IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Complaint Intake: #21115-A

September 8, 2010

Steven E. Ballard
LEFF LAW FIRM, L.L.P.
P.O. Box 2447
222 South Linn Street
Iowa City, IA 52244-2447

RE: Amended Final Complaint Investigation Report – #21115-A

Dear Mr. Ballard:

I. Amended Final Complaint Investigation Report – Jefferson Point, North Liberty, IA

Enclosed is the **Amended Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) per the terms of the Consent Order entered into by the parties on August 3, 2010. The Amended Final Report notes **Regulatory Insufficiencies,** as defined in the area of: Staffing.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Amended Final Complaint Investigation Report

Assisted Living Program:

Victoria Huffman, Administrator
Jefferson Point Assisted Living
45 W. Jefferson St.
North Liberty, IA 52317-4802

Complaint Intake: #21115-A

Date of Investigation:

December 10, 2008

Monitor(s):

Lincoln Newsom, RN
Stephanie Cummins, SW

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code governing assisted living programs. A regulatory insufficiency requires a plan of correction (POC) 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 rule violations [321 IAC 26.2(5)(a)]. The POC should identify how, and by a specific date, an insufficiency will be corrected. The POC is due to DIA within ten (10) working days of the assisted living program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a POC's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Jefferson Point Assisted Living on December 10, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	18
Current number of tenants with cognitive disorder:	0
Total Population:	18

Dementia Specific Program (DSP)* – **Not applicable.**

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There have been no substantiated Regulatory Insufficiencies this certification period.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Staffing - The provisions of this section address the assisted living program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. IOWA ADMIN. CODE r. 321-25.33.

Complaint Allegation: It is alleged a tenant's oxygen level registered 58% by pulse oximeter and the reading was done by an aide and then the RN was contacted by telephone.

Monitoring Observation: Four staff were interviewed concerning Tenant #1. Staff #1 stated she had been trained at a previous job on the use of pulse oximetry. She stated in the event of a tenant emergency staff is to stay with the tenant, call the hospital and have them page the nurse on call. Staff #1 also stated she was not called by the tenant through out the night.

Staff #2 stated she had not had training in the use of pulse oximetry. She stated in the event a tenant is having an emergency, she is to call the nurse on call. Staff #2 stated she had not been directed by the RN to obtain vital signs of Tenant #1, but was to remain with the tenant. She stated she had not been aware of the tenant's oxygen concentrator not working at any time and the tenant was able to use the call light, if help was needed. She also stated she had not ever been aware of a time the tenant was without his/her oxygen.

Staff # 3 stated, she had taken Tenant #1 to the dining room, by wheelchair, for dinner and returned the tenant to his /her room after dinner. She stated she did not see the tenant being short of breath at that time or any other time during her shift. She stated, at times, the oxygen tubing would become disconnected, but she never heard of the oxygen delivery system not working. If the tenant needed assistance he /she would call on the phone. She stated she had never seen the tenant without oxygen being on and both times she saw the tenant on her shift the oxygen was on.

The program's RN provided a written statement indicating Nursing Assistant II's are not trained to use a pulse oximeter. The RN stated in the event a tenant is having a medical problem staff are to call the RN on call. She stated she is not always on call so it could be a nurse, other than her, that would take the call.

Staff #2 stated she called the program's RN at approximately 8:40 a.m. and advised her that Tenant #1's oxygen was not working. The tenant was very lethargic, was taking very deep breaths and was talking but not using correct words. It took the RN approximately 15 minutes to respond. Staff #2 stated that upon the RN's arrival, the RN came into the tenant's room, checked the oxygen and noticed it was not working. The RN then placed the tenant on an oxygen tank.

The RN stated she was informed of the tenant's condition around 8:30 to 8:45 a.m. and she was in the program within 40 minutes. She stated she advised staff to remain with the tenant until she arrived. Staff indicated no other instructions were given to them, relative to the tenant's change in condition. The RN stated upon her arrival she obtained her nursing bag and pulse oximeter and went to the tenant's room. She stated the tenant's oxygen level was 56% at that time. She stated the tenant was sitting on the edge of the bed and was not able to hear what she was saying. She then checked the oxygen

concentrator by placing the nasal cannula under water and noted there was no bubbling. She then hooked Tenant #1 up to a portable oxygen tank. She stated she then called the company providing the concentrator to advise them it was not working and she checked all the connections and then the oxygen worked. She stated she then placed the tenant back onto the oxygen concentrator, and the tenant's oxygen level increased to 78%. The tenant's vital signs at that time were: blood pressure 66/30, pulse 88, respirations 20, lungs were clear with diminished bases, and the tenant's color was pale. She stated she then placed a call to the Pulmonary Hypertension Clinic and relayed her findings. She was instructed by the clinic to send the tenant to the Emergency Room (ER). The tenants' mother was called prior to 911 being called to advise her of the tenant's condition. The RN then questioned Tenant #1, in writing, before activating 911 at approximately 10:00 a.m. At 10:15 a.m. the tenant's blood pressure was 72/38 with an oxygen saturation of 88%. The RN stated she heard the motor running on the oxygen concentrator, upon her arrival, but did not look to see if either a yellow or red light was on.

Despite the RN indicating the oxygen concentrator was not functioning properly on 11-27-08, no documentation was found to indicate the oxygen concentrator was further evaluated. No training was provided relative to potential oxygen concentrator problems. The OASIS forms of 11-24-08 and 12-4-08 stated that tenant and caregiver both manage all tasks related to equipment, completely and independently.

An Emergency run report dated 12/05/2008, stated "Staff on scene states that she was notified at 0900 that pt had an O2 saturation of 55% during AM check, at 0530." "Staff arrived at work at 0900 and was made aware of pts low O2 saturation." "She went to pts room and noted that pt was entirely out of oxygen and was attempting to fill pts portable O2 tank." "When she was unable to determine how to fill tank, she called for transport to the hospital." "Pt states that pain in ... leg and arms has improved since placement on the oxygen."

On 11/27/08 the program had an on-call RN who stated in an interview that on 11/27/08, while at the program evaluating the tenant, the tenant's family member mentioned the dial on the oxygen concentrator was not working and she looked at it and found, indeed it was not working and would not allow the user to increase or decrease the air flow. She stated she believes she advised the programs RN but she was not able to recall specifics nor could she provide documentation to the fact that she had notified the programs RN of her concern. She also stated she was not sure if there was any follow up on the issue with the concentrator and that it would be something important to know. She stated she did not call the company that provided the concentrator due to "It was Thanksgiving; there was nothing I could of done with it." She also stated, "I believe it would be a staff concern to get it checked on."

During the course of the investigation, the following information was obtained.

Two staff interviews and the RN's interview revealed that calls are made, at times, to on call nurses who are not consistently familiar with the care givers and tenants at Jefferson Point. The delegation nurse is required to know the tenant's co-morbid diagnosis, as well as, the experience of the caregiver, in order to give medical recommendations that are tenant specific. The Jefferson Point Emergency Care Plan stated staff have been instructed to call in specific situations involving Diabetes, Infection, Urinary Problems,

Heart/ Lung problems and other problems. The form does not include any instruction to dial 911.

- Regulatory Insufficiency: The program did not have sufficient trained staff available at all times to fully meet tenants' identified needs. IOWA ADMIN. CODE r. 321-25.33(1).

- Regulatory Insufficiency: The owner or management corporation of the program did not ensure that all personnel employed by or contracting with the program received training appropriate to assigned tasks and target population. IOWA ADMIN. CODE r. 321-25.33(5).

- Regulatory Insufficiency: Any nursing services shall be available in accordance with Iowa Code chapter 152 and 655-Chapter 6. IOWA ADMIN. CODE r. 321-25.33(6).

Dated this 9th day of September, 2010.