IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

January 21, 2009

Nick Jedlicka, Director
Lakeview Lodge Assisted Living
312 Southbrooke Drive
Waterloo, IA 50702-5804

RE: Recertification Monitoring Evaluation Report, Lakeview Lodge Assisted Living, Waterloo, IA

Dear Mr. Jedlicka:

The Department of Inspections and Appeals (DIA) has completed the review of your Plan of Correction (POC) in response to the **Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC.

Enclosed you will find the Assisted Living Program Certificate with effective dates of **January 23, 2009 through January 22, 2011**. If you have any questions regarding this certification, please contact me at 515-281-5003.

Sincerely,

Connie Schaffer

Connie Schaffer
Certification Coordinator – Central Iowa
Health Facilities Division
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Recertification & Incident Investigation Report

Assisted Living Program: **Incident Intake: #21199-I**

Nick Jedlicka, Director
Lakeview Lodge Assisted Living
312 Southbrooke Drive
Waterloo, IA 50702-5804

Date of Incident Investigation:

December 16, 2008

Monitor(s):

Hal L. Chase, RN BSN MPH
Stephanie Cummins, MA

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 an Incident 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 recertification on-site and incident investigation visit was conducted at Lakeview Lodge Assisted Living on December 16, 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 and provides specialized care in a dedicated setting.

Total Population of DSP:	49
Total Census of ALP:	49

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

Tenant/Family Satisfaction Results – One family interview was held. The family member stated he would recommend the program "no question about it." He stated the nursing services so close after hours were a benefit of the program. Dignity issues were important and the program provides privacy and care. There are three meals a day and staff were conscience of who gets along and the seating at tables. The program encourages families to get involved. There is a written calendar of activities provided and there is always something going on. Activities included: bus ridges, Red Hat Club, outdoor activities, house tours and exercises. The family member stated the "aides are phenomenal" and they have the "right crew." The family member stated he visits in the evenings and on weekends and has witnessed staff conducting activities. Staff are quick to inform family of changes. The family member stated the tenant could not be safer and he felt blessed to have the tenant at the program. The family member stated staff are people that do it for the right reasons.

Accreditation Status – Not applicable.

Program History – There were no substantiated complaints during this certification period.

Incident Investigation – The 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)]

Monitoring Observation: Tenant #2, an 88 year old, was admitted on 6-23-08 and has diagnoses of: Alzheimer's Disease, Unspecified Essential Hypertension (HTN), and Diabetes Mellitus without Compensation Type II, Unspecified Hereditary & Idiopathic Peripheral Neuropathy, History of Cholecystectomy, Bilateral Total Knee Replacement and Hysterectomy. The tenant was staged at a five on the GDS on 12-4-08, which indicated moderately severe cognitive decline. Physician order of 9-26-08 indicated Cholestyramine use three times daily due to fecal oozing and Trivase three times daily for possible fungal infection to peri-anal area. Physician notes of 11-26-08 indicated the tenant was seen by his/her physician due to bilateral toenails that were elongated and painful with ambulation. Health and cognitive evaluations were completed on 9-12-08 and 12-4-08, but these evaluations did not reflect concerns related to fecal oozing, possible peri-anal infection, needed foot care and ambulation change. The program did not complete functional, cognitive and health evaluations with a change in health status to determine if any modifications to services were needed.

Tenant #3, a 78 year old, was admitted on 11-29-07 and has diagnoses of: Alzheimer's Disease, Diabetes Mellitus, Gastro Esophageal Reflux Disease, Chronic Back Pain, HTN, and Gastritis/Esophagitis. The tenant was staged at a four on the GDS on 10-3-08, which indicated moderate cognitive decline. An addendum dated 3-26-08 was added to the service plan of 10-29-08 indicated interventions related to inappropriate sexual behavior and comments to staff. The program did not complete functional, cognitive and health evaluations with a change in health status to determine if any modifications to services were needed.

- Regulatory Insufficiency: The program did not evaluate each tenant's functional, cognitive and health status as needed 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]

Monitoring Observation: Tenant #2's physician orders of 9-26-08 related to Cholestyramine use due to fecal oozing and Trivase crème for possible fungal infection to peri-anal area and 11-26-08 of bilateral toenails that were elongated and painful with ambulation. The program did not update the service plan of 8-15-08 to reflect interventions related to peri-anal care and assistance with ambulation.

Tenant #5, a 94 year old, was admitted on 5-29-07 and diagnoses include: Dementia, Diverticulosis, Glaucoma, Cholelithiasis, Esophagitis, Status Post Bilateral Hip Replacements, and Urinary Incontinence, Barrett's Esophagus. The tenant was staged at a six on the GDS, which indicated severe cognitive impairment. Staff #2 and #3 indicated the tenant had made inappropriate comments towards staff. The quarterly assessment dated 11-4-08 stated over the past few months the tenant had become less inhibited and frequently made suggestive comments to staff. The service

plan stated the tenant's behavior was appropriate and he/she often compliments the opposite sex. The service plan did not address interventions related to suggestive comments towards staff.

- Regulatory Insufficiency: The program did not update the service plan as needed to meet the needs of the tenant. (25.28(3))

- Regulatory Insufficiency: The program did not individualize the service plan to indicate the tenant's identified needs and the tenant's request for assistance and expected outcomes. (25.28 (4)(a))

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]

- Monitoring Observation: Tenant #2's physician order of 9-26-08 indicated Cholestyramine use three times daily due to fecal oozing and Trivase three times daily for possible fungal infection to peri-anal area. Physician notes of 11-26-08 indicated the tenant was seen by his/her physician due to bilateral toenails that were elongated and painful with ambulation. The program did not complete a nurse review with a change in health status as evidenced by fecal oozing, possible peri-anal infection, needed foot care and ambulation change, to make recommendations and referrals as appropriate.

  Tenant #3's file indicated the tenant was staged at a four on the GDS which indicated moderate cognitive decline. An addendum dated 3-26-08 was added to the service plan of 10-29-08 indicated interventions related to inappropriate sexual behavior and comments to staff. Nurse reviews were completed on 6-9-08, 7-3-08 and 10-29-08 but the program did not monitor the progress on the previous recommendations of interventions established on 3-26-08 in a 90-day nurse review. Staff #2 and #3 identified Tenant #3 as having an intimate sexual relationship with another tenant. The program did not complete a nurse review to determine if the intimate sexual relationship with another tenant, who has dementia, would require the RN to make recommendations and referrals as appropriate.

  Tenant #4, an 87 year old, was admitted on 12-11-08 and diagnoses include: Depression with Post Traumatic Stress Disorder, Shrapnel Head Injury, Hypertension (HTN), Hyperlipidemia, Anxiety and Dementia. The tenant was staged at a six on the GDS, which indicated severe cognitive impairment. According to the Director, the tenant walked out of the front entrance as family members entered from the outside. The tenant approached a parked vehicle (to see if it belonged to the tenant) and then walked to the nursing facility approximately 30 yards from the program's entrance. Staff at nursing facility alerted the program's staff and brought the tenant back, according to the Director. According to the Director, the tenant was not injured and there were no poor outcomes related to the incident. This occurred on 12-14-08 at approximately 2:15 p.m. A nurse review was not completed as needed.

- Regulatory Insufficiency: The program did not assess and document the health status, make recommendations and referrals as appropriate and monitor progress on

previous recommendations at least every 90 days and when there are changes in health status.

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]

Incident Allegation: The program reported that on 12-14-08 at 2:00 p.m. Tenant #4 left the secured program when a visitor came in. The alarm did not sound because the tenant had removed the Wanderguard bracelet sometime earlier. Staff discovered the tenant immediately and returned him/her without incident or injury.

- Monitoring Observation: Tenant #4 evaluations and a service plan were completed prior to taking occupancy. The tenant's service plan prior to taking occupancy stated (under Behavior) the tenant is at risk for elopement and he/she will wear a Wanderguard. Staff to make sure he/she is wearing the Wanderguard. Staff will use distraction, humor and redirection when he/she is agitated or wanting to leave.

  According to the nurse, on 12-12-08 at approximately 5:00 p.m. another tenant's family member held the door open for Tenant #4 and the tenant went out the door. Staff #4 immediately went outside and was able to redirect the tenant back into the building. According to the nurse, the Wanderguard was functional and the alarm did sound.

  According to an incident report, on 12-14-08 at approximately 2:15 p.m. Tenant #4 left the building. According to the Director, the tenant walked out of the front entrance as family members entered from the outside. The tenant approached a parked vehicle (to see if it belonged to the tenant) and then walked to the nursing facility approximately 30 yards from the program's entrance. Staff at nursing facility alerted the program's staff and staff brought the tenant back, according to the Director. The alarm did not sound because it was later found the tenant removed the Wanderguard, which was on his/her ankle. The Director, indicated from the time the tenant left until the time he/she returned was approximately 10 to 15 minutes. The program placed a Wanderguard in the tenant's coat pocket (approximately 20-24 hours) until the program was able to place another Wanderguard unit on the tenant's ankle. Currently the tenant was wearing a Wanderguard on his/her ankle. The Wanderguard was also kept in the tenant's coat pocket as a back up safety precaution, according to the Director. Staff will continue to monitor the status of the tenant's Wanderguard to ensure he/she is not removing the unit. According to the Director, staff watch the tenant more closely when he/she is exhibiting exit seeking behavior and assist the tenant when the tenant goes to the exits. The tenant's family, the nurse, the Director, the tenant's physician and the Department of Inspections were notified of the incident. The Director state the tenant was fully clothed and was wearing a winter parka, baseball cap and gloves. The tenant was not injured and there were no poor outcomes related to the incident. The tenant was admitted on 12-11-08 and the incident occurred on 12-14-08.

- Regulatory Insufficiency: None noted.

Dated this 21st day of January, 2009.