IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: **36153-C**
36295-C

December 2, 2011

Ms. Sue Hyde, Administrator
Keelson Harbour Assisted Living
2810 Aurora Avenue
Spirit Lake, IA 51360

RE: Final Complaint Investigation Report, Keelson Harbour Assisted Living, Spirit Lake, Iowa

Dear Ms. Hyde:

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

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

ADMINISTRATION
(515) 281-5457
FAX: (515) 242-6863

ADMINISTRATIVE HEARINGS
(515) 281-6468
FAX: (515) 281-4477

HEALTH FACILITIES
(515) 281-4115
FAX: (515) 242-5022

INVESTIGATIONS
(515) 281-5714
FAX: (515) 242-6507

Telephone Number for the Hearing Impaired: (515) 242-6515

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint Investigation Report

Assisted Living Program:

Complaint Intake #: 36153-C
36295-C

Sue Hyde, Administrator
Keelson Harbour Assisted Living
2810 Aurora Avenue
Spirit Lake, IA 51360

Date of Complaint Investigation:

October 25, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH
Lori Miner, RN BSN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	38
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	47
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	19
Total Population of Program at time of on-site	22
TOTAL census of Assisted Living Program	69

Program History – There were substantiated regulatory insufficiencies in the areas of Nurse Review, Staffing and Dementia Specific Education for Program Personnel during this certification period.

Complaint Investigation – The Complaint/investigator(s) made the observations detailed in the following areas:

A. Medications

Complaint Allegation #36295-C: It was alleged a tenant was given medication belonging to another tenant on two separate occasions. Both incidents required evaluation at a local hospital emergency room.

- Monitoring Observation: Tenant #1 (the Tenant), an 84 year old, was admitted on 1-10-11 and had diagnoses of: Alzheimer's, Anxiety, Atrial Fibrillation, Bilateral Breast Cancer, Bilateral Mastectomy, Bilateral Knee Replacement, Depressive Disorder, Hypertension (HTN), Hypothyroidism and Right Hip Athroplasty.

  An incident report of 9-10-11 indicated Staff #4 became distracted when administering medications to the Tenant and gave the Tenant another tenant's medication. The Tenant was given Tenant #3's Metoprolol 12.5mg, Reglan 10mg, Tamsulosin 0.4mg and Tramadol 100mg. Staff called the Program Nurse, who called the Tenant's physician. An order was given to check the tenant's pulse every two hours through the night and to send the Tenant to a local hospital emergency room if the Tenant's pulse was below 50 or the systolic blood pressure was below 80 mm/hg. The following morning, the Tenant's pulse was 46. The Tenant was transported to a local hospital emergency room and returned to the program with discharge instructions to hold Metoprolol.

Staff training records indicated Staff #4 received training by the Program Nurse on medication administration. The program took corrective action by suspending the staff person making the error, from administering medications to tenants until further training was received.

On 10-13-11, indicated Staff #5 administered another tenant's medication to the Tenant. The Tenant's blood pressure was taken and indicated it was elevated. The Tenant was taken to a local hospital emergency room for evaluation. Hospital emergency staff reported the Tenant was given 12.5mg of Metoprolol and not the prescribed dosage of 100mg of Metoprolol. Discharge instructions indicated no further monitoring was needed.

Staff training records indicated Staff #5 received training by the Program Nurse on medication administration. The program took corrective action by re-educating Staff #5 on proper process of medication administration. On 10-20-11 an in-service was given on medication administration and the need to triple check medications before administering medications. A review of the six rights of medication administration to staff

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

- Monitoring Observation: A monitor observed Staff #2 administer medications to tenants. Staff #2 initialed a medication administration records (MARs) prior to administering medications to tenants.

  Review of MARs for October, 2011 indicated the following:

Tenant #3.	Ibuprofen 600mg	Not charted as given at 12:00 p.m. on 10-25-11
Tenant #4	Acetaminophen 650mg	Not charted as given at 12:00 p.m. on 10-15-11 & 10-16-11
Tenant #5	Azopt 1% eye drops	Not charted as given at 8:00 p.m. on 10-23-11
Tenant #6	Meclizine 25 mg tablet	Not charted as given at 8:00 p.m. on 10-23-11
	Monopril 10 mg	Not charted as given at 8:00 p.m. on 10-23-11
	Sinemet 25 mg/100 mg	Not charted as given at 8:00 p.m. on 10-23-11
	Torpol XL 100 mg	Not charted as given at 8:00 p.m. on 10-23-11
	Tylenol 1000 mg	Not charted as given at 8:00 p.m. on 10-23-11
	Desitin ointment	Not charted as applied at 8:00 a.m. on 10-24-11 & 10-25-11
	KCL (Potassium) 10 meq	Not charted as given at 8:00 p.m. on 10-23-11
Tenant #7	Ipratropium/Albuterol Nebulizer 0.5/3.0 ml	Not charted as given at 2:00 p.m. on 10-18-11

  The program did not properly document the administration of medication or the reason medication was not administered to the tenants listed above.

- 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))

B. Staffing

Complaint Allegation #36153-C: It was alleged a tenant had been walking on a broken leg "for awhile" and was not cared for until the tenant complained of being in pain.

- Monitoring Observation: Tenant #2 (the Tenant), a 56 year old, was admitted on 9-17-07 and had diagnoses of Dementia and Schizophrenia and a history of Bilateral Knee Replacement. The Tenant resided in the Dementia unit. Annual functional and health evaluations were completed on 9-16-11 and indicated no change in function. A cognitive evaluation was completed on 9-16-11, which indicated none or minimal memory loss. A service plan of 9-16-11 indicated the Tenant was independent with ambulation and transfer.

  Medication Administration Records (MARs) indicated the tenant was given Tylenol 500mg – one tablet every four to six hours, as needed (PRN) for pain. Additionally, Ultram 50mg – one tablet every four to six hours, as needed for pain. Ultram could be taken with Tylenol. MARs for July 2011 through October 2, 2011, indicated Tylenol 500mg was given almost daily, as the Tenant complained of knee pain, knee pain to the left knee and knee pain when ambulating.

  Progress notes of 5-19-10 through 9-16-11 indicated the Tenant had two incidents of falls. On 5-19-10, the Tenant had lost his/her balance and had fallen backwards, landing on buttocks. No specific injury was noted. On 1-10-11, the Tenant had fallen in his/her apartment. The Tenant reported he/she had tripped on a bed frame and twisted his/her knee. On 7-12-11 the Tenant was seen by a physician and no new orders were given. On 10-2-11, at approximately 5:30 p.m. staff called the Program Nurse and reported the tenant was having a lot of knee pain despite PRN medication given earlier. Staff reported staff was not aware of the Tenant falling and the Tenant denied falling. The Program Nurse instructed staff to have the Tenant transferred to a local hospital emergency room for evaluation. Hospital staff reported the Tenant had a fracture on a prosthetic knee.

  Staff #1, #2 and #3 reported the tenant had no history of frequent or recent falls. Staff #4 reported on 10-2-11 the Tenant had complained of knee pain, which was normal. She reported the tenant took Tylenol and Tramadol "around the clock." The Tenant was in his/her room when she arrived to work. She had asked the Tenant how he/she was doing and the Tenant reported "it hurt a little." She started to administer medications to tenants. Coming back to the dining room, she heard the Tenant screaming "help me, help me, I'm going to fall!" The Tenant was found leaning against the wall crying and screaming in pain. She asked the Tenant if he/she had fallen and the Tenant said "no." She called the Program Nurse and was directed to have the Tenant taken to the local hospital emergency room for evaluation.

Hospital records indicated the Tenant had a diagnosis of a Left Periprosthetic distal femur fracture. The Tenant was discharged a local nursing facility, as the Tenant was non weight bearing on the left leg. Progress notes 10-3-11 indicated the tenant was discharged from the program.

- Regulatory Insufficiency: None noted.