IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake: 36796-C
36714-C

January 17, 2012

Ms. Jean Parrish, Director
Prime Living Apartments
725 Pearl Street
Sioux City, IA 51101

RE: Final Complaint/Incident Investigation Report, Prime Living Apartments, Sioux City, Iowa

Dear Ms. Parrish:

Enclosed is the **Final Complaint/Incident 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/Incident 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 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Complaint/Incident Intake #: 36796-C
36714-C

Jean Parrish, Director
Prime Living Apartments
725 Pearl Street
Sioux City, IA 51101

Date of Complaint/Incident Investigation:

November 28, 29 & 30, 2011

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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:	51
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	52
TOTAL census of Assisted Living Program	52

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

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

A. Policies and Procedures

Complaint/Incident Allegation #36796-C: It was alleged a tenant had a valuable item missing.

- Monitoring Observation: The Wellness Director indentified one tenant who had an item missing.

  Tenant #5 (the Tenant), a 76 year old, was admitted on 6-1-08 and diagnoses include Bipolar, Dementia without Behavioral Disturbances, Hyperlipidemia, Thalassemia and Mental Disorder. The Tenant was staged at a two on the Global Deterioration Scale (GDS), which indicated very mild cognitive decline.

  The Wellness Director said a police officer was at the Program to see the Tenant and he/she had jewelry missing. She called the Tenant's family and they arrived at the Program. The Wellness Director thought maybe the Tenant had misplaced the item.

  The Director said she heard from the Wellness Director that a police officer was at the Program regarding the Tenant's missing jewelry.

  According to a police report dated 9-23-11, the Tenant could not locate his/her ring that was placed in a jewelry box a month ago. It occurred from 7-23-11 to 8-23-11.

  The Tenant said he/she had a diamond ring missing and he/she reported it to the police department. The Tenant felt safe at the Program and did not know what happened to the ring.

According to the Program's policy on Incident Reporting, staff members would complete an incident report form with any minor or major incident that occurred. The policy indicated the following incidents would be reported: any incident that required the intervention of law enforcement and any incident that resulted in injury to self, to others or to property. The policy was effective 1-1-11.

Incident reports were reviewed from 1-3-11 to the time of the investigation. An incident report was not found related to the missing jewelry. It could not be determined what happened to the missing jewelry; however, the Program did not complete an incident report or investigation related to missing jewelry. The Program did not follow the policy on incident reporting.

- Regulatory Insufficiency: The program's policies and procedures on incident reports, at a minimum, shall include the following: All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. (IAC r. 481-67.2(1)(e))

B. Evaluation

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

Monitoring Observation: Tenant #2 (the Tenant) a 68 year old was admitted on 6-11-11 and diagnoses include Dementia, History of Deep Vein Thrombosis (DVT), Stress Incontinence, Edema, History of Leg Pain, Depression, High Cholesterol, Kidney Failure and Bipolar Disorder. The Tenant was staged at a two on the GDS, which indicated very mild cognitive decline. The Tenant was discharged from the Program on 11-7-11. A physician order was received on 8-3-11 to insert a catheter. The Service Notes dated 8-3-11 at 2:00 p.m. indicated an order was received to insert a catheter for prevention of skin breakdown and incontinence. Staff was to empty the catheter five times a day. The Service Plan dated 7-4-11, was updated on 8-3-11 and stated a catheter was placed for incontinence and prevention of skin breakdown. It was updated to reflect staff was to empty the catheter five times a day. The Service Notes dated 8-3-11 at 4:30 p.m. indicated the catheter was not inserted correctly. A fax from the adult health center dated 8-4-11 stated the catheter was placed and to notify the physician on 8-5-11 on how the catheter was tolerated. During an interview with the Wellness Director, she stated the catheter did not stay in place. The service plan was not updated to reflect the absence of a catheter. There was no documentation in the file to reflect the physician was notified the catheter did not remain in place. Evaluations were not completed as needed.

The Tenant Assessment dated 7-4-11 indicated staff would remind the Tenant to change briefs four times a day. According to the Service Notes dated 7-5-11, staff assisted Tenant with a shower and noticed the skin around the vaginal area was red and Tenant stated it was sore. Staff also noticed open areas on the buttocks. According to the adult health center Plan of Care dated 7-14-11, the Tenant was incontinent of urine at all times. According to the November 2011 Medication Administration Record (MAR), staff was to remind the Tenant to change briefs as often as possible. The MAR indicated staff reminded the Tenant every shift.

Staff #1 stated staff was instructed to remind the Tenant to toilet every time staff saw the Tenant. The Health/Functional Assessment dated 11-3-11 indicated bladder incontinence and bowel continence. Evaluations were not completed as needed.

A physician order dated 10-25-11 indicated left shin application of a thin layer of Silvadene every AM and PM and leave open to air. The right leg dressing would be completed at the adult health center. The Program was to leave the dressing on the right leg dressed and to not use Tubigrips. The MAR indicated the Program completed dressing changes to the left shin each AM and PM from 10-25-11 through 11-5-11. The adult health center records indicated wound care was provided three times per week, starting on 10-25-11 through 11-4-11. Evaluations were not completed as needed.

Tenant #3 (the Tenant), a 57 year old, was admitted on 1-28-11 and diagnoses include Bipolar Disorder, Borderline Personality Disorder, Anxiety, Depression, Hypertension (HTN), Gastroesophageal Reflux Disease, B12 Deficiency, Gastric Bypass and History of Left Ankle Fracture. Service Notes from 7-18-11 to 11-18-11 documented entries of staying in his/her apartment all shift, crying and voiced feeling upset about being alone. According to hospital discharge records, the Tenant was admitted on 11-1-11 and the discharge records were signed by the Tenant on 11-3-11. A Crisis Plan was dated 11-3-11. Service Notes indicated the Tenant returned from the hospital and orders were noted. According to a Medical Visit Form dated 11-11-11, the reason for the visit was increased depression, suicidal thoughts and feeling desperate. The summary of the visit indicated a safety plan was not utilized and the Tenant was referred to inpatient care for stabilization. The Service Notes indicated on 11-13-11 the Tenant returned from the hospital with no new orders. Evaluations were not completed as needed.

Tenant #4 (the Tenant), a 57 year old, was admitted on 8-8-10 and diagnoses include Diabetes, Hypothyroidism, Nerve Pain, Depression, History of Brain Injury from Motor Vehicle Accident and Right Hand Laceration. Service Notes from 8-4-11 to 11-29-11 documented entries of staying in his/her apartment all shift, he/she had an alcoholic beverage and felt really depressed and had a sore on his/her buttocks. According to incident reports from 9-2-11 to 11-4-11 the Tenant had six documented incidents regarding falls or losing his/her balance. Evaluations were not completed as needed.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

C. Service Plans

Complaint/Incident Allegation #36714-C: It was alleged there were concerns with services a tenant received.

Monitoring Observation: Tenant #1 (the Tenant) a 77 year old was admitted on 9-27-10 and diagnoses include Gout, HTN, Hypothyroidism, Enlarged Prostate, High Cholesterol, Double Bypass heart surgery, Cataract and Renal Failure. The Tenant was staged at a two on the GDS, which indicated very mild cognitive decline. According to the Service Notes dated 2-9-11, the Tenant was told it was shower day and the Tenant refused by telling staff to get out. The staff member returned later to tell the Tenant to take a shower and the Tenant said to get out and was yelling at the staff member. Service Notes dated 3-9-11 stated the Tenant refused to shower. During an interview with Staff #1 on 11-29-11, it was reported the Tenant frequently refused showers. The service plan dated 9-1-11 indicated staff was to assist with showers twice a week. The service plan did not include interventions for staff when the Tenant refused showers. The service plan did not reflect the identified needs of the Tenant.

Tenant #2's file was reviewed. A physician order was received on 8-3-11 to insert a catheter. The Service Notes dated 8-3-11 at 2:00 p.m. indicated an order was received to insert a catheter for prevention of skin breakdown and incontinence. Staff was to empty the catheter five times a day. The Service Plan dated 7-4-11, was updated on 8-3-11 and stated a catheter was placed for incontinence and prevention of skin breakdown. It was updated to reflect staff was to empty the catheter five times a day. The Service Notes dated 8-3-11 at 4:30 p.m. indicated the catheter was not inserted correctly. A fax from the adult health center dated 8-4-11 stated the catheter was placed and to notify the physician on 8-5-11 on how the catheter was tolerated. During an interview with the Wellness Director, she stated the catheter did not stay in place. The service plan was not updated to reflect the absence of a catheter. There was no documentation in the file to reflect the physician was notified the catheter did not remain in place. The service plan was not updated as needed and did not reflect the identified needs of the Tenant.

The Tenant Assessment dated 7-4-11 indicated staff would remind the Tenant to change briefs four times a day. According to the Service Notes dated 7-5-11, staff assisted Tenant with a shower and noticed the skin around the vaginal area was red and Tenant stated it was sore. Staff also noticed open areas on the buttocks. According to the adult health center Plan of Care dated 7-14-11, the Tenant was incontinent of urine at all times. According to the November 2011 MAR, staff was to remind the Tenant to change briefs as often as possible. The MAR indicated staff reminded the Tenant every shift. Staff #1 stated staff was instructed to remind the Tenant to toilet every time staff saw the Tenant. The Health/Functional Assessment dated 11-3-11 indicated bladder incontinence and bowel continence. The Service Plan completed on 7-4-11 and updated on 8-3-11 indicated the Tenant was continent of bowel and bladder. The service plan did not accurately reflect the Tenant's incontinence issues. The service plan was not updated as needed and did not reflect the identified needs of the Tenant.

A physician order dated 10-25-11 indicated Left shin application of a thin layer of Silvadene every AM and PM and leave open to air. The right leg dressing would be completed at the adult health center. The Program was to leave the dressing on the right leg dressed and to not use Tubigrips. The MAR indicated the Program completed dressing changes to the left shin each AM and PM from 10-25-11 through 11-5-11. The adult health center records indicated wound care was provided three times per week, starting on 10-25-11 through 11-4-11. The service plan did not reflect wound care needs. The service plan was not updated as needed and did not reflect the identified needs of the Tenant.

The Service Notes dated 11-5-11 at 8:30 p.m. indicated staff received an emergency phone call from the Tenant who stated he/she had called 911 requesting an ambulance because of loose stools and vomiting. The Tenant was transferred to the emergency room.

Tenant #3's file was reviewed. Service Notes from 7-18-11 to 11-18-11 documented entries of staying in his/her apartment all shift, crying and voiced feeling upset about being alone. According to hospital discharge records, the Tenant was admitted on 11-1-11 and the discharge records were signed by the Tenant on 11-3-11. A Crisis Plan was dated 11-3-11. Service Notes indicated the Tenant returned from the hospital and orders were noted. According to a Medical Visit Form dated 11-11-11, the reason for the visit was increased depression, suicidal thoughts and feeling desperate. The summary of the visit indicated a safety plan was not utilized and the Tenant was referred to inpatient care for stabilization. The Service Notes indicated on 11-13-11 the Tenant returned from the hospital with no new orders. The service plan did not address the Tenant's behaviors and interventions related to the behaviors. The service plan was not updated as needed and did not reflect the identified needs of the Tenant.

Tenant #4's file was reviewed. Service Notes from 8-4-11 to 11-29-11 documented entries of staying in his/her apartment all shift, he/she had an alcohol beverage and felt really depressed and had a sore on his/her buttocks. The service plan did not address the Tenant's behaviors and interventions related to the behaviors. The service plan did not address the sore of the Tenant's buttocks. According to incident reports from 9-2-11 to 11-4-11 the Tenant had six documented incidents regarding falls or losing his/her balance. The service plan did not reflect the fall history. The service plan was not updated as needed and did not reflect the identified needs of the Tenant.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. (481-69.26(3))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

D. Nurse Review

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

- Monitoring Observation: Tenant #4's file was reviewed. According to incident reports from 9-2-11 to 11-4-11 the Tenant had six documented incidents regarding falls or losing his/her balance. Nurse reviews were not completed as needed. The Tenant's service plan was updated on 10-3-11 to reflect a change in bathing services. A nurse review was not completed when a minor discretionary change was made to the service plan. Nurse reviews were not completed as needed.

  Tenant #6 (the Tenant) a 70 year old was admitted on 12-31-08 and diagnoses include Hypothyroidism, HTN, Depression, High Cholesterol, History of DVTs, Diabetes, Anemia, History of Dizziness, Cataract Removal and a Stroke in 2002. The Tenant was discharged from the Program on 10-26-11. According to the Service Notes dated 8-19-11, the Tenant pushed the pendant and was found on the floor in the bathroom. The Tenant stated the fall occurred while getting off the toilet. A nurse review was not completed as needed. According to the Service Notes dated 9-17-11 and an Incident/Accident Report dated 9-17-11, the Tenant pushed the pendant and staff found the Tenant on the floor after sliding out of bed. A nurse review was not completed as needed.

- 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 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))