IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 33351-M

April 28, 2011

Craig Johnson, Executive Director
Wesley Central Assisted Living
3520 Grand Avenue
Des Moines, IA 50312

RE: Final Complaint Investigation Report, Wesley Central Assisted Living, Des Moines, Iowa

Dear Mr. Johnson:

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 Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #: 33351-M**

Craig Johnson Executive Director
Wesley Central Assisted Living
3520 Grand Ave.
Des Moines, Iowa 50312

Date of Incident Investigation:

April 4-5, 2011

Monitor(s):

Joyce Kix RN
Maribeth Freland RN

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 an Incident 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:

An on-site visit was conducted at Wesley Central Assisted Living on April 4-5, 2011. In preparing this report, the following information was considered:

Current Program Census:

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

Current number of tenants without cognitive disorder:	44
Current number of tenants with cognitive disorder:	2
Total Population:	46

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 – The program did not receive any regulatory insufficiencies during this certification period.

On-Site Monitoring Evaluation – The monitors made the observations detailed in the following areas.

During the course of the investigation of the incident, the following information was identified.

A. Medications

- Monitoring Observation: Tenant #6, a 90 year old, was admitted on 2-26-03 with diagnoses of: Dementia, Depression, Renal Insufficiency, Osteoarthritis and Hypertension (HTN). The Global Deterioration Scale (GDS) scored the tenant at 4 indicating moderate cognitive decline. The program provided medication administration for the tenant. The medication administration record (MAR) documented a physician's order dated 5-13-09 for Hydrocodone/APAP 5/500, one to two tablets four times a day as needed. The MAR indicated staff administered the medication at least once a day. During interview, Staff #2 and #3 stated they administered one half of one tablet to the tenant instead of the whole tablet. Staff #2 stated the registered nurse (RN) told them to do it because the tenant was at risk for falling. Staff #3 stated she gave ½ tablet because that's what was in the pill planner set up by the RN. The tenant's clinical record lacked documentation of communication with the physician to obtain direction to change the dose or frequency of administration of the medication. Multiple staff reported a belief that one-half tablet of the Hydrocodone/APAP had not been effective with pain relief on several occasions and multiple staff reported the tenant reported pain often throughout the day while being cared for by staff.

  Tenant #9, a 97 year old, was admitted on 9-18-09 with diagnoses of: Osteoarthritis, Osteoporosis, Seizure Disorder, HTN and Legal Blindness secondary to Macular Degeneration. The cognitive assessment completed 11-11-10 indicated the tenant had no cognitive decline. The program administered medications for the tenant. The clinical record contained an original handwritten physician's order dated 2-11-11, signed by the tenant's physician on legal prescription pad for Hydrocodone 5/APAP 500 (#50) , one half to one tablet four times a day. This was written in blue ink. In black ink the letters prn (indicating as needed) had been written. The tenant's physician had maintained a copy of the original order which did not include the word "prn". The physician reported he had intended to order a scheduled dose of Hydrocodone four times a day for pain control. The pharmacy also maintained a copy of the written physician's order. It also did not include the word "prn". The pharmacist stated the RN had called in an order clarification on 2-11-11 changing the dosage to "prn" or as needed. The clinical record lacked documentation of a physician's order to change the order to as needed.

  The staff documented on the back of the MAR that ½ tablet was given on 2-11-11 at 7:30 pm for complaints of hip pain and another ½ tablet was given at 8:30 pm 2-11-11 for severe hip pain. The front of the MAR had only one set of initials indicating administration of Hydrocodone. The clinical record lacked documentation of clarification by the RN of the physician's order when to give ½ tablet and when to give a whole tablet. Delegated uncertified staff are unable to clinically assess and/or determine what the dose should be without perimeters established by the RN.

- Regulatory Insufficiency: The administration of medications shall be provided by a registered nurse, a licensed practical nurse or advanced registered nurse practitioner

registered in Iowa or by unlicensed personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67,5(6) a.)

B. Nurse Review

Monitoring Observation: Tenant #3, a 90 year old, was admitted on 2-17-03 with diagnoses of: HTN, Osteoporosis, Hypothyroidism, Depression, Dementia and Osteoarthritis. On 12-15-10 the cognitive assessment indicated the tenant with little or no cognitive decline. The program provided medication administration for Tenant #3. The annual comprehensive evaluation completed 12-15-10 indicated the tenant reported no pain. According to MAR, on August 2010, the physician ordered Hydrocodone 7.5 mg/500, one tablet as needed every six hours. According to the documentation completed by staff, the last dose the tenant took was on 8-14-10. According to the pharmacy controlled medicine report, 270 tablets had been delivered for the tenant since 1-6-11. The nurse failed to identify the discrepancy between the tenant's lack of need and/or use of pain medication during the required 90 day medication review.

Staff 1, a registered nurse, completed a 90 Day Review for Tenant #6 on 1-12-11 reporting the tenant exhibited no pain or discomfort. According to the MAR, the program administered Hydrocodone/APAP and Naproxen for arthritic pain at least one time a day. Multiple staff reported the tenant continued to report arthritic pain throughout the day. On 4-5-11 Staff #1 reported she had not reviewed the tenant's medications during the 90 Day Review completed on 1-12-11.

The program provided medication administration for the Tenant #9. The clinical record indicated the tenant had no cognitive impairment. Staff 1, a registered nurse, completed a 90 Day Review on 2-17-11 reporting the tenant exhibited no pain or discomfort. The tenant began taking Hydrocodone/APAP for arthritic pain on 2-11-11. On 4-5-11 Staff #1 reported she had not reviewed the tenant's medications during the 90 Day Review completed on 2-11-11.

- Regulatory Insufficiency: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r. 481-69.28(1))

Dated this 26th day of April 2011.