Iowa Department of Inspections and Appeals
Assisted Living Program
Re-certification Monitoring Evaluation Report

Assisted Living Program:

Kathy Berner, Administrator
The Continental at St. Joseph's
19999 St. Joseph's
Centerville, IA 52544

Date of Monitoring Visit:

June 7, 2004

Monitor(s):

Charlotte Kemp, RN
Mary Oliver, 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 25.8(3)]. 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 Re-certification Monitoring Evaluation 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 this chapter 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 specialized care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site monitoring evaluation was conducted at The Continental at St. Joseph's on June 7. In preparing this report, the following information was considered:

Current Program Census:

General Population Program -

Current General Population ALP Census: **31** Current number of tenants with dementia: **8**

***Dementia Specific Program* – Program** is a self-declared dementia-specific program with 10 tenants.

Tenant/Family Satisfaction Results – Four family members and three tenants were interviewed privately. Family members and tenants generally expressed a high level of satisfaction with the program. Two tenants complained that the quality of the food had declined within the last two weeks. Administrative staff explained that the primary cook had been on vacation for the past two weeks.

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

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas:

A. 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: Prior to admission, the program used a 20-page assessment form, which they did not complete. For four of four tenants, a pre-admission assessment was only partially completed (a word or two jotted on the bottom of each page). The pre-admission assessment did not include an assessment of cognitive ability. Other assessments of cognitive ability were completed more than a month after admission for all four of these tenants. Service plans were reviewed within 30 days of admission for these four tenants, but there was no documentation of a new evaluation being completed at that interval.

Tenant #1: No assessment of Tenant #1's status and needs was completed when the tenant returned from an 11-day hospital stay due to Acute Myocardial Infarction on 4-23-04. Staff interviews and record review also identified this tenant as one who wandered outside the building; however, there were no assessments to identify the wandering or identify interventions to keep the tenant safe. On 3-3-04, Tenant #1 fell to the floor and bumped the back of tenant's head.

Tenant #2: There was no documentation of an assessment after Tenant #2 had a stasis ulcer on tenant's leg and began to require oxygen.

Tenant #3: The record did not include an assessment after Tenant #3's elopement behavior intensified and when the tenant began to be violent with staff. The tenant's intensified behavior was not identified and options for interventions were not assessed.

Tenant #4: An evaluation was not performed when the daughter of Tenant #4 and the physician questioned the tenant's ability to self-administer medications.

- Regulatory Insufficiency: The program did not assess tenants at the required intervals, in order to determine needed services.

B. 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: On two occasions, Tenant #1 was found outside the building trying to get the attention of staff to let the tenant in. One of those occasions was at 1:00 a.m. when the tenant was found outside in the rain. On numerous occasions, Tenant #3 unsuccessfully attempted to elope from the building. On four occasions, Tenant #3 was successful in eloping from the unit and/or the building and was verbally and physically aggressive toward staff members.

Tenant #1: 4-9-04, at 9:00 a.m. The LPN found Tenant #1 outside knocking on the locked service entry door wanting to get in. On 5-25-04 at 1:10 a.m., Tenant #1 was found in the vestibule area sitting on a blanket on the floor tapping on the glass. The incident report indicated the tenant was outside in the rain. It was not noted how the tenant got out of the building during the night. The tenant had a history of wandering.

Tenant #3: Tenant #3 set off the door alarms seven times from 2-22-04 through 2-24-04 and several times on 2-25-04 before the tenant tried to elope again at 6:30 p.m. and began swinging at staff members. The tenant then returned to the tenant's bedroom, began throwing things around and was verbally aggressive. On 3-6-04 at 11:40 a.m., Tenant #3 got out of the unit by pressing the proper sequence of numbers. When staff attempted to get the tenant to return to the unit, the tenant shoved and pushed staff, got away and went to another area where the tenant was tearing at the curtains. With much coaxing the tenant returned to the unit. On 3-20-04, at 10:30 a.m. Tenant #3 got out of the unit by pushing on the West exit door until it opened. The Tenant walked out doors, almost to the road, accompanied by staff members trying to redirect the tenant. The tenant was then coaxed into the company car and was taken for a ride for about 20 minutes by a staff member. On 5-16-04, from 5:35 p.m. through 7:20 p.m. Tenant #3 pushed a staff member against the wall and held her there. The tenant then continued down the hall to the lower North commons where the tenant struggled with the staff members at the door. The tenant was cussing, swinging, and swearing until the Manager of the Program arrived to assist. The tenant was described as very angry and violent. On 6-5-04, at 9:15 p.m., the communication log stated, "[Tenant #3] got out about 8:10[p.m.]" "[Tenant #3] broke out again around 9:00 p.m." The nurse was called in from home to assist, and the tenant returned to the unit around 9:50 p.m.

- Regulatory Insufficiency: The program retained two tenants who were in need of a higher level of care.

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

Monitoring Observation: Service plans were reviewed for three tenants. Service plans were not based on the evaluations. There were numerous signatures on service plans with a variety of dates. At times, it was unclear what the signatures were related to. The service plan included an attachment page for signatures related to the initial service plan, 30-day review, 90-day review, 180-day review, and 270- day review. This form did not allow for any documentation of the review, other than the signatures. Signatures of all people involved in the development of the service plan were not always included and the dates of the signatures were sometimes spread across several days or weeks.

Tenant #1: Service plan updates dated 5-5-04 included statements about what the tenant may need post hospital, not what the tenant actually needed. There was no indication of a service plan that reflected the tenant's actual needs post-hospital. The service plan stated services included under the "base rent", not necessarily what the tenant needed. On 3-11-03, the service plan related to medication changed from medication reminders to staff administering medications. The record includes no explanation of why this change was made.

Tenant #2: Numerous undated and handwritten changes were made to the service plan. There was no documentation as to who made these changes or why the changes were made. A nursing note on 6-21-03 states, "requests wkly checks be done." There were no notes dated 6-21-03 on the service plan nor was there any indication of what type of checks were to be completed or by whom. There was a note on the service plan that staff would help the tenant with Ted hose in the a.m. and p.m.

Tenant #3: There were dated and undated changes to the service plan without any indication in documentation as to why changes were being made. The service plan dated 10-27-03 included a statement that the tenant was an elopement risk and that staff should check on tenant's whereabouts frequently and redirect as needed. Nursing notes indicate the tenant, starting on 2-22-04, began making significant and numerous attempts to leave the unit and the building, sometimes successfully. The service plan was not changed to indicate a change in the tenant's behavior. The service plan did not indicate a problem with the tenant's behavior until 4-5-04 when nursing notes indicated that as early as 2-25-04 the tenant was violent towards staff. The plan to redirect the tenant was inadequate in that it did not give staff any instruction as to how to redirect the tenant safely and successfully.

- Regulatory Insufficiency: The program did not ensure service plans were based on documented evaluation and needs of the tenant, nor were the evaluations timely.

D. Nurse Review - Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. [321 IAC 25.30]

Monitoring Observation: Of the four files reviewed, two tenant's files were missing the 90-day reviews. The monitors reviewed the program's nurse review documentation. Nurse reviews were not always accomplished due to unavailability of the RN. Documentation of nurse reviews throughout the program files was limited in that sometimes only a signature on the signature attachment page of the service plan indicated the reviews.

Regulatory Insufficiency: The program did not complete nurse reviews at the required intervals.

E. 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]

Monitoring Observation: On 5-16-04 and 6-5-04, Tenant #3 left the building when there was only one staff member on duty in the unit where the tenant resided. The staff member was required to be with the tenant until other staff members were called in to assist, this left other tenants unattended. Interviews with staff members indicated that more staff was required.

- Regulatory Insufficiency: The program did not provide adequate staff coverage ensuring safety of all tenants when one tenant required thorough attention.

F. Transportation – When the program provides transportation services directly or under contract with the program, the services shall be provided as required. [321 IAC 25.38]

Monitoring Observation: Until 5-19-04, no rules regarding transportation existed, therefore, until that time the program was in compliance. The program used a company car and the Administrator's personal car to transport tenants for free, on Tuesdays and Thursdays and for a fee on other days. Nursing notes indicate the program routinely transported tenants to the hospital emergency room and on rides. The program indicated that the automobiles were driven by two staff members and was able to produce documentation that one of the two people had a current regular drivers license; the other person had an expired license in the file and was not available to bring in a current license. Neither of these people had a class "D" Chauffeur's license as required by the Iowa Department of Transportation. The Memory Unit communication log stated that on 5-25-04, the LPN took four tenants for a car ride. On 5-29-04, a universal worker took four tenants on a car ride. On 5-30-04, three tenants were taken to Wal-Mart; but there was no indication of who drove the vehicle. On 5-30-04, a universal worker took five tenants for a ride to lunch. In each of the cases noted, there was no indication as to which automobile was used. The program administration, when asked, did not indicate the employees involved had permission to transport tenants.

- Regulatory Insufficiency: The program routinely provides transportation to tenants without assuring approved vehicles are used and without assuring drivers are appropriately licensed and have a safe driving record.

G. Activities – The program provides appropriate programming for tenants based on individual interests. Programming shall support the service plans, be consistent with the program statement and occupancy policies, and available in writing as required. [321 IAC 25.39]

Monitoring Observation: Tenant #3 was unable to plan activities and attempted successfully and unsuccessfully to elope from the unit and from the building. The tenant's service plan did not include a plan for activities except to say, "provide both planned and spontaneous activities."

- Regulatory Insufficiency: The program did not develop an activity plan for tenants who could not plan their own activities.

H. 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]

Monitoring Observations: Tenant #4 was assessed to be normal on a mini-mental test on 8-30-03, normal when assessed for depression and to be at level 2 on the Global Deterioration Scale on 8-29-03. Tenant #4 maintained responsibility for payment of bills and making other financial decisions. A nursing note on 3-19-04 (late for 3-16-04) stated that Tenant #4 told the ER physician that the program was locking tenant's medication up and not giving it to tenant when he needed it. The ER doctors supposedly said that it was against the law to do that. The nurse's note further stated that the tenant's daughter had delegated meds to be set up and dispensed to the tenant by staff. On 3-18-04, documentation in the nursing notes indicated the physician and daughter determined the program should administer medications for Tenant #4. There was no documentation that this was discussed with or approved by Tenant #4 who was alert and oriented. At 11:00 a.m. on 4-7-04, the nurse documented that Tenant #4 was alert and oriented times 3 with some occasional problems with short-term memory. At 5:00 p.m. on 4-7-04, nursing documentation stated that Tenant #4 was upset over medication set up and medication administration bill that the tenant received that day. Subsequently, a Negotiated Managed Risk document was developed and signed by the tenant, the tenant's daughter, Program Administrator and the program's Social Worker.

- Regulatory Insufficiency: The program did not promote tenant self-direction and tenant participation in the decision making process.

Dated this 2nd day of July 2004.