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

Assisted Living Program: **Complaint Intake #:** 7938

Mark Hudson, Administrator
Mill Pond
1201 SE Mill Pond Court
Ankeny, Iowa 50021

Date of Investigation:

July 29, 2004

Monitor(s):

Jan O'Briant, LISW

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 Mill Pond Assisted Living on July 29, 2004. In preparing this report, the following information was considered:

Current Program Census:

General Population Program -

Current General Population ALP Census: 53 Current number of tenants with dementia: 14

Dementia Specific Program – Not applicable.

Complaint History – No complaints on file 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 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 is alleged the program staff disconnected a tenant's call light on July 22, 2004 and July 28, 2004 because the tenant pushed the call light button frequently.

- Monitoring Observation: Four direct care staff members and the program RN were interviewed. Tenant #1's file was also reviewed as was the program communication log. Tenant #1 was not interviewed.

  Tenant #1 is 105 years old and has resided at the program since May 22, 1995. Tenant #1 has diagnoses of Congestive Heart Failure, Hypertension, Degenerative Joint Disease, Arthritis, Osteoporosis, Anemia and Glaucoma. Tenant #1 is also very hard of hearing. Until three weeks ago Tenant #1 was independent in many personal cares and was able to ambulate and transfer with the assistance of one. Tenant #1 is still able to transfer with the assistance of one, but is using a wheelchair for ambulation and needs increased assistance with personal cares. Based on the program's evaluation, the tenant is within the appropriate level of care for assisted living.

  The tenant is experiencing increased confusion and anxiety and likes to hold the call button apparatus. The tenant pushes the call light button frequently with no apparent need of staff assistance. Interviews with four direct care staff revealed knowledge of the alleged disconnection of the call light although all denied they had personally disconnected it. Staff Members #1 and #3 said they thought the program RN had approved the disconnection of the call light for this tenant. All four said they knew it was wrong to disconnect the call light at any time.

  Staff entries in the communication log dated Thursday, 7-22-04 state "we had to unplug her call-light from the wall, because she pushes it without realizing what it's for. She is still holding on the button when is ok. For now we gave her a Ativan at 7:15 pm, but she is still restless tonight calling out 'Heidi' and 'God help me'." On Wednesday, 7-28-04, communication log staff member entries include: "Please don't unplug her call light. She was scared to death this a.m. when Sandy went in. She just clung to her and said she had to go to toilet so bad. Said she had to go for hours." A second entry states: "I had to, because she pushes her button every 5 minutes. She didn't understand what she was doing most of the night." The entries in the communication book are unsigned.

  The program RN reported she knew the staff had unplugged the call light for Tenant #1, but had only approved this action when staff, family or friends were with the tenant. The RN also reported the tenant is scheduled for 2-hour checks throughout the day and night and that the staff lets the tenant hold the call light button in her hand to decrease her anxiety. It appears, however, the call light was left unplugged by staff even when the tenant was alone as evidenced by the communication log entries.

  Interventions that the program has begun to address for the tenant's increasing anxiety include: enlisting the assistance of the tenant's family and friends to "sit"

with her to help relieve her anxiety and the RN obtained a physician order on July 22nd for Lorazepam 0.25 mg. liquid every 4-6 hours, as needed, for anxiety. Notes on July 23rd indicate this new medication has been effective in relieving some the tenant's anxiety.

- Regulatory Insufficiency: The program did not ensure 24-hour access to an Emergency Response System (ERS) for a tenant, as required by rule.

B. Assisted Living Definition – Program encourages family involvement, tenant self-direction, and tenant participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence. [Iowa Code section 231C.2]

Complaint Allegation: It is alleged the program RN performed a dressing change on the neck of a tenant with the door open to the RN office and the tenant was exposed with an open garment. It is alleged the tenant's privacy and dignity were compromised by the incident.

- Monitoring Observation: The monitor reviewed the tenant's file and interviewed Tenant #2. The monitor also interviewed the program RN about the alleged incident. Tenant #2 is 84 years old and was admitted to the program on November 20, 2002, with diagnoses of Mold Spore, Depression and Anxiety. In early 2004, the tenant was diagnosed with Squamous Cell Carcinoma and underwent out- patient surgery to remove a mass on the tenant's neck. The tenant then underwent thirty-three radiation treatments with resulting burns and irritation to the neck and shoulder skin. Tenant #2 reported that tenant applies a medicated cream to the affected skin three times a day. On the day in question, the tenant stopped by the RN's office and asked the RN to apply a bandage to the tenant's neck to keep the cream from rubbing onto the tenant's clothes. The tenant reported that it was the tenant's choice to go to the office for assistance and did not prefer the RN to come to the tenant's apartment. The tenant does not remember if the office door was open or closed, nor does the tenant remember if the tenant's garment was unbuttoned. The tenant does not feel the tenant was exposed and the tenant denies that the tenant's dignity was compromised by the event. The tenant further reported that the tenant has been prescribed a different skin cream that is not as messy and that further bandages will probably not be needed.

  The RN was also interviewed and remembers the tenant coming to the office and asking the RN to put a Telfa pad on her neck. The RN confirmed this was not a routine dressing change. The RN does not remember if she closed the door or not, but does remember the tenant's back was to the door.

- Regulatory Insufficiency: None noted.

Dated this 13th day of August 2004.