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

Assisted Living Program: **Complaint Intake #: 12071**

Mary Jo Hansen
Keystone Cedars
6325 Rockwell Drive NE
Cedar Rapids, IA 52402

Date of Investigation:

January 13, 2005

Monitor(s):

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 (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 Keystone Cedars on January 13, 2005. 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:	40
Current number of tenants with cognitive disorder:	8
Total Population:	48

Dementia Specific Program (DSP) **–**

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	7
Current number of tenants without cognitive disorder:	1
Total Population:	8

Accreditation Status –Not applicable.

Complaint History – No substantiated complaints this certification period.

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

A. Occupancy Agreement – The program shall enter into an occupancy agreement with the tenant or tenant's legal representative, if applicable, prior to the tenant's taking occupancy that clearly describes the rights and responsibilities of the tenant and of the program, and shall sign a managed risk policy disclosure statement. [321 IAC 25.22]

Complaint Allegation: It is alleged the program did not provide a tenant with an updated occupancy agreement signed by the tenant, legal representative and the program when an increase in service level occurred.

- Monitoring Observation: It is alleged the program did not provide a tenant with an updated occupancy agreement signed by the tenant, legal representative and the program when an increase in service level occurred. The tenant was admitted to the general population part of the program on 9-13-04. The tenant experienced several behavioral problems and was hospitalized from 12-9-04 to 12-16-04 in the psychiatric unit of a local hospital. When the tenant returned to the program the tenant was transferred from the general population to the memory care unit. Nurse's notes dated 12-16-04 indicated the tenant would maintain the current service level for Activities of Daily Living (ADL's). According to program files the monthly rate for the tenant was $2790.00 per month for a one bedroom deluxe in the general population and an additional $300.00 a month for personalized assistance making the total monthly rent in the general population $3090.00. The rate for a studio apartment in the memory care unit was $3550.00 a month, a difference of $460.00. The tenant's occupancy agreement was not updated and signed showing agreement by the tenant, or tenant's legal representative, and the program, to reflect the move from the general population to the memory care unit or the monetary difference that occurred as a result of the move. The program received notice from the tenant and tenant's legal representative on 12-23-04 that the family did not feel the tenant's needs were being met at the assisted living program and the tenant would be transferring on 12-29-04 to a care center in the area. The program billed the family a prorated amount for January rent for the tenant and the family did not feel they should pay the entire amount.

- Regulatory Insufficiency: The program did not provide an updated occupancy agreement signed, in agreement by the tenant, tenant's legal representative and the program, prior to tenant being transferred to the memory care unit.

B. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

- Monitoring Observation: During the course of the complaint investigation it was found that the program did not use the Global Deterioration Scale (GDS) on those tenants that scored moderately using the scored objective tool. The program has a memory care unit housing eight tenants and also had tenants with cognitive impairment housed in the general population. One tenant was hospitalized from 12-9-04 to 12-16-04 due to behavioral issues. The tenant moved from the general population to the memory care unit upon the tenant's return from the hospital. The program updated the service plan when the tenant returned but did not provide

documentation of an evaluation of the tenant's cognitive abilities, functional abilities, and health status prior to returning from a hospitalization or upon a change in condition.

- Regulatory Insufficiency: The program did not evaluate each tenant appropriately with change in condition or return from hospital visit.

C. 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]

- Monitoring Observation: It is alleged the program retained a tenant that required a higher level of care than allowed in assisted living. Tenant #1 was admitted to the program on 9-13-04 with diagnoses of Diabetes Mellitus Type II, chronic back pain, Hypertension, Graves Disease and Depression. Upon admission to the program the tenant did not receive program assistance with medications. According to the nurse's notes and the current service plan on 11-12-04 the program began to assist the tenant with medications. Staff indicated the RN drew up the insulin, staff handed the tenant the insulin and the tenant administered it. The staff took blood sugars twice a day at 0700 and at 2000. According to program files the tenant then received insulin at 0700 and 1700 each day. The service plan indicated the tenant was independent with toileting, transfers and dressing. The tenant had a private duty RN that assisted with bathing. According to nurse's notes on 10-14-04 the tenant was seen in the hospital for a blood clot in the left lower leg behind the knee. The tenant had an outside agency that provided care for the leg and the service level at the program did not change. On 10-20-04 at 0430 the tenant yelled for help and was found on the floor next to the bed with a bruise on the right knee and reddened areas on the right side of the forehead where the tenant had hit the bedside stand during the fall. On another occasion on this date the tenant was found on the floor in the living room with no apparent injuries; however, the tenant's blood sugar was 26. On 11-3-04 the tenant was found in bed not responding well to questions and had a blood sugar of 32. On 11-4-04 the tenant was shaky and the tenant's blood sugar was 26. On 11-11-04 the tenant was very disoriented talking about picking up a spouse who had died and the tenant's blood sugars were at 156. On 11-12-04 the nurse's notes stated tenant's confusion was increasing. On 11-18-04 the nurse's notes indicated the tenant was showing extreme confusion and was not oriented to place or time. Mood alteration was noted and the tenant was observed to be very angry and argumentative at times. On 11-26-04 the tenant was hospitalized for a 23-hour evaluation in a psychiatric unit for increased confusion, not sleeping at night, and depression. On 12-8-04 the tenant was found outside the building. On 12-9-04, per the nurse's notes, the tenant was found putting garbage bags over the tenant's feet thinking they were clothes and had a shirt put on as if it were pants. The tenant was very disoriented and confused and was admitted to the psychiatric unit of the hospital for evaluation. On 12-16-04 the tenant was transferred back to the program and was moved to the memory care unit of the program; however, the nurse's notes indicated the service level did not change. On 12-18-04 nurse's notes indicated the tenant was confused about what to do with the insulin shot and the Oral Medication Technician on duty had to walk the tenant through the process. The tenant also was confused and was found eating a paper napkin and butter wrapped in foil. On 12-19-04 at 1000 the tenant was found on the

floor in the bathroom and was unresponsive. The tenant was taken to the hospital by ambulance and according to the nurse's notes the tenant returned to the program at 1245.

The family felt due to five emergency room visits between 10-13-04 and 12-19-04 the program could not meet the tenant's needs and; therefore, requested an immediate transfer without giving a 30-day notice to the program.

- Regulatory Insufficiency: The program did not transfer a tenant who met the criteria for exclusion of tenant due to being a danger to self at the point the tenant was no longer able to manage diabetic needs.

D. 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 the program did not provide appropriate services to respond to the identified needs of the tenant.

- Monitoring Observation: According to staff interviews and review of program files on 12-19-04 an Oral Medication Technician checked the tenant's blood sugars at 0700 and they were 83. At approximately 0700 to 0715 the Oral Medication Technician gave the tenant an insulin shot to inject and this was documented on the Medication Administration Record (MAR). According to staff, the Oral Medication Technician left the memory care unit after the medications were administered. Staff interviews indicate breakfast was served between 0730 and 0800. Staff Member #1 stated in an interview that the tenant was checked sometime between 0830 and 0900 and the staff member reminded the tenant to come out to breakfast, which was approximately one hour to one and one half hours after the insulin was given. Staff states the tenant was still wearing pajamas at that time. At 1000 the Oral Medication Technician returned to the memory care unit and staff stated that the tenant had not come out for breakfast. The Oral Medication Technician checked on the tenant and found the tenant on the bathroom floor unresponsive. The tenant was taken to the hospital by ambulance with a blood sugar of 31. Staff indicated the tenant usually needed reminders to come out to meals but not usually an escort.

  The program maintained monthly assessment/sign off sheets for each tenant that were signed off by direct care staff. At the bottom of the sheet there was a place for each day of the month for first, second and third shifts to sign. This tenant's assessment, under eating, indicated tenant eats independently, requires reminders, and needs an escort PRN. It also stated "make sure resident is up for meals if not up Oral Medication Technician must be notified." Staff Member #1 signed off on 12-19-04 on the monthly assessment/sign off sheet. In addition to the monthly sheets the program also had meal check off sheets that were primarily used to track billing for food service as well as, making sure all tenants were out for meals. A meal check off sheet for the memory care unit could not be found for 12-19-04.

The staff member indicated it was the first time she had worked with this tenant in the memory care unit. Administrative staff indicated it was the first insulin dependent diabetic to be in the memory care unit. An all staff in-service was held on procedures and protocols for diabetic tenants after this incident occurred.

- Regulatory Insufficiency: The program did not have sufficiently trained staff to meet the tenant's needs.

Dated this 24th day of January 2005.