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

Assisted Living Program: **Complaint Intake # : 12832**

Shelly Robins, Administrator
Windsor Manor Assisted Living
608 South 15th St.
Indianola, Iowa 50125

Date of Investigation:

April 7, 2006

Monitor(s):

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 Windsor Manor Assisted Living on April 7, 2006. 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:	22
Current number of tenants with cognitive disorder:	1
Total Population:	23

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 in a DSP that holds itself out as providing specialized care in a dedicated setting:	8
Current number of tenants without cognitive disorder:	1
Total Population:	9

***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 Evaluation of Tenant, Service Plan, Medications and Staffing 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 was alleged the tenant was not evaluated adequately as the tenant's condition changed and lack of evaluations resulted in increased illness and a hospital stay.

- Monitoring Observation: Tenant #1, 83 years old, was admitted to the general population unit on 4-7-05 and moved to the dementia specific unit on 1-19-06. From 3-6-06 to 3-9-06 the tenant was hospitalized with a urinary tract infection. The tenant entered the program staged a 3 on the Global Deterioration Scale and at a 6 on last evaluation conducted on 3-9-06. The diagnoses listed on all service plans were: Kyphosis, Alzheimer's, Depression, wt loss, Cardio Vascular Accident (CVA), Coronary Artery Disease (CAD), Hypertension (HTN), History (Hx) Dehydration, Hx Falls, Lung mass, Neck mass, Right (R) Shoulder Injury, Diffuse Degenerative Arthritis, Hypokalemia, Cataracts, and Urinary Tract Infection (UTI). The tenant's needs increased gradually in all areas. In the area of urinary incontinence a Foley catheter was placed and later removed with continuing problems with incontinence. The tenant's son is her general power of attorney and was identified by the tenant as the responsible person. Staff communication logs of 2-18-06 through 3-6-06 stated Tenant #1 was becoming markedly more agitated and began emptying own catheter. There is no record of an assessment to identify the reason for the increased agitation and new behavior of emptying the catheter. A registered nurse (RN) note at 1415 on 3-3-06 states the nurse contacted the doctor about dark amber and cloudy urine output by the tenant. "Informed that R will not be treated for UTI unless symptomatic. Cont. to monitor for temp, [increased] confusion, etc. R afebrile at this time." There is no record of further evaluation of the tenant's temperature, blood pressure, or pulse to determine if any symptoms were present. The next RN note at 0800 on 3-6-06 states, "Staff reports that R not having urine output in bag. R has been emptying catheter bag on own but there is no evidence of that either. Depends have been wet. WM staff reports that R had low-grade temperature (99) over the weekend. Gave Tylenol Sunday a.m. et R hasn't been running fever since. This RN in to look at R. Denies pain @ this time. Abd. non-distended. Non-tender. Staff reports that R on pendant a lot et increasingly agitated." There is no written record of the temperature taken over the weekend and no written record that staff monitored the tenant's temperature, blood pressure, or pulse after there was a verbal report to the nurse of a 99 degree temperature over the weekend. An RN note at 1310 on 3-6-06 states the nurse called the physician "re: above sx. Concerned that cath may be clogged. Also concerned that R cont. to mess with cath and empty on her own in chair, bed, floor etc. R increasingly agitated about catheter. Will await return call from Dr. office." Following this note there is no record the tenant was evaluated for temperature, blood pressure, pulse, distention of bladder or complaints of pain before the RN left for the day. The tenant was taken to the hospital by a friend during the second shift, the time is not recorded. An RN note at 0800 on 3-7-06 states, "Report from staff that R taken to ER last noc by a friend of the family who is an RN. R had temp of 103 last noc. C/O of pain et abd tender to touch." A nursing note at 15:20 on 3-7-06 states, "T.C. received from Mercy Hospital. R has urinary infection currently on Levaquin IV et will be for a few days. Awaiting blood et urine cultures. R also needing to be hydrated."

- Regulatory Insufficiency: The program does not consistently evaluate a tenant's cognitive, functional and health status as needed with a change in condition.

B. Tenant Documents – Program maintains a complete file for each tenant containing all appropriate documentation. [321 IAC 25.27]

Complaint Allegation: It is alleged the RN changed the record regarding care provided to Tenant #1 before the tenant was hospitalized on 3-6-06.

- Monitoring Observation: Nursing notes, communication logs, the Vital Sign Flow Sheet, evaluation documents and service plans were reviewed for evidence of change. No such evidence was found.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It is alleged the program had a record of 0cc urine output from Tenant #1's catheter from 2-28-06 through 3-6-06.

- Monitoring Observation: Notes by the RN and service plans state that staff was to empty the tenant's catheter at the end of every shift and record the amount of output on a sheet posted in the tenant's bathroom. The Director of Nursing (DON) said the staff recorded output from 1-19-06 through 3-6-06 on two sheets. The first sheet, 1-19-06 through the first two shifts of 2-14-06 are available, the second sheet of recordings is not available and the DON states the second sheet disappeared.

Complaint Allegation: It is alleged the RN described an incident in the nursing record of 3-14-06 that was not the same as the description of the incident related by the Certified Nurse Aide (CNA) involved.

- Monitoring Observation: An RN note at 1420 on 3-14-06 states, "T.C. received from WM staff to this RN. R pulled out Foley catheter. R has been messing with catheter et pulling on it on a daily basis. Staff informed that this RN will insert new Foley catheter this eve. Upon return to facility. Instructed to take R to BR Q2H until then. IMTRC with Dr. Bender's office." The CNA on duty that afternoon, was interviewed by telephone and stated that when the tenant was in a lot of pain, the CNA removed the catheter at the telephoned direction of the RN.

  During the course of the investigation the following information was obtained.

  The staff communication log for first shift dated 3-27-2006 states Tenant #1 fell, was picked up by two staff members and had a red mark on the tenant's back. There is no nursing note by the RN or an incident report.

  - Regulatory Insufficiency: The program does not maintain a complete file with required documents.

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

Complaint Allegation: It was alleged the batteries were removed from Tenant #1's emergency pendant.

- Monitoring Observation: Tenant #1 wore an emergency pendant to be pushed when the tenant needed help and this was documented in Service Plans dated 1-19-06 and 3-14-06. Staff communication logs from 2-17-06 through 3-6-06 indicate Tenant #1 was using the emergency pendant to call for help from staff on an ever increasing basis. Interviews with staff indicate this escalated to 50 to 60 calls per hour for several hours on 3-6-06. The administrator said in a telephone interview with the monitor on 4-12-06, "I had the batteries removed because… was calling for help when …didn't need help. I don't remember exactly when the batteries were removed and when they were placed back in the pendant. A couple of weeks ago after the catheter was removed and …was less agitated." There is no documentation the battery was taken out of the pendant or when it was replaced. While the batteries were out, the tenant was allowed to wear the pendant, if the tenant wanted to. On 4-7-06, the tenant was asked by the monitor how the tenant would get help. Tenant response, "I usually have this thing around my neck and I push that, but it's not there today so I don't know what I would do, probably yell loud." When staff was asked about the pendant, staff said, "Oh, it's in … bathroom. I saw it there this morning. … doesn't need it here. … is the only one who has one. We watch … and we keep … door open." When interviewed about the pendant, the RN stated, "… was using it 45 to 65 times an hour and… doesn't need it here. We just let … have it because … used to it from having one when … lived on the other hall."

- Regulatory Insufficiency: The program did not provide the services needed by the tenant in the service plan.

During the course of the investigation the following information was obtained.

- Monitoring Observation: A service plan developed on 1-19-06 for Tenant #1 after a hospital and Skilled Nursing Facility (SNF) stay did not address the tenant's move from the general population unit to the dementia unit. A service plan dated 3-14-06 was developed five days after the tenant returned from a hospital stay.
  The service plan dated 1-19-06 states, "[Tenant #1] has a foley bath with belly bag. WM staff will drain bag at the end of every shift and PRN. Output will be recorded on sheet in bathroom." Staff communication logs from 2-18-06 through 3-6-06 state the tenant was emptying his/her own catheter and had markedly increased agitation. The service plan was not changed to address the problem of not being able to measure the tenant's output or to address the tenant's increased agitation.

- Regulatory Insufficiency: The program did not develop and update the service plan for the tenant based on evaluations and designed to meet the specific service needs of the tenant.

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 Tenant #1 did not receive appropriate nursing care resulting in significant illness requiring hospitalization.

Monitoring Observation: Staff communication logs of 2-18-06 through 3-6-06 stated Tenant #1 was becoming markedly more agitated and emptying own catheter. There is no record of an evaluation of the tenant to identify the reason for the increased agitation and new behavior of emptying the catheter. A RN note at 1415 on 3-3-06 states the nurse contacted the doctor about dark amber and cloudy urine output by the tenant. "Informed that R will not be treated for UTI unless symptomatic. Cont. to monitor for temp, [increased] confusion, etc. R afebrile at this time." There is no record of further evaluation of the tenant's temperature, blood pressure, pulse, or level of confusion to determine if any symptoms were present. The next RN note at 0800 on 3-6-06 states, "Staff reports that R not having urine output in bag. R has been emptying cath bag on own but there is no evidence of that either. Depends have been wet. WM staff reports that R had low-grade temperature (99) over the weekend. Gave Tylenol Sunday a.m. et R hasn't been running fever since. This RN in to look at R. Denies pain @ this time. Abd. non-distended. Non-tender. Staff reports that R on pendant a lot et increasingly agitated." There is no written record of the temperature taken over the weekend and no written record that staff monitored the tenant's temperature, blood pressure, or pulse after there was a verbal report to the nurse of a 99 degree temperature over the weekend. An RN note at 1310 on 3-6-06 states the nurse called the physician "re: above sx. Concerned that cath may be clogged. Also concerned that R cont. to mess with cath and empty on her own in chair, bed, floor etc. R increasingly agitated about catheter. Will await return call from Dr. office." Following this note there is no record the tenant was evaluated for temperature, blood pressure, pulse, distention of bladder or complaints of pain before the RN left for the day. The tenant was taken to the hospital by a friend during the second shift, the time is not recorded. An RN note at 0800 on 3-7-06 states, "Report from staff that R taken to ER last noc by a friend of the family who is an RN. R had temp of 103* last noc. C/O of pain et abd tender to touch." A nursing note at 1520 on 3-7-06 states, "T.C. received from Mercy Hospital. R has urinary infection currently on Levaquin IV et will be for a few days. Awaiting blood et urine cultures. R also needing to be hydrated. …"

- Regulatory Insufficiency: The program does not provide nursing and service plan services in accordance with Iowa Code chapter 152 and 655—Chapter 6.

E. 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 was alleged the use of an emergency pendant to call for help was not respected.

- Monitoring Observation: Employee #1 explained staff are directed to be sure to open the tenant's door whenever the tenant closes it. The DON explained the tenant's relative is quite adamant about staff keeping the door open and staff felt it was best for the tenant's safety. The tenant's relative is not a legal guardian. The tenant's service plan called for the tenant to use a pendant alarm to use in an emergency. Tenant #1 is evaluated to have a Global Deterioration Scale (GDS) score of 5–6. The tenant when interviewed, explained that he/she usually has, a thing to call for help. "It's not there today. I don't know what I would do, probably yell loud for help." The tenant understood the pendant and had an alternative plan to obtain help when the pendant was not available, as it was not that morning when it was left in the bathroom.

- Regulatory Insufficiency: The program does not encourage tenant self-direction, tenant participation in decisions, tenant choice, dignity and independence.

Dated this 2nd day of May, 2006.