IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 38488-C

June 11, 2012

Ms. Nicole Ellermeier, Manager
Whispering Creek Assisted Living
2607 Nicklaus Blvd.
Sioux City, IA 51106

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

Dear Ms. Ellermeier:

I. Final Complaint/Incident Investigation Report – Whispering Creek Assisted Living, Sioux City, IA

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. The Report notes Regulatory Insufficiencies in the area(s) of: Nurse Review, Evaluations and Medications. **Whispering Creek Assisted Living** ("Program") is being assessed a $1,000 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 to the State of Iowa in the amount of six hundred fifty dollars ($650) 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 $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on June 7, 2012, has been reviewed and will constitute the final POC related to the on-site visit of April 23 & 24, 2012.

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/Incident Investigation Report

Assisted Living Program:

Nicole Ellermeier, Manager
Whispering Creek Assisted Living
2607 Nicklaus Blvd.
Sioux City, Iowa 51106

Complaint/Incident Intake #:

38488-C

Date of Complaint/Incident Investigation:

April 23 and 24, 2012

Monitor(s):

Maribeth Freland RN
Joyce Kix RN

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:	19
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	24

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	16
Total Population of Program at time of on-site	16
TOTAL census of Assisted Living Program	40

Program History – There were no regulatory insufficiencies found during this certification period.

Complaint/Incident Investigation – The Complaint/Incident investigators made the observations detailed in the following areas:

A. Nurse Review

Complaint/Incident Allegation: It was alleged the program's nurses did not assess tenant changes in health status when changes occurred. It was also alleged the program's nurses did not assure health care orders were current to meet tenant individualized needs.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6 and #7. The monitors also reviewed the program's incident reports from August 2011 to April 2012 and interviewed staff members as applicable.

  Tenant #1 had been diagnosed on 4-4-12 with bronchitis and an acute urinary tract infection. Tenant #1 had not gotten much better and was becoming weaker requiring hospitalization from 4-8-12 to 4-13-12 for acute renal failure and possible sepsis. Upon return from the hospital, the nurse completed a timely nurse review. Tenant #1's clinical record contained appropriate nurse reviews completed at least every 90 days as required by regulation.

  Tenant #2, an 85 year old, was admitted to the program on 7-23-10 with the diagnoses of Dementia, Hypertension (HTN) and Osteoporosis. Tenant #2 resided in the program's memory care unit. Tenant #2 scored a 5 on the Global Deterioration Scale (GDS) completed on 3-29-12, indicating moderately severe cognitive decline.

The Service Plan, dated 3-29-12, documented Tenant #2 was independent with grooming, dressing, transfers, mobility and toileting. Tenant #2's clinical record included documentation indicating he/she experienced symptoms of constipation and urinary tract infection on 4-9-12. A family member took Tenant #2 to obtain a medical evaluation at the emergency room. Tenant #2 was started on medication for both constipation and diagnosed urinary tract infection and returned to the program. During interview, Staff #1, certified medication aide (CMA); Staff #5, CMA; Staff #6, certified nursing assistant (CNA); Staff #7, CNA; and Staff #8, CMA reported Tenant #2 began experiencing increased incontinence and a need for physical assistance to cleanse after incontinent episodes and changing of incontinence products for about one week prior to 4-9-12. This need for assistance with toileting and incontinence care continued through 4-19-12. The clinical record lacked a nurse review following Tenant #2's emergency room visit or any time between 4-9-12 and 4-19-12 despite the apparent changes in Tenant #2's functional status.

Tenant #2's clinical record included documentation indicating Tenant #2 fell on 4-19-12. The incident report, dated 4-19-12, documented Staff #8, CMA, found Tenant #2 lying on his/her stomach on the bathroom floor in his/her apartment at 6:40 a.m. and this fall was not witnessed by staff according to the incident report. Staff #8 reported Tenant #2's eye and cheek area were bruised and swollen. Tenant #2 was bleeding from the nose and mouth. The CMA documented Tenant #2 reported pain; however, Tenant #2 could not specify where the pain existed due to cognitive impairment. The CMA attempted to obtain vital signs but was unable to as Tenant #2 was in pain when Staff #8 attempted to move Tenant #2. An ambulance was summoned and Tenant #2 was subsequently taken to the emergency room at 7:05 a.m. on 4/19/12 for x-rays and medical evaluation. Tenant #2 returned to the program at approximately 12:30 p.m. with papers documenting facial and cervical spine x-rays had been taken, resulting in the diagnosis of multiple facial fractures.

The clinical record contained a nurse review completed by Staff #10, Licensed Practical Nurse (LPN), at 10:15 AM on 4-19-12 determining Tenant #2 had no significant change in condition. Tenant #2 had not yet returned from the emergency room when the LPN completed the nurse review; therefore, the LPN could not have completed a hands-on evaluation of Tenant #2 or could not have been aware of any changes in Tenant #2's functional status at that time. During interview, Staff #1, CMA; Staff #3, CMA; Staff #5, CMA; Staff #6, CNA; Staff #7, CNA; and Staff #8, CMA reported Tenant #2 returned to the program unable to bear weight on his/her left leg, unable to pivot when standing, unable to dress him/herself and unable to participate in toileting. Tenant #2 was reporting pain to his/her left hip area; a bruise was noted to be on Tenant #2's left hip area and Tenant #2 required use of Hydrocodone for pain three times daily between 4-19-12 and 4-23-12.

Staff #8, CMA, reported notifying Staff #10, LPN, on 4-19-12 after learning that the emergency room had not done hip x-rays and prior to Tenant #2's return from the hospital, that Tenant #2's position when he/she was lying on the floor after falling was suspect for a fracture as Tenant #2's legs looked off to the side and one leg looked shorter than the other leg. Staff #10, LPN, worked during the day on 4-20-12 having the opportunity to visualize Tenant #2 and talk to staff members about Tenant #2's condition following the previous days fall.

Staff #3, CMA, reported she contacted Staff #10, LPN, on 4-21-12 during the day shift to report finding a bruise on Tenant #2's left hip (this was also documented on the aide shift report sheet). Tenant #2's clinical record lacked a nurse review after Tenant #2's return from the emergency room or any time prior to the morning of 4-23-12 despite the apparent changes in Tenant #2's functional status. On 4-23-12 at 9:18 AM, Staff #10, LPN, completed a nurse review, subsequently sending Tenant #2 to the hospital for changes in Tenant #2's functional status. Tenant #2 was diagnosed with a fracture of the left hip and had surgery to place pins in the hip later in the day on 4-23-12. Tenant #2 did not return to the program prior to the end of the onsite visit on 4-24-12.

During interview, Staff #10, LPN, denied talking with any staff members about Tenant #2, specifically discussing Tenant #2's position on the floor following the fall on 4-19-12, discussing Tenant #2's change in functional status or discussing any bruising to Tenant #2's hip until the morning of 4-23-12. Staff #10 reported she did not question any staff members about Tenant #2's fall as she had trusted the information documented on the incident report. The incident report did not describe the position of Tenant #2's body after his/her fall, except to document Tenant #2 was laying on his/her stomach. The incident report did not indicate Tenant #2's extremity range of motion; however, the report indicated Tenant #2 was in pain when staff members attempted to move Tenant #2's arms or roll Tenant #2 over. The LPN reported she did assess Tenant #2 after his/her return from the hospital on 4-19-12; however, she could not produce this documentation to the monitors.

The program did not complete a nurse review following Tenant #2's emergency room visit on 4-9-12, despite Tenant #2's increased incontinence and a new requirement for staff members to assist Tenant #2 with toileting. The nurse review completed by the LPN on 4-19-12 to assess for changes was done while Tenant #2 remained at the hospital. The LPN did not complete a nurse review following Tenant #2's return back to the program from the hospital. Staff members reported having concerns with Tenant #2's physical health and functional status beginning on 4-19-12 immediately upon Tenant #2's return from the hospital. Staff members reported making the LPN aware of Tenant #2's changes on 4-19-12 and 4-21-12. The LPN was present at the program on 4-19-12 and 4-20-12. The LPN did not complete a nurse review until 4-23-12 to address any changes in Tenant #2's health or functional status despite multiple staff member reports that Tenant #2 was exhibiting changes in toileting, transferring, mobility and dressing abilities.

Tenant #3, a 78 year old, was admitted to the program on 12-3-09 with the diagnoses of Diabetes, HTN, Macular Degeneration and Chronic Obstructive Pulmonary Disease. Tenant #3 resided in the program's general population area. Tenant #3 experienced no cognitive impairment. Tenant #3's service plan, dated 3-7-12, documented Tenant #3 required the assistance of one person with all transfers and stand by assistance with ambulation at times.

Incident reports documented Tenant #3 fell on 1-22-12, three different times on 2-9-12, 2-27-12, 3-16-12 and 4-11-12. The clinical record contained nurse reviews following the falls on 1-22-12, 2-9-12, 2-27-12, 3-16-12 and 4-11-12. During interview, Tenant #3 reported a CNA assisted him/her following the fall on 4-11-12.

Tenant #3 denied any nurse visit to assess Tenant #3 either the day of the fall or the following few days. During interview, Staff #10, LPN, who had completed the nurse review documented on 4-12-12, verified she had not completed any physical evaluation of Tenant #3's health or functional status and did not receive any verbal intake of information about Tenant #3 following his/her fall on 4-11-12. The LPN reported she took the information from the incident report and documented that information, which had been obtained by the CNA immediately following Tenant #3's fall. The LPN reported she trusted the information collected by the aide therefore did not believe an actual assessment of Tenant #3 by herself would be necessary. The LPN did not assess Tenant #3 for any injuries or functional changes which may have occurred as a result of the fall.

Tenant #4 did not have need for completion of a nurse review during his/her residence at the program between 3-14-12 and 4-2-12, at which time Tenant #4 moved out of state.

Tenant #5, a 74 year old, was admitted to the program on 8-1-11 with diagnoses of Dementia, HTN and Coronary Artery Disease. Tenant #5 resided in the program's general population area. Tenant #5 scored a 3 on the GDS, completed on 8-29-11, indicating mild cognitive decline.

The clinical record included documentation indicating Tenant #5 saw a physician for a routine follow up appointment on 12-8-11, returning to the program without any changes in physician's orders. On 12-9-11, Tenant #5 began experiencing loose stools throughout the day. Staff members noted Tenant #5's blood pressure to be lower than normal for Tenant #5. The program nurse notified Tenant #5's physician on 12-9-11, reporting Tenant #5's loose stools and low blood pressure. The clinical record contained a physician's order, dated 12-9-11, directing staff members to hold Tenant #5's blood pressure medication at 9:00 PM, due to continuance of the low blood pressure. Tenant #5's blood pressure continued to remain low on the morning of 12-10-11 and Tenant #5's skin color was noticeably changed. The program contacted Tenant #5's family member to transport Tenant #5 to the emergency room for medical evaluation on 12-10-11. Tenant #5 was subsequently admitted to the hospital with diagnoses of dehydration and acute renal failure and returned to the program on 12-15-11. Staff #11, LPN completed a nurse review on 12-15-11 upon Tenant #5's return to the program, finding no significant changes in Tenant #5's status. The LPN completed timely nurse reviews, finding no significant changes in condition after completing the reviews.

Tenant #6, a 75 year old, was admitted to the program on 8-18-11 with diagnoses of Diabetes, HTN and Coronary Artery Disease. Tenant #6 resided in the program's general population area. The program's cognitive assessment, completed on 9-12-11, indicated Tenant #6 experienced no cognitive decline.

Tenant #6's clinical record included a physician's order, dated 8-18-11, directing staff members to monitor Tenant #6's blood sugars four times daily, notifying the physician if the blood sugar reading was above 400 or below 85. The program did not have any physician orders at that time directing treatment if Tenant #6 was having a hyperglycemic or hypoglycemic episode.

The August 2011 Medication Administration Record (MAR) included documentation of Tenant #6's blood sugar readings every day at 7:30 a.m., 11:30 a.m., 4:30 p.m. and 8:30 p.m.. The monitors noted the following blood sugar readings: 8-19-11 at 11:30 a.m. (76); 8-20-11 at 7:30 a.m. (84); 8-21-11 at 11:30 a.m. (45); 8-22-11 at 11:30 a.m. (83); 8-23-11 at 11:30 a.m. (49); 8-24-11 at 11:30 a.m. (57); 8-24-11 at 8:30 p.m. (43); 8-25-11 at 7:30 a.m. (65); and 8-25-11 at 11:30 a.m. (57) and 8-25-11 at 1:30 p.m. (29). The same MAR showed staff members gave Tenant #6 his/her scheduled dosage of Novolog insulin 4 units SQ at 7:30 a.m., 11:30 a.m. and 4:30 p.m. from 8-19-11 despite the low blood sugar readings. The clinical record lacked any documentation of notification of the low blood sugar readings by the direct care staff to the program RN or Tenant #6's physician prior to giving Tenant #6 his/her scheduled dosage of insulin. The monitors found no documentation indicating the program nurses identified the staff member's failure to notify Tenant #6's physician prior to giving the insulin with blood sugars lower than 85 as directed by Tenant #6's physician. This practice continued to happen from 8-19-11 to 8-25-11 without nurse review or intervention, resulting in Tenant #6's low blood sugar incident on 8-25-11. The clinical record included documentation of physician notification by facsimile of the low blood sugar occurring on 8-21-11 at 11:30 a.m. but lacked physician notification of any of the blood sugars below 85 which occurred on 8-19, 20, 22, 23, 24 or 25-11.

Tenant #6's clinical record included documentation indicating Tenant #6 experienced a hypoglycemic incident on 8-25-11 at approximately 1:00 p.m. Tenant #6's family member visited, finding Tenant #6 in his/her apartment in an unresponsive state. During interview, Staff #9, RN, reported the family member called her to Tenant #6's apartment. She checked Tenant #6's blood sugar, noting it to be "low". Tenant #6 was unresponsive. Staff #9 noted the program had no physician's orders for emergent care during a hypoglycemic incident. Staff #9 borrowed Glucose gel from Tenant #7, who also resided at the program. Tenant #6 was unable to swallow the Glucose gel so Staff #9 borrowed Intramuscular (IM) Glucagon from Tenant #7 and administered it to Tenant #6 intramuscularly. Staff #9 reported she obtained orders from Tenant #6's physician after the incident was resolved, concurring she administered both medications without physician's orders.

The clinical record contained a physician's order, dated 8-25-11, which ordered Glucagon 1 milligram (mg) to be administered IM as needed when blood sugar readings were below 50 and accompanied by symptoms of hypoglycemia, such as coma, convulsions, or inability to swallow. The same order also included a notation to approve administration of one tube of Glucose gel on 8-25-11 at 2:00 PM for low blood sugar. The clinical record also included a physician's order dated 8-25-11, which directed staff members to hold the scheduled dosage of Novolog insulin if any blood sugar reading was less than 120, notify the physician if the blood sugar was less than 85 and to send routine weekly documentation to the physician of all blood sugar readings after 8-25-11.

Staff #11, LPN, completed a nurse review following Tenant #6's hypoglycemic episode on 8-25-11 finding no significant changes in condition. Tenant #6 returned to his/her usual state following treatment for the hypoglycemia.

The program nurses had not identified that staff members were not following physician's orders to report any blood sugar readings which were less than 85 and were continuing to give Tenant #6 his/her scheduled insulin despite the low blood sugar readings without notification to either the nurse or the physician for 7 days. The program nurses did not complete a nurse review during those 7 days.

Tenant #7 did not require completion of a nurse review due to any potential significant changes during his/her residence at the program between 1-1-12 and 4-23-12. Tenant #7's clinical record contained appropriate nurse reviews completed at least every 90 days as required by regulation.

- Regulatory Insufficiency: 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 monitor, at least every 90 days or after a significant change in the tenant's condition, to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r. 481-69.27(1))

- Regulatory Insufficiency: 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))

B. Evaluation

Complaint/Incident Allegation: It was alleged the program nurses did not evaluate tenant changes in condition in a timely manner, resulting in hospitalization need. It was also alleged the program did not notify family members in a timely manner when tenants experienced health concerns.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6 and #7. The monitors also reviewed the program's incident reports from August 2011 to April 2012 and interviewed staff members as applicable.

  Tenant #1 had been diagnosed on 4-4-12 with bronchitis and an acute urinary tract infection. Tenant #1 had not gotten much better and was becoming weaker requiring hospitalization from 4-8-12 to 4-13-12 for acute renal failure and possible sepsis. Upon return from the hospital, Tenant #1 did not exhibit any significant changes in condition.

Tenant #2 exhibited moderately severe cognitive decline. The clinical record included documentation indicating Tenant #2 had activated a durable power of attorney to make decisions for Tenant #2.

Tenant #2's Service Plan, dated 3-29-12, documented Tenant #2 was independent with grooming, dressing, transfers, mobility and toileting. Tenant #2's clinical record included documentation indicating he/she experienced symptoms of constipation and urinary tract infection on 4-9-12. Tenant #2's family took him/her obtain medical evaluation at the emergency room. Tenant #2 was started on medication for both constipation and diagnosed urinary tract infection and returned to the program. During interview, Staff #1, CMA; Staff #5, CMA; Staff #6, CNA; Staff #7, CNA; and Staff #8, CMA reported Tenant #2 began experiencing increased incontinence and a need for physical assistance to cleanse after incontinent episodes and changing of incontinence products for about one week prior to 4-9-12. This need for assistance with toileting and incontinence care continued through 4-19-12. The clinical record lacked a significant change evaluation completed by a registered nurse following identification of Tenant #2's apparent changes in functional status.

Tenant #2's clinical record included documentation indicating Tenant #2 fell on 4-19-12. According to the incident report, dated 4-19-12, documented Staff #8, CMA, found Tenant #2 lying on his/her stomach on the bathroom floor in his/her apartment. Staff #8 reported Tenant #2's eye and cheek area were bruised and swollen. Tenant #2 was bleeding from the nose and mouth. The CMA documented Tenant #2 reported pain; however, Tenant #2 could not specify where the pain existed due to his/her cognitive impairment. The CMA attempted to obtain vital signs but was unable to as Tenant #2 was in pain when Staff #8 attempted to move Tenant #2 or roll him/her over. An ambulance was summoned and Tenant #2 was subsequently taken to the emergency room for x-rays and medical evaluation. Tenant #2 returned to the program at approximately 12:30 PM with papers documenting facial and cervical spine x-rays had been taken, resulting in the diagnosis of multiple facial fractures.

During interview, Staff #1, CMA; Staff #3, CMA; Staff #5, CMA; Staff #6, CNA; Staff #7, CNA; and Staff #8, CMA reported Tenant #2 returned to the program unable to bear weight on his/her left leg, unable to pivot when stood, unable to dress his/herself and unable to participate in toileting. Tenant #2 was reportedly reporting pain to his/her left hip area, a bruise was noted to be on Tenant #2's left hip area and Tenant #2 required use of Hydrocodone for pain three times daily between 4-19-12 and 4-23-12.

On 4-19-12, after learning that the emergency room had not done hip x-rays, Staff #8, CMA, notified Staff #10, LPN, that Tenant #2's position when he/she was lying on the floor after falling was suspect of a fracture as Tenant #2's legs looked off to the side and one leg looked shorter than his/her other leg. Staff #10, LPN, worked during the day on 4-20-12 having the opportunity to visualize Tenant #2 and talk to staff members about Tenant #2's condition following the previous days fall. Staff #3, CMA, reported she contacted Staff #10, LPN, on 4-21-12 during the day shift to report finding a bruise on Tenant #2's left hip (this was also documented on the aide shift report sheet).

Tenant #2's clinical record lacked a nurse review after Tenant #2's return from the emergency room or any time prior to the morning of 4-23-12 despite the apparent changes in Tenant #2's functional status. On 4-23-12 at 9:18 a.m., Staff #10, LPN, completed a nurse review, subsequently sending Tenant #2 to the hospital for changes in Tenant #2's functional status. Tenant #2 was diagnosed with a fracture of the left hip and had surgery to place pins in the hip later in the day on 4-23-12. Tenant #2 did not return to the program prior to the monitors ending of the visit on 4-24-12.

During interview, Staff #10, LPN, denied talking with any staff members about Tenant #2, specifically discussing Tenant #2's position following the fall on 4-19-12, discussing Tenant #2's change in functional status or discussing any bruising to Tenant #2's hip until the morning of 4-23-12. Staff #10 reported she did not question any staff members about Tenant #2's fall as she had trusted the information documented on the incident report. The incident report did not describe the position of Tenant #2's body after his/her fall, except to document Tenant #2 was laying on his/her stomach. The incident report did not indicate Tenant #2's extremity range of motion; however, the report did indicate Tenant #2 was in pain when staff members attempted to move Tenant #2's arms or roll Tenant #2 over. The LPN reported she did assess Tenant #2 after his/her return from the hospital on 4-19-12; however, she could not produce this documentation to the monitors.

The program registered nurse did not complete an evaluation of Tenant #2's health, functional and cognitive status following the reported changes in Tenant #2's increased incontinence and a new requirement for staff members to assist Tenant #2 with toileting following the 4-9-12 diagnosis of urinary tract infection. The program registered nurse did not complete an evaluation of Tenant #2's health, functional and cognitive assessment in a timely manner following reported changes in toileting, transferring, mobility and dressing abilities. The program notified Tenant #2's durable power of attorney when Tenant #2 experienced health concerns.

Tenant #3 fell on 4-11-12. The clinical record contained a nurse review following the fall. Tenant #3 did not exhibit any changes to his/her health or functional status related to the fall; therefore did not require an evaluation.

Tenant #4 did not require completion of an evaluation as a result of significant changes in condition during his/her residence at the program between 3-14-12 and 4-2-12, at which time Tenant #4 moved out of state.

Tenant #5 exhibited mild cognitive decline. The clinical record lacked any documentation indicating Tenant #5 had activated his/her durable power of attorney; therefore, Tenant #5 was independent in making his/her own medical decisions. Tenant #5's clinical record included documentation indicating Tenant #5 saw a physician for a routine follow up appointment on 12-8-11, returning to the program without any changes in physician's orders. On 12-9-11, Tenant #5 began experiencing loose stools throughout the day. Staff members noted Tenant #5's blood pressure to be lower than normal for Tenant #5. The program nurse notified Tenant #5's physician on 12-9-11, reporting Tenant #5's loose stools and low blood pressure. The clinical record contained a physician's order, dated 12-9-11, directing staff members to hold Tenant #5's blood pressure medication at 9:00 p.m., due to continuance of the low blood pressure.

Tenant #5's blood pressure continued to remain low on the morning of 12-10-11 and Tenant #5's skin color was noticeably changed. The program contacted Tenant #5's family member to transport Tenant #5 to the emergency room for medical evaluation on 12-10-11. Tenant #5 was subsequently admitted to the hospital with diagnoses of dehydration and acute renal failure and returned to the program on 12-15-11. Staff #11, LPN completed a nurse review on 12-15-12 upon Tenant #5's return to the program, finding no significant changes in Tenant #5's status. An evaluation was not required as no significant changes were noted.

On 12-28-11, Tenant #5 returned to see the physician for a routine follow up appointment, returning to the program with orders to apply lotion to toes to alleviate dry rough areas.

On 12-29-11, at approximately 11:00 a.m., Tenant #5 reported experiencing abdominal pain. Staff members reported Tenant #5 appeared to be slightly pale with bluish tinged lips but Tenant #5 denied feeling short of breath. Tenant #5 reported thinking the discomfort to be gas pain and did not wish to go to the emergency room at that time. Staff members contacted Staff #11, LPN, who instructed staff members to monitor Tenant #5's vital signs, keeping in contact with the LPN. Staff members later contacted Staff #11 to report the abdominal pains continued and that Tenant #5 had not eaten lunch or supper. The LPN notified Tenant #5's family member of Tenant #5's symptoms. The LPN called back to the program and staff members reported Tenant #5 was now cold, clammy but denied Tenant #5 was shaking. Staff #11 directed staff members to summon an ambulance to transport Tenant #5 to the emergency room for medical evaluation. Tenant #5 was transported from the program at approximately 7:00 p.m. Staff #11 notified the family member of Tenant #5's departure. At 11:30 p.m., Staff #11 contacted the emergency room to check on Tenant #5's status and was informed Tenant #5 had been admitted to the hospital with a diagnosis of pancreatitis. Tenant #5 went to a skilled facility following hospitalization to recuperate. Tenant #5 was admitted to hospice during his/her skilled care stay and subsequently died while residing at the skilled facility.

The LPN completed timely nurse reviews, finding no significant changes in condition after completing the reviews. Tenant #5 did not experience a significant change in condition following his/her hospitalization for dehydration and acute renal failure; therefore, did not require an evaluation. Staff members responded in a timely manner to Tenant #5's abdominal pain on 12-29-11. Tenant #5 did not wish to seek medical evaluation at the beginning of his/her symptoms. Tenant #5 exhibited only mild dementia and had not yet activated his/her durable power of attorney as Tenant #5 still made independent medical decisions. The program did not have to contact Tenant #5's family member unless directed to do so by Tenant #5.

Tenant #6 exhibited no cognitive decline. The clinical record lacked any documentation indicating Tenant #6 had activated a durable power of attorney to make decisions for Tenant #6. Tenant #6 was independent in making his/her own medical decisions.

Tenant #6's clinical record included a physician's order, dated 8-18-11, directing staff members to monitor Tenant #6's blood sugars four times daily, notifying the physician if the blood sugar reading was above 400 or below 85.

The program did not have any physician orders at that time directing treatment if Tenant #6 was having a hyperglycemic or hypoglycemic episode.

The August 2011 Medication Administration Record (MAR) included documentation of Tenant #6's blood sugar readings every day at 7:30 a.m., 11:30 a.m., 4:30 p.m. and 8:30 p.m. The monitors noted the following blood sugar readings: 8-19-11 at 11:30 a.m. (76); 8-20-11 at 7:30 a.m. (84); 8-21-11 at 11:30 a.m. (45); 8-22-11 at 11:30 a.m. (83); 8-23-11 at 11:30 a.m. (49); 8-24-11 at 11:30 a.m. (57); 8-24-11 at 8:30 p.m. (43); 8-25-11 at 7:30 a.m. (65); and 8-25-11 at 11:30 a.m. (57) and 8-25-11 at 1:30 p.m. (29). The same MAR showed staff members gave Tenant #6 his/her scheduled dosage of Novolog insulin 4 units SQ at 7:30 a.m., 11:30 a.m. and 4:30 p.m. from 8-19-11 despite the low blood sugar readings. The clinical record lacked any documentation of notification of the low blood sugar readings by the direct care staff to the program RN or Tenant #6's physician prior to giving Tenant #6 his/her scheduled dosage of insulin. The monitors found no documentation indicating the program nurses identified the staff members failure to notify Tenant #6's physician prior to giving the insulin with blood sugars lower than 85 as directed by Tenant #6's physician. This practice continued to happen from 8-19-11 to 8-25-11 without nurse review or intervention, resulting in Tenant #6's hypoglycemic incident on 8-25-11. The clinical record included documentation of physician notification by facsimile of the low blood sugar occurring on 8-21-11 at 11:30 a.m. but lacked physician notification of any of the blood sugars below 85 which occurred on 8-19, 20, 22, 23, 24 or 25-11. Tenant #6's clinical record lacked documentation of a nurse evaluation of Tenant #6's health, functional and cognitive status following Tenant #6's change in blood sugar readings for 7 days.

Tenant #6's clinical record included documentation indicating Tenant #6 experienced a hypoglycemic incident on 8-25-11 at approximately 1:00 p.m. Tenant #6's family member visited, finding Tenant #6 in his/her apartment in an unresponsive state. During interview, Staff #9, RN, reported the family member called her to Tenant #6's apartment. She checked Tenant #6's blood sugar, noting it to be "low". Tenant #6 was unresponsive. Staff #9 noted the program had no physician's orders for emergent care during a hypoglycemic incident. Staff #9 borrowed Glucose gel from Tenant #7, who also resided at the program. Tenant #6 was unable to swallow the Glucose gel so Staff #9 borrowed IM Glucagon from Tenant #7 and administered it to Tenant #6 intramuscularly. Staff #9 reported she obtained orders from Tenant #6's physician after the incident was resolved, concurring she administered both medications without physician's orders.

Staff #11, LPN, completed a nurse review following Tenant #6's hypoglycemic episode on 8-25-11 finding no significant changes in condition. Tenant #6 returned to his/her usual state following treatment for the hypoglycemia; thereby not requiring an evaluation to be completed. The program nurses failed to perform an evaluation of Tenant #6's health, functional and cognitive status when Tenant #6 exhibited unusual blood sugar readings signifying hypoglycemia for seven continuous days. Tenant #6 did not exhibit dementia and had not yet activated a durable power of attorney. Tenant #6 still made his/her own medical decisions. The program did not have to contact Tenant #6's family member unless directed to do so by Tenant #6.

Tenant #7 did not have need for completion of an evaluation due to any potential significant changes during his/her residence at the program between 1-1-12 and 4-23-12.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall 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 with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

C. Service Plans

Complaint/Incident Allegation: It was alleged the program did not provide assistance with bathing as identified as an individualized need in tenant service plans.

- Monitoring Observation: The monitors held a group tenant meeting with nine cognitively intact tenants in attendance. The group reported the program staff members performed assistance with bathing and other personal care tasks as each tenant required.

  The program maintained documentation of bathing schedules; however, the program did not have staff members document when each tenants bathing assistance occurred. Regulation does not require the assisted living to have staff members initial or sign off when personal care tasks are completed.

- Regulatory Insufficiency: None noted.

D. Medications

Complaint/Incident Allegation: It was alleged the program staff did not follow physician's orders for medications and administered medications in error resulting in a need for medical evaluation/intervention. It was also alleged the program staff borrowed other tenants' medications when a tenant did not have the medication available.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6 and #7, finding no concerns related to medication administration for Tenants #1, #2, #3, #4 and #5. The monitors reviewed the medication error reports between August 2011 and April 2012. The monitors identified the following medication errors:

Tenant #	Medication	Physician's Order	Error
Tenant #6	Novolog insulin	Give 4 units 3 times daily subcutaneously (SQ) and dosage per sliding scale per blood sugar reading.	9-10-11 Blood sugar not checked- sliding scale dosage not given at 7:30 a.m. and 11:30 a.m. and scheduled dose not given

			at 11:30 a.m.
Tenant #6	Cipro	9-23-11 Give 500 milligrams (mg) twice daily for seven days.	9-23-11, 9-24-11 and 9-25-11 not given any doses as initiation inadvertently delayed until 9-26-11.
Tenant #6	Novolog insulin	Give 4 units SQ 3 times daily. Hold if blood sugar less than 120.	12-3-11 Blood sugar at 7:30 a.m. was 84. Novolog 4 units given at 7:30 a.m.
Tenant #7	Novolog insulin	Give 5 units at 8:00 a.m. and dosage per sliding scale at 8:00 a.m. and 12 noon per blood sugar reading. Give 6 units at 12 noon.	9-10-11 blood sugar not checked- sliding scale dosage not given at 8:00 a.m. and 12 noon and scheduled dose not given at 8:00 a.m. and 12 noon
Tenant #7	Novolog insulin	Give sliding scale insulin SQ- 2 units for blood sugars 201-250.	1-3-12 Blood sugar 212- 3 units given.
Tenant #7	Novolog insulin	Give 6 units SQ at noon.	1-9-12 6 units of Lantus insulin given instead of Novolog insulin.
Tenant #7	Novolog insulin	Give sliding scale insulin SQ- 2 units for blood sugars 201- 250.	1-14-12 Blood sugar 244- only 1 unit was given.
Tenant #7	Novolog insulin	Give sliding scale insulin SQ- 2 units for blood sugars 201-250.	1-26-12 Blood sugar 209- only one unit was given.

Tenant #6's clinical record included a physician's order, dated 8-18-11, directing staff members to monitor Tenant #6's blood sugars four times daily, notifying the physician if the blood sugar reading was above 400 or below 85. The program did not have any physician orders at that time directing treatment if Tenant #6 was having a hyperglycemic or hypoglycemic episode.

The August 2011 Medication Administration Record (MAR) included documentation of Tenant #6's blood sugar readings every day at 7:30 AM, 11:30 a.m., 4:30 p.m. and 8:30 p.m. The monitors noted the following blood sugar readings: 8-19-11 at 11:30 a.m. (76); 8-20-11 at 7:30 a.m. (84); 8-21-11 at 11:30 a.m. (45); 8-22-11 at 11:30 a.m. (83); 8-23-11 at 11:30 a.m. (49); 8-24-11 at 11:30 a.m. (57); 8-24-11 at 8:30 p.m. (43); 8-25-11 at 7:30 a.m. (65); and 8-25-11 at 11:30 a.m. (57) and 8-25-11 at 1:30 p.m. (29). The same MAR showed staff members gave Tenant #6 his/her scheduled dosage of Novolog insulin 4 units SQ at 7:30 a.m., 11:30 a.m. and 4:30 p.m. from 8-19-11 despite the low blood sugar readings. The clinical record lacked any documentation of notification of the low blood sugar readings by the direct care staff to the program RN or Tenant #6's physician prior to giving Tenant #6 his/her scheduled dosage of insulin.

Tenant #6's clinical record included documentation indicating Tenant #6 experienced a hypoglycemic incident on 8-25-11 at approximately 1:00 p.m. Tenant #6's family member visited, finding Tenant #6 in his/her apartment in an unresponsive state. During interview, Staff #9, RN, reported the family member called her to Tenant #6's apartment. She checked Tenant #6's blood sugar, noting it to be "low". Tenant #6 was unresponsive. Staff #9 noted the program had no physician's orders for emergent care during a hypoglycemic incident. Staff #9 borrowed Glucose gel from Tenant #7, who also resided at the program. Tenant #6 was unable to swallow the Glucose gel so Staff #9 borrowed IM Glucagon from Tenant #7 and administered it to Tenant #6 intramuscularly. Staff #9 reported she obtained orders from Tenant #6's physician after the incident was resolved.

The clinical record contained a physician's order, dated 8-25-11, which ordered Glucagon 1 mg to be administered IM as needed when blood sugar readings were below 50 and accompanied by symptoms of hypoglycemia, such as coma, convulsions, or inability to swallow. The same order also included a notation to approve administration of one tube of Glucose gel on 8-25-11 at 2:00 p.m. for low blood sugar. The clinical record also included a physician's order, dated 8-25-11, which directed staff members to hold the scheduled dosage of Novolog insulin if any blood sugar reading was less than 120. The physician's order also included the direction to notify the physician if the blood sugar was less than 85 and to send routine weekly documentation to the physician of all blood sugar readings after 8-25-11.

- Regulatory Insufficiency: The administration of medications shall be provided by a registered nurse, a licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6) a.)

E. Staffing

Complaint/Incident Allegation: It was alleged program staff members were not appropriately trained to administer medications appropriately.

- Monitoring Observation: The program reviewed the personnel files of Staff #1, #2, #3 and #4. All four staff members had documentation of training by the delegating RN/Director of Nursing (DON), documentation indicating the nurse had observed each staff member's demonstration of the task and documentation indicating the nurse determined each to be competent to perform the task for medication management, eye drop administration, ear drop administration, suppository administration, blood sugar testing using a glucometer, administration of insulin via prefilled syringes and administration of insulin via a prefilled insulin pen. The program's registered nurse had delegated performance of the above stated tasks to Staff #1, #2, #3 and #4.

The monitors interviewed Staff #1, #3, #5, #6 and #8, all staff members who administer medication to program tenants.

During interview, all five staff members reported the program RN/DON had delegated each to all modes of medication administration as described above. No one reported feeling uncomfortable with medication administration.

The monitors observed staff administration of insulin during a medication pass. There were no errors identified and technique was appropriate.

- Regulatory Insufficiency: None noted.

F. Other

Complaint/Incident Allegation: It was alleged the program did not wash bed linens often enough, resulting in tenant rashes.

- Monitoring Observation: The monitors held a group tenant meeting with 9 cognitively intact tenants in attendance. The group reported the program washed bed linens each week with only an occasional time when the bed linens would not get returned to tenant rooms as quickly as usual; however, all indicated if brought to the attention of staff members, the bed linens were returned right away and placed on the beds. No one reported having skin rashes due to the program's failure to wash the bed linens.

  The program did not keep documentation to show when bed linens were washed and did not require staff members to document when performing the task; therefore, the monitors could not determine when linens had been washed. Regulation does not require assisted living programs to document when bed linens are washed or changed.

- Regulatory Insufficiency: None noted.