IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
45482-C

December 3, 2013

Ms. Kristi Wheeler, RN Director
Prairie Hills Assisted Living
173 East Rochester
Ottumwa, IA 52501

RE: Amended Final Complaint/Incident Investigation Report, Prairie Hills Assisted Living, Ottumwa, Iowa

Dear Ms. Wheeler:

Enclosed is the **Amended 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.

The Department has reviewed your Request for Reconsideration. The Request is denied in the area of Staffing. Documentation of the 2 hour checks did not occur at the times required. The Request is denied in the area of Evaluations. The Report indicates significant changes in condition did occur to warrant a full evaluation for Tenants 5 & 7. The Request is accepted in the area of Policy and Procedure.

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
Amended Final Complaint/Incident Investigation Report

Assisted Living Program:

Kristi Wheeler, RN Director
Prairie Hills Assisted Living
173 East Rochester
Ottumwa, IA 52501

Complaint/Incident Intake #: 45482-C

Date of Complaint/Incident Investigation:

October 1, 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:	37
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	38

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	7
TOTAL census of Assisted Living Program	45

Program History – The Program received regulatory insufficiencies in the areas of Staffing, Evaluations and Medications during this certification period.

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

A. Staffing

Complaint/Incident Allegation: It was alleged staff failed to provide necessary cares which resulted in a tenant falling to the floor.

- Monitoring Observation: Six tenant files were reviewed. There were no documentation of falls with Tenants #2, #3, and #4.

  Tenant #1, an 82 year-old, was admitted on 8-30-13 and had diagnoses of: Atrial Fibrillation, Chronic Pain, Hypertension (HTN) and Diabetes. Tenant #1 was admitted to the program following a left hip fracture. Tenant #1 resided in the general population and had no cognitive impairment.

  An incident report dated 9-24-13 indicated Tenant #1 pushed the emergency pendant. Staff arrived to find Tenant #1 on the floor. Tenant #1 stated an attempt was made to sit in the chair and Tenant #1 missed the chair. Tenant #1 was assisted off the floor. A skin tear was observed, cleansed, and dressed. According to the service plan, Tenant #1 was independent with transfers and required occasional assistance when ambulating long distances.

Tenant #5, an 88 year-old, was admitted on 2-11-13 and had diagnoses of: HTN, Chronic Kidney Disease, Degenerative Joint Disease, Benign Prostatic Hypertrophy with Bladder Neck Obstruction, and History of Cerebrovascular Accident. A cognitive screening completed 6-27-13 indicated Tenant #5 had no cognitive impairment. Tenant #5 lived with a spouse in the general population. Evaluations of function, cognition, and health were completed for Tenant #5 on 6-27-13 following hospitalization for weakness and left arm pain. The functional evaluation and the service plan of 6-27-13 indicated Tenant #5 was independent with bathing, dressing, mobility, transfers, and toileting.

The service plan was updated on 7-25-13 with a nurse review following new orders to monitor Tenant #5's weight and blood pressure, and a change in a medication. The service plan continued to indicate Tenant #5 was independent with bathing, dressing, mobility, transfers, and toileting.

On the evening of 8-22-13, Tenant #5's spouse was transported to the hospital and did not return to the program. Nurse's notes for Tenant #5 dated 8-23-13 indicated Tenant #5 was found on the floor on the morning of 8-23-13. According to an incident report completed by Staff #2, Tenant #5 was found lying on the floor between the bed and the wall when Staff #2 entered the apartment in the morning. In an interview with Staff #2 she stated Tenant #5 was not wearing the call pendant. The incident report documented Tenant #5 reported rolling out of bed. Staff #2 stated Tenant #5 reported being unable to get up. There were no documented injuries.

A nurse review was completed for Tenant #5 during the afternoon of 8-23-13. The purpose of the review was to update Tenant #5's service plan in the absence of the spouse. The nurse review noted Tenant #5 required assistance with bathing, dressing, assisting Tenant #5 into bed, and checking on Tenant #5 during the night. According to the nurse review this was not a change of condition as the spouse had previously assisted with the tasks.

Tenant #7, a 75 year-old, was admitted on 2-8-10 and had diagnoses of: HTN, Spinal Stenosis, Stroke Syndrome, Depression, and Stress Incontinence. Tenant #7 had no cognitive impairment and resided in the general population. Tenant #7 was independent with ambulation. An incident report dated 8-2-13 and timed 3:50 a.m. documented Tenant #7 used the call pendant to notify staff of a fall. Tenant #7 reported having a bad dream and being chased. Tenant #7 reported falling on the floor and believed it was an attempt to get away from being chased. Tenant #7 was noted to have a bump on the forehead and a black eye. Tenant #7 also complained of neck, back, and finger pain. Tenant #7 refused further medical treatment.

Files for three tenants who sustained falls were reviewed. There was no documentation to indicate a lack of care resulted in the falls.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: After being found on the floor on 8-23-13, Tenant #5's service plan was updated to include staff checks of Tenant #5 every two hours throughout the night. A review of the two-hour check form documenting the checks was reviewed. Tenant #5 was checked every two-hours throughout the night on 8-23 and 8-24-13. On 8-25-13, the form documented a family member assisted Tenant #5 into bed at 9:00 p.m. There were no checks documented as completed during the night of 8-25-13 (11:00 p.m, 1:00 a.m., 3:00 a.m., and 5:00 a.m.) According to the nurse's notes, Tenant #5 left the program on 8-26-13.

  Every two hour checks were not completed on four occasions during the night of 8-25-13 as indicated in the service plan.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

B. Evaluation

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

Monitoring Observation: A nurse review was completed for Tenant #5 during the afternoon of 8-23-13. The purpose of the review was to update Tenant #5's service plan in the absence of the spouse. The nurse review noted Tenant #5 required assistance with bathing, dressing, assisting Tenant #5 into bed, and checking on Tenant #5 during the night. According to the nurse review this was not a change of condition as the spouse had previously assisted with the tasks; however, the service plan dated 7-25-13 indicated Tenant #5 was independent with bathing, dressing, mobility, transfers, and toileting and did not indicate the spouse provided assistance. In an interview with the RN, she stated the family of Tenant #5 reported to her the spouse had been providing assistance to Tenant #5. In the absence of the spouse, the family requested the program provide assistance to Tenant #5. The RN stated she was unaware the spouse had been providing assistance to Tenant #5.

The most recent evaluations of Tenant #5 dated 6-7-13 and updated with nurse review on 7-25-13 revealed Tenant #5 was independent with bathing, dressing, mobility, transfers, and toileting and did not indicate the spouse provided assistance. The service plan was updated on 8-23-13 following the absence of the wife to include assistance with bathing, dressing, assisting Tenant #5 into bed, and checking on Tenant #5 during the night. Evaluations were not completed with a change of condition.

An incident report dated 8-2-13 and timed 3:50 a.m. documented Tenant #7 used the call pendant to notify staff of a fall. Tenant #7 reported having a bad dream and being chased. Tenant #7 reported falling on the floor and believed it was an attempt to get away from being chased. Tenant #7 was noted to have a bump on the forehead and a black eye. Tenant #7 also complained of neck, back, and finger pain. Nurse's notes dated 8-2-13 and timed at 9:46 a.m. documented Tenant #7 fell after a dream in which Tenant #7 was chased by someone. Tenant #7 was observed to have bruising on the left eye, and the left ring finger was bruised and swollen.

There was no documentation of the status of the back or neck pain indicated in the incident report. Tenant #7 refused further medical treatment.

Tenant #7 sustained a head injury as indicated by the incident report documentation of a bump to the forehead and a black eye. Tenant #7 also complained of neck and back pain. Evaluations were not done following a change of condition, a head injury with back and neck pain.

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

C. Medications

Complaint/Incident Allegation: It was alleged medications were not passed correctly.

- Monitoring Observation: Staff #1 was observed administering eye drops to Tenant #2. Staff #1 used hand sanitizer, applied gloves, then walked from the cart with the Medication Administration Record (MAR) over to Tenant #2. Staff #1 retrieved a bottle of eye drops from a shelf next to Tenant #2 and proceeded to administer the eye drops. Staff #1 did not check the bottle of eye drops against the MAR to ensure the drops in the bottle were the drops ordered.

  Staff #2 was observed initiating a nebulizer treatment for Tenant #6. Staff #2 took a plastic tube of nebulizer medication from the cabinet and placed it in the nebulizer equipment. Staff #2 did not check the medication label on the box of plastic tubes against the MAR to ensure the correct medication was placed in the nebulizer.

  According to the delegation form for routine medication administration, medications should be verified using the "six rights" of right tenant, right medication, right dose, right time, right route and documentation. The delegation form for eye drop administration indicated staff was to check the eye drop bottle against the MAR to make sure it was the correct medication. The delegation form for nebulizer did not indicate the nebulizer medication was to be checked against the MAR; however, in an interview with the Registered Nurse (RN), she stated she did expect staff to do so.

  The eye drops for Tenant #2 were stored on a shelf next to Tenant #2's chair. The shelf was not locked or secured. The eye drops were administered traditionally by the program. According to the service plan of 9-27-13, Tenant #2 self-administered medications except for a cream and eye drops. Medication administered traditionally by the program was not stored.

According to the RN this is a tenant rights issue. Tenant #2 is cognitively well and has a right to decide where the eye drops are stored even though Tenant #2 can't administer her own eye drops and has no as needed doses of the eye drops

The program did not follow its policy on medication administration. Medications were not stored correctly when the program administered medications traditionally.

- Regulatory Insufficiency: Each program shall follow its own written medication policy. (IAC r. 481-67.5)

- Regulatory Insufficiency: When medications are administered traditionally by the program: (b) 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. 481-67.5(6)(b))