-4-10, the tenant's physician ordered a urinalysis culture and sensitivity and physical and occupational therapy. On 10-11-10, the tenant was diagnosed with a UTI and was prescribed an antibiotic for five days. On 11-11-10, the tenant was sent to a hospital emergency room due to a fall and right hip pain. The tenant was admitted to the hospital for a right broken hip, but on 11-12-10, family reported the tenant didn't fracture a hip, but would receive therapy during hospitalization. On 11-15-10, the tenant returned to the program. On 11-18-10, the tenant was not participating in transfers. The tenant's physician ordered the tenant be evaluated for physical therapy.

Resident care notes of 11-19-10 indicated the tenant was admitted for PT The tenant required "extensive" assistance from staff to get ready for physical therapy. On 11-21-10, the tenant was found lying on the floor. On 11-23-10, the tenant called for assistance and was found sitting on the floor next to the bed. A nurse review of 11-30-10 indicated the tenant had increased periods of confusion. PT recommended the use of a bed side rail. On 12-2-10, the tenant refused to shower due to right upper leg pain and reported pain medication wasn't affective. Notes of 12-16-10 indicated the tenant had fallen on 12-6-10 and again on 12-12-10. On 12-20-10, the tenant was found on the floor and the tenant reported falling out of a wheel chair while trying to put on shoes. The tenant complained of right upper leg pain and reported it felt like his/her leg was broken. The tenant was evaluated by a local hospital emergency room and returned to the program the same day.

Resident care notes of 1-3-10 indicated the tenant had white patches on tongue. A physician ordered Nystatin swish and swallow-three times daily for 10 days, due to adverse reactions to antibiotic therapy for a UTI.

The tenant's service plan of 9-27-10 was not updated with a change in health status and didn't include interventions as documented in the tenant's diagnosis of a UTI, falls, hospitalization for right hip pain, physical therapy, increased confusion, the use of bed side rails and adverse effects from antibiotic use.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481 – 69.26(1))

- 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))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate; at a minimum the tenant's identified needs and preferences for assistance. (IAC r. 481 – 69.26 (4)(a))

C. Medications

Complaint Allegation #32188-C: It was alleged during the tenant's hospitalization, family and staff found 40 to 50 bottles of OTC medications and 300 prescription medications laying around the tenant's apartment.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1's service plan of 1-26-10 and 11-29-10 indicated the program administered medications. A physician's communication of 8-18-10 indicated the tenant would not allow staff to observe the tenant take his/her medications. The program wasn't sure if the tenant was taking the medications as ordered. The tenant's physician ordered staff to leave medications with the tenant.

  On 9-2-10, the program notified the physician the program nurse had been in the tenant's apartment and found no less than one week's worth of medication sitting in medication cups. On 9-14-10, the tenant's lab results indicated a critical low potassium level. The physician was notified the tenant would, at times, throw medications away. Staff had found a week's worth of potassium tablets in the trash. Later the same day, the physician ordered the program to give two doses of potassium chloride 20 meq, three times daily and to observe the tenant taking the medication. If the tenant refused the medications, the program could send the tenant to the hospital emergency room for intravenous potassium chloride. The tenant refused medication and refused to go to the hospital emergency department.

  A managed risk agreement was initiated on 9-17-10 and addressed the tenant's refusal of medications, the hoarding of medication and the use of OTC medications which resulted in a critical Potassium level and refusal of doctor ordered emergency room transfer. The program continued to deliver medication to the tenant as ordered and the tenant would take or not take the medication. Staff would no longer remove unused medication from the tenant's apartment unless asked by the tenant to do so.

On 9-20-10, the physician was notified the program the tenant continued to take medications from staff but refused to allow staff watch him/her swallow the medications. Staff reported seeing medications in medication cups at the bedside, but couldn't determine how much medication were present. The program delivered medication to the tenant, but weren't responsible if the tenant didn't take the medication. The program would not retrieve medication from the tenant's apartment. Resident care notes of 9-22-10 indicated the tenant wasn't taking his/her medications and staff would remove medications whenever possible.

On 11-18-10, the tenant called requested staff open OTC medications. The nurse told the tenant all medications were to be administered by the program and refused to open the OTC medications. On 12-2-10, the program gave the tenant a 30-day notice staff would administer medication and if not taken staff will take the medications back to the medication cart and the tenant had one hour to take them before they were destroyed. On 12-13-10, the program notified the tenant's physician the tenant had not taken his/her medications and the tenant had numerous OTC medications in the apartment.

The nurse stated the tenant refused medications beginning in August 2010. Staff didn't have to see if the tenant took the medications. Staff charted the medications as given. The tenant didn't follow the objectives identified in the managed risk agreement of 9-17-10 and the 30 day notice to improve living conditions on 12-2-10. Each agreement had specific interventions related to medication administration. Staff LPN #1 stated in August 2010 the tenant refused medications and would often refuse staff entry into his/her apartment. Staff would leave the medications, would go back and check to see if the tenant took the medications and would chart the medications as taken or refused. Staff #2 stated the tenant refused medications in August or September 2010. The tenant would refuse medications daily and on all shifts. On the evening shift the tenant would throw the medications at staff. She stated she was not given any new directions or actions to take when the tenant refused medications and cares.

The program did not administer medications in accordance to the applied requirements of medication administration.

- Regulatory Insufficiency: When medications are administered traditionally by the program, 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))

Dated this 16th day of February, 2011.