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

Assisted Living Program: **Complaint Intake #: 12965**

Mr. Phillip Chase, Administrator
Silvercrest at the Woodlands
12605 Woodlands Parkway
West Des Moines, IA 50325

Date of Investigation:

June 29 & 30, 2006

Monitor(s):

Hal L. Chase, RN BSN MPH
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 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 revisit 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 Silvercrest at the Woodlands on June 29 & 30, 2006. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* **–** Not applicable.

Dementia Specific Program (DSP)* **–** A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants without cognitive disorder:	60
Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	10
Total Population:	70

***These are the census numbers represented by the program to be applicable.**

Accreditation Status – Not applicable.

Complaint History – There were substantiated complaints in the areas of Medications, Evaluation of Tenant and Service Plans during this certification period.

Complaint Investigation – The complaint investigator(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)]

Complaint Allegation: It is alleged the program does not complete a functional, health and cognitive evaluation when there is a change in the tenant's status.

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 1-17-03 with diagnoses of Hypertension (HTN), Gout, Arthritis, History of Hip Fracture, Depression and Cystitis. The tenant's most current functional and health evaluation was completed on 1-17-06 but it was not completed

  Nurse's notes of 3-30-06 indicate the tenant was complaining of tenderness to his/her third toe left foot. Nurse's notes of the same entry state a corn like area was noted with a white center and redness surrounding the area. The tenant was seen by his/her physician on 3-31-06. The physician noted an infected third toe of the left foot and diagnosed Erythema with a small amount of bloody drainage. The physician ordered an antibiotic to be given for ten days. The physician saw the tenant on 4-12-06 and 5-3-06 related to the tenant's foot care.

  Nurse's notes of 4-25-06 indicate the tenant uses a cane to ambulate. Nurse's notes of 5-13-06 indicate the tenant became physically aggressive spraying an aerosol can of freshener into the face of a staff member. Nurse's notes of 5-16-06 indicate the tenant came to the reception area and yelled he/she wanted his/her foot cutoff. No other history of aggressive behavior has been noted prior to these events. Despite a change in the tenant's condition evidenced by an injury and infection to the third toe of the left foot, a change in being independent with mobility to now using a cane, and aggressive behavior towards staff, the program the program did not complete a functional, health and cognitive evaluation in order to identify how these changes may require the program to provide additional service needs of the tenant.

  Tenant #2, a 90 year old, was admitted on 2-13-2003 with diagnoses of Depression, Unstable Bladder, Peripheral Edema, Atherscelortic Cardio Vascular Disease, Hypothyroid, Microvascular Dementia, Hypokalemia, Osteoarthritis, Osteoporosis, Coronary Artery Disease (CAD), Pulmonary Hypertension and Emphysema, Hypomagnesia and Bilateral Lacunar Planis. Nurse's notes of 2-1-06 indicate the tenant was hospitalized on 2-1-06 with diagnoses of Nausea, Vomiting and Dehydration. The tenant returned to the program on 2-6-06. Despite a change in the tenant's condition evidenced by a hospitalization the program did not complete a functional, health and cognitive evaluation in order to identify how these changes may require the program to provide additional service needs of the tenant.

  Nurse's notes of 3-8-06 indicate the tenant was displaying symptoms of coughing and shortness of breath. On 3-29-06, the tenant was reported to be gagging when food was attempted. The tenant was taken to the hospital emergency room on 3-29-06, returning to the program the same evening. On 4-29-06, staff noticed and treated a skin tear to right upper shin. On 5-9-06, staff noticed a large skin tear to the tenant's right arm. Steristrips were applied. Despite a change in status as evidenced by shortness of breath on 3-8-06, gagging when food was attempted on 3-29-06, and skin tears on 4-29-06 and 5-9-06, the program did not complete a functional, health and

cognitive evaluation in order to identify how these changes may require the program to provide additional service needs of the tenant.

Tenant #3, a 77 year old, was admitted on 10-22-05 with diagnoses of History of Hepatitis C, Supraventricular Tachycardia, Thrombocytopenia, Chronic Liver Disease, Esophageal Varices, Leukocytopenia, Failure to Thrive, Left Femoral Neck Fracture, and Left Hip Hemiporesis. The tenant's most current functional and health evaluation is dated 2-1-06. The program incorrectly scored the results of the cognitive evaluation by totaling the points obtained by the tenant incorrectly. This resulted in the program stating the tenant was moderately impaired when the tenant actually scored results of no or mild impairment.

The functional evaluation dated 2-1-06 indicates the tenant is totally independent with eating, yet the health evaluation of 2-1-06, and the service plan of 2-1-06 indicates the tenant refuses food and drinks fluids and directs staff to encourage the tenant to eat. It is not clear if the tenant is independent with meals or if staff is to assist with meals. The health evaluation of 2-1-06 indicates the condition of the tenant's skin is rough, dry and possibly scaly, with bruising to lower legs. Staff communication log entry of 6-26-06 indicates the tenant has a small open area on his/her right buttocks. Nurse's notes of 6-27-06 indicate Hospice completed a routine visit noting an open sore to the right hip. Hospice staff cleaned with water and applied a Duoderm bandage.

The health evaluation of 2-1-06 indicates the tenant has a Foley catheter with no additional information noted. Nurse's notes dated 4-30-06 indicate Hospice staff attempted to irrigate Foley catheter but was unable to do so. Nurse's notes of 4-30-06 indicate the tenant was transported to Mercy emergency department for catheter care. Nurse's notes of 5-1-06 indicate the tenant was transported to Mercy Radiology where the Foley catheter was deflated and a new Foley was inserted.

Despite a change in status evidenced by a change from being independent with meals to staff assisting with meals, ongoing problems with the tenant's Foley catheter, and the onset of an open sore on the tenant's right buttocks the program did not complete a functional, health and cognitive evaluation in order to identify how these changes may require the program to provide additional service needs of the tenant.

Tenant #4, a 91 year old, was admitted on 10-8-04, with diagnoses of HTN, Sensorineural Hearing Loss (SNHL) Left ear, Coronary Artery Disease, Dementia Alzheimer's Type, Vomiting Upper Gastrointestinal Bleed with Reflux Esophagitis, Hiatal Hernia, 35-38 Gastritis, and a History of Pneumonia. The program completed a GDS on 1-27-0-6 staging the tenant at five denoting moderately severe cognitive decline. The RN states the tenant was admitted to Hospice on 1-13-06 due to a change in status. Despite a change in status evidenced by being admitted to Hospice the program did not complete a functional, health and cognitive evaluation to identify how these changes may integrated with Hospice care until 1-27-06. The program did not coordinate personal and health related cares with what Hospice was providing.

Regulatory Insufficiency: The program does not consistently evaluate a tenant's functional, health and cognitive status when a change in status occurs.

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]

During the course of the investigation, it was found the program retained a tenant who requires routine two-person assist with health-related and personal cares.

- Monitoring Observation: Tenant #2, a 90 year old, was admitted on 2-13-03 with diagnoses of Depression, Unstable Bladder, Peripheral Edema, Artherosclerotic Cardiovascular Disease, Hypothyroidism, Microvascular Dementia, Hypokalemia, Osteoarthritis, Osteoporosis, Coronary Artery Disease (CAD), Pulmonary Hypertension, Emphysema, Hypomagnesia and Bilateral Lacunar Planis. On 3-6-06 the tenant scored a 6 out of 11 on the MSQ indicating moderate advanced impairment, and the program staged the tenant at a five on the GDS indicating moderately severe cognitive decline.

  Four of six staff interviewed identified the tenant as needing two-person assistance with transfer. Staff #1 stated the tenant is a two-person assist more times than not, can ride in a wheelchair, but is unable to use the wheelchair as a stand assist and is given time to transfer independently but can't follow directions. Staff #2 stated the tenant routinely calls for help, can use a wheelchair for mobility and is given time to transfer independently but is unable to do so. Staff #3 stated the tenant is a two-person transfer "all the time," is given time to transfer independently but "can't do it." Staff #4 stated the tenant is a two-person transfer "routinely for toileting" and "doesn't think" the tenant can transfer independently. She states "it is hard to say" if the tenant can use an assistive device due to the tenant's cognitive impairment and she has seen a decline in the tenant in the last few months. The monitor observed two staff giving personal cares to the tenant and noted the tenant was unable to understand directions given by staff.

  The tenant's physician was on-site and completed a health review, which indicated the tenant "has progressive weight loss and progressive dementia." The physician states the tenant is a current two-person transfer and recommends the tenant be placed on Hospice. Despite a change in the tenant's condition evidenced by statements from staff the tenant is a two-person transfer, a progressive weight loss and a decline in cognition, the program did not determine the tenant exceeded occupancy criteria.

- Regulatory Insufficiency: The program does not exclude a tenant that is a routine two-person transfer

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

Complaint Allegation: It is alleged the program does not develop service plans reflective of the tenant's needs for assistance with health-related and personal cares.

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 1-17-03 with diagnoses of HTN, Gout, Arthritis, History of Hip Fracture, Depression and Cystitis. Guardianship & Conservatorship was granted on 8-12-05. The program started a

Mental Status Questionnaire (MSQ) with the tenant on 1-17-06 but it was not completed.

The tenant was seen by his/her physician on 3-31-06 because of an infected third toe of the left foot and diagnosed Erythema with a small amount of bloody drainage. Nurse's notes of 4-25-06 indicate the tenant uses a cane to ambulate. Nurse's notes of 5-16-06 indicate the tenant became physically aggressive spraying an aerosol can of freshener into the face of a staff member. Despite changes in the tenant's health status after 1-17-06, the program did not update the service plan to reflect the needs of the tenant.

Tenant #2, a 90 year old, was admitted on 2-13-03 with diagnoses of Depression, Unstable Bladder, Peripheral Edema, Artherosclerotic Cardiovascular Disease, Hypothyroidism, Microvascular Dementia, Hypokalemia, Osteoarthritis, Osteoporosis, Coronary Artery Disease (CAD), Pulmonary Hypertension, Emphysema, Hypomagnesia and Bilateral Lacunar Planis. On 3-6-06 the tenant scored a 6 out of 11 on the MSQ indicating moderate advanced impairment, and the program staged the tenant at a five on the GDS indicating moderately severe cognitive decline. Nurse's notes of 2-1-06 indicate the tenant was hospitalized with an admitting diagnosis of Nausea, Vomiting and Dehydration and returned to the program on 2-6-06. The tenant's service plan was reviewed on 2-6-06 and no changes were made. On 2-8-06, a swallow study was ordered. On 2-10-06 the tenant was complaining of pain with urination and an order for a urinary analysis was given by the physician. On 2-14-06, the physician ordered a pureed diet for the tenant. Nurse's notes of 3-8-06 indicate the tenant was displaying symptoms of coughing and shortness of breath. On 3-29-06, the tenant was reported to be gagging when food was attempted. The tenant was taken to the hospital emergency room on 3-29-06, returning to the program the same evening. On 4-29-06, staff noticed and treated a skin tear to right upper shin. On 5-9-06, staff noticed a large skin tear to the tenant's right arm. Steristrips were applied.

Despite a change in status as evidenced by swallow study, pain with urination the program did not update the service plan to reflect the needs of the tenant until 3-6-06. Additionally, the tenant experienced shortness of breath, gagging when food was attempted, and two skin tears occurred with no updating of the tenant's service plan. The service plan of 3-6-06 indicates the tenant initiates all of his/her own activities despite a moderately severe cognitive impairment. The tenant is unable to plan or initiate his/her own activities. The program did not develop planned and spontaneous activities based upon the tenant's abilities and personal interests.

Tenant #3, a 77 year old, was admitted on 10-22-05 with diagnoses of History of Hepatitis C, Supraventricular Tachycardia, Thrombocytopenia, Chronic Liver Disease, Esophageal Varices, Leukocytopenia, Failure to Thrive, Left Femoral Neck Fracture, and Left Hip Hemiporesis. The program incorrectly scored the results of the cognitive evaluation by totaling the points obtained by the tenant incorrectly. This resulted in the program stating the tenant was moderately impaired when the tenant actually scored results of no or mild impairment.
The current service plan is dated 2-1-06.

The functional evaluation dated 2-1-06 indicates the tenant is totally independent with eating, yet the health evaluation of 2-1-06, and the service plan of 2-1-06 indicates the tenant refuses food and drinks fluids and directs staff to encourage the tenant to eat. It is not clear if the tenant is independent with meals or if staff is to assist with meals.

The health evaluation of 2-1-06 also indicates the condition of the tenant's skin is rough, dry and possibly scaly, with bruising to lower legs; however, skin care is not listed in the current service plan.

Nurse's notes of 2-28-06 indicate the tenant is receiving Hospice care. The tenant's file contains two Hospice care reviews dated 3-22-06 and 4-5-06 but no actual care plan identifying what cares and services Hospice is providing. Nurses notes dated 4-18-06 indicate the tenant is taking mainly fluids, bites of food and Ensure. Nurse's notes dated 4-30-06 indicate Hospice staff attempted to irrigate Foley catheter and was unable to do so. Nurse's notes of 4-30-06 indicate the tenant was transported to Mercy Emergency Department for catheter care. Nurse's notes of 5-1-06 indicate the tenant was transported to Mercy Radiology where the Foley catheter was deflated and a new Foley was inserted. Staff communication log entry of 6-26-06 indicates the tenant has a small open area on the buttocks. Nurse's notes of 6-27-06 indicate Hospice completed a routine visit noting an open sore to the right hip. Hospice staff cleaned with water and applied a Duoderm bandage. Nurse's notes dated 6-29-06 indicate the tenant is unable to bear weight for transfer. Despite changes in the tenant's status after 2-1-06, the program did not update the service plan and does not demonstrate collaborative care with Hospice identifying what services are provided by Hospice.

Tenant #4, a 91 year old, was admitted on 10-8-04, with diagnoses of HTN, SNHL Left ear, Coronary Artery Disease, Dementia Alzheimer's Type, Vomiting, Upper Gastrointestinal Bleed with Reflux Esophagitis, Hiatal Hernia, Gastritis, and a History of Pneumonia. The tenant's current functional, health and cognitive evaluations were completed 1-27-06. The tenant scored a 1 out of 11 on the MSQ indicating severe brain dysfunction and was staged at a five on the GDS denoting moderately severe cognitive decline. According to the RN, the tenant was admitted to Hospice on 1-13-06. Mercy Hospice care stated the tenant was admitted on 1-13-06 and discharged on 4-12-06. The tenant's current service plan of 1-27-06 is not signed by the tenant or the tenant's legal representative and does not identify services or cares provided by Hospice. Despite a moderate severe cognitive impairment, the service plan of 1-27-06 indicates the program did not develop planned and spontaneous activities based upon the tenant's abilities and personal interests.

- Regulatory Insufficiency: The program does not consistently update service plans as needed with a change in tenant's condition based on current evaluations, including current needs of the tenant.

- Regulatory Insufficiency: The program does have not appropriately signed service plans.

- Regulatory Insufficiency: The program does not develop service plans that address specific planned and spontaneous activities for those with dementing illness.

D. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

Complaint Allegation: It is alleged the program was not giving a tenant medications as prescribed.

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 1-17-03 with diagnoses of HTN, Gout, Arthritis, History of Hip Fracture, Depression and Cystitis. The tenant's current functional and health evaluation was completed on 1-17-06. A review of the tenant's Medication Administration Record (MAR) of 3-26-06 indicate multiple medication errors.

  Tenant #5, an 88 year old, was admitted on 9-11-05 with diagnoses of Diabetes Mellitus, HTN (not origin specific), Senile Dementia Uncompromised, Depressive Disorder, Atrial Fibrillation, Osteoarthritis et al, Hyperplasia of Prostate, Esophagitis Unspecified, Constipation (not origin specific), Ischemic Heart Disease (not origin specific), Congestive Heart Failure, Hyperlipidemia, History of frequent falls and History of rib fractures. The tenant's current functional evaluation was completed on 3-14-06. The current health evaluation was completed on 4-12-06. On 4-12-06 the tenant scored a 3 out of 11 on the MSQ indicating severe brain dysfunction, and the program completed a GDS staging the tenant at a five denoting moderately severe cognitive decline.

  A review of the tenant's MAR for June 2006 indicates multiple medication errors on 6-7-06 and 6-29-06 where medications were not charted as given with no explanation noted. A PRN medication was given on 6-10-06, 6-11-06, 6-18-06 and 6-19-06 with no documentation noting a date, time, initials of staff administering medication, dose, reason for administering, and results of giving the PRN medication. Another PRN medication, an anti-psychotic, was given on 6-1-06, 6-3-06 through 6-8-06, 6-10-06, 6-12-06 through 6-22-06, and 6-26-06 through 6-28-06 with no documentation noting a date, time, initials of staff administering medication, dose, reason for administering, and results of giving the PRN medication.

- Regulatory Insufficiency: The program does not document medications given by the program and does not give an explanation if medications were not administered.

- Regulatory Insufficiency: The program does not document when medications are ordered to be given as needed with date, time, initials of staff administering medication, dose, reason for administering and results of giving the PRN medication.

E. 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]

During the course of the investigation, it was determined the program does not complete a nurse review every 90 days to ensure the tenants' personal and health-related cares are met, and when a change in condition warrants a review.

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 1-17-03 with diagnoses of HTN, Gout, Arthritis, History of Hip Fracture, Depression and Cystitis. The tenant's last nurse review was completed on 1-17-06 with the previous nurse review completed on 12-16-04. The program does not complete a nurse review every 90 days as required.

  Tenant #3, a 77 year old, was admitted on 10-22-05 with diagnoses of History of Hepatitis C, Supraventricular Tachycardia, Thrombocytopenia, Chronic Liver Disease, Esophageal Varices, Leukocytopenia, Failure to Thrive, History of Left Femoral Neck Fracture, and Left Hip Hemiparesis. The tenant's last nurse review was completed on 2-1-06 with the previous nurse review completed on 10-31-05. The program did not complete a nurse review in May 2006 as required.

  Tenant #4, a 91 year old, was admitted on 10-8-04, with diagnoses of HTN, SNHL Left ear, Coronary Artery Disease, Dementia Alzheimer's Type, Vomiting, Upper Gastrointestinal Bleed with Reflux Esophagitis, Hiatal Hernia, Gastritis, and a History of Pneumonia. The tenant's last nurse review was completed on 12-5-05 with the previous nurse review completed on 3-11-05.

- Regulatory Insufficiency: The program does not consistently monitor each tenant receiving personal and health-related care from the program every 90 days.

F. 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]

During the course of the investigation, it was determined the program does not have documentation of staff training for those who provide health-related and personal care to tenants.

- Monitoring Observation: The program was asked to provide training records of staff that provide personal and health-related cares to meet the identified needs of tenants. Eight personnel files were reviewed. Three of eight staff files reviewed included documentation of training for medication administration provided by the program RN. Eight of eight staff files reviewed does not have any documentation of training for personal and health-related cares.

- Regulatory Insufficiency: The program did not maintain documentation of training received by program personnel.

G. Dementia-specific education for program personnel – A dementia-specific program shall employ or contract with personnel who have received appropriate dementia-specific education and training. [321 IAC 25.34]

During the course of the investigation, it was determined staff did not receive a minimum of six hours of dementia-specific training prior to or within 90 days of employment.

- Monitoring Observation: The program is a Dementia Specific program having 10 tenants with a GDS of four and greater. All staff are required to receive a minimum

of six hours of dementia-specific education training prior to or within 90 days of employment and two hours annually. Direct contact staff are required to receive a minimum of six hours of dementia-specific continuing education annually. A review of nine direct contact staff hired between 11-15-05 through 2-25-06 indicate staff have not received a minimum of six hours of dementia-specific training prior to or within 90 days of employment. The program administrator and the RN stated non-direct contact and direct contact staff did not receive the required number of hours of dementia-specific continuing education within the last 12 months. The program provided a sign-in sheet indicating four of the nine direct contact staff reviewed had fifteen minutes of Alzheimer's training on 2-10-06. No other documentation was provided.

- Regulatory Insufficiency: The program did not provide staff with appropriate dementia-specific training.

Dated this 20th day of July, 2006.