IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

November 5, 2014

Complaint Intake #: 49427-C

Ms. Jeanine Chartier, Owner
Char-Mac Assisted Living
200 East Char-Mac Drive
Lawton, IA 51030

RE: Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report – Char-Mac Assisted Living, Lawton, IA

Dear Ms. Chartier:

Enclosed is the **Final Complaint/Incident Investigation & Recertification Monitoring Evaluation 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. **No Regulatory Insufficiencies were found during this evaluation.**

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0074** with effective dates of **April 8, 2014** through **April 7, 2016**.

If you have any questions in regard to this certification, 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 & Recertification Monitoring Evaluation Report

Assisted Living Program:

Jeanine Chartier, Owner
Char-Mac Assisted Living
200 East Char-Mac Drive
Lawton, IA 51030

Complaint Intake #: 49427-C

Date of Monitoring Visit:

October 28th and 29th, 2014

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 were provided by the Program at the time of the on-site.

General Population Program	
Number of tenants without cognitive disorder:	33
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	34
TOTAL census of Assisted Living Program	34

Tenant/Family Satisfaction Results – A meeting was held with 12 tenants. The best thing about the program was the care, the food, the friendly tenants, and the friendly staff. Housekeeping was completed to the tenants' satisfaction in apartments and common areas. Maintenance responded quickly to requests for assistance. Tenants used a call button to call for help and staff members were reported to respond in five to ten minutes. Staff member were described as very friendly and treated the tenants kindly and with respect. Tenants reported they liked the food and variety of foods was offered. Hot foods were served hot. Cold foods were served appropriately cold and no foods were served frozen unless supposed to, like ice cream. There were enough activities offered and no suggestions were made for additional activities. Tenants like the music and outside entertainment. The tenants reported feeling safe at the program, were generally satisfied and would recommend it to others.

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

A. Food Service

Complaint Allegation: It was alleged the food was of low quality and small portions were served. It was alleged the food was unpalatable. It was alleged cheese sandwiches were served as an alternative. It was alleged the bread was still frozen when the sandwich was served.

Monitoring Observation: The program provided documentation of a food license, and menus based on government guidelines. Menus were reviewed and provided foods in all food categories. The evening meal was observed on 10-28 -14 and the noon meal was observed on 10-29-14. Menus were followed. Cook #1 and Cook #2 were interviewed and stated they used prepared recipes and knew serving sizes.

Cook #1 and Cook #2 stated portions were served based on tenant request as some tenants did not want a full serving. Cook #1 and Cook #2 stated second portions were available. Cook #1 and Cook #2 reported cheese sandwiches were available if the tenant did not like the food served, or leftovers from the previous day were offered.

Sandwiches were observed being served during the evening meal on 10-28-14. The sandwiches had been prepared ahead of time and the container with the sandwiches of ham and cheese was placed in a container with ice.

An impromptu tenant meeting was held in the middle of the evening meal on 10-28-14. Tenants reported getting enough to eat, the food was good, and the sandwiches were not frozen.

The monitor asked the program to provide a bite-sized portion of all foods served during the noon meal on 10-29-14. The monitor was served after tenants were offered seconds to ensure enough food was available for the tenants. The food was warm, the potatoes were real as chunks of potato were present in the mashed potatoes, and the gravy was hot. There were chunks of chicken in the casserole. The food was palatable.

A tenant meeting was held on 10-29-14 with 12 tenants present. The tenants reported they got enough to eat, and portion sizes were not too small. The tenants reported they were offered seconds. The flavor of the food was good. Alternatives were usually leftovers from the day before. The tenants reported there had been no frozen food so cold it couldn't be eaten.

There was no evidence at the time of the onsite visit to suggest a regulatory insufficiency existed.

Regulatory Insufficiency: None noted.

B. Policies and Procedures

Complaint Allegation: It was alleged staff members failed to give a tenant blood pressure medication as ordered. It was alleged medication was found on a tenant's table when the staff was to administer the medication. It was alleged a tenant did not have weights checked daily as ordered. It was alleged staff had charted the medications and weights when the cares had not been provided.

Monitoring Observation: The program was asked to provide medication error reports going back to 6-1-14. The program provided documentation of one medication error report for the time period. The incident report documented Staff #1 put Isosorbide Dinitrate 80 milligrams (a heart medication) in a cup and left the cup for Tenant #1 to take. It was documented Tenant #1 always took the pills.

In an interview with the Registered Nurse (RN) she stated staff members were to observe tenants taking medications.

In an interview with the owner, she stated medication errors were taken seriously. Staff #1 had been terminated from employment.

Medication passes were observed with two staff members, Staff #2 and #3, and four tenants. On all four occasions, the staff member observed the tenants taking the medication.

There were no eye drops due at the time of the observed medication passes. The RN identified four tenants who received eye drops. The monitor observed the RN opening the medication cupboards in the tenants' apartments. The eye drops were all located in

the front of the cupboard and easily accessible for staff members administering medications.

The program provided a list of tenants who had been hospitalized. Clinical records for three of those tenants were selected.

Tenant #1 a 79 year-old, was admitted on 4-2-14 and had diagnoses of: Depression, Gout, Renal Failure, Diabetes, Hypertension, Cirrhosis of the Liver, Congestive Heart Failure (CHF), and Neuropathy.

Nurse's notes dated 6-3-14 documented Tenant #1 was experiencing shortness of breath and the blood sugar was high at 241. The nurse's notes Tenant #1 did not follow a diabetic diet. Nurse's notes documented the dosage of Lasix, a water pill, was increased. Daily weights were also discussed with Tenant #1. Tenant #1 refused the daily weights, stating it was too much. Notes of 6-9-14 documented support stockings were ordered and Tenant #1 was encouraged to keep the legs elevated to help with fluid retention in the legs.

Notes of 7-14-14 documented Tenant #1 was to elevate the legs often. Notes of 7-21-14 documented Tenant #1 had increased swelling in the legs and a 13 pound weight gain was noted. The physician was notified. Tenant #1 was to be seen at the clinic on 7-22-14.

On 7-22-14, nurse's notes documented Tenant #1 complained of indigestion and left with family to obtain an over-the-counter medication for relief. The over-the-counter medication Tenant #1 requested contained a large amount of sodium, and the RN did not "give the ok" for Tenant #1, with a history of CHF, to take the medication. Upon returning to the program, Tenant #1 was short of breath and sweaty. The blood pressure was checked and found to be 165-190 systolic. The RN encouraged Tenant #1 to go to the hospital, but Tenant #1 refused. The RN documented she observed Tenant #1 with shortness of breath, diminished lung sounds, pitting edema to the lower legs, an oxygen saturation of 85% (low normal 92%). An ambulance was called and Tenant #1 was taken to the hospital.

Tenant #1 returned to the program on 7-25-14, dropped off belongings, and left the program before the RN could complete a health evaluation. When the health evaluation was completed on 7-28-14, Tenant #1 had a four pound weight gain according to the nurse's notes. The physician was notified. The clinical record contained flow sheets which documented weights, blood sugars, and oxygen saturation levels. Weekly care logs documented tasks completed.

After the evaluations of 7-28-14, the service plan was updated, which according to the nurse's notes, indicated more services were needed as the physician had requested close monitoring following the hospitalization for CHF. Nurse's notes of 7-30-14 documented Tenant #1's reluctance to sign the service plan as Tenant #1 did not want more cares provided. Nurse's notes also documented Tenant #1 was self-administering some medications.

Notes of 7-31-14 documented Tenant #1's non-compliance and Tenant #1's desire to leave the program. The program accepted Tenant #1's written notice to leave the program on 8-15-14.

Nurse's notes 8-3 through 8-13-14 documented continued monitoring of Tenant #1's condition. Tenant #1 was admitted to the hospital on 8-13-14 and did not return to the program.

Tenant #2, a 94 year-old, was admitted on 8-7-13 and had diagnoses of: Right Hip Replacement, Atrial Fibrillation, Chronic Hip Pain, Chronic Kidney Disease Stage III, Chronic Lower Extremity Edema, and Arthritis.

Nurse's notes dated 6-5-14 through 8-13-14 documented vital signs and weights were regularly checked. Nurse's notes dated 8-10-13 through 8-13-14 documented the RN's assessment of Tenant #2's complaint of constipation. The nurse's notes documented the physician was contacted when minimal results were obtained after the use of a laxative. Tenant #2 was admitted to the hospital on 8-13-14 with a diagnosis of bowel obstruction. Tenant #2 was admitted to a higher level of care following hospitalization.

Weekly care logs documented tasks completed for Tenant #2.

Tenant #3, an 88 year-old, was admitted on 8-8-12 and had diagnoses of: Diabetes, Coronary Artery Disease, Chronic Kidney Disease Stage IV, Dementia, Seizure, and Peripheral Vascular Disease. Tenant #3 had seven errors on the Short Portable Mental Status Questionnaire.

Nurse's notes for Tenant #3 dated 7-3-14 through 9-15-14 documented vital signs and weights. Notes of 7-7-14 documented Tenant #3 had a seizure. Tenant #3 was admitted to the hospital and returned to the program on 7-9-14.

Nurse's notes of 7-15-14 documented Tenant #3 was vomiting and dizzy. Tenant #3 went to the physician's office on 7-16-14 and was admitted to the hospital for observation for rehydration. Tenant #3 returned to the program on 7-19-14.

Notes of 7-23-14 documented Tenant #3 had a fever and was complaining of shivers and sweating. Vital signs were documented. Tenant #3 was taken to the hospital and returned on the same day. During the early morning hours of 7-24-14, it was documented Tenant #3 had an oxygen saturation level of 84 %. Tenant #3 returned to the hospital.

Tenant #3 returned to the program. Nurse's notes dated 8-5-14 through 9-5-14 documented vital signs and RN monitoring of Tenant #3's condition. Tenant #3 was again admitted to the hospital on 9-4-14 and did not return to the program.

The program provided documentation of one medication error occurring after 6-1-14. The program terminated the staff member responsible for the error. Clinical records were reviewed for three tenants who were hospitalized. The clinical records documented weights, blood sugars, vital signs, and oxygen saturation levels. The nurse's notes documented ongoing monitoring of tenants' condition changes.

Regulatory Insufficiency: None noted.