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

Assisted Living Program: **Complaint Intake #: 16263**

Mr. Jeremy Gerrish, Administrator
Highland Ridge Assisted Living
100 Village View Circle
Williamsburg, IA 52361-9684

Date of Investigation:

March 14, 2008

Monitor(s):

Lincoln Newsom, RN

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 Highland Ridge Assisted Living on March 14, 2008. 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:	34
Current number of tenants with cognitive disorder:	4

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. ***(Delete the DSP statement that is not applicable.)***

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	10
Current number of tenants without cognitive disorder:	0
Total Population:	48

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable

Program History – There were substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenant, Service Plan, Medications, Nurse Review, Staffing and Record Checks.

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: Tenant #1 was in the dining room, stood up from the table and fell. A staff had turned their back to assist another tenant and did not see the tenant fall. The tenant was unresponsive for several minutes and was transferred to the hospital with a laceration to the forehead.

Monitoring Observation: Tenant #1, a 75 year old, was admitted on 8-3-05 and had a diagnosis of Dementia. A cognitive evaluation was completed on 7-31-07, staging the tenant at a six on the Global Deterioration Scale (GDS), indicating severe cognitive decline. The tenant resided in the memory care unit. Integrated progress notes of 2-18-08 indicated the tenant fell in the dinning room/ kitchen area and sustained a laceration above the left eye. Emergency services were called and the tenant was transported to the hospital. The tenant did not return to the memory care unit. At the time of the tenants' injury, the program had not completed functional, cognitive and health evaluations with a change in the tenant's condition to determine any modifications to needed services.

- Regulatory Insufficiency: The program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy and as needed, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any modifications to services needed. The evaluation shall be conducted by a health care professional or a human service professional. (25.23(2))

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

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

Monitoring Observation: Tenant #1's service plan dated 7-31-07, did not include Hospice services. (During the on-site of 1-16-08, the program was advised that Hospice needed to be reflected on the service plan.) On 1-17-08 the Licensed Practical Nurse (LPN), added "weight loss, hospice called," to the service plan; however, the service plan did not identify the services provided. The program did not update the service plan to identify tenant needs or identify expected outcomes.

- Regulatory Insufficiency: The program did not individualize the service plan and indicate, at a minimum, the service provider(s) if of other than the program. (25.28)(4)(c))

C. 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, the following information was obtained.

Monitoring Observation: Tenant #1 had Hospice services start on 9-10-07. DIA had reviewed this tenant during the 1-16-08 monitoring visit and determined the program did not complete a nurse review with a change in condition. At the time of the tenant's injury of 2-18-08, the program had still not completed a nurse review.

- Regulatory Insufficiency: The program did not assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor the progress on previous recommendations when there are changes in health status. (25.30(3))

J. Other – The provisions of this section address the program's noncompliance with other applicable statutory and administrative rule requirements.

During the complaint investigation of 1-16-08, the program received regulatory insufficiencies for: Evaluation of Tenant, Service Plan, Medications, Nurse Review, Staffing and Record Checks. During the course of this investigation, it was determined the program did not follow their Plan of Correction as it related to Evaluation of Tenants, Service Plan and Nurse Review.

- Regulatory Insufficiency: The program did not implement the Plan of Correction submitted. (26.2(6)(a))

Dated this 30th day of April, 2008.

April 16, 2008

Ann Martin, Bureau Chief
Adult Services Bureau

RE: Plan of Correction for Complaint Intake #16263

Dear Mrs. Martin:

Enclosed is the Plan of Correction for Intake #16263 from Highland Ridge Assisted Living in Williamsburg, Ia.

The creation of this Plan of Correction does not constitute agreement with the Preliminary Complaint Investigation, Civil Penalty, or Conclusions related to Intake #16263. It is being created to comply with the Laws and Statutes of the State of Iowa.

If you have any questions please call me at 319-668-3800.

Best Regards,

Jeremy Gerrish
Campus Administrator
Highland Ridge

Iowa Department of Inspections and Appeals
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa, 50319-0083

April 15, 2008

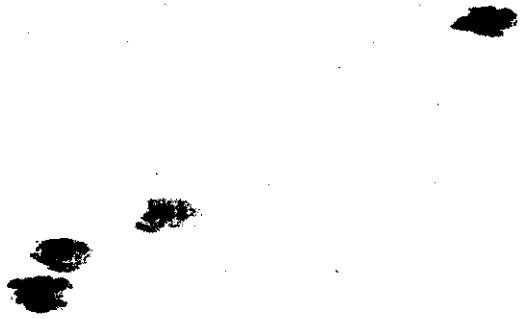
Request for Reconsideration

Regarding Complaint Intake #: 16263 dated March 14, 2008
For
Highland Ridge Assisted Living
100 Village View Circle
Williamsburg, Iowa, 52361-9684

Highland Ridge Assisted Living is hereby exercising its right of Request for Reconsideration, in reference to Complaint #16263. Specifically; Evaluation of Tennant, Service Plan, Nurse Review, and Other "failure to implement Plan of Correction."

Review of timeline:

- 01-16-2008: The office of Inspections and Appeals was on site at Highland Ridge Assisted Living on complaint intake #15266.
- 02-18-2008: [redacted] (tenant) fell in the staff attended community dining room. Tenant was transported to the emergency room for evaluation, and was admitted to the hospital. Tenant fall was self-reported to DIA.
- 02-21-2008: Highland Ridge Assisted Living received Preliminary Complaint Investigation Report for intake #15266.
- 02-22-2008: Family decides to "hold" [redacted]'s Assisted Living room while she is in the hospital. At this time the plan is to have [redacted] return to Highland Ridge Assisted Living. A POC is developed including [redacted] since she is presumed to return to Highland Ridge Assisted Living
- 02-26-2008 Highland Ridge Plan of Correction sent to DIA.
- The client did not return to Highland Ridge Assisted Living after the occurrence 02-18-2008.
- 03-14-2008: A subsequent on-site visit was done by the office of Inspections and Appeals secondary to the self-report and occurrence of 02-18-2008.
- 04-15-2008: The report of investigation and request for Plan of Correction received by Highland Ridge Assist Living, in regard to site visit of 03-14-2008.



A. Evaluation of Tenant

1. Tenant #1 has been discharged.
2. All Tenants will have functional, cognitive, and health evaluations as appropriate - including change of conditions, and services will be modified as needed.
3. The team will meet weekly or as needed to review tenants with changes of condition and make service plan adjustments as needed.
4. The Clinical Administrator will quarterly monitor for continuing compliance.

B. Service Plan

1. Tenant #1 has been discharged.
2. All Tenants will have service plans updated as needed, but not less than annually, by the team, designed to meet the specific needs of the Tenant.
3. The team will meet weekly, or as needed, to review and update service plans to meet the individual needs if the Tenants.
4. The Clinical Administrator will quarterly monitor for continuing compliance.

C. Nurse Review

1. Tenant #1 has been discharged.
2. A nurse will review, assess, and update change of condition and service plans as needed for all Tenants.
3. The team will meet weekly, or as needed, to review and update service plans to meet the individual needs if the Tenants. The Clinical Administrator or designee will review, asses, and update change of condition and service plans.
4. The Clinical Administrator will monitor quarterly for continuing compliance.

D. Other: Regulation #26.2(6)(a) "did not implement the Plan of Correction submitted" as noted in the complaint.

Highland Ridge has made the appropriate corrections as sited above and in the previous Plan of Correction dated 02-26-2008.

It is the belief of Highland Ridge Assisted Living that we should be exonerated from non-compliance of the Plan of Correction for the on-site visit of 01-16-2008. The report of the investigation and request for Plan of Correction was not received by Highland Ridge until three days after the occurrence on 02-18-2008. We therefore cannot be held accountable to a plan that was not yet written or even received from the office of Inspections and Appeals.

Further, only the medical record of Tenant [redacted] was reviewed during the on-site visit of 03-14-2008. We agree that "Evaluation of Tenant, Service Plan, and Nurse Review" were not completed on this tenant. Nor could it be done due to the tenant never returning to Highland Ridge Assisted Living. Other records that were indicated in the Plan of Correction dated 2-26-2008 were not reviewed during this on-site visit. Therefore, item J. Other – Program did not implement the Plan of Correction submitted, should be lifted as well. The Plan of Correction was implemented on all Tenants except for the one that never returned to Highland Ridge Assisted Living.

Therefore, based on the dates of occurrences, site visits, receipt of the request for Plan of Correction and resulting submission of the Plan of Correction, coupled with a single record review, it is the request of Highland Ridge Assisted Living, that investigative report #16263, dated April 14, 2008, be rescinded and the resulting civil penalty of a fine in the amount of $2.500.00 be lifted.

As always, if you have further questions and/or require further information, please feel free to contact me.

Thank you for your time and consideration.

Jeremy Gerrish
Administrator
Highland Ridge Assisted Living
100 Village View Circle
Williamsburg, Iowa, 52361-9684
319-668-3800