IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 33228-C

April 15, 2011

LuAnn Rogge, Administrator
Heartland Care Center Assisted Living
604 E. Fenton
Marcus, IA 51035

RE: Final Complaint Investigation Report – Heartland Care Center Assisted Living, Marcus, IA

Dear Ms. Rogge:

Enclosed is the **Final Complaint Investigation Report** from the on-site monitoring visit of April 6, 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 #: 33228-C**

LuAnn Rogge, Administrator
Heartland Care Center Assisted Living
604 E. Fenton
Marcus, IA 51035

Date of Investigation:

April 6, 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 Heartland Care Center Assisted Living on April 6, 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:	13
Current number of tenants with cognitive disorder:	3
Total Population:	16

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. Medications

Complaint Allegation: It was alleged a nurse told staff to give a tenant his/her medication. Staff refused because he/she was not trained as a certified nursing assistant (CNA). The nurse hid the medications behind a box of Kleenex and when staff person returned, the medications were gone. It was alleged after a staff person received his/her CNA certification, he/she was asked to administer medications to tenants.

- Monitoring Observation: A review of Staff #3, #4, #5, #6, #7 and #8 staff personnel files revealed each received nurse delegated training for personal and health related cares except for medication administration. The program nurse stated only registered nurses (RN) and licensed practical nurses (LPN) administered medications and treatments to tenants.

  Staff #1 LPN and #2 LPN stated only RNs and LPNs administered medications and treatments to tenants. Both stated they had never asked unlicensed staff to administer or give medications to tenants. Staff #3 and #4, both certified nursing assistants (CNA) stated only RNs and LPNs administered medications and treatments to tenants and had not been asked by RNs and LPNs to administer medications or treatments to tenants.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint Allegation: It was alleged a staff person "shot" candy into a tenant's mouth.

- Monitoring Observation: The Administrator, program nurse and Staff #1, #2, #3 and #4 stated they had no knowledge of staff shooting candy into a tenant's mouth. Each stated they hadn't seen or heard of any staff doing this. Tenant #1 stated he/she had not seen or heard of staff acting inappropriate, including shooting candy into a tenant's mouth.

- Regulatory Insufficiency: None noted.

C. Other

Complaint Allegation: It was alleged a staff nurse would often be in the tenant's room, rubbing lotion on the tenant's back and would take 30 to 45 minutes to complete. It was alleged a tenant would turn his/her light on several times to try and get a nurse into his/her room. The tenant reported he/she had fallen in the bathroom, put himself/herself back to bed and when staff entered the room, the tenant's shirt was off and was surprised it wasn't the nurse.

- Monitoring Observation: Three tenant files were reviewed. Tenant #2, a 79 year old, was admitted on 8-1-10 and had diagnoses of: Dehydration, Bronchitis, Abdominal Pain, Arthritis, Scoliosis, Degenerative Joint Disease (DJD), Cerebral Vascular Accident (CVA), History of Prostate Cancer, Chronic Back Pain and Hypertension (HTN). A service plan of 9-14-11 revealed the tenant was independent with activities

of daily living (ADLs). A cognitive evaluation of 9-13-11 revealed the tenant scored 27 out of 30 on the mini mental status exam, which indicated normal cognition. Medication review indicated Cetaphil Lotion was to be applied twice daily to back and arms and ice was to be applied to the lower back and hip as needed. The tenant was also prescribed Tramadol – two tablets as needed, during the night time hours.

Nurse's notes of 12-12-10 revealed the tenant was found sitting on the floor in his/her spouse's room. No injuries were reported. On 12-13-10 the tenant complained of upper back soreness. The tenant refused warm and cold packs and no bruising was indicated. Nurse's notes of 2-12-11 revealed the tenant had fallen in the bathroom. Range of motion was completed and the tenant had no bruising or open areas. The tenant complained of whole body soreness and a warm pack was applied.

Nurse's notes of 4-5-11 revealed the program nurse met with the tenant related to the tenant's concern with his/her relationship with an LPN. The program nurse explained to the tenant the LPN had other responsibilities. The program nurse indicated the LPN's relationship with the tenant was professional, but shared concerns the tenant's spouse was jealous. The tenant indicated he/she understood and would visit with the program nurse if any concerns came up.

- Regulatory Insufficiency: None noted.

Dated this 15th day of April, 2011.