IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED

Complaint: #23519-C

August 24, 2009

Lyla Erwin, Administrator
Windsor Manor Assisted Living
229 Pearl Street
Grinnell, IA 50112-2593

RE: I. Final Complaint Investigation Report, Windsor Manor Assisted Living, Grinnell, IA
II. Appeals/Hearings
III. Civil Penalty
IV. Conclusion

Dear Ms. Erwin:

I. Final Complaint Investigation Report, Windsor Manor Assisted Living, Grinnell, IA

Enclosed is the **Final Complaint Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C, 321 Iowa Administrative Code chapter 25 (pertaining to assisted living programs), and 321 Iowa Administrative Code chapter 26 (pertaining to monitoring, civil penalties, and complaints). The report notes Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Criteria for Exclusion of Tenants, Service Plan, Nurse Review and Staffing. Windsor Manor Assisted Living – Grinnell ("Program") is being assessed a $1,000.00 civil penalty

DIA is accepting the Plan of Correction (POC) following the program's submission of additional information.

II. Appeals/Hearings

The Program may appeal the DIA decision in accordance with 321 Iowa Administrative Code rule 26 4, within 30 days of notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to 481 Iowa Administrative Code chapter 10. If the Program appeals, the civil penalty will be suspended, pending appeal process.

III. Civil Penalty

If, within thirty (30) days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 231C.14. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send written notice to the Certification Coordinator and remit the penalty assessed by check or money order in the amount of six hundred fifty dollars ($650 00) within 30 business days after the receipt of this demand letter.

IV. Conclusion

The Program is being assessed a $1,000 00 civil penalty DIA may revisit the program to confirm compliance in fulfilling the POC's corrective measures. If the program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

If you have any questions regarding this certification, please contact your Certification Coordinator, Connie Schaffer, at 515-281-5003

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Complaint Intake: #23519-C

Lyla Erwin, Administrator
Windsor Manor Assisted Living
229 Pearl Street
Grinnell, IA 50112-2593

Date of Investigation:

July 1, 2009

Monitor(s):

Hal Chase, RN BSN MPH
Joyce Kix, 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 Windsor Manor Assisted Living on July 1, 2009. In preparing this report, the following information was considered.

Current Program Census:

General Population Program (GPP)* – A program that is not include a Dementia Specific program but may have tenants with cognitive disorder

Current number of tenants without cognitive disorder	28
Current number of tenants with cognitive disorder:	1
Total Population of GPP	29

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP	8
Total Census of ALP:	37

***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 have been substantiated Regulatory Insufficiencies in the areas of: Occupancy Agreement, Evaluation of Tenants, Tenant Documents, Service Plan, Medications, Nurse Review, Staffing, Food Service, Structural Requirements and Other.

The complaint history during this certification period includes the complaint investigations of: October 15, 2007 for Recertification and the first revisit to Complaint #12393 with Regulatory Insufficiencies in the areas of: Occupancy Agreement, Evaluation of Tenant, Tenant Documents, Service Plan, Medications, Nurse Review, Food Service, Staffing and Other, which resulted in a fine of $4,500.00 The Program was issued a Conditional Certificate and the Program Administrator and Registered Nurse were required to attend assisted living program management training.

Investigation of January 2 & 3, 2008 for Complaint #15352, the first revisit of the Recertification and second revisit for Complaint #12393, with Regulatory Insufficiencies in the areas of: Medications, Nurse Review, Food Service, Staffing and Other, which resulted in a fine of $8,000.00 and the program to remain under the Conditional Certificate. The Program Administrator and Registered Nurse were required to attend assisted living program management training. The program would be allowed no new admissions, and were to submit weekly nurse reviews of medications, a policy and procedure to control accurate count of narcotics and nurse delegation training related to narcotics.

Investigation of May 5, 2008 for the first revisit of Complaint #15352, second revisit of the Recertification and third revisit of Complaint #12393, with a Regulatory Insufficiency in the area of Structural Requirements. The program was to remain under the Conditional Certificate and was able to admit new tenants. All other sanctions were no longer required.

Investigation of August 5, 2008 for the second revisit to Complaint #15352, second revisit to the Recertification and the fourth revisit to Complaint #12393. There were no Regulatory Insufficiencies and the program was issued their Standard Certificate effective December 7, 2007 through December 6, 2009 The program's sanctions were discontinued.

Investigation of January 26, 2009 for Complaint #21685-C with Regulatory Insufficiencies in the areas of: Medications and Nurse Review

Complaint Investigation – The complaint investigators 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, an 85 year old, was admitted on 8-12-08 and had diagnoses of: Senile Dementia with Behavior Disorder, Depression, Leukocytosis, Abdominal Pain, Diverticulitis, Ulcerative Colitis, Allergic Rhinitis and Dehydration. The tenant was staged at five on the Global Deterioration Scale (GDS) on 4-13-09, which indicated moderately severe cognitive decline. Nurse's notes of 1-8-09 indicated the physician was contacted regarding lower leg and back pain. An order for Vicodin 5mg/325mg tablets every four hours as needed for pain was obtained. A physician's order of 1-13-09 documented additional diagnoses of Osteoporosis and Back Pain and ordered the use of a wheeled walker. The physician was contacted on 1-16-09 as the tenant was having multiple mood swings daily, crying frequently, refusing to do anything independently and asking staff to feed him/her Nurse's notes of 2-9-09 indicated a request for a mental health referral due to "increased behaviors" including complaints of pain, crying, yelling loudly at others and refusal of cares and medications. A physician's order of 2-9-09 indicated an order to transfer the tenant to the dementia unit on 4-13-09 The program did not complete functional, cognitive and health evaluations to determine if modifications of services were needed related to back and leg pain, behaviors, and when the tenant was transferred to the dementia unit. The tenant passed away on 4-16-09

  Tenant #2, an 81 year old, was admitted on 3-19-09 and has diagnoses of: Dementia with Agitation, Atrial Fibrillation, Chronic Renal Insufficiency, Hyperglycemia and Peripheral Neuropathy The tenant was staged at five on the GDS on 3-3-09, which indicated moderately severe cognitive decline. Functional, cognitive and health evaluations were completed on 3-3-09, prior to admission. Nurse's notes of 3-19-09 indicated the tenant was agitated, tipping furniture, removing pillows, blankets and throwing papers and magazines. The program notified the tenant's physician on 3-24-09 of the tenant's "extreme agitation" and requested a mental health consult. A letter prepared by the program on 4-2-09 indicated the tenant's behavior of physical aggression toward inanimate objects, toward himself/herself and towards others had been escalating since admission. Staff #1 stated the tenant was aggressive and a danger to himself/herself. Staff #2 stated the tenant tried to hit staff, throw "things" and would be more "violent to self. Staff #3 stated the tenant was verbally aggressive, swinging at staff and was inappropriate from the day of admission. The program did not complete functional, cognitive and health evaluations to determine if modifications of services were needed related to the tenant's aggressive behavior

- Regulatory Insufficiency: The program did not evaluate each tenant's functional, cognitive and health status, as needed, to determine the tenant's continued eligibility for the program and to determine any modifications to services needed. (25.23(2)

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]

Complaint Allegation: It is alleged two staff are needed to transfer Tenant #1.

- Monitoring Observation: Tenant #1's service plans of 3-20-09 and 4-13-09 indicated the tenant used a walker, a wheel chair for long distances and needed the assistance of one with transfer Staff #1, #2 and #3 did not identify the tenant as needing a routine two-person assist with transfer.

Complaint Allegation: It is alleged Tenant #2 is violent and resides in the dementia unit.

- Monitoring Observation: Tenant #2's file indicated the tenant was admitted on 3-19-09 and was accompanied by the local county sheriff's department. Prior to admission, the tenant was admitted on an involuntary status at a local behavioral health center. The tenant had a history of having increased agitation and aggression; hitting, pushing his/her spouse and threatening to "kill" his/her spouse. Nurse's notes of 3-19-09 indicated the tenant was agitated, tipping furniture, removing pillows, blankets and throwing papers and magazines. The program notified the tenant's physician on 3-24-09 of the tenant's "extreme agitation" and requested a mental health consult. On 4-3-09 the tenant's "behaviors" had escalated. The tenant was overturning furniture, including televisions, removing arms from chairs, pulling a thermostat off the wall, pulling fire alarms, climbing over half walls, hanging upside down with his/her feet caught in venetian blinds and swinging at "people." On 4-3-09 the tenant was transferred to another facility for treatment and has not returned to the program. Staff #1 stated the tenant was aggressive and a danger to himself/herself. Staff #2 stated the tenant tried to hit staff, throw "things" and would be more "violent to self. Staff #3 stated the tenant was verbally aggressive, swinging at staff and was inappropriate from the day of admission.

- Regulatory Insufficiency: The program did not exclude a tenant who exceeded occupancy and retention criteria. (25.23(3)

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 staff attempted to "force" Tenant #1 to sit straight up and the tenant was moaning in pain. Staff are not "patient" with him/her and have not tried other positioning devices.

- Monitoring Observation: Tenant #1's nurse's notes of 1-8-09 indicated the tenant's physician was contacted regarding pain in the lower back and legs with increased intensity Physician's order of 1-8-09 initiated Vicodin 5mg/325mg tablets every four hours as needed for pain. Physician's order of 1-13-09 documented additional diagnoses of Osteoporosis and Back Pain and directed for the use of a wheeled walker with a seat. A facsimile to the physician of 1-16-09 indicated Tenant #1 was having multiple mood swings daily, crying frequently, refusing to do anything independently asking staff to feed him/her. Nurse's notes of 2-9-09 indicated a request for a mental health referral due to "increased behaviors" including complaints of pain, crying and

yelling loudly at others and refusal of cares and medications. A Physician's order of 2/9/09 documented an order to transfer Tenant #1 to the Dementia unit. The program did not update the service plan as needed and did not establish interventions in the service plan related to the tenant's back and leg pain.

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

- Tenant #2's nurse's notes of 3-19-09 indicated the tenant was agitated, tipping furniture, removing pillows, blankets and throwing papers and magazines. The program notified the tenant's physician on 3-24-09 of the tenant's "extreme agitation" and requested a mental health consult. A letter prepared by the program on 4-2-09 indicated the tenant's behavior of physical aggression toward inanimate objects, toward himself/herself and towards others had been escalating since admission. Staff #1 stated the tenant was aggressive and a danger to himself/herself. Staff #2 stated the tenant tried to hit staff, throw "things" and would be more "violent to self. Staff #3 stated the tenant was verbally aggressive, swinging at staff and was inappropriate from the day of admission. The service plan of 3-3-09 was not updated to establish interventions for staff to implement when the tenant demonstrated aggressive behaviors.

- Regulatory Insufficiency: The program did not consistently update each tenant's service plan, as needed, when a tenant needs personal or health related care, by a multidisciplinary team that consists of no fewer than three individuals, including a health care professional and other staff appropriate to meet the needs of the tenant, in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. (25.28(3))

- Regulatory Insufficiency: The program did not consistently develop service plans that were individualized and indicated at a minimum; the tenant's identified needs and requests for assistance and expected outcomes; any services and care to be provided pursuant to the occupancy agreement with the tenant and the service provider(s) if other than the program. (25.28(4)(a)

D. 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 nurse's notes of 1-8-09 indicated the tenant's physician was contacted regarding pain in the lower back and legs with increased intensity Physician's order of 1-8-09 initiated Vicodin 5mg/325mg tablets every four hours as needed for pain. Physician's order of 1-13-09 documented additional diagnoses of Osteoporosis and Back Pain and directed for the use of a wheeled walker with a seat. A facsimile to the physician of 1-16-09 indicated Tenant #1 was having multiple mood swings daily, crying frequently, refusing to do anything independently including asking staff to feed him/her Nurse's notes of 2-9-09 indicated a request for a mental health referral due to "increased behaviors" including complaints of pain, crying and yelling loudly at others and refusal of cares and medications. Physician's order of 2/9/09 documented an order to transfer Tenant #1 to the dementia unit. The

RN did not assess and document the health status of the tenant with a change in condition.

- Tenant #2's nurse's notes of 3-19-09 indicated the tenant was agitated, tipping furniture, removing pillows, blankets and throwing papers and magazines. The program notified the tenant's physician on 3-24-09 of the tenant's "extreme agitation" and requested a mental health consult. A letter prepared by the program on 4-2-09 indicated the tenant's behavior of physical aggression toward inanimate objects, toward himself/herself and towards others had been escalating since admission. Staff #1 stated the tenant was aggressive and a danger to himself/herself. Staff #2 stated the tenant tried to hit staff, throw "things" and would be more "violent to self. Staff #3 stated the tenant was verbally aggressive, swinging at staff and was inappropriate from the day of admission. The RN did not assess and document the health status of the tenant with a change in condition.

- Regulatory Insufficiency: The program did not consistently provide for a registered nurse to assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor the progress on previous recommendations at least every 90 days or if there were changes in health status. (25.30 (3)

E. 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 is alleged staff are pushing Tenant #1 in his/her wheelchair without foot rests.

- Monitoring Observation: Tenant #1's service plan of 3-20-09 and 4/13/09 indicated the tenant was independent with a walker and a wheelchair for longer distances.

Complaint Allegation: It is alleged the program is short staffed "all the time."

- Monitoring Observation: In a prepared statement the Administrator indicated the program maintained a minimum of two universal workers on duty per eight hour shift. The program staff schedule for June 2009 documented at least two employees were working at all times. Interviews with Staff #1, #2 and #3 indicated at least two employees were on duty at all times. One tenant stated staffing was "pretty good" and another reported they had not seen instances of cares not getting done.

Complaint Allegation: It is alleged staff lack training, not knowing how to operate blood testing equipment and never changed the lancet used to draw blood to test blood glucose.

- Monitoring Observation: The program's procedure for nurse delegation of glucometer testing indicated instruction to dispose of the lancet after use into a sharps container. During observation of blood glucose testing, Staff #1 did not dispose of the lancet after use. The Certificate of Completion for Staff #3 for Dependent Adult Abuse Training for Mandatory Reporters was dated 10-30-08. The program's curriculum approval expired 1-14-08.

- Regulatory insufficiency: The program did not consistently have sufficient trained staff available at all times to fully meet tenants' identified needs. (25.33(1)

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

Complaint Allegation: It is alleged tenants do not have access to occupational therapy services.

- Monitoring Observation: The program Administrator stated a local rehabilitation agency provided services to the program tenants as needed. A telephone call to the rehabilitation agency confirmed the agency provided services currently to two tenants and was available to evaluate all tenants as needed. Tenant #4 had received physical and occupational therapy evaluations when ordered.

Complaint Allegation: It is alleged the program did not report an incident involving substantial injury or death to the department within 24-hours of the occurrence.

- Monitoring Observation: Tenant #1's file indicated the tenant was transferred to the dementia unit on 4-13-09. Nurse's notes of 4-15-09 at 9:45am indicated the patient was "non-responsive." Nurse's notes of 4-16-09 at 9:09am indicated the tenant was pronounced dead.

- Regulatory Insufficiency: None noted.

Dated this 24th day of August, 2009.