IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint Intake #: 42748-C

April 17, 2013

Ms. Robbie Hinz, Manager
Prairie Hills at Tipton
219 South Cedar Street
Tipton, IA 52772

RE: Final Complaint/Incident Investigation Report, Prairie Hills at Tipton, Tipton, Iowa

Dear Ms. Hinz:

Enclosed is the **Final Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Prairie Hills at Tipton
Robbie Hinz, Manager
219 South Cedar St.
Tipton, IA 52772

Complaint/Incident Intake #:

#42748-C

Date of Complaint/Incident Investigation:

March 18, and 19, 2013

Monitor(s):

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.

General Population Program	
Number of tenants without cognitive disorder:	32
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	32
Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	6
TOTAL census of Assisted Living Program	38

Program History – The program has not received any regulatory insufficiencies during this certification period.

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

A. Medications

Complaint/Incident Allegation: It was alleged that staff administered over-the-counter medications without physician's orders. It was alleged that tenant's medications were not appropriately labeled. It was alleged that tenant's were drawing up their own insulin when the program was responsible for drug administration. It was alleged that there were multiple medication errors. It was alleged that narcotic drugs were not counted.

- Monitoring Observation The monitor observed a medication pass with Staff #5 on 3-18-13 and found no medication errors. All over-the-counter medications were labeled and had physician's orders. The current medication administration records (MAR) were reviewed with no medication errors identified. Two tenants, documented as competent to complete the task, were identified to administer insulin independently using a pen after the staff member checked for proper dosage. The program provided only one medication error report which had occurred during the past three months. The error had been identified and appropriately followed up with physician notification. Staff #1, Manager, stated the program policy was to count narcotic medications daily, alternating from day shift to evening shift responsibilities on a weekly basis. Staff #1 reported that counting narcotic medication could inadvertently be missed on a day but the counts were always verified and the count was monitored by nursing staff. The monitor observed Staff #7 and #10 counting narcotics on 3-18-13 at 1:40 p.m.

All counts were completed and accurate with the amount of drugs identified. Narcotic counts sheets were reviewed for multiple tenants with no discrepancies in count identified.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation: It was alleged that staff members were not trained properly and were required to administer vaginal creams, cut diabetic tenant's toe nails, shave tenant's with straight razors and other tasks not delegated by the registered nurse (RN).

- Monitoring Observation: The personnel files were reviewed for universal workers (UW) #3, #4, #5, #6, #7 and #9. All delegations had been completed by the current delegating RN. According to the MAR, Staff #3, #7 and #9 had administered vaginal cream and had been appropriately delegated by the RN. All mentioned staff members had eight hours of dementia training for 2012. Staff #7 and #8 stated during interview that the current RN had completed delegation of tasks by observing a return demonstration.

- Regulatory Insufficiency: None noted.

C. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged that tenants were admitted to the program that exceeded the criteria for assisted living.

- Monitoring Observation: Tenant #1, an 84 year old, was admitted to memory care unit of the program 4-15-12 with diagnoses of; Dementia, Hypothyroidism, and Arthritis. The service plan completed 5-14-12 indicated the tenant needed assistance with bathing, grooming, dressing, toileting and medication administration. The tenant scored "5" on the Global Deterioration Scale (GDS) completed 5-14-12 which indicated moderately severe cognitive decline. On 3-18-13 at 3:00 p.m. Staff #8, UW, instructed Tenant #1 to stand and come to the bathroom for a scheduled toileting. The tenant stood and ambulated independently with a walker and cueing from the staff member. Tenant #1 refused to toilet stating there was no need. During interview, Staff #7 and #8 stated that Tenant #1 required multiple cueing to toilet but would eventually cooperate. Both staff also reported that Tenant #1 had in the past on at least two occasions gone to the bathroom and smeared feces inappropriately but that did not occur routinely. Tenant #1 did not exceed the criteria for assisted living at the time of the review.

  Tenant #2, a 79 year old, was admitted to the memory care unit of the program 11-18-12 with diagnoses of; Hypertension (HTN), Depression, and Congestive Heart Failure (CHF). The service plan completed 12-4-12 indicated the tenant needed assistance with transferring and ambulation, bathing, grooming, dressing, toileting and medication administration.

The tenant scored "2" on the Cognitive Assessment completed 12-4-12 which indicated low risk for cognitive decline. The functional assessment completed by the RN on 12-4-12 documented Tenant #2 was continent; however, the service plan indicated the program had developed a toileting schedule for the tenant. Nurse's Notes dated 11-28-12 documented Tenant #2 was having bouts of incontinence and was found soaking wet in the mornings. Tenant #2 was advised of the need to comply with the toileting and remain dry or there may be a need to look for a higher level or care. Nurse's Notes dated 12-3-12 documented Tenant #2 refused to toilet and instead requested that staff members change the incontinent brief for the tenant. The program served the tenant 30-day notice to discharge 1-31-13 and Tenant #2 transferred from the program 3-8-13.

Tenant #3, an 86 year old, was admitted to the general population of the program 2-17-13 with diagnoses of; Diabetes, HTN, CHF, Depression and Atrial Fibrillation. The service plan completed 3-7-13 indicated the tenant needed assistance with bathing, grooming, dressing and medication administration. The tenant scored "5" on the GDS completed 3-7-13 which indicated mild cognitive decline. Tenant #3 was independently ambulatory with the use of a walker and assisted with insulin injection after staff members verified the dosage. Tenant #3 did not exceed criteria for assisted living at the time of the review.

Tenant #4, a 90 year old, was admitted to memory care unit of the program 8-21-09 with diagnoses of Alzheimer's and HTN. The service plan completed 4-17-12 indicated the tenant needed assistance with bathing, dressing, toileting, grooming and medication administration. The tenant scored "4" on the GDS completed 4-17-12 which indicated moderate cognitive decline. Tenant #4 was independently ambulatory with the use of a walker and did not exceed criteria for assisted living at the time of the review.

Tenant #5, an 87 year old, admitted 7-28-12, lived by choice in the memory care unit of the program with the diagnosis of Diabetes. The service plan completed 11-5-12 indicated the tenant needed assistance with bathing, dressing, and medication administration. The tenant scored "1" on the GDS completed 11-5-12 which indicated no cognitive decline. Tenant #5 ambulated independently and did not exceed criteria for assisted living at the time of the review.

Tenant #6, a 91 year old, lived in the memory care unit of the program since admission 9-5-11 with diagnoses of Arthritis and Depression. The service plan completed 1-22-13 indicated the tenant needed assistance with bathing, dressing, grooming, toileting, ambulation outside of apartment and medication administration. The tenant scored "3" on the GDS completed 1-22-13 which indicated mild cognitive decline. Tenant #5 transferred independently, requiring assistance of 1 staff member when outside of room. Tenant #6 did not exceed criteria for assisted living at the time of the review.

Tenant #7, a 93 year old, lived in the memory care unit of the program. Upon admission 1-10-09, Tenant #7 had diagnoses of HTN, Transient Ischemic Attacks, Gastric Reflux, and Osteopenia. The service plan completed 1-11-13 indicated the tenant needed assistance with all activities of daily living. The service plan included an up-date dated 3-5-13 for staff to check on the tenant hourly.

The tenant scored "6" on the GDS completed 1-11-13 which indicated severe cognitive decline. Tenant #7 was admitted to Hospice Care 1-11-13. During interview on 3-18-13, Staff #7 and #8 reported that Tenant #7 transferred with the assistance of one staff member and would assist with toileting with prompting. Tenant #7 did not exceed criteria for assisted living at the time of the review.

Tenant #8, an 89 year old, lived in the memory care unit of the program with diagnosis of Alzheimer's, Cataracts, Glaucoma, HTN, and History of Breast Cancer. The service plan completed 12-5-12 indicated the tenant needed assistance with bathing, dressing, and medication administration. The tenant scored "5" on the GDS completed 12-5-12 which indicated moderately severe cognitive decline. Tenant #8 ambulated and toileted independently and did not exceed criteria for assisted living at the time of the review.

- Regulatory Insufficiency: None noted.

D. Life Safety

Complaint/Incident Allegation: It was alleged that syringes were left unlocked in the memory care unit putting tenants at risk.

- Monitoring Observation: The monitor observed the needles for the insulin pens in one tenant's room to be unlocked. The tenant had been judged by the nurse as competent to place the needles on the pen. The department does not have regulatory authority since the needle does not represent an imminent danger to the other tenants.

- Regulatory Insufficiency: None noted.

E. Other

Complaint/Incident Allegation: It was alleged that the program's smoking area was moved adjacent to a side door which was not away from the building.

- Monitoring Observation: The department does not have regulatory authority in the area of where the program establishes as a smoking area.

- Regulatory Insufficiency: None noted.

During the course of the investigation the following information was identified.

F. Nurse Review

- Monitoring Observation: The service plan for Tenant #1 indicated the tenant ambulated independently with the use of a walker. Communication Note dated 2-11-13 documented Tenant #1 had more difficulty walking. Communication note dated 2-19-13 directed staff members to put pills in applesauce for easier swallowing. Communication note dated 2-25-13 documented Tenant #1 had redness on the midline buttock area which required treatment with an ointment. Communication

Note dated 3-13-12 directed staff to document Tenant #1's behaviors as he/she had been quite agitated. On 3-18-13 at 3:00 p.m. Staff #8, UW, instructed Tenant #1 to stand and come to the bathroom for a scheduled toileting. The tenant stood and ambulated independently with a walker and cueing from the staff member. Tenant #1 refused to toilet stating there was no need. During interview, Staff #7 and #8 stated that Tenant #1 required multiple cueing to toilet but would eventually cooperate. Both staff also reported that Tenant #1 had in the past on at least two occasions gone to the bathroom and smeared feces inappropriately but that did not occur routinely. The clinical record lacked evidence of completion of a nurse review to address the changes in condition noted.

Tenant #2 was admitted 11-18-12. The service plan had been developed 12-4-12. Nurse's Note dated 12-6-12 documented Tenant #2 was having difficulty getting out of a chair and complained of being weak. Tenant #2 did not have funding from Medicaid acknowledged until 2-27-13 at which time a physician's order was obtained for physical therapy. The clinical record lacked documentation of completion of a nurse review to address the changes in condition noted.

- Regulatory Insufficiency: 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))

G. Evaluation

- Monitoring Observation: The service plan for Tenant #1 indicated the tenant ambulated independently with the use of a walker. Communication Note dated 2-11-13 documented Tenant #1 had more difficulty walking. Communication note dated 2-19-13 directed staff members to put pills in applesauce for easier swallowing. Communication note dated 2-25-13 documented Tenant #1 had redness on the midline buttock area which required treatment with an ointment. Communication Note dated 3-13-12 directed staff to document Tenant #1's behaviors as he/she had been quite agitated. On 3-18-13 at 3:00 p.m. Staff #8, UW, instructed Tenant #1 to stand and come to the bathroom for a scheduled toileting. The tenant stood and ambulated independently with a walker and cueing from the staff member. Tenant #1 refused to toilet stating there was no need. During interview, Staff #7 and #8 stated that Tenant #1 required multiple cueing to toilet but would eventually cooperate. Both staff also reported that Tenant #1 had in the past on at least two occasions gone to the bathroom and smeared feces inappropriately but that did not occur routinely. The clinical record lacked evidence of completion of cognitive, health and functional evaluations to address the changes in condition noted.

  Tenant #2 was admitted 11-18-12. The service plan had been developed 12-4-12. Nurse's Note dated 12-6-12 documented Tenant #2 was having difficulty getting out of a chair and complained of being weak. Physical Therapy completed an evaluation 1-3-13 and documented Tenant #2 was not ambulating outside of the apartment due to moderate fear of falling. Physical Therapy planned to treat Tenant #2 two times a week for 30 days for strengthening, improvement in transferring, and to regain independence in all activities.

Tenant #2 did not have funding from Medicaid acknowledged until 2-27-13 at which time a physician's order was obtained for physical therapy. The clinical record lacked evidence of completion of cognitive, health and functional evaluations to address the changes in condition noted.

The Nurse's Notes dated 2-7-13 documented Tenant #6 was found sitting on the floor with clothing down. Staff members were instructed to give stand-by assist for ambulation. Another note on 2-12-13 indicated Tenant #6 was forgetting to take medication as set up by pharmacy and was just "more forgetful" so the program took over medication administration 2-18-13. On 2-19-13 the program received an order to have physical therapy evaluate for lower extremity weakness and history of falls. On 2-22-13 physical therapy completed an evaluation and planned one to two visits a week for eight weeks for strengthening and balance activities. The clinical record lacked evidence of completion of cognitive, health and functional evaluations to address the changes in condition noted.

- 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))

H. Service Plans

- Monitoring Observation: The service plan for Tenant #1 indicated the tenant ambulated independently with the use of a walker. Communication Note dated 2-11-13 documented Tenant #1 had more difficulty walking. Communication note dated 2-19-13 directed staff members to put pills in applesauce for easier swallowing. Communication note dated 2-25-13 documented Tenant #1 had redness on the midline buttock area which required treatment with an ointment. Communication Note dated 3-13-12 directed staff to document Tenant #1's behaviors as he/she had been quite agitated. On 3-18-13 at 3:00 p.m. Staff #8, UW, instructed Tenant #1 to stand and come to the bathroom for a scheduled toileting. The tenant stood and ambulated independently with a walker and cueing from the staff member. Tenant #1 refused to toilet stating there was no need. During interview, Staff #7 and #8 stated that Tenant #1 required multiple cueing to toilet but would eventually cooperate. Both staff also reported that Tenant #1 had in the past on at least two occasions gone to the bathroom and smeared feces inappropriately but that did not occur routinely. The clinical record lacked evidence of completion of a nurse review to address the changes in condition noted and lacked up-dates to the service plan for specific interventions to provide care for Tenant #1.

  Tenant #2 was admitted 11-18-12. The service plan had been developed 12-4-12. Nurse's Note dated 12-6-12 documented Tenant #2 was having difficulty getting out of a chair and complained of being weak.

Physical Therapy completed an evaluation 1-3-13 and documented Tenant #2 was not ambulating outside of the apartment due to moderate fear of falling. Physical Therapy planned to treat Tenant #2 two times a week for 30 days for strengthening, improvement in transferring and to regain independence in all activities. Tenant #2 did not have funding from Medicaid acknowledged until 2-27-13 at which time a physician's order was obtained for physical therapy. The clinical record lacked evidence or inclusion of intervention for physical therapy in the service plan.

- 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))