IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 40429-I
40768-I

November 16, 2012

Mr. Paul Crane, Administrator
Primrose Retirement Community
1801 E. Kanesville Blvd.
Council Bluffs, IA 51503

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

Dear Mr. Crane:

I. Final Complaint/Incident Investigation Report – Primrose Retirement Community, Council Bluffs, 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 Insufficiency in the area(s) of: Medications. **Primrose Retirement Community** ("Program") is being assessed a $500 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 three hundred twenty five dollars ($325) 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 $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on October 8, 2012, has been reviewed and will constitute the final POC related to the on-site visit of September 13, 17 and 18, 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:

Paul Crane, Administrator
Primrose Retirement Community
1801 E. Kanesville Blvd
Council Bluffs, IA 51503

Complaint/Incident Intake #: 40429-I
40768-I

Date of Complaint/Incident Investigation:

September 13 & 17 & 18, 2012

Monitor(s):

Hal L. Chase, RN BSN MPH

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:	22
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	25
TOTAL census of Assisted Living Program	25

Program History – There were substantiated Regulatory Insufficiencies in the areas of Medication found during this certification period.

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

A. Program Reporting to the Department

Complaint/Incident Allegation: The Program reported on 7-31-12 Tenant #1 had fallen in the early morning of 7-31-12. Tenant #1 had pressed his/her pendant and staff found Tenant #1 on the floor adjacent to the bed. Tenant #1 reported he/she was returning from the bathroom when he/she fell. Tenant #1 had a bump on the right upper arm, the right eye was bruised and his/her nose was bleeding. Tenant #1 was transported to a hospital emergency room for evaluation. Tenant #1 sustained a sub-dermal hematoma. Tenant #1 had two previous incidents of falls.

- Monitoring Observation: Three tenant files were reviewed. No issues were found with regard to two of the tenant files.

  Tenant #1, a 94 year old, admitted on 7-22-12 and had diagnoses of: Atrial Fibrillation, Hypertension (HTN), Arthritis, History of Urinary Tract Infections and History of Bladder Cancer. A cognitive evaluation was completed on 7-22-12, which indicated intact intellectual functioning.

  A functional and health evaluation was completed on 7-22-12 which indicated a history of falls. A service plan of 7-22-12 indicated a fall prevention program was initiated, which included physical assistance with transfer and stand by assistance with ambulation. Tenant #1 had an emergency pendant device, which he/she wore at all times. Tenant #1's nurse's notes of 7-22-12 through 7-31-12 indicated Tenant #1 was encouraged by staff to call for assistance when ambulating.

  Three incident reports dated 7-27-12, 7-28-12 and 7-31-12 indicated Tenant #1 had reported he/she was going to or coming from the bathroom and when he/she slid off the bed or lost his/her balance.

Nurse reviews were completed after each fall in addition to a 72 hour follow-up evaluation by the Program nurse. Emergency response records indicated on 7-27-12, Tenant #1's emergency pendant alarmed at 3:55 a.m. and staff responded within two minutes of being called. On 7-28-12 Tenant #1 activated his/her emergency pendant and staff responded within two minutes of being called. A third incident, on 7-31-12, Tenant #1 activated his/her emergency pendant and staff responded within five minutes of being called. Tenant #1 was transported by ambulance to a hospital emergency room for evaluation and was later admitted to the hospital. Tenant #1 did not return to the Program

Staff #1 and Staff #2 reported they encouraged Tenant #1 to call for assistance when he/she wanted to ambulate. Staff was directed to toilet Tenant #1 every two-hours as indicated on their assignment sheets.

Tenant #1 was cognitive and was able to make his/her choices related to ambulating without the assistance of staff. The Program responded within a reasonable period of time when Tenant #1 called for assistance.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation: The Program reported on 9-13-12 nine tablets of Tramadol 50 mg, belonging to Tenant #2 was missing. The Program initiated an investigation on 9-10-12 through 9-12-12 and determined three Licensed Practical Nurses (LPNs) had access to Tenant #2's medication during these dates.

- Monitoring Observation: Tenant #2, a 77 year old, was admitted on 2-17-10 and had diagnoses of: History of Stroke, HTN, Hypothyroidism, History of Depression, Hyperlipidemia, Degenerative Disc Disease, Left Sided Weakness, Impulsivity, Dependent Personality Disorder, History of Uterine Cancer and Carotid Artery Stenosis. A Global Deterioration Scale (GDS) was completed on 3-25-12 and staged Tenant #2 at three, which indicated mild cognitive decline. A service plan of 3-25-12 indicated the Program administered medications to Tenant #2.

  Medication Administration Records (MARs) for 8-1-12 indicated Tenant #2 was prescribed Tylenol 325 mg – two tablets twice daily and Tramadol 50 mg-one tablet and Tylenol 325mg-one tablet every four hours as needed (prn) for pain. On 8-14-12 Tenant #2 was prescribed Tramadol 50 mg and Tylenol 325 mg every four hours. On 8-16-12 Tenant #2's physician discontinued prn Tylenol 325mg every four hours as Tenant #2 was already receiving Tylenol 325mg-two tablets twice daily. A new order was received for Tramadol 50 mg – four times daily.

  The Program nurse reported Tenant #2's family member reported he/she had received billing for Tramadol from Tenant #2's pharmacy and had inquired as to the quantity ordered. The Program nurse reported she reviewed orders made and received by staff and reviewed the quantity of Tramadol in the medication cart.

The Program nurse photocopied bubble packs of the prn Tramadol 50mg on 9-10-12 and 9-13-12 and a review of MARs for the same period indicated nine tablets of Tramadol were missing from the medication cart. A review of staff schedules for the period of 9-10-12 through 9-12-12 revealed three LPNs had access to the medication cart. Following the investigation by the Program nurse, the Program required two LPNs to count Tramadol at the beginning and end of each shift.

A review of MARs and pharmacy records revealed a total of 76 Tramadol 50 mg were unaccounted for between 8-1-12 through 9-12-12. A monitor interviewed Staff #3 LPN, #4 LPN and #5 LPN on 9-17-12. Each reported they could not explain the missing Tramadol. A review of the MARs and pharmacy records for this period indicated 76 tablets of Tramadol 50 mg was missing. A review of documentation and interviews with Staff #1, #2 and #3 was inconclusive in determining the cause of the missing Tramadol. The Program was responsible for Tenant #2's medication as they were administering medication to Tenant #2 in accordance to with the requirements in 655-Chapter 6 governing nurse delegation.

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