IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

December 5, 2008

Complaint #20466-C

Mr. Michael Jarrell, Administrator
Elm Crest Retirement Community
2108 12th Street
Harlan, IA 51537

RE: Complaint Investigation Report, Elm Crest Retirement Community, Harlan, IA

Dear Mr. Jarrell:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated November 14, 2008. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary. The Final report is enclosed for your information.

We appreciate your prompt action in correcting the Regulatory Insufficiencies. If you have questions, please contact me at 515-281-5721.

Sincerely,

Tamara Halvorson

Tamara Halvorson
ASB Lead Certification Coordinator
Adult Services Bureau

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

Assisted Living Program:

Complaint Intake #: 20466-C

Michael Jarrell, Administrator
Elm Crest Retirement Community
2108 12th Street
Harlan, IA 51537

Date of Investigation:

October 27, 2008

Monitor(s):

Michael Streepy, 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 Elm Crest Retirement Community on October 27, 2008. 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 in a DSP that serves 5 or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale (GDS):	9
Current number of tenants without cognitive disorder:	22
Total Population:	31

***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 in the areas of: Evaluation of Tenant, Service Plan, Medications, Nurse Review, Food Service, Staffing and Dementia-Specific Education 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)]

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

- Monitoring Observation: Tenant #1, a 91 year old, had been admitted to the program on 12-27-07 with diagnoses including: Congestive Heart Failure, Post Inflammatory Pulmonary Fibrosis and Depressive Disorder. Review of the tenant's record reveals communication with the attending physician of a fall with laceration requiring sutures to the right temporal area and physician orders for antibiotic ointment and ice as needed and neuron checks for 24 hours. On 08-28-08 the tenant had a fall without injury. On 09-04-08 the tenant returned from a physician visit with an order for oxygen with activity. Nurse's notes titled ECRC Assisted Living Resident Notes, dated 10-13-08, revealed the tenant complaining of left rib cage pain and lower left back pain. The tenant was seen by the physician and returned to the program with an order for Vicodin 5/500 one to two every 4 to 6 hours as needed for severe pain. The record contained no documentation of functional, cognitive or health evaluations with the changes in condition.

  Tenant #2, a 90 year old, was admitted to the program 03-31-03 with diagnoses including: Senile Dementia, Depressive Disorder, Anxiety, Hypertension, Osteoarthritis and Osteoporosis. ECRC Assisted Living Resident Notes dated 09-28-08 reveal a staff witnessed fall in the tenant's bathroom at 21:30. The tenant was taken to the emergency room and returned at 23:30. The notes indicated a broken wrist and shoulder with order for an immobilizer on the wrist and shoulder. The notes indicate the tenant was given Tramadol 50 milligrams for pain. From 10-02-08 through 10-17-08, notes indicate the tenant is assisted with activities of daily living by staff. Tenant documentation dated 10-06-08 reveals a physician order to decrease the Tramadol dose by half, change the tenant immobilizer to a sling, and Physical Therapy. ECRC Assisted living Resident Notes dated 10-09-08 indicate the tenant with cognitive and behavioral changes including visual and auditory hallucinations. Tenant record review also reveals a Physical Therapy Assessment and plan of treatment dated 10-14-08. The record contained no documentation of functional, cognitive or health evaluations with the changes.

- Regulatory Insufficiency: The program did not consistently ensure evaluation of each tenant's functional, cognitive and health status would be completed as needed, to determine the tenant's continued eligibility for the program and to determine any modifications to services needed. (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 record reveals communication with the attending physician of a fall with laceration requiring sutures to the right temporal area and physician orders for antibiotic ointment and ice as needed and neuron checks

for 24 hours. The record reveals on 09-04-08 the tenant returned from a physician visit with an order for oxygen with activity. ECRC Resident Notes dated 10-13-08 reveal the tenant complaining of left rib cage pain and lower left back pain. The tenant was seen by the physician and returned to the program with an order for Vicodin 5/500 one to two every 4 to 6 hours as needed for severe pain. The record contained no documentation of update to the service plan since 01-28-08.

Tenant #2's record reveals ECRC Resident Notes dated 09-28-08, revealing a staff witnessed fall in the tenant's bathroom at 21:30. The tenant was taken to the emergency room and returned at 23:30. The notes indicated a broken wrist and shoulder with order for immobilizer on the wrist and shoulder. From 10-02-08 through 10-17-08 the notes indicate the tenant is assisted with activities of daily living by staff. Tenant documentation dated 10-06-08 reveals a physician order to change the tenant immobilizer to a sling and for Physical Therapy. ECRC Resident Notes dated 10-09-08 indicate the tenant with cognitive and behavioral changes including visual and auditory hallucinations. Tenant record review also reveals a Physical Therapy Assessment and plan of treatment dated 10-14-08. The record contained no documentation of the outside service for physical therapy or an update to the service plan after 10-01-08.

- Regulatory Insufficiency: The program did not consistently ensure a service plan would be developed for each tenant based on evaluations conducted in accordance with 25.23(1) and 25.23(2), and designed to meet the specific needs of the individual tenant. (25.28(1))

- Regulatory Insufficiency: The program did not consistently ensure the service plan would be individualized and indicate at a minimum the tenant's identified needs and the tenant's requests for assistance and expected outcomes and the service providers if other than the program. (25.28(4)a, 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's record had documentation dated 08-04-08 of communication with the attending physician of a fall with laceration requiring sutures to the right temporal area and physician orders for antibiotic ointment and ice as needed and neuron checks for 24 hours. The record contained documentation on 09-04-08 of the tenant's return from a physician visit with an order for oxygen with activity. ECRC Resident Notes dated 10-13-08, reveal the tenant complaining of left rib cage pain and lower left back pain. The tenant was seen by the physician and returned to the program with an order for Vicodin 5/500 one to two every 4 to 6 hours as needed for severe pain. The record contained no documentation of nurse review with the changes in health status.

Tenant #2's record had ECRC Resident Notes dated 09-28-08, indicating a staff witnessed fall in the tenant's bathroom at 21:30. The tenant was taken to the emergency room and returned at 23:30. The notes indicated a broken wrist and

shoulder with order for an immobilizer on the wrist and shoulder. The notes indicate the tenant was given Tramadol 50 milligrams for pain. From 10-02-08 through 10-17-08 the notes indicate the tenant is assisted with activities of daily living by staff. Tenant documentation dated 10-06-08 reveals a physician order to decrease the Tramadol dose by half, change the tenant immobilizer to a sling and Physical Therapy. ECRC Resident Notes dated 10-09-08, indicate the tenant with cognitive and behavioral changes including visual and auditory hallucinations. Tenant record review also reveals a Physical Therapy Assessment and plan of treatment dated 10-14-08. The record contained no documentation of nurse review with the changes in health status.

- Regulatory Insufficiency: The program did not consistently ensure a registered nurse would be provided to assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress on previous recommendations at least every 90 days or if there are changes in health status. (24.30(3))

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: Complaint 20466-C alleges the program call system was malfunctioning over a 2 month period and completely unusable for about a 3 week period. The complaint also alleges during this time period Tenant #1 had fallen and was on the floor for 90 minutes.

- Monitoring Observation: Interview with program administration and maintenance personnel reveals the program call system had been inoperable for a period as described. The program was unable to get the board repaired with the normal vendor and it took approximately 3 to 4 weeks to discover this. A new board had to be manufactured; the process took another 3 to 4 weeks according to the administrator. Program staff checked with the tenants every 15 minutes from 09-06-08 through 09-15-08. The maintenance supervisor stated it was only during this period the system was completely inoperable. The program established a temporary system with both lights and audible sound from October 6th through October 17th. The new board was installed on October 17, 2008. The tenant who was reported to have fallen and could not get assistance for 90 minutes was not available for interview. Interview with the tenant's next of kin, a son and Power of Attorney, was conducted. The family member stated the tenant had been hospitalized for an unrelated medical condition and was not able to be interviewed. The family member stated the tenant had not mentioned any instance of being unable to get assistance following a fall.

- Regulatory Insufficiency: None noted.

Dated this 14th day of November, 2008.