IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake: 37865-C

March 26, 2012

Ms. Barbara McFerran, Administrator
Prairie Hills at Independence
505 Enterprise Drive SW
Independence, IA 50644

RE: Final Complaint/Incident Investigation Report – Prairie Hills at Independence, Independence, IA

Dear Ms. McFerran:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of March 13, 2012, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding 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/Incident Investigation Report

Assisted Living Program:

Barbara McFerran, Administrator
Prairie Hills at Independence
505 Enterprise Drive SW
Independence, IA 50644

Complaint/Incident Intake #: 37865-C

Date of Complaint/Incident Investigation:

March 13, 2012

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:	35
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	35
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	5
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	14
TOTAL census of Assisted Living Program	49

Program History –

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged the tenants in the dementia unit did not receive the same food as the tenants in the general population. It was alleged some of the food served in the dementia unit was difficult for tenants to eat.

- Monitoring Observation: The Dietary services policy indicated the Program provided three nutritional meals daily, prepared under sanitary conditions to satisfy the needs of individual tenants. Menus were planned to provide the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Science and would be 100% of those allowances. The Program would seek to give individual treatment to each tenant, both in the food served and the atmosphere in which it was provided. Liberalized diets would be provided for all tenants. The Program did not provide therapeutic diets.

  The lunch meal was observed in the general population and dementia unit. In the general population, porcupine meat balls or boneless pork ribs in barbeque sauce, parsley potatoes, corn, lettuce salad and a bread/cake dessert was served. Food was dished up, plated and transported to the dementia unit in an insulated cart. In the dementia unit porcupine meat balls, parsley potatoes, corn, lettuce salad and bread/cake dessert was served. The other entrée choice was not offered; however the

rest of the meal was the same as what was served in the general population. Staff #1 assisted with the meal in the dementia unit and served beverages and food, assisted with cutting up food and opened up containers. Staff #1 was present during the time the meal was observed. The atmosphere in the dementia unit dining room appeared pleasant and the tenants said they liked the food. The items served reflected what was listed on the menu and the same items were served with the exception of a choice of an entrée. In the general population tenants filled out a sheet and indicated their preferences for upcoming meals. This was not the practice in the dementia unit. The dementia unit had nine tenants that had a Global Deterioration Scale (GDS) of four or greater, which indicated moderate cognitive impairment.

Staff #1 stated the menus were the same for the tenants in the dementia unit and the tenants in the general population. Staff #2 stated the tenants in the dementia unit did not receive multiple option choices as it was too overwhelming for the tenants to decide between multiple choices. The Wellness Assistant stated the menus were generally the same between the dementia unit and general population but sometimes if something was not easily chewable for the tenants in the dementia unit, a substitution was offered.

Staff #1 and the Wellness Assistant stated the food served for both populations was the same. Staff #2 stated normally tenants in the dementia unit received one option and the general population was offered two options.

Staff #1, #2, and the Wellness Assistant stated no tenants had difficulty eating the food served. Staff #1 stated the food served in the dementia unit was what everyone could eat. Staff could call the kitchen to get another option if needed and they always had soup as an additional option. Staff #2 stated staff would cut up food and sit with tenants while eating if needed in the dementia unit. The Wellness Assistant stated few tenants needed to have their food cut in order for it to be chewed.

Staff #5, the Kitchen Manager, said the menus were the same for the dementia unit and the general population. She said the general population was given a choice. She said only one of the entrees was sent to the dementia unit. She said if there were enough of both entrees both would be sent to the dementia unit. She said no one had said anything to her regarding difficulty eating the food served. She said there was a monthly tenant council to address issues.

The same menus were used for the dementia unit and general population. The same food was served with the exception of the choice of entrée. The tenants in the general population filled out a sheet and indicated their preferences for upcoming meals. Per staff interview it was too overwhelming for tenants in the dementia unit to decide between the multiple choice options. A meal was observed and the same food was served with the exception of a choice of an entrée. Per staff interviews there were no issues with tenants and difficulty eating the foods. The tenants commented they enjoyed the food during the meal; staff assisted with various aspects of the meal and the atmosphere appeared pleasant.

- Regulatory Insufficiency: None noted.

B. Service Plans

Complaint/Incident Allegation: It was alleged a tenant had a wound and did not receive appropriate services.

- Monitoring Observation: Four tenant files were reviewed. Two current tenants and two discharged tenants.

Tenant #1, a 91 year old, was admitted on 4-26-06 and diagnoses include: Dementia, Peripheral Vascular Disease, Lower Left Extremity Cellulitis, Hypertension (HTN), History of Venous Stasis Ulcers, Arthritis and Hip, Right Knee and Right Ankle Surgery. Tenant #1 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit.

According to Nurse's Notes dated 1-27-12, Tenant #1 had another small opening to the right lower extremity (RLE). The opening was not a new opening but it was the same wound that kept reopening. A nurse review indicated Tenant #1 had a small circular opening approximately ½ cm in diameter and another small elongated opening starting at the circular opening and going down his/her shin. The elongated opening was approximately ¼ cm wide and 2 cm long. The information was faxed to an advanced registered nurse practitioner at a local wound clinic. Orders were received for Aquacel moistened with saline then cover with dry gauze and secure with tubigrip. Nurse's Notes dated 2-20-12 indicated Tenant #1 would not keep the dressing on RLE. The wound was not healing and Tenant #1 had an upcoming appointment at a wound clinic. Notes indicated on 2-23-12 orders were received to complete a daily change to RLE using Santyl ointment, gauze and Tegaderm. The order also indicated to apply triple antibiotic ointment twice daily to forehead. On 3-1-12 an order was received to continue Santyl but to discontinue occlusive dressing and to use roll gauze to secure dressing with size E tubigrip. The orders indicated a culture was taken and the results were pending. On 3-5-12 an order was received to start Keflex 500, 4 times daily for 10 days. On 3-8-12 Keflex was discontinued, Bactrim DS one tablet by mouth twice daily, Gentamycin cream, dry gauze and tape was ordered. It was indicated it was okay for Tenant #1 to wear compression hose on bilateral extremities.

A Wound Clinic Assessment Record dated 3-8-12 indicated the wound was 2.4 x 1.1 x.01 cm. The wound was a pressure wound and the condition of the wound was moist and slough. The wound exudate was described as small, red, tan and did not have an odor. The wound progress was indicated as stable and there was no wound pain when at rest.

The service plan reflected Tenant #1 had chronic stasis ulcers to lower extremities and frequent skin tears. As needed wound treatment would be reflected on the Medication Administration Records (MARs). Staff was to notify nursing of any concerns such as open areas, wounds that were getting larger rather than smaller, increased redness/edema, foul odor or odorous drainage, complaints of pain or fever. The service plan indicated Tenant #1 scratched his/her head frequently and often had open lesions on his/her scalp. There were interventions listed related to Tenant #1 itching his/her scalp. Tenant #1's file reflected evaluations, nurse reviews and faxes to a local wound clinic that addressed the wound and treatment. The service plan

reflected chronic stasis ulcers to lower extremities and interventions. The service plan reflected the identified needs of Tenant #1.

Tenant #2, an 88 year old, was admitted on 8-22-06 and diagnoses include: Dementia, HTN and Trans Ischemic Attacks. Tenant #2 was staged at a six on the GDS, which indicated severe cognitive decline. Tenant #2 resided in the dementia unit. Tenant #2 was discharged from the Program on 12-27-11. A service plan dated 11-11-11 indicated staff was to report to nursing any areas of redness to the skin. A pillow would be propped under Tenant #2's left side and left foot nightly after Tenant #2 was asleep to keep pressure off the left buttocks, hip and foot. Tenant #2 was to be turned three times per night until pressure ulcer was healed. The service plan indicated to apply Elta Seal as ordered to pressure ulcer until healed. Watch Tenant #2's elbows, heals and buttocks for reddened or open areas. Report any concerns to nursing. If Tenant #2 had any skin concerns treat with dressing changes as per MAR. The service plan was updated on 12-16-11 to reflect open area on right hip.

A nurse review completed on 11-11-11 stated staff continued to prop Tenant #2's foot on a pillow while he/she was in bed or used a heel protector. Tenant #2 continued to have a small ulcerative area to medial aspect on right ball of foot, 0.25 inches, however the area was not open. Tenant #2 was started on Keflex antibiotic for 10 days for a new pressure ulcer located on the left hip, size of 4 inches in diameter, 2 drying open areas and fading erythema. Tenant #2 saw his/her physician on 11-10-11 and Elta Seal was ordered to be applied to the left thigh three times a day until healed. Tenant #2 was also to be turned three times during sleeping hours until healed.

A nurse review completed on 11-22-11 indicated Tenant #2 had a change of condition with skin breakdown due to inability to turn self in bed, inability to feed self and often unwilling even with much encouragement to get out of bed and to do Activities of Daily Living such as toileting, dressing and transfers. Staff continued to prop Tenant #2's foot on a pillow while he/she was in bed or used a heel protector. The ulcerative area to ball of foot appeared to have resolved. The pressure ulcer located on the left hip was no longer open and it still had a hard area located in the center. Tenant #2 was to be turned three times during sleeping hours until healed.

A nurse review completed on 12-2-11 indicated a family care conference was held to review declining issues. Tenant #2 needed the assistance of two for bed turns and at times was resistant to being turned.

A nurse review completed on 12-16-11 indicated staff notified nursing Tenant #2 had an open area on the right hip. A large circular open area approximately 2 inches in diameter was noted on the right hip. A fax was sent to Tenant #2's physician describing the open area on the right hip and request for treatment orders. Physician orders were received for Elta Seal three times per day to right hip until healed and start Keflex 500 mg orally three times per day for ten days.

Tenant #2's MARs from 11-10-11 through 12-27-11 indicated wound treatment was performed three times per day as ordered, with the exception of one time on 11-26-11 when Tenant #2 refused the wound treatment. Tenant #2's MARs from 11-10-11 through 12-27-11 indicated to turn Tenant #2 three times per night while in bed. Documentation of turning three times per night was completed each night. From 11-

10-11 through 12-26-11, of a total of 114 times scheduled to turn Tenant #2, he/she refused to be turned 21 times.

Staff #1 stated Tenant #2 had open wounds on each hip and required lots of turning. She stated Tenant #2 was propped up with pillows and would take the pillows out and roll onto his/her back. She stated Tenant #2 was up in her chair most of the day. Staff #2 stated she would monitor wounds closely and report changes to the nurses. She stated Tenant #2 had bed sores and they tried everything. Pillows were used for repositioning. She stated nurses were there all the time to keep a close eye on the wounds. Tenant #2's file reflected evaluations, nurse reviews and faxes to the physician that addressed the wound and treatment. The service plan reflected the wound, treatment and interventions. The MARs indicated physician orders were followed and Tenant #2's refusals were documented. The service plan reflected the identified needs of Tenant #2.

Tenant #3 was an 81 year old, admitted on 10-21-11, and diagnoses include: Alzheimer's Disease, Depression, History of Skin Cancer removed behind the left ear, Osteoporosis, Hyperlipidemia, Lumbar Laminectomy, Equilibrium Problems and History of Diarrhea. Tenant #3 was staged at a four on the GDS, which indicated moderate cognitive decline. A service plan completed on 2-9-12 did not indicate any wounds or wound treatments.

According to an Accident and Incident report dated 2-17-12, Tenant #3 fell and hit his/her nose and left eye in a bathroom and was bleeding. Tenant #3 was transported to the emergency room (ER). According to a nurse review, Tenant #3 was transferred from the ER to a hospital to have facial lacerations repaired. Tenant #3 returned to the Program on 2-19-12 with an oral antibiotic and an antibiotic ointment to apply to the sutures three times a day. A nurse review indicated scripts were received on 2-20-12, orders were written on the MAR and staff was instructed on orders. The service plan indicated staff administered medications per MAR. The service plan reflected the identified needs of Tenant #3.

Tenant #4, a 100 year old, was admitted on 4-1-06 and diagnoses include: Memory Loss, History of Asthma, HTN and Gastro Esophageal Reflux Disease. Tenant #4 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #4 was discharged from the Program on 2-19-12. Tenant #4's service plan did not indicate any wounds or wound treatment and reflected the identified needs of Tenant #4.

Staff #1, #2, #3 and #4 had documented nurse delegated training on wound care.

Review of tenant files indicated the service plans reflected the identified needs of the tenants. Tenant #1 and Tenant #2 had wounds and the files showed evaluations, nurse reviews, updated service plans and communication with health care professionals regarding the treatment of the wounds. Review of the files indicated medical orders related to wound care and related services were completed as ordered and tenant refusals of orders were documented.

- Regulatory Insufficiency: None noted.