IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 33452-C

May 24, 2011

Mary K. Harris, RN Manager
Oakwood Place Assisted Living
4130 Northwest Blvd.
Davenport, IA 52806

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

Dear Ms. Harris:

I. Final Complaint Investigation Report – Oakwood Place Assisted Living, Davenport, 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: Medications, Nurse Review, Staffing and Tenant Rights. **Oakwood Place Assisted Living** ("Program") is being assessed a $2500 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 sixteen hundred twenty five dollars ($1625) 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 $2500 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on May 17, 2011, has been reviewed and will constitute the final POC related to the on-site visit of April 4 & 5, 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,

Ann Martin

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 #: 33452-C**

Mary K. Harris, RN Manager
Oakwood Place Assisted Living
4130 Northwest Blvd
Davenport, IA 52806

Date of Investigation:

April 4 & 5, 2011

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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 Oakwood Place 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 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:	2
Total Population of GPP:	32

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	12

Total Census of ALP: 54

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

Program History – There were substantiated Regulatory Insufficiencies this certification period in the areas of, Tenant Documents, Service Plans, Food Service, Staffing, Dementia Specific Educations, Record Checks, Nurse Review, Criteria for Exclusion of Tenants and not reporting Dependent Adult Abuse.

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. Criteria for Exclusion of Tenants

Complaint Allegation: It was alleged there were tenants that required total care.

- Monitoring Observation: Review of six tenant files, three staff interviews and an interview with the nurse indicated none of the current tenants exceeded admission and retention criteria. The nurse stated Tenants #2 and #4 were scheduled to transfer to the nursing facility on 4-13-11. Tenant #3 was scheduled to transfer to the nursing facility on 4-5-11.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged there was a tenant that had a history of wandering and had eloped and staff were required to check on the tenant hourly.

- Monitoring Observation: Tenant #1 was studied on 2-15-11 (32557-I) and Tenant Rights was cited in the report. Tenant #1 was studied on 3-1-11 (33041-I) and Level of Care and Tenant Rights was cited. Tenant #1 was studied on 3-15-11 (33130-I; 33081-C) and Level of Care was cited in the preliminary report. Tenant #1 transferred to a nursing facility on 3-3-11. Staff #1, #2 and #3 did not identify any other tenants that eloped.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged a tenant required total care and was incontinent and required routine toileting assistance. It was alleged the tenant had skin breakdown.

- Monitoring Observation: Tenant #2 was studied on 3-15-11 (33130-I; 33081-C) related to cares, incontinence and skin breakdown. No regulatory insufficiencies were identified in the preliminary report related to Tenant #2's cares, incontinence and skin breakdown.

- Regulatory Insufficiency: None noted.

B. Tenant Documents

Complaint Allegation: It was alleged that tenant information was not recorded on flow sheets.

- Monitoring Observation: Review of six tenant files indicated daily flow sheets were found and tenant information was documented on these records. Staff #1 and #3 stated staff communicated verbally shift to shift. Staff #2 stated there was a communication book in the medication office. The nurse stated staff communicated shift to shift via verbal report and at times left a note regarding a procedure. The nurse indicated staff were to communicate all changes to the nurse.

According to Chapters 67 and 69 there is not a requirement for the maintenance of written staff communication records. The rules require monitors have full access to all records. At the time of the investigation the monitors received all records requested.

- Regulatory Insufficiency: None noted.

C. Medications

Complaint Allegation: It was alleged a tenant was prescribed a medication and did not received it for two months.

- Monitoring Observation: Tenant #8, a 92 year old, was admitted on 8-26-09 and diagnoses include: Transient Ischemic Attack (TIA), Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Urinary Frequency, Gastro Esophageal Reflux Disease (GERD), Hypertension (HTN) and Hypokalemia. The tenant was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. The tenant was transferred to the nursing facility on 3-15-11. An order for Namenda was dated 1-28-11 and was noted on 1-28-11. The order was on the Medication Administration Record (MAR); however, was not available until 1-31-11. An order for application of triple antibiotic ointment and band-aid daily to base of fifth toe on the right foot for three days was dated 2-14-11. The order was noted on 2-14-11 and the treatment started on 2-15-11. An order was dated 3-1-11 to discontinue Flexeril and Enalapril and decrease Lasix to 20 mg daily. The order was noted on 3-1-11 and the MARs reflected the decreased dose of Lasix started on 3-2-11 and Flexeril and Enalapril were discontinued on the MAR dated 3-1-11. The previous Lasix dose of 40 mg daily was also discontinued on 3-1-11. Review of MARs and physician orders indicated medications ordered were consistently noted and transcribed appropriately on the MAR.

  Staff #1, #2 and #3 stated tenants received the medications prescribed. Staff #1 and #3 stated there was no delay in the medications transcribed to the MAR. The nurse said tenants received the medications prescribed and medications were put on the MAR immediately.

  A family member was interviewed and indicated sometimes medication changes once ordered would be reflected two to three days later on the MAR.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged medications were not counted appropriately and large amounts of medications were accounted for or missing.

- Monitoring Observation: The program self reported missing or unaccounted medications including Tramadol, Lorazepam and Plavix. This was studied on 8-30-10 (30331-C; 29943-I, 30300-I, 30433-I) and no regulatory insufficiencies were identified. Tenant #7 resided in the independent living building and the current count sheets were reviewed which indicated medications were counted appropriately.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: The table below represents lack of documented results for as needed medication. The table also represents treatments either not documented as completed or not completed.

Tenant #5	Acetaminophen 500 mg one tab by mouth every 4 hours for pain. (Physician ordered this medication as needed for pain. In reviewing the MARS, the medication was administered for insomnia)	1-17-11, 1-20-11, 1-24-11, 2-23-11, 2-24-11, 3-1-11, and 3-9-11; The result of the as needed medication was not documented.
Tenant #6	Colostomy Care change every three days and as needed	From 3-4-11 to 3-7-11 (four days) not documented as completed or not completed. As of 4-5-11 the last documented completion of the task was on 3-28-11. It was documented on daily flow records as completed on 4-3-11; however, it was not documented on the MAR as completed.

- 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))

D. Nurse Review

Complaint Allegation: It was alleged a tenant could not sleep at night and paged frequently to report difficulty sleeping. It was alleged the tenant was prescribed a medication; however, the medication was not effective.

- Monitoring Observation: Tenant # 5, a 90 year old, was admitted on 6-16-07, and diagnoses include: Depression, Back Pain, HTN, and Dysphasia, unspecified. The tenant transferred to the nursing facility on 3-10-11. A review of the MARs for January, February, and March 2011, indicated an order for Melatonin 5 mg by mouth given at bedtime each night for insomnia. In reviewing the Daily Report logs, it was documented on 1-17-11, 2-9-11, 2-21-11 and 2-22-11 the tenant could not sleep. According to MARs as needed Acetaminophen 500 mg was administered on eight occasions from 1-17-11 to 3-9-11. One of eight times the effectiveness of the Acetaminophen was documented. On 5-19-10, an order was received for APAP 500 mg, one tab, every four hours as needed for pain.

The as needed medication, according to the MARs, was given due to the tenant's complaint of not being able to sleep eight times from 1-17-11 to 3-9-11. The medication was not administered per physician order. A nurse review was not completed for insomnia.

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

- Monitoring Observation: Tenant #6, a 91 year old was admitted on 11-7-09 and diagnoses include: Hyperlipidemia, Depression, Osteoporosis, Macular Degeneration, Hypothyroid and Colostomy. The tenant was staged at a four on the GDS, which indicated moderate cognitive impairment. A review of the MARs for January, February and March 2011, indicated an order for Nystop 100,000 units/GM apply topically every day as needed to peri-area. On 6-8-10 an order was received for Nystatin Powder lightly to skin when wafer was changed and skin washed with water and patted dry, discontinue when healed. MARs indicated Nystop was administered over 20 times from 1-8-11 to 3-25-11 and the reason for administration indicated bleeding stoma or red stoma. The order on the MAR indicated Nystop applied to peri-area; however, it was applied to the stoma site. The medication was not administered per physician's order. The MARs also reflected an order for Hydrocortisone 2.5% cream apply to itchy areas twice daily as needed. Hydrocortisone cream was applied over 15 times between 1-11-11 and 3-23-11 for itching around wafer. The service plan indicated to notify the nurse of bleeding from stoma or red or open areas especially under the wafer. A nurse review was not completed as needed related to bleeding, red stoma and itching around the wafer despite the frequent use of as needed medications.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program. (IAC r. 481-69.27(2))

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

E. Staffing

Complaint Allegation: It was alleged a tenant's colostomy was not cleaned or checked frequently and the tenant had pain.

- Monitoring Observation: Tenant #6's file was reviewed. Staff #1, #2, #3 and #4 indicated the tenant's colostomy was cleaned and checked appropriately. They stated the tenant did not have pain. Staff #4 stated the tenant was able to use his/her pendant to call staff when the bag needed changed. Staff #1, #3 and #4 reported the tenant picked at it. The nurse reported the tenant was checked twice per shift and it was cleaned appropriately.

The service plan indicated the colostomy bag needed to be checked twice on first and second shifts and once during the night shift. The service plan indicated to change colostomy bag every three days and as needed.

A family member was interviewed and indicated the colostomy was cleaned appropriately. The family member said some staff were more knowledgeable and willing to take care of it. The colostomy care had improved, according to the family.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged there were not enough staff to assist the assisted living tenants and independent living tenants

- Monitoring Observation: Three tenant and two family interviews were conducted. Two of the three tenants reported it had taken as long as 30 minutes for their pendants to be answered. Two of the three tenants stated staffing had not met their needs because staff were on call for the independent living. When staff left the assisted living, the tenants waited until they returned to have their lights answered. One night between 7:00 to 8:00 p.m., one tenant was in his/her bathroom, had pulled down his/her pants and fell on the floor. The tenant pushed his/her pendant and waited for 20 minutes with bare skin on the cold floor for someone to respond. The tenant was told the delay was due to staff being at the independent living apartments. Another time a tenant had a diabetic reaction due to a low blood sugar. The tenant activated his/her pendant. While the tenant waited for a response, the tenant went to the kitchen and poured orange juice into a glass, spilled it on the floor, became very frustrated, cleaned up the spilled juice, drank it, and went to the bathroom to turn off the pendant. Staff never responded, according to the tenant. One family member reported the pendant was activated and waited 20 minutes during the day shift for a response. Another family member stated staff were spread too thin between the assisted living and the independent living. The family member stated the tenant waited 20, 30 and up to 60 minutes for a response to the pendant. The reason for the delay was due to staff responding to falls in the independent living apartments.

  Staff # 1 stated there was enough staff on first shift when there were four staff scheduled. Staff #1 stated staff assisted independent living tenants when the independent living nurse was gone or on weekends. She stated there were scheduled medications and eye drops. Staff responded to pendants after the independent living nurse left. She said there were no issues with response or cares in assisted living due to independent living duties. Staff # 2 stated there was not enough staff to meet the needs of the tenants when one staff member is called away to the independent living. That left one staff in the assisted living and she did not think it was safe. She stated Tenant #7, an independent living tenant, required medication administration four times per day. The bedtime medication was administered by assisted living staff. She also assisted Tenant #9 with eye drops post cataracts surgery. She stated there were times when she was in independent living and assisted living tenants had to wait 20 to 40 minutes. Staff # 3 stated there were enough staff. She indicated medications were given to the independent living tenants if the nurse was not there. She also stated that second shift medications were given to independent living tenants by the assisted living staff.

On the weekends the assisted living staff covered the independent living tenants for medications, eye drops, and responded to phones that were off the hook and pendants calls. She stated the frequency of that varied but assisted living was not short staffed as other staff cover during these times.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

F. Tenant Rights

Complaint Allegation: It was alleged there were not enough staff to assist the assisted living tenants and independent living tenants

- Monitoring Observation: Three tenant and two family interviews were conducted. Two of the three tenants reported it had taken as long as 30 minutes for their pendants to be answered. Two of the three tenants stated staffing had not met their needs because staff were on call for the independent living. When staff left the assisted living, the tenants waited until they returned to have their lights answered. One night between 7:00 to 8:00 p.m., one tenant was in his/her bathroom, had pulled down his/her pants and fell on the floor. The tenant pushed his/her pendant and waited for 20 minutes with bare skin on the cold floor for someone to respond. The tenant was told the delay was due to staff being at the independent living apartments. Another time a tenant had a diabetic reaction due to a low blood sugar. The tenant activated his/her pendant. While the tenant waited for a response, the tenant went to the kitchen and poured orange juice into a glass, spilled it on the floor, became very frustrated, cleaned up the spilled juice, drank it, and went to the bathroom to turn off the pendant. Staff never responded, according to the tenant. One family member reported the pendant was activated and waited 20 minutes during the day shift for a response. Another family member stated staff were spread too thin between the assisted living and the independent living. The family member stated the tenant waited 20, 30 and up to 60 minutes for a response to the pendant. The reason for the delay was due to staff responding to falls in the independent living apartments.

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On the weekends the assisted living staff covered the independent living tenants for medications, eye drops, and responded to phones that were off the hook and pendants calls. She stated the frequency of that varied but assisted living was not short staffed as other staff cover during these times.

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

- Monitoring Observation: The assisted living was a part of Ridgecrest Village, a continuous care retirement community (CCRC). Independent living was also part of the CCRC. Village Home Services (VHS) was a separate entity that provided cares and services to tenants in independent living. The VHS nurse, a licensed practical nurse (LPN) was interviewed. She worked from 8:00 to 4:30 p.m. weekdays. She helped Tenants #10, #11, #12 and #13 (independent living tenants) with bathing. Two independent living tenants, #12 and #13, received whirlpools in the assisted living program one time per week. Tenant #7 and #14's medications were stored in the yellow section locked medication cabinet at the assisted living program. The VHS nurse did not have a key to that locked medication cupboard. The staff assigned to the yellow section and the assisted living nurse had the key. After she left for the day and on weekends assisted living staff administered medications. Assisted living staff and the VHS nurse counted the medications and maintained count records and MARs for independent living residents.

  The nurse stated after the independent living nurse left staff answered calls until 10:00 p.m. and then the nursing facility responded. If staff responded to an emergency staff were supposed to call the nursing facility nurse and once the nurse arrived staff returned to assisted living. She stated Staff #5, an LPN, worked until 6:00 p.m. and responded to phones off the hook and emergency calls. The nurse stated she had not heard about consequences from the assistance provided to the independent living.

  The monitors observed Tenants #7 and #14 (independent living tenants) had medications stored in the assisted living. The medications were stored in the locked medication cabinet. There were narcotic count records for Tenant #7. There were MARs for Tenants #7, #9 and #14.

- Regulatory Insufficiency: All tenants have the right to receive care, treatment and services which are adequate and appropriate (IAC r.481-67.3(2))

Dated this 20th day of May, 2011.