IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 29714-C

March 25, 2011

Ms. Lauri Fulkerth, Administrator
Arlington Place Assisted Living
101 N. E. 5th Street
Pocohontas, IA 50574

RE: Final Complaint Investigation Report, Arlington Place Assisted Living, Pocohontas, Iowa

Dear Ms. Fulkerth:

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 515/281-4116.

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 #:** 29714-C

Arlington Place Assisted Living
Lauri Fulkerth, Administrator
101 N.E. 5th Street
Pocohontas, IA 50574

Date of Investigation:

February 24, 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 Arlington Place Assisted Living on February 24, 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:	30
Current number of tenants with cognitive disorder:	1
Total Population:	31

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 substantiated 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. Tenant Documents

Complaint Allegation: It was alleged three tenants developed skin wounds. One tenant transferred to a nursing facility for wound healing and returned to the program. One tenant had a severe coccyx wound and family moved the tenant as he/she was not receiving appropriate care and was under weight. A third tenant had a skin wound on his/her coccyx and family was concerned care wasn't given. The tenant vomited in bed at least twice without staff assisting to clean it up.

Monitoring Observation: Tenant #1, a 90 year old, was admitted on 6-8-06 and had diagnoses of: Diabetes Mellitus, Gout, Hypertension (HTN) and a history of Hemorrhoids. Nurse's notes of 4-12-10 revealed the tenant was hospitalized for Cellulitis of the Right Leg. On 7-8-10, the tenant returned to the program. Nurse's notes revealed the program completed a nurse review and indicated the tenant needed assistance twice weekly with showers, assistance with TED hose, escort assistance to and from meals and activities. A nurse review was completed again on 8-7-10 and indicated the tenant requested as needed (prn) escort assistance, with no other changes in services. Nurse's notes of 12-22-10, revealed the tenant were seen by a physician for hemorrhoids and staff assisted with hemorrhoid treatment. Nurse's notes of 2-7-11, revealed the tenant requested medication administration. Functional and health evaluations of 4-23-08, revealed the tenant had an open area on the right buttocks on 3-11-08, which had healed on 3-26-08. Tenant #1 stated he/she had an ulcer on his/her buttocks in the spring of 2010, but has since healed. The tenant stated he/she received excellent care for their open wounds.

No other evaluations, service plans, nurse review's and nurse's notes were found in the tenant's file. The tenant's file was incomplete.

Tenant #2, a 90 year old, was admitted on 6-8-06 and had diagnoses of: Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and HTN. Functional, cognitive and health evaluations were completed on 6-17-10 and the health evaluation indicated the tenant had an open sore above the tail bone due to lack of movement. The service plan of 6-17-10 revealed no interventions related to the tenant's open sore. The tenant's file had nurse's notes of 6-17-09 through 1-17-10, with no other nurse's notes found. Medication Administration Records (MARs) for June and July 2009 and January 2010, February, 2010 and June 2010 were the only MARs found in the tenant's file. MARs for the above periods did not indicate prescribed treatments for the tenant's open sore. Program records indicated the tenant was discharged from the program October 2010.

No other evaluations, service plans, nurse review's and nurse's notes were found in the tenant's file. The tenant's file was incomplete.

Tenant #3, a 91 year old, was admitted on 10-8-07 and had diagnoses of: HTN and Vertigo. Nurse's notes of 9-8-09 revealed the tenant went to a physician for a sore on his/her leg and arm. Functional, cognitive and health evaluations completed on 9-21-09 were the only evaluations found. The physician ordered treatment to lower and upper left extremities daily and antibiotic therapy for 10 days. Nurse's notes of 1-19-10 revealed the tenant's left leg was healed. Nurse's notes of 5-18-10 revealed the tenant was sent to a hospital emergency room for rib pain and returned the same day.

Nurse's notes of 6-5-10 revealed the tenant was sent to a hospital emergency room as the tenant had been unresponsive and weak. The tenant returned later the same day. Nurse's notes of 7-13-10 revealed the tenant was discharged at the family's request.

No other evaluations, service plans, nurse review's and nurse's notes were found in the tenant's file. The tenant's file was incomplete.

Staff #1 stated Tenant #1 did not have any open sores. The tenant had a sore on his/her heel and a sore on his/her coccyx, but they had since healed. Tenant #2 and #3 had an open sore on each of their coccyx, but each received appropriate care. Tenant #2 moved out of the program sometime in October 2010. Tenant #3 moved out of the program in July 2010.

Staff #2 stated Tenant #1 had an ulcer on his/her coccyx when at the nursing facility. The tenant had seen a physician for treatment but the ulcer has healed and there was no open sore at this time.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include the initial evaluations and updates, the initial individual service plan and updates. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception and medication lists, which shall be maintained in conformance with 481—subrule 67.5(4). (IAC r. 481-69-25 (1)(c,e,i,j))

Dated this 24th day of March, 2011.