IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
42912-C

April 30, 2013

Mr. Gary Troth, Executive Director
Northern Hills Assisted Living
4002 Teton Trace
Sioux City, IA 51104

RE: Final Complaint/Incident Investigation Report, Northern Hills Assisted Living, Sioux City, Iowa

Dear Mr. Troth:

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: **Complaint/Incident Intake #:** 42912-C

Gary Troth, Executive Director
Northern Hills Assisted Living
4002 Teton Trace
Sioux City, IA 51104

Date of Complaint/Incident Investigation:

March 25 and 26, 2013

Monitor(s):

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:	60
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	60
TOTAL census of Assisted Living Program	60

Program History – The program received regulatory insufficiencies in the areas of Staffing during this certification period.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged the program did not have incontinence briefs available for a tenant that needed them.

- Monitoring Observation: The following tenants were identified during interview: Tenant #1, a 92 year-old, was admitted on 1-5-08 and had diagnoses of: Osteoporosis, Peripheral Edema, Hypertension (HTN), History of Breast Cancer, Hypercholesterolemia, Hypothyroidism, and Pruritis. Tenant #1 was staged at two on the Global Deterioration Scale (GDS) which indicated very mild cognitive decline. The service plan dated 1-4-13 indicated Tenant #1 had a private caregiver two hours twice daily to assist with cares. The service plan indicated this arrangement gave Tenant #1 time needed to get ready. The evaluations indicated Tenant #1 was "set" in his/her ways. The service plan indicated Tenant #1 was independent with toileting and the family provided incontinence products.

  Staff #1, medication manager, reported Tenant #1's family ordered incontinence products and staff members called the family when the supply was low. Staff #1 did not recall a time when the program had ever run out of incontinence products. Staff #1 reported the program had a supply to use in the interim if a tenant ran out of incontinence products.

  Staff #2, medication manager, reported Tenant#1's family ordered incontinence products, and does not recall running out of incontinence products

Staff #3, medication manager, reported Tenant #1's family provided incontinence products. Staff #2 reported about four months ago, Tenant #1 was out of incontinence products once. Staff #3 reported the program had some incontinence products on hand.

Tenant #2, an 87 year-old, was admitted on 1-4-01 and had diagnoses of: HTN, Rheumatoid Arthritis, Osteoporosis, Depression with Psychotic Ideation, Gastroesophageal Reflux Disease, and Dementia. Tenant #2 was staged at two on the GDS which indicated very mild cognitive decline. The service plan dated 12-29-12 indicated Tenant #2 had agreed to a private caregiver in the morning and evening to provide companionship and to assist with cares. The service plan indicated Tenant #2 needed reminders every two hours to change incontinence products and required assistance with toileting once at night. The service plan indicated the program would be responsible for ordering incontinence products from the pharmacy as Tenant #2 had no immediate family. According to the Registered Nurse (RN), the computerized system was used and incontinence products were ordered with the click of a button. Tenant #2 was discharged from the program on 3-8-13. The program noted Tenant #2 was requiring the assist of two persons for transfer more frequently and in conversations between the RN and Tenant #2, Tenant #2 reported being ready to move to a higher level of care.

Staff #1, #2, and #3 reported the program ordered incontinence products for Tenant #2 while at the program. None of the staff members reported running out of products.

Tenant #3, an 88 year-old, was admitted on 11-1-11 and had diagnoses of: HTN, Chronic Obstructive Pulmonary Disease, Vascular Dementia, Osteoporosis, Cardiomegaly, and Incontinence. Tenant #3 was staged at three on the GDS which indicated mild cognitive decline. The service plan dated 3-11-13 indicated Tenant #3 used incontinence products which the program ordered. Tenant #3 was able to verbally indicate to staff members the need to toilet. Incontinence products were observed in Tenant #3's apartment. Tenant #3 refused interview by the monitor.

Staff #2 reported Tenant #3 had incontinence products ordered from the pharmacy which delivers the products to the program. Staff #2 stated Tenant #3 had not run out of incontinence products.

The RN stated most of the time tenants or family members ordered incontinence products. When the program ordered incontinence products it was usually because there was no immediate family available. Incontinence products were ordered with the click of the button, and the pharmacy delivered. The RN did not recall a tenant who did not have incontinence products available. The program also kept a supply of packaged, new incontinence products that had been donated.

During a medication pass, Tenant #4 was informed there were no alcohol wipes available as part of necessary diabetic supplies. Tenant #4 reported the program ordered the supplies needed and Tenant #4 reported supplies were generally available. Staff # 4 who was passing medications, immediately obtained alcohol wipes and proceeded with checking Tenant #4's blood sugar.

There was no evidence tenants went without needed supplies.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation: It was alleged a Licensed Practical Nurse (LPN) passed medications and did not know the medications being given or the reason the medications were given.

- Monitoring Observation: Three medication passes done by two staff (#1 and #4) were observed over the course of two days. Staff #1 and #4 were not LPN's. According to Staff #1, #2, and #3, LPN's don't routinely pass medications. Staff #3 reported an LPN last passed medications three to four months ago. Staff #4 reported she had been employed at the program since January and had not seen an LPN pass medications. According to the Staff #5, LPN and the RN, LPN's rarely pass medications. Universal workers are not required to know the medications being given or the reason medications are given.

  An LPN was not observed passing medications.

- Regulatory Insufficiency: None noted.

During the course of the investigation, the following was noted:

- Monitoring Observation: A medication pass was observed with Staff #4 on 3-25-13 at approximately 4:00 p.m. Staff #4 took a plastic vial of an inhaled nebulized medication for Tenant #5 and placed the vial in one hand. The vial was not labeled with Tenant #5's name. Staff #4 also picked up a bottle of an inhaled nebulized medication, for Tenant #6 and placed it in the other hand. The bottle was not labeled with Tenant #6's name. Staff #4 escorted Tenant #6 to the apartment and put the medication in the nebulizer and gave the inhaler to Tenant #6. Staff #4 left the apartment without cleansing hands. Staff #4 then went to Tenant #5's apartment and started the nebulizer and left the apartment without cleansing hands. Staff #4 returned to the centralized medication cart to assist Tenant #4 with a blood sugar check. Staff #4 applied gloves without cleansing hands prior. After completion of the blood sugar check and assisting Tenant #4 with insulin administration, the gloves were removed and hand sanitizer was applied.

  Staff #4 carried two unlabeled containers of inhaled medication, one in each hand, for two different tenants and went into each tenant's apartment to administer the medication. Staff #4 did not cleanse hands between tenants. The program did not follow accepted professional standards for medication administration.

- 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))