IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

RODNEY A. ROBERTS, DIRECTOR

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

Complaint/Incident Intake #: 36696-C

January 23, 2012

Ms. Jana Happe, Manager
Gardens at Cherokee
1610 Highway 3
Cherokee, IA 51012

RE: Final Complaint/Incident Investigation Report, Gardens at Cherokee, Cherokee, Iowa

Dear Ms. Happe:

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. The Request for Reconsideration has been accepted for Staffing; however, your Request for Reconsideration has been denied for Service Plans due to the program has to update and individualize Service Plans for tenants.

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/Incident Investigation Report

Assisted Living Program:

Jana Happe, Manager
The Gardens at Cherokee
1610 Highway 3
Cherokee, IA 51012

Complaint/Incident Intake #: 36696-C

Date of Complaint/Incident Investigation:

December 6 & 7, 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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	30
Number of tenants with cognitive disorder:	8
Total Population of Program at time of on-site	38
TOTAL census of Assisted Living Program	38

Program History – There were no Regulatory Insufficiencies found during this certification period.

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

A. Service Plans

Complaint/Incident Allegation: It was alleged a tenant fell and sustained an injury.

Monitoring Observation: Tenant #2's file was reviewed. According to a Nurse Review dated 11-14-11, staff informed the Nurse around 12:00 p.m. that the Tenant complained of pain on the left side of his/her chest under his/her arm radiating down to his/her elbow. Vitals were obtained and the Tenant's oxygen saturation was 93%. The Tenant said that it had been going on since the morning and had gotten worse. The Tenant's pain was rated a six out of ten. The Nurse discussed with the Tenant the pain could be related to his/her heart and it could have been a heart attack. The Tenant verbalized understanding and refused to be transferred or taken to the ER. The Tenant's family member was contacted and came in to see the Tenant. The family member had come to the Program and left before the Nurse talked with the family member. The Nurse contacted the family member and left messages for the family member to contact the Nurse. The Tenant agreed to have the Nurse contact the physician. The Nurse contacted the physician's office and spoke with the nurse and explained the signs and symptoms and that the Tenant did not want to be transferred. The Tenant had a DNR code status. At 3:20 p.m. the Nurse received a verbal order for Nitro as directed as needed and oxygen 2L/NC as needed for chest pain. A written order for Nitro as needed as directed and oxygen at 2L/NC as needed for chest pain was dated 11-15-11 and was noted on 11-16-11. The Nurse contacted a pharmacy and the Nitro was delivered. The Nurse placed the Tenant on oxygen and administered the Nitro. At 3:45 p.m. the first Nitro was administered and vital signs were obtained.

The Tenant's pain was rated a seven to eight out of ten and the oxygen saturation was 92% at 2L/NC. The second Nitro was administered at 3:50 p.m. and vitals were obtained. At 3:55 p.m. the third Nitro was administered and vitals were obtained. The Tenant's pain was rated a five out of ten and the oxygen saturation was 96% at 2L/NC. At 4:00 p.m. and 4:30 p.m. vitals were obtained, the Tenant did not rate any pain and the oxygen saturation was 97% at 2L/NC. The Tenant was much more alert and was assisted out of bed into the chair. The Nurse contacted the physician to update that his/her chest pain had resolved and the physician verbalized agreement not to transfer. The Tenant still denied chest pain and the Nurse removed the oxygen and set it under the end table. The Tenant was instructed to page if he/she started to have chest pain. The Tenant's family member was notified of the events that had taken place.

According to an Incident Report Form dated 11-15-11 at 8:10 a.m. staff responded to the Tenant's page and the Tenant was on the floor with his/her feet by the closet and his/her head beside the open bathroom door. The Tenant was on his/her left side with his/her arm underneath him/her. The Tenant had his/her walker beside her and the oxygen tubing under his/her hip and legs with the oxygen tank by the bed. The Tenant put his/her hand on the back of the head and complained of severe hip pain. Staff put a pillow under the Tenant's head and did not move the Tenant. Vitals were taken and the Tenant agreed to have an ambulance called. The ambulance arrived and the Tenant's family member called the apartment and was notified. Nurse's/Care Notes dated 12-1-11 indicated family notified the Program the Tenant transferred to skilled care Status/Post Hip Fracture.

On 11-14-11 at 4:00 p.m. and 4:30 p.m. vitals were obtained, the Tenant did not rate any pain and the oxygen saturation was 97% at 2L/NC. The Tenant was much more alert and was assisted out of bed into the chair. The Tenant still denied chest pain and the Nurse removed the oxygen and set it under the end table. According to a Safety Check Form staff completed two hour checks on the Tenant and if the Tenant did not have his/her walker staff was to put the walker by him/her and remind him/her to use it at all times. Checks were consistently documented. At 11:00 p.m. on 11-14-11 the Tenant was sleeping in the chair and on 11-15-11 at 1:00 a.m. staff had to put the walker in the Tenant's bedroom and the Tenant was in bed. On 11-15-11 at 3:00 a.m. and 5:00 a.m. the Tenant was sleeping in the bed. On 11-15-11 at 7:00 a.m. the Tenant was awake and in bed. Staff #3 worked second shift on 11-14-11; she checked the Tenant at 11:00 p.m. and did not see the Tenant with oxygen and did not see the tank. Staff #4 worked third shift on 11-14-15 to 11-15-11; she checked on the Tenant at 1:00 a.m., 3:00 a.m. and 5:00 a.m. and she did not administer oxygen or observe the Tenant with oxygen.

Staff #2 worked the first shift on 11-15-11 and checked on the Tenant at approximately 6:50/7:00 a.m. The Tenant was in bed with walker beside the bed and had oxygen tubing on his/her face. She had never seen oxygen on the Tenant before. During breakfast she received a page from the Tenant and found him/her lying between the bathroom and the closet. She got Staff #1 and the Manager. The Manager called the Nurse. The Tenant reported his/her hip and neck hurt and the Tenant was given a blanket and pillow to make the Tenant more comfortable. The Manager called the ambulance, the Tenant was taken to the hospital and the Tenant had a hip fracture.

She said she did not know the oxygen was hooked up to the tank until after the Tenant had fallen. When the Tenant was on the floor the tubing was on his/her face and it was taken off after it was discovered the tank was empty. The tank was by the nightstand and she did not see any carrying device for the oxygen tank.

Staff #1 stated on 11-15-11 while assisting in the dining room with the breakfast meal, Tenant #2's pendant was activated and Staff #2 responded. When Staff #1 arrived at the Tenant's apartment, the Tenant was lying on the floor, head near the bathroom doorway, with the Tenant's body on the bedroom floor. The Tenant was laying on his/her left side with the arm that had the wrist pendant on under his/her body. The Tenant was wearing oxygen tubing with part of the tubing under the body. The oxygen tank was on the floor, was set at 2 liters; however, the tank was empty. The Tenant's color was good but the Tenant was in pain. Staff #1 completed the oxygen saturation on the Tenant but failed to document the result.

The oxygen saturation level was not documented on the incident report at the time of incident; however, the paramedic report indicated the Tenant's oxygen saturation was 98% at 8:30 a.m.

The Tenant's service plan was not updated and did not reflect the Nitro, chest pain and Oxygen as needed with chest pain.

Tenant #3 (the Tenant), an 87 year old, was admitted on 6-22-11 and diagnoses include HTN, Incontinence, Left Knee replacement and History of Cardiovascular Accident. According to an Incident Report Form dated 11-3-11, the Tenant was found lying on the floor in the doorway of the bedroom. The Tenant was assisted up and complained of general aches and left knee pain.

According to a Nurse Review completed on 11-3-11, the Tenant had fallen and was unable to bear weight on the left knee and it was swollen and warm. The Tenant refused to go to the ER but agreed to see the physician at the office. The physician withdrew fluid from the knee and drew blood work. On 11-4-11 at 2:30 p.m., the physician was informed the Tenant's right knee was very swollen and warm to the touch and it appeared filled with fluid. The Tenant was unable to bear weight on the left knee without increased pain. On 11-4-11 at 5:00 p.m. the physician came to the Program to assess the Tenant and wrote an order to admit the Tenant to the local hospital.

Cognitive, functional and health evaluations were completed on 11-4-11 related to a required need for minimal assist with dressing and bathing due to a possible infection in the left knee. The evaluations indicated the Tenant required the assist of two to transfer to a wheelchair with a gait belt. The Nurse Review completed on 11-3-11 included a notation dated 11-4-11 that the Nurse was unable to update the service plan prior to transfer, however, the service plan dated 7-11-11 was not updated when evaluations were completed related to these changes and did not reflect the changes.

According to the Nurse's/Care Notes dated 11-7-11, the Tenant was transferred from the local hospital to a regional hospital where the Tenant remained at the time of the investigation.

The service plan was not based on evaluations and was not updated as needed. The service plan did not reflect the Tenant's need for dressing, bathing and transfer assistance.

Tenant #5 (the Tenant), an 88 year old, was admitted on 5-28-11 and diagnoses include Congestive Heart Failure, HTN, Hypercholesterolemia, History of Prostate Cancer and History of Renal Failure. The Tenant was discharged on 8-5-11.

Cognitive, functional and health evaluations were completed on 7-20-11 related to edema, weight gain and confusion. The evaluations indicated a 5 pound weight gain in the last 30 days and edema in bilateral lower extremities. The service plan was not updated when evaluations were completed related to these changes and did not reflect the changes. According to a Nurse Review dated 7-30-11, the Tenant was seen in the ER and was fatigued and had increased swelling in bilateral lower extremities. The Tenant had 2+ pitting edema and had gained 9 pounds in the last week.

According to an Incident Report Form dated 8-2-11, the Tenant was found on the floor and stated he/she was walking from the bathroom and his/her feet became tangled in the oxygen tubing. The Tenant tried to grab the motorized cart but it was beyond the Tenant's reach and the Tenant could not find his/her pendant which was around the Tenant's neck. The Tenant used his/her walker at the time of the fall. The Tenant's oxygen saturation was documented as 93%. According to an Incident Report Form dated 8-3-11, the Tenant paged and when staff responded the Tenant was sitting on the floor and said he/she fell on the way to bathroom using the walker when he/she became dizzy. The Tenant sustained a small cut on the middle finger and a purpling bruise started on his/her back. According to an Incident Report Form dated 8-4-11 the Tenant was found lying on the floor in the living room and had fallen. The Tenant sustained a cut on the right arm and side of his/her forehead. The service plan was not based on evaluations and was not updated as needed. The service plan did not reflect the Tenant's use of oxygen, edema, weight gain and confusion.

Incident reports were found for the incidents detailed above for Tenant #2, Tenant #3 and Tenant #5. None of the falls were witnessed by staff and none required the Program to report the incidents to the Department. Tenant #2, Tenant #3 and Tenant #5 did not have service plans updated as needed when changes were needed and the service plans did not reflect the identified needs of the tenants.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1))

- 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))