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

Assisted Living Program: **Complaint Intake #: 7958**

Patt Holder, Manager
Glenwood Place
2907 6th St.
Marshalltown, IA. 50158

Date of Investigation:

August 30, 2004

Monitor(s):

Mary Oliver, LISW
Hal Chase, RN

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may re-visit the assisted living program to confirm progress in fulfilling a plan'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 Glenwood Place Assisted Living on August 30, 2004. 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:	31
Current number of tenants with cognitive disorder:	4
Total General Population:	35

Dementia Specific Program (DSP) **–**

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	8

Accreditation Status – Not applicable.

Complaint History – There are no substantiated complaints during this certification period.

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

A. Criteria for exclusion of tenants - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

Complaint Allegation: It was alleged the program had several tenants in the dementia unit and the general population that were a high level of care. Two tenants screamed at each other in the presence of others, one coughed and spit on tables, the floor, and sometimes in the food of other tenants. It was alleged one tenant was routinely a two-person transfer. It was alleged that one tenant needed to be fed and one tenant often fell asleep at the table during meals. It was alleged that some tenants were often found in wet beds in the morning.

- Investigation Observation: Two tenants did yell at one another, however, according to documentation and staff interviews, this behavior occurred mainly in the apartments of the two tenants, only occasionally in a public area. It was not deemed to be a danger to either of them or others or to present a major disturbance to other tenants. Both tenants involved where independent in their care.

  It was determined through staff interview and file review that several tenants dozed during meal times. The tenants who did this did not choke or fall out of their chairs or into their food. Staff members said the tenants could be awakened easily to finish eating the meal. This behavior was not a danger to the tenants involved or others.

  It was determined that some tenants did awaken with wet beds. The program was able to keep these and other tenants clean and dry during the day. The incontinence was being managed.

  Tenant #3 has a history of aggressive and abusive behavior. The first incident of aggressive behavior documented in the current file was dated 2-10-04. On 4-28-04, the program stated via a fax to the physician, that the tenant had become consistently more aggressive and agitated and requested a psychiatric referral. On 6-21-04, Tenant #3 was kicking and hitting while an aide was helping the tenant to bed. On 7-21-04, Tenant #3 entered the room of another tenant and tried to help that tenant out of a chair against the tenant's will. Tenant #3 later left tenant's bedroom and again entered another tenant's room while that tenant was receiving care from an aide. On 7-21, Tenant #3 followed a tenant around in the commons area. The other tenant was upset and beginning to cry and was saying, "No," "No," repeatedly. According to nurse aide notes, the tenant being followed by Tenant #3 almost fell down. On 8-11-04, Tenant #3 kicked an aide in the face and later slapped an aide in the face when medications were offered.

  In response to the preliminary identification of Tenant #3 exceeding occupancy criteria, the program provided input, subsequent to the on-site by DIA, that the tenant's current function and health care needs are, at this time, within the parameters allowed in an assisted living program.

  Tenant #5 was referred to a psychiatrist for aggressive behavior. The tenant was hospitalized for the month of June through July 13, 2004. The psychiatrist's 7-27-04 note said, "[The tenant] has been violent toward staff on a few occasions." Nurse aide notes, dated 7-27-04, described one event of behavior where the tenant hit an

aide five times with a clenched fist while care was being given. Resident Flow Sheets for July 13 through July 30 describe the Tenant #5's behavior as agitated on four occasions. Those episodes occurred between July 17 and July 30. Documentation indicated this tenant had one major episode of aggressive behavior between July 13 and July 30, thus was not deemed to be a danger to self or others.

Tenant #7 was observed and reported by staff members to require a two-person transfer on a regular basis. This tenant also had a habit, of spitting on the floor, walls, tables, and sometimes in other people's food and drink. This behavior created a health risk to other tenants and staff members. On 6-22-04, Tenant #7 was seen by the psychiatrist for evaluation and medication to alleviate excessive spitting behavior. On 7-27-04, the psychiatrist documented that the tenant's behavior had not improved. When the behavior remained unchanged, the program did not document or discuss transferring the tenant to another level of care. This tenant also had a recent history of biting, kicking, hitting and slapping aides as they attempted to provide care. On one occasion, the tenant tried to hit the aide with a knife and later tried to poke the aide with a fork. On one recent occasion the tenant tried to remove tenant's clothing in a public area.

In response to the preliminary identification of Tenant #7 exceeding occupancy criteria, the program provided input that the tenant, subsequent to the on-site by DIA, was discharged to a higher level of care facility, Westbrook Acres, on September 8, 2004.

Tenant #8's was being provided by Hospice. The tenant had oxygen, a catheter, breathing treatments and medications, and unstable diabetes requiring sliding scale insulin administered by the RN or a family member. This tenant occasionally requires feeding. While the tenant required a high level of care, the tenant did not meet the transfer criteria.

- Regulatory Insufficiency: The program retained Tenant #5, who met discharge criteria.

B. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

During the course of the investigation, it was found that the tenants' service plans contained significant problems.

- Investigation Observation: The service plans for Tenants #2 through #8 did not address behavior problems. The only approach documented, when a tenant had a problem behavior, was to refer them to the psychiatrist for evaluation and medications. The intervention plan for Tenant #7, described by staff, but not documented on the service plan, was to place the tenant in their bedroom until the spitting stopped.

- Regulatory Insufficiency: The program did not ensure service plans were individualized in that the plans did not address tenants' problem behaviors.

C. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation: It was alleged that the program did not have adequate staff to meet the needs of all tenants and that two tenants on the dementia unit had their safety pendants taken away. It is also alleged the program was altering work records to indicate a person worked fewer hours than they actually worked and that the manager did not remain in the building to assist staff during a tornado warning.

- Investigation Observation: The program schedules one CNA to work on each unit for each shift. There are eight tenants in the Waylans Dementia Unit. Each of the eight tenants requires assistance or are totally dependant on staff for toileting, dressing, bathing, and grooming thereby requiring the staff person to go to the tenant's room to provide care and leaving other tenants unattended. The aide is required to alert the aide in the other unit so they can come to the dementia unit to help. This procedure leaves the tenants on the non-dementia unit without supervision or assistance. The tenants in this unit are allowed to enter a locked outdoor courtyard through an alarmed exit door. When a tenant goes through the courtyard door, a silent alarm activates the aide's beeper to alert them. The aide is instructed to check and see who left and to assure their safety. If the aide cares for a tenant in their room, they are unable to check on the person who may have left through the door. Eight of the eight tenants in the dementia unit were determined by staff to need a physical assist to leave the dementia unit in the event of a fire or tornado. Three of six staff members stated that they did not think there was adequate staff to meet the care and safety needs of tenants in the dementia unit and that there should be a "float" person who could help on either unit when help was needed.

  Two tenants did have their safety pendants removed. It was determined that this was appropriate in that those tenants could no longer understand how to call staff by using the pendants. The alternative plan, to assure safety of tenants without pendants, was to check on and document where each tenant was every hour, 24 hours a day.

  There is no requirement for the manager to remain in the building when there is a tornado warning if other staff members are present to care for tenants. There was no indication tenants were not cared for appropriately during tornado warnings.

  Program staff members that were interviewed stated that the Administrative staff changed work hours to reflect fewer hours than what were actually worked in order to avoid paying overtime. This is an issue for another branch of government and the staff was so instructed.

- Regulatory Insufficiency: None noted.

Dated this 12th day of October, 2004.