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 #:
54969-C

October 12, 2015

Ms. Sharon Lukes, Administrator
Windhaven AL Center
5500 South Main Street
Cedar Falls, IA 50613-7437

RE: Final Complaint/Incident Investigation Report, Windhaven AL Center, Cedar Falls, Iowa

Dear Ms. Lukes:

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, following an investigation by DIA on **September 23, 24 and 28, 2015.**

An investigation of Complaint #54969-C was completed. There were no regulatory insufficiencies cited related to Complaint #54969-C.

The following allegations were investigated in regards to Complaint #54969-C:

Allegation: Staffing
Findings: Unsubstantiated
Comments: Observations, review of four tenant files, staff interviews and review of Program documents did not reveal concerns related to staffing.

Allegation: Service Plans
Findings: Unsubstantiated
Comments: Review of four tenant files, staff interviews and review of Program documents did not reveal concerns related to service plans.

During the course of the investigation a regulatory insufficiency was cited in the area(s) of: Medications.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

If you have any questions in regard to 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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0244	A. BUILDING: _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDHAVEN ASSISTED LIVING CENTER	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments 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: 85 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site: 91 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 28 Total Population of Program at time of on-site: 30 TOTAL census of Assisted Living Program: 121 There were no regulatory insufficiencies identified related to the investigation of Complaint #54969-C. During the course of the investigation the following regulatory insufficiency was cited:	A 000		
A 036	481-67.5(6)a Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) 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 certified and	A 036		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0244	A. BUILDING: _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDHAVEN ASSISTED LIVING CENTER	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	Continued From page 1 noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on tenant file reviews, a staff interview and review of Program documents the Program failed to provide the administration of medications by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645-Chapter 327 for three of four tenant files reviewed (Tenants #1, #2 and #3). Review of tenant files indicated the administration of medications and the completion of treatments were not documented. Medications administered as needed were not appropriately documented, including the reason for giving the medication and the response. 1. Tenant #1, an 86 year old, was admitted on 4-17-15 and diagnoses included: diabetes and Alzheimer's disease. The service plan indicated Tenant #1 received staff assistance with medication administration. According to a Physician's Order document, Tenant #1 had an order for compression garments on in the a.m. and off in the p.m. According to the September 2015 Medication	A 036		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0244	A. BUILDING: _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDHAVEN ASSISTED LIVING CENTER	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	Continued From page 2 Administration Records (MARs), on 9-12-15 (p.m.) staff did not document the completion of removing the compression garments. According to the August 2015 MARs, there were 11 entries staff did not document the completion of applying the compression garments in the a.m. According to the August 2015 MARs, there were 20 entries staff did not document the completion of removing the compression garments in the p.m. According to the July 2015 MARs, there were 3 entries staff did not document the completion of applying the compression garments in the a.m. According to the July 2015 MARs, there were 3 entries staff did not document the completion of removing the compression garments in the p.m. 2. Tenant #2, an 89 year old, was admitted on 4-22-11 and diagnoses included: diabetes type II, depressive disorder, hypertension (HTN), gastroparesis, astigmatism and hypermetropia. The service plan indicated Tenant #2 received staff assistance with medication administration. According to a Physician's Order document, Tenant #2 had an order for ibuprofen 400 milligram (mg)tablet, take 1 tablet by mouth every 8 hours as needed. According to the September 2015 MARs, Ibuprofen 400 mg tablet, take 1 tablet by mouth every 8 hours as needed was documented as administered 8 times. The back of the MAR indicated 2 doses of Ibuprofen were administered and the reason for the administration of the medication was documented. On the front of the MAR entries documented the date, time, staff initials and result. The result was charted as plus sign for	A 036		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0244	A. BUILDING: _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDHAVEN ASSISTED LIVING CENTER	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	Continued From page 3 the entries on the front of the MAR. According to the August 2015 MARs, Ibuprofen 400 mg tablet, take 1 tablet by mouth every 8 hours as needed was documented as administered 14 times. The back of the MAR indicated 2 doses of Ibuprofen were administered and the reason for the administration of the medication was documented. On the front of the MAR entries documented the date, time, staff initials and 10 of the 14 entries had the result charted, which was charted as either a plus sign or a check mark. According to the July 2015 MARs, Ibuprofen 400 mg tablet, take 1 tablet by mouth every 8 hours as needed was administered 13 times. The back of the MAR indicated 2 doses of Ibuprofen were administered and the reason for the administration of the medication was documented. On the front of the MAR entries documented the date, time, staff initials and 2 entries documented the result with a plus sign. According to a Physician's Order document, Tenant #2 had an order for Alprazolam 0.5 mg tablet, 1 tablet by mouth every 4 hours as needed. According to the August 2015 MARs, the medication was documented as administered on 8-9-15. The date, time, staff initials and a check mark for the result were documented on the front of the MAR. On the back of the MAR, there was no documentation of the as needed medication including the reason the medication was administered. According to a Physician's Order document, Tenant #2 had an order for blood sugar checks daily. The August 2015 MARs indicated Tenant	A 036		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0244	A. BUILDING: _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDHAVEN ASSISTED LIVING CENTER	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	Continued From page 4 #2 had blood sugar checks daily at breakfast and Tenant #2 self reported to staff the blood glucose readings. According to the August 2015 MARs, there were 6 entries staff did not document the blood glucose readings. According to Tenant #2's July 2015 Diabetic Journal, there were 15 entries staff did not document Tenant #2's blood glucose readings and 4 entries charted as "missed." According to a Physician's Order document, Tenant #2 had an order for Lidocaine 5% patch, apply 1 patch to the lower back, on for 12 hours and off for 12 hours. Staff applied and Tenant #2 removed. The July 2015 MARs indicated there were 20 entries with either staff initials circled, the letter "R" circled or circles on the MAR. The back of the MAR did not reflect the explanation for the documentation on the front of the MAR. 3. Tenant #3, an 87 year old, was admitted on 1-8-14 and diagnoses included: anemia, anxiety, chronic pain, depression, fatigue, HTN and glaucoma. The service plan indicated Tenant #3 received staff assistance with medication administration. According to a Physician's Order document, Tenant #3 had an order for Potassium CL 20 milliequivalent (MEQ), 2 packets (40 MEQ) mixed in liquid daily at bedtime. According to the August 2015 MARs, on 8-17-15 staff did not document the administration of the medication. According to a Physician's Order document, Tenant #3 had an order for Temazepam 15 mg capsule, 1 capsule by mouth at bedtime.	A 036		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0244	A. BUILDING: _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDHAVEN ASSISTED LIVING CENTER	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	Continued From page 5 According to the August 2015 MARs, on 8-17-15 staff did not document the administration of the medication. 4. According to an interview with the Senior Director of Assisted Living, as needed medications were documented on the back of the MAR and information documented would include: the reason the medication was given and the response. 5. According to the Program's policy regarding medications, when medications were administered traditionally by the Program, the administration of medications would 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.	A 036		

1912 CELEBRATING A CENTURY 2012

WesternHome communities

October 21, 2015

Rose Boccella
Program Coordinator
Adult Services Bureau

Please see our plan of correction related to the regulatory insufficiency in the area of medications: 481-67.5

Staff failed to consistently document the application/ removal of compression stockings on tenant #1. The reason for and result of PRN medications were missing for tenant #2 as well as gaps in the blood glucose log. Tenant #3 did not receive medications as ordered but there was no documentation given. Both medications have been discontinued per order.

1. A nurses meeting is scheduled for October 22, 2015. Nurses will be re-educated on the importance of documenting treatments (compression stockings, etc.). Nurses are to review the MARS to ensure they are completed prior to the end of their shift. Nurses will "flag" the MAR when a PRN medication is given as a reminder to follow up on response. Staff will also be re-educated on the proper documentation when administering a PRN medication.
2. A designated nurse and /or Director of Windhaven will audit MARS weekly to monitor compliance. There will be an increased focus on documentation during orientation of new staff.

420 E. 11th Street Cedar Falls, Iowa 50613 Phone: (319) 277-2141 Fax: (319) 268-8338

3. Auditing the MARS weekly as part of Quality Assurance Program to ensure on going monitoring of MARS for proper documentation.
4. The regulatory insufficiency will be completed by October 26, 2015.

If you have any questions in regard to the POC, please contact me at 319-277-2141 or Sharon. Lukes@westernhome.org.

Thank you,

Sharon Lukes, RN, BSN

Sharon Lukes, RN, BSN
Senior Director of Assisted Living
Director of Windhaven Assisted Living

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

October 22, 2015

Complaint Intake #: 54969-C

Ms. Sharon Lukes, Administrator
Windhaven AL Center
5500 South Main Street
Cedar Falls, IA 50613

RE: Plan of Correction

Dear Ms. Lukes:

DIA has completed the review of your Plan of Correction (POC) in response to the **Final Complaint/Incident Investigation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiency, DIA accepts your POC.

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