IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

July 31, 2012

Complaint/Incident Intake: 39352-C

Mr. Brent Olson, Director
Whispering Willow Assisted Living
601 Dawn Avenue
Fredericksburg, IA 50630

RE: Final Complaint Investigation and Recertification Monitoring Evaluation Report – Whispering Willow Assisted Living, Fredericksburg, IA

Dear Mr. Olson:

Enclosed is the **Final Complaint Investigation & Recertification Monitoring Evaluation 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 completed the review of your Plan of Correction (POC) in response to the **Preliminary Complaint Investigation & Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0284** with effective dates of **September 9, 2012** through **September 8, 2014**.

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

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(515) 281-5714
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Telephone Number for the Hearing Impaired: (515) 242-6515

If you have any questions in regard to this certification, 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 Investigation and Recertification Report

Assisted Living Program:

Brent Olson, Director
Whispering Willow Assisted Living
601 Dawn Ave.
Fredericksburg, IA 50630

Complaint/Incident Intake #:

#39352-C

Date of Complaint/Incident Investigation:

June 13 and 14, 2012

Monitor(s):
Joyce Kix, RN
Lori Miner, RN BSN

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

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

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	12
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	13

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	7
TOTAL census of Assisted Living Program	20

Tenant/Family Satisfaction Results – A meeting was held with 6 tenants. The best thing about the program was the tenants did not have to do anything if they didn't want to. Housekeeping was completed to the tenants' satisfaction in both apartments and common areas. Maintenance responded to requests in a timely manner. Tenants used call buttons to request assistance. Staff members were reported to respond in less than five minutes. Staff members were described as very good and treated the tenants kindly and with respect. The food good and there were enough activities offered. The tenants generally felt safe at the program and would recommend it to others.

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

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

A. Policies and Procedures

Complaint/Incident Allegation: It was alleged that tenant's blood sugar monitoring equipment was not properly sanitized after use.

- Monitoring Observation: The monitors observed two medication administrations which included blood sugar checks. The staff person utilized the tenant's individual accu-check machine. Staff #1 reported that each tenant had their own machine to check blood sugars so they did not require sanitation between uses.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation: It was alleged that medications were not properly stored, disposed of and there were multiple medications errors. It was alleged that tenants who self-medicated did not receive their medications promptly when delivered from the pharmacy. It was alleged that medications were left out on the table in medication cups and not delivered in privacy.

Monitoring Observation: A medication pass was observed on 6-13-12. Tenant # 11 resided in the same apartment with a spouse. When the staff member opened the locked drawer in the apartment, two medication planners were present. The staff member described one planner as being white and the other blue. The planners were not labeled with each tenant's name, nor was there documentation on the Medication Administration Record (MAR) of a description of the planner. There was no documentation to determine which planner belonged to which tenant in the apartment. A description of the planner was written on the MAR after the medication pass. The staff member administered medication from an unmarked planner to Tenant #11

Tenant #1 had a physician's order noted 3-20-12 for Glucagon one milligram (mg)/one milliliter (ml) to be administered subcutaneously (SQ) or intramuscularly (IM) for an episode of low blood sugar. On 6-13-12 at approximately 11:10 a.m. the locked medication drawer in Tenant #1's apartment was opened by the Nurse. The Glucagon in the medication drawer expired in January 2012. The Glucagon was removed from the drawer at that time. A medication pass was observed on 6-13-12 at approximately 11:50 a.m. At that time, the Glucagon with the same expiration date of January 2012 was back in the locked drawer.

Tenant #2 had a physician's order noted 3-20-12 for Glucagon one mg/one ml to be administered SQ for an episode of low blood sugar. A review of the June 2012 MAR indicated the Glucagon could be administered SQ or IM. The physician's order did not indicate an IM route. The physician's order was not transcribed correctly. The Glucagon in Tenant #2's medication drawer was not expired.

Observation on 6-13-12 at 9:05 a.m. revealed the nurse's station door open and unobserved with the file cabinet containing tenant medications unlocked and accessible to unauthorized persons. Observation on 6-14-12 at 1:00 p..m. revealed the nurse's station door open and unobserved with the file cabinet containing tenant medications unlocked and accessible to unauthorized persons. At this time, the registered nurse was notified of the necessity to keep the medications locked.

Two medication administration passes were observed. Medications were given to the tenant's in their apartments in privacy and not left on the dining table for them to take independently. Staff #14 was observed by the monitors filling medication planners. Staff #14 had been delegated by the registered nurse to complete the medication set-up.

Six tenants resided in the memory care unit. During interview at 9:45 a.m., Staff #1 reported that all tenants had received their 8:00 a.m. medications. Observation of MARS for those six tenants at 9:35 a.m. revealed that the staff person had not signed for the administration of medications. The Director provided a program policy that directed, "Once medications are administered, staff will sign the MAR prior to locking the cabinet up again."

The program Medication Policy directed for solid medications to be given to the nurse for destruction and liquid medications are to be flushed down the toilet. The disposal of medications is to be documented on the medication administration record. Staff #1 and #2 reported that medications for destruction were given to the nurse or flushed. The monitors did not observe medication bottles or labels in the garbage.

The program reported that eight tenants administered their own medications. During the group meeting there were no concerns identified regarding availability of medications.

Tenant medications were not kept within their expiration date and were not kept in a locked place. Medication planners were not marked appropriately with tenant's names. Medications were not signed as given immediately after administration.

- 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.)

- Regulatory Insufficiency: When medications are administered traditionally by the program: ~~Medications shall be kept in a locked place or container that is not~~ accessible to persons other than employees responsible for the administration or storage of such medications. (IAC r. 481-69.5(6) b.)

C. Staffing

Complaint/Incident Allegation: It was alleged that tenants were not provided with the services determined necessary by service plans.

- Monitoring Observation: The monitors reviewed clinical records for eight current tenants. All documentation of cares provided was completed as planned. A community meeting was held with six tenants who all reported that services were provided as planned. All tenants who received cares appeared clean and well-cared for.

- Regulatory Insufficiency: None noted

D. Evaluation

Complaint/Incident Allegation: It was alleged that changes in tenant condition were not followed up appropriately.

Monitoring Observation: Tenant #1, an 88 year-old, was admitted on 6-21-09 and had diagnoses of: Cerebrovascular Accident with Expressive Aphasia in 2008, Atrial Fibrillation, Pulmonary Hypertension, Coronary Artery Disease, Diabetes Mellitus Type 2, and Asthma. Annual functional and health evaluations were completed on 7-8-11. A cognitive evaluation was not completed at that time. In an interview with the Nurse, it was revealed because of the expressive aphasia, Tenant #1 was unable to answer questions for the mini mental examination. A Global Deterioration Scale (GDS) score was not generated. Ten separate evaluations of function and health were completed between 7-8-11 and 6-8-12 for both change of condition and 90-day review. Cognitive evaluations were not completed with the functional and health evaluations. Cognitive evaluations were not completed annually and with change in condition.

Tenant #2, an 83 year-old, was admitted on 3-18-11 and had diagnoses of: Diabetes Mellitus Type 2, Hyperlipidemia, Hypertension (HTN), Peripheral Neuropathy, and Osteoarthritis. Tenant #2 was staged at three on the GDS which indicated mild cognitive decline. Functional, cognitive, and health evaluations were completed on 5-3-12 for a change of condition; Tenant #2 exhibited strong smelling urine, and sediment was noted in the urine. The physician was notified and antibiotics were ordered. A nurse review was completed on 5-9-12 after completion of the antibiotics for the urinary tract infection.

Tenant #6, an 85 year old, was admitted 7-31-09 with diagnoses of: Paralysis Agitans, Coronary Artery Disease and Gastro Esophageal Reflux Disorder. A mental Status questionnaire completed 12-12-11 indicated Tenant #6 with moderately advanced cognitive impairment. Tenant #6 was admitted to Hospice 10-17-11. The clinical record contained documentation dated 12-19-11 that Tenant #6 had been very confused for the past two days. Nursing documentation on 3-14-12 indicated Tenant #6 experienced an open area to the coccyx and had difficulty swallowing pills. The clinical record lacked documentation of functional, health or cognitive evaluations completed after 12-23-11. Tenant #6 was discharged from the program 4-4-12 to a higher level of care. Evaluations were not completed with significant changes in condition.

Evaluations were not always completed with significant changes of condition or annually as required.

- 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))

E. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged that tenants exceeded the level of care allowed in assisted living.

Monitoring Observation: Clinical records were reviewed for nine current and three discharged tenants.

Tenant #3, a 74 year-old, was admitted on 10-18-11 and had diagnoses of: Cardiomyopathy, Alzheimer's Dementia, and HTN. Functional, cognitive, and health evaluations were completed on 1-20-12. Tenant #3 was staged at six to seven on the Global Deterioration Scale (GDS) which indicated severe to very severe cognitive decline. An addendum to the service plan identified staff response to tenant behaviors. Nurse's notes dated 3-20-12 documented Tenant #3 swinging arms and fists and kicking a staff member in the stomach. Notes of 4-1-12 documented Tenant #3 was hitting a staff member during the day shift. On the evening shift of 4-1-12 Tenant #3 was described as physically combative and highly aggressive. Tenant #3 was discharged from the program on 4-2-12.

Tenant #4, a 78 year old, was admitted to the secure memory care unit 1-17-12 with diagnoses of: Vascular Dementia, Behavioral Disturbance, Depressive Disorder and Osteoarthritis. Tenant #4 scored a 4 on the Global Deterioration Scale (GDS), dated 2-10-12, which indicated moderate cognitive decline. The psychiatric assessment completed at the hospital on 1-8-12 documented Tenant #4 had been a resident of a care center and had tried to escape and had made a comment that he/she wanted to die. Nurse's notes of 1-18-12 documented Tenant #4 had all possessions packed and wanted to leave the program. Tenant #4 attempted to exit again on 1-25-12 and pulled the door shut on a staff member's arm when she attempted to redirect him. On 1-26-12 Tenant #4 was anxious and upset and dropped a plate on the floor and exclaimed that the food was "shit"! Nurse's note of 1-29-12 document Tenant #4 was very agitated and wanted to run. Tenant #4 was shaking all over from anxiety. On 2-1-12, Tenant #4 put on a coat and hat and wanted to walk outside. After walking outside, Tenant #4 came in and staff removed the coat and hat from the tenant's room at family request. On 2-2-12, Tenant #4 told staff that he was going over the fence and going north. Tenant #4 attempted to climb the fence but staff retained him and re-entered the building, after which Tenant #4 attempted to exit the doors repeatedly. On 2-3-12 Tenant #4 set off the main entrance alarm while attempting to exit. On 2-7-12 Tenant #4 was very anxious and took the screens off the dining room windows trying to exit and also set off door alarms two times. On 2-11-12, staff members documented two hours of one on one time spent with Tenant #4 to keep him/her from leaving. Tenant #4 also attempted to leave through the window of the apartment. On 2-14-12 the nurse's note document Tenant #4 was on the move and worked on the windows to get out. On 2-15 and 2-16-12 Tenant #4 took the screens off the windows in the activity room and could not redirect. The director stated that he felt the secure environment of the memory care unit would keep Tenant #4 safe but after 30 days realized it would not work. Tenant #4 was discharged from the program 2-17-12.

Tenant #6 was admitted 7-31-09 to the general population. Tenant #6 was admitted to Hospice 10-17-11. The clinical record contained documentation dated 12-19-11 that Tenant #6 had been very confused for the past two days. Nursing documentation on 3-14-12 indicated Tenant #6 experienced an open area to the coccyx and had difficulty swallowing pills. Tenant #6 was discharged from the program 4-4-12 to a higher level of care. Tenant #6 experienced a decline in condition and was transferred appropriately to a higher level of care.

The monitors did not identify any tenants past or present who exceeded the level of care for assisted living admission or retention.

- Regulatory Insufficiency: None noted

F. Tenant Documents

Complaint/Incident Allegation: It was alleged that documentation on tenants' records regarding services provided was being forged.

- Monitoring Observation: Clinical records for eleven tenants were reviewed. The monitors found no evidence of documentation forged. Staff #1 and #4 were interviewed. Both denied knowledge of other staff documenting falsely.

- Regulatory Insufficiency: None noted

G. Service Plans

Complaint/Incident Allegation: It was alleged that tenants did not receive the services required for their care.

Monitoring Observation: Tenant #4, a 78 year old, was admitted to the secure memory care unit 1-17-12. The psychiatric assessment completed at the hospital prior to admission documented Tenant #4 had been a resident of a care center and had tried to escape and had made a comment that he/she wanted to die. Nurse's notes of 1-18-12 documented Tenant #4 had all possessions packed and wanted to leave the program. Tenant #4 attempted to exit again on 1-25-12 and pulled the door shut on a staff member's arm when she attempted to redirect him. On 1-26-12 Tenant #4 was anxious and upset and dropped a plate on the floor and exclaimed that the food was shit! Nurse's note of 1-29-12 document Tenant #4 was very agitated and wanted to run. Tenant #4 was shaking all over from anxiety. On 2-1-12, Tenant #4 put on a coat and hat and wanted to walk outside. After walking outside, Tenant #4 came in and staff removed the coat and hat from the tenant's room at family request. On 2-2-12, Tenant #4 told staff that he was going over the fence and going north. Tenant #4 attempted to climb the fence but staff retained him and re-entered the building, after which Tenant #4 attempted to exit the doors repeatedly. On 2-3-12 Tenant #4 set off the main entrance alarm while attempting to exit. On 2-7-12 Tenant #4 was very anxious and took the screens off the dining room windows trying to exit and also set off door alarms two times. On 2-11-12, staff members documented two hours of one on one time spent with Tenant #4 to keep him/her from leaving. Tenant #4 also attempted to leave through the window of the apartment. On 2-14-12 the nurse's note document Tenant #4 was on the move and worked on the windows to get out. On 2-15 and 2-16-12 Tenant #4 took the screens off the windows in the activity room and could not redirect. Tenant #4 was transferred on 2-17-12 out of program. The service plan dated 1-13-12 lacked direction for specific interventions for behaviors exhibited and did not meet the needs of Tenant #4.

Tenant #7, a 72 year-old, was admitted on 10-10-11 and had diagnoses of: Anxiety, Depression, HTN, and Osteoarthritis. Tenant #7 scored 26 of 30 on the MMSE on 1-9-12. Tenant #7 resided in the locked dementia unit. Functional and health evaluations were completed within 30 days, 11-7-11; a cognitive evaluation was not completed. The service plan was updated but was not based on a cognitive evaluation.

Tenant #8, an 84 year-old, was admitted on 8-29-09 and had diagnoses of: B Large Cell Lymphoma of the Sacral Area, Backache, Spinal Stenosis, Dizziness, Gastroesophageal Reflux Disease, Neuralgia, Sciatica, Cardiac Dysrhythmia Depressive Disorder, and HTN. Tenant #8 scored 29 of 30 on the MMSE dated 11-30-11. Tenant #8 resided in the general population. The service plan was updated on 5-1-12 with a change of condition. Functional and health evaluations were completed; a cognitive evaluation was not. The service plan was not based on a cognitive evaluation.
The service plan revealed Tenant #8 would self-administer medications from a pre-filled medication box. The nurse's notes dated 5-1-12 revealed Tenant #8 denied the need/did not want to use medications. In an interview with Tenant #8, Tenant #8 stated he/she does not take medications because medications make him/her sick. Tenant #8 stated this had been discussed with the physician and the physician agreed. Tenant #8 stated staff members assist with the application and removal of shoes and socks daily. Tenant #8 stated he/she usually had assistance with a bath weekly. A review of the Services Provided Sheet revealed Staff #14 had provided nine of the baths to Tenant #8 in May and June 2012. Staff #14 stated Tenant #8 sometimes refused baths. Documentation for 6-6-12 indicated Tenant #8 refused a bath. The service plan for Tenant #8 indicated the program was pre-filling a medication box. The program identified Tenant #8 did not require this service. The service plan did not meet individualized needs of Tenant #8.

Service plans were not always developed and maintained with specific interventions designed using information from evaluations.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific 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))

H. Food Service

Complaint/Incident Allegation: It was alleged that diabetic diets were not followed.

Monitoring Observation: Physician orders for Tenant #1, dated 3-20-12 did not include special dietary requirements related to diabetes. The program is not required and does not provide therapeutic diets.

Tenant #2 had a diagnosis of Diabetes Mellitus Type 2. On 3-20-12, the physician ordered "Shoot for diabetic diet 2,000 calories per day." According to the Nurse, the program does not provide therapeutic diets. The program has worked with the family to discuss food in the apartment. The physician's order also stated "no sweets." The kitchen provided a list of persons who get fruit instead of sweets. The Cook provided documentation from the kitchen that Tenant #2 was diabetic. During breakfast on 6-13-

12, the Cook was overheard asking Tenant #2 if he/she wanted the sugar-free syrup for pancakes. Tenant #2 was observed with the sugar-free syrup.

- Regulatory Insufficiency: None noted.

I. Life Safety

Complaint/Incident Allegation: It was alleged that windows in the locked memory care unit were screwed shut and would not open. It was alleged that a tenant's room had a very strong odor of urine.

- Monitoring Observation: The building has 100% sprinkler coverage and the windows are not required to open.

Tour of the program was completed 6-14-12. One tenant room had a strong odor of urine present. The odor did not drift into the hallway or other areas of the program. There were no concerns of cleanliness mentioned during the group meeting. While a deviation from the requirement of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists. The director was advised of the monitor's finding and reported that the room would be thoroughly cleaned.

- Regulatory Insufficiency: None noted

J. Tenant Rights

Complaint/Incident Allegation: It was alleged a tenant was not reimbursed for damages to property from a water sprinkler break. It was alleged that tenant's property were being borrowed for use of other tenants. It was alleged that tenant's property was being stolen.

Monitoring Observation: Although there was no documentation in the clinical record, Tenant #7 stated water damage was sustained to the mattress after a water leak. Tenant #7 indicated the damage was reported to the program. After two attempts, a monitor was unable to contact family in regards to compensation received. The Director provided documentation of financial reimbursement to Tenant #7 for items lost during the outage and a rebate for being out of the apartment while it was repaired.

During interview, Staff #1 reported that supplies for tenants were not used communally. There may have been times when an incontinent brief was borrowed but it was replaced.

The Director provided documentation of investigation of reports of missing money. He stated that all staff members have keys to access tenant's rooms while they are working. During the time period when a tenant reported money missing, there were eight staff members who had access. The police report indicated a theft was unverified. During group interview, the tenants reported they had heard something about money missing but had never experienced a loss themselves.

- Regulatory Insufficiency: None noted