IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 47346-C

June 19, 2014

Ms. Judi Faas, Director
Traditions of West Union
609 Hwy 150 North
West Union, IA 52175

RE: Final Complaint/Incident Investigation Report – Traditions of West Union, West Union, IA

Dear Ms. Faas:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of June 5, 9, 10 and 11, 2014, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Judi Faas, Director
Traditions of West Union
609 Hwy 150N
West Union, Iowa 52175

Complaint/Incident Intake #: 47346-C

Date of Complaint/Incident Investigation:

June 5, 9, 10 & 11, 2014

Monitor(s):

Wendy E. Kuhse, RN BS

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:	19
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	26
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	9
TOTAL census of Assisted Living Program	35

Program History – During the course of the Recertification visit and complaint/incident investigation conducted on September 12, 16 and 17, 2013, the Program received regulatory insufficiencies in the areas of: Medications, Structure, Staffing, Evaluations and Service Plans.

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

A. Evaluation

Complaint/Incident Allegation: It was alleged tenants had pressure sores and/or skin issues and in one alleged case, the nurse did not assess the tenant.

- Monitoring Observation:

  Tenant #1, a 95 year old, was admitted on 10-01-12 and had diagnoses of: Coronary Artery Disease (CAD) Hypertension (HTN), Paroxysmal Ventricular Tachycardia, Sick Sinus Syndrome, and History of Pacemaker Placement.

  According to documentation in the Program Nursing Assessment dated 01-13-14 Tenant #'s skin was normal with no documentation of an open area. There was no documentation on the task sheets for Tenant #1 dated June 2014 indicating any changes in pain, anxiety, aggression or skin.

  During an interview on 06-10-14 at 11:05 a.m., Tenant #1's family stated Tenant #1 had a sore on Tenant #1's toe and family told the nurse, however the nurse didn't look at the sore. Family stated the sore is okay now and this alleged incident occurred about 2 or 3 months ago.

Tenant #2, a 91 year old, was admitted on 07-11-09 and had diagnoses of : Liver Cysts, Pancreatitis, Distal Bile Duct Stricture, Chronic Renal Failure, Degenerative Joint Disease, Gastro Enteral Reflux Disease (GERD), and Peripheral Edema.

According to nursing assessment dated 01-17-14, Tenant #2 had an area of irritation on Tenant #2's buttocks that became dry and cracked, and staff applied calmoseptine ointment for prevention of skin breakdown.

According to the 90-day nurse review dated 04-29-14 indicated there were no changes in Tenant #2's cognitive or functional status and no changes to Tenant #2's service plan. Nurse's notes dated 05-18-14 indicated Tenant #2 was hospitalized and then discharged to a nursing home on 05-21-14 for skilled nursing care. A nurse's note dated 06-02-14 indicated Tenant #2 returned to the Program. There was no documentation that Tenant #2 had any skin issues.

According to task sheets dated June 2014, staff assisted Tenant #2 in preventing skin breakdown by applying a Gaymar mat to Tenant #1's bed, and also assisting Tenant #1 to lie down following medication administration twice daily.

During an interview on 06-11-14 at 9:52 a.m. Tenant #2 reported having had sores on the buttocks but currently they are not open areas, and staff put ointment on the areas. Tenant #2 also stated a pressure relief cushion is placed in the wheelchair and the recliner chair Tenant #2 uses.

Tenant #3, an 86 year old, was admitted on 04-13-12 and had diagnoses of: Parkinson's Disease with Movement Disorder, Weakness and Disability, Prostate Cancer, CAD, GERD, Chronic Obstructive Pulmonary Disease, and Chronic Kidney Disease.

According to the Service Plan dated 03-10-14 Tenant #3 also had Psoriasis and staff applied a prescribed cream to the affected areas (lower back, thighs, buttocks) daily after Tenant #3's shower. The Service Plan also indicated Tenant #3 had a red area on Tenant #3's buttock and staff also applied an ointment and Tenant #3 used a gel cushion to sit on.

Observation on 06-09-14 at 12:18 p.m. revealed staff assisted Tenant #3 to use the restroom. Observation while staff provided hygiene cares revealed no open areas to Tenant #3's buttocks. During an interview at the time, Staff #1 stated Tenant #3 did not have any open areas. Staff #1 stated at times, Tenant #3 picks at the Psoriasis lesions which then become open areas.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged a non-nurse professional was completing evaluations on tenants.

- Monitoring Observation: Tenant #1, #2, #3, #4, #5 and #6 files were reviewed and evaluations were documented as completed by the nurse, and within the appropriate time frames.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation: It was alleged staff did not observe the complete medication pass for tenants and as a result, medications were found on the floor.

Monitoring Observation:

Observation of a medication pass on 06-09-14 revealed Staff #1 and Staff #2 to administer medications to 4 tenants. In each medication pass, staff placed the medications directly from the medication cup into each tenant's mouth, or hand. No medications were observed on the floor or dropped on the floor during the medication administration pass.

Random observation on 06-10-14 of the Memory Care Unit revealed no medications on the floor of the common areas or tenants' apartments.

Observation on 06-10-14 at 12:35 p.m. indicated staff had just completed a medication pass for Tenant #3. During an interview, and unidentified staff stated staff usually just pour the medications from the medication cup into Tenant #3's mouth. Staff added that occasionally staff will use a spoon to place individual medication tablets into Tenant #3's mouth.

During the investigation the Director provided a Policy and Procedure on "Documentation of Medication Services on the MAR (medication administration record)". Included in the policy was a procedure on medications being dropped or soiled which directed staff to contact the nurse for instructions or directions replacing the medication.

During an interview on 06-10-14 at 12:39 p.m. the Director of Nursing (DON) stated she has had housekeeping staff bring her medications that were found in tenants' apartments. The DON stated at times she couldn't tell what the medications were, due to them being partially dissolved. The DON stated she disposed of the medications.

- Regulatory Insufficiency: None noted.

C. Staffing

Complaint/Incident Allegation: It was alleged there was not an adequate number of staff working to meet the personal grooming (oral care, hair care and hygiene) needs of the tenants.

- Monitoring Observation:

  Observation on 06-10-14 at 8:32 a.m. revealed 7 tenants in the Memory Care Unit. Tenants were seated at the dining room table with staff assisting one tenant. Tenants were observed to be clean and tidy in appearance and dressed in clean appropriate clothing. No offensive odors were detected.

  Staff # 2, #4, and #5 were interviewed during the investigation and indicated several tenants required an extensive amount of staff time. Staff #2 indicated staff in the Memory Care Unit did not have time to do one on one activities with the tenants, but were able to assist in the completion of the tenants daily cares including toileting and feeding assistance. Staff indicated some tenants required more time due to being hard of hearing, or being forgetful or easily distracted, and/or requiring two staff assistance at times.

- Regulatory Insufficiency: None noted.

D. Tenant Documents

Complaint/Incident Allegation: It was alleged that tenants' sustained falls, but incident reports of the falls were not completed.

Monitoring Observation:

Tenant #4, a 76 year old was admitted on 10-09-10 and diagnoses include: History of Hypertension, Diabetes, Chronic Renal Failure, on Dialysis, CAD, Congestive Heart Failure, Myocardial Infarction and Macular Degeneration.

Complete evaluations (cognitive, functional and health) were completed on 01-07-14. According to the service plan dated 01-07-14, indicated Tenant #4 was able to transfer and ambulate independently but tired easily on dialysis days. The service plan indicated Tenant #4 had problems with his/her knee giving out as well as slipping out the bed and/or chair.

Review of the Nurse Progress Notes from 01-07-14 through 04-15-14 indicated Tenant #4 had 10 falls and/or incidents in which Tenant #4 'blacked out." Review of Tenant #4's record revealed staff documented the incidents in the Nurse Progress Notes as well as on a communication log and/or incident report.

Review of 5 additional tenant files (#1, #2, #3, #5 and #6) revealed staff completed communication logs or incident reports and/or including fall investigations when tenants were involved in any incident (falls, skin tears, elopement).

- Regulatory Insufficiency: None noted.

E. Service Plans

Complaint/Incident Allegation: It was alleged that staff did not have any information about one tenant on admission to the program.

- Monitoring Observation:
  Tenant #5, a 68 year old was admitted on 02-18-14 and had diagnoses which include: Cerebral Vascular Accident, Myocardial Infarction, HTN, Diabetes and Benign Prostate Hypertrophy.

  An initial service plan was completed on 02-14-14 with a review of the plan on 03-17-14. The service plan indicated Tenant #5 was independent with activities of daily living.

  Five additional tenant files (Tenants #1, #2, #3, #4, and #6) were reviewed. Service plans were developed and reviewed for each tenant in the appropriate timeframes.

  Staff interviews (staff # 2,#4 and #5) indicated they each reviewed tenant service plans in order to be aware of what cares and services each tenant received.

- Regulatory Insufficiency: None noted.