IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

October 23, 2009

Complaint #24203-C

Kris Ward, Executive Director
The Fountains Assisted Living
3752 Thunder Ridge Rd
Bettendorf, IA 52722-1210

RE: Complaint Investigation Report, The Fountains Assisted Living, Bettendorf, IA

Dear Ms. Ward:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated July 29 and August 12 & 13, 2009. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary.

We appreciate your prompt action in correcting the Regulatory Insufficiencies. If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

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

Assisted Living Program: **Complaint Intake #: 24203-C**

Kris Ward, Executive Director
The Fountains Assisted Living
3752 Thunder Ridge Rd
Bettendorf, IA 52722-1210

Date of Investigation:

July 29 & August 12 & 13, 2009

Monitor(s):

Hal 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 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 The Fountains Assisted Living on July 29 & August 12 & 13, 2009. 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 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):	24
Current number of tenants without cognitive disorder:	47
Total Population:	71

***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 no substantiated Regulatory Insufficiencies 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, an 84 year old, was admitted on 2-1-08 and diagnoses include: Macular Degeneration, Hypothyroidism and Memory Loss. The tenant was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. The tenant had a change in services provided on 6-3-09 and on 6-27-09, post falls and an emergency room (ER) visit. Health and functional evaluations were completed at these intervals. The computerized evaluations refer to a GDS score; however, a GDS tool was not completed. Cognitive evaluations were not completed with a significant change in the tenant's condition.

Tenant #3, a 89 year old, was admitted on 7-17-07 and diagnoses include: Dementia, Degenerative Joint Disease, Unsteady Gait and Kyphosis. Clinical notes dated 7-28-09, indicated the tenant was staged at a five on the GDS, indicating moderately severe cognitive decline; however, a GDS tool was not used to determine cognitive status. Clinical notes dated 7-20-09, indicated functional and health evaluations were completed after the tenant returned from an ER evaluation following a fall. The tenant's physician recommended Hospice care and the tenant was admitted to Hospice on 7-23-09. The program did not complete a cognitive evaluation to determine if modifications to services were needed when the tenant was admitted to Hospice.

Tenant #4, an 82 year old, was admitted on 2-25-09 and diagnoses include: Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and a History of Pneumonia. Clinical notes dated 3-9-09, indicated the tenant sustained a laceration to the left calf. The tenant was transported to the ER where butterfly strips were applied to the laceration. Clinical notes dated 3-13-09, indicated the tenant reported a small area was oozing from the skin tear on the back of his/her left leg. The physician ordered staff to apply Bactrim. Clinical notes dated 3-19-09, indicated a physician order was given for staff to observe the area and leave the wound open to the air. The program did not complete functional, cognitive and health evaluations to determine if modifications to services were needed related to the laceration and wound care. Clinical notes dated 3-20-09, indicated the program completed 30-day functional and health evaluations but did not complete a 30-day cognitive evaluation. Clinical notes dated 4-10-09, indicated the tenant returned from his/her physician with orders to see a physician that specializes in wound care. The tenant returned from seeing a wound specialist with orders for a home health agency to begin wound treatment. A review of the tenant's file indicated the home health agency provided wound care from 4-9-09 through 8-6-09. The program did not complete functional, cognitive and health evaluations to determine if modifications to services were needed related to additional wound care. Clinical notes dated 7-15-09, indicated the tenant would be discharged from home health services and would be admitted to Hospice care on 7-18-09. The program did not complete functional, cognitive and health evaluations to determine if modifications to services were needed related to Hospice care. Clinical notes dated 7-28-09, indicated the tenant was sitting in the lobby, incontinent of urine and not able to comprehend where his/her apartment was

or how to get to there and refused to let staff assist in taking a shower and changing his/her clothes. The program did not complete functional, cognitive and health evaluations to determine if modifications to services were needed related to the change in the tenant's behavior. Clinical notes dated 8-3-09, indicated the tenant was transferred from the general population to the dementia unit related to short term memory problems. The program completed functional and health evaluations but did not complete a cognitive evaluation.

Tenant #5, an 83 year old, was admitted on 11-2-07 and diagnoses include: Dementia, Parkinson's Disease, Diabetes Mellitus, Chronic Renal Disease, Chronic Anemia and Hyperlipidemia. Clinical notes dated 5-7-09, indicated the tenant was staged at a six on the GDS, indicating severe cognitive decline, however, a GDS tool was not used to determine cognitive status. Clinical notes dated 3-6-09, indicated the tenant had an increase in pacing, agitation and fell with an abrasion to the forehead and bruising to the right great toe and second toe and was unable to wear shoes due to the pain. The tenant was transported to the ER and was admitted to the hospital for anemia and a blood transfusion. The tenant returned to the program on 3-10-09 and functional and health evaluations were completed on 3-11-09, but a cognitive evaluation was not completed. Clinical notes dated 3-26-09, indicated Hospice would evaluate the tenant and explain their benefits to the tenant's family. The tenant was admitted to Hospice on 3-26-09 and the program did not complete functional, cognitive and health evaluations to determine if modifications to services were needed related to the tenant being admitted to Hospice. Clinical notes dated 5-5-09, indicated the tenant was hospitalized for multiple seizures. Functional and health evaluations were completed on 5-7-09, but a cognitive evaluation was not completed to determine if modifications to services were needed related to the seizures. Clinical notes dated 5-9-09, indicated the tenant was "very aggressive," and was verbally threatening to strike out at staff and tenants. The program did not complete functional, cognitive and health evaluations to determine if modifications to services were needed related to the aggression and verbal threats. The tenant was discharged from the program on 5-27-09.

- Regulatory Insufficiency: The program did not consistently evaluate each tenant's functional, cognitive and health status within 30-days of occupancy and 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 had a fall on 6-27-09 and was seen in the ER. The service plan was changed on 6-27-09, upon the tenant's return to the program, to reflect changes regarding ambulation and dining services. The service plan was signed by the nurse on 6-27-09 and by the tenant's legal representative on 6-28-09; however, the service plan was not signed by two additional staff and was not based on a cognitive evaluation.

Tenant #3's service plan was updated on 7-20-09 and reflected new interventions related to bathing, grooming, toileting, dining, activities and sleep needs, but the service plan

was not supported by a cognitive evaluation. Clinical notes dated 7-20-09 indicated the tenant's physician recommended Hospice care and on 7-23-09 the tenant was admitted to Hospice. The program updated the service plan on 7-28-09. The 7-28-09 service plan did not reflect coordinated care between Hospice and the program. The service plan did not include the interventions identified in the Hospice care plan. A service plan dated 7-20-09 was signed by the nurse but not by the tenant. A service plan dated 7-28-09 was signed by the nurse but not by the tenant, the tenant's legal representative and two additional staff.

Tenant #4's initial service plan dated 2-25-09, was not updated within 30 days of admission. Clinical notes dated 3-13-09 indicated the tenant reported "small oozing" from a skin tear on the back of the tenant's left leg. Clinical notes dated 4-10-09, indicated the tenant returned from his/her physician with orders to see a physician that specialized in wound care. The wound specialist ordered a home health agency to begin wound treatment. A review of the tenant's file indicated the home health agency provided wound care from 4-4-09 through 8-6-09. The tenant's service plan was updated on 5-9-09, after the tenant returned from an extended hospitalization, but did not include interventions related to the wound care given from an outside provider. Clinical notes dated 7-15-09 indicated the tenant would be discharged from home health services and would be admitted to Hospice care. The tenant's file indicated the tenant was admitted to hospice on 7-19 -09. The program updated the service plan on 7-28-09 but it was not supported by a cognitive evaluation and was completed after the tenant was admitted to Hospice.

Tenant #5's clinical notes dated 3-6-09 indicated the tenant had an increase in pacing, agitation, a fall with an abrasion to the forehead, bruising to the right great and second toes and was unable to wear shoes due to the pain. The tenant was hospitalized on 3-6-09 and returned to the program on 3-10-09. A service plan was updated on 3-11-09 but was not supported by a cognitive evaluation and did not establish interventions related to the increased pacing and agitation. Clinical notes dated 3-26-09 indicated Hospice would evaluate the tenant for Hospice care and explain Hospice benefits to the tenant's family. The tenant was admitted to Hospice on 3-26-09. The service plan was updated on 3-25-09, but was not supported by a cognitive evaluation and did not establish interventions related to Hospice care. Clinical notes dated 5-5-09, indicated the tenant was hospitalized for multiple seizures and notes dated 5-8-09, indicated the tenant returned to the program on 5-7-09. Discharge instructions dated 5-7-09 indicated the tenant was to be turned every two hours. The program updated the service plan on 5-8-09, but did not establish interventions related to seizures and a physician's order to turn the tenant every two hours. Clinical notes dated 5-9-09, indicated the tenant was "very aggressive" and was verbally threatening to strike out at staff and tenants. A physician order dated 5-14-09 indicated the tenant was to receive two to five liters of oxygen, per nasal cannula, as needed, for shortness of breath. The program did not update the service plan to establish interventions related to aggression, verbal threats to strike staff and tenants and the use of oxygen therapy. The tenant was discharged from the program on 5-29-09.

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

- Regulatory Insufficiency: The program did not consistently update each tenant's service plan within 30 days of occupancy and, 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; and for tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. (25.28(4)a-d))

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 #3's file contained three separate incident reports that indicated there were tenant injuries. On 6-18-09, staff found the tenant on the floor and noted redness on the left side of the tenant's hip, on 7-15-09, staff found the tenant on the bathroom floor and noted two scratches on the back of the tenant's left arm and bruising on the right arm and on 7-18-09 staff found the tenant on the floor, face down and non-responsive. In each incident, the nurse did not assess and document the health status of the tenant.

Tenant #5's clinical notes dated 3-11-09 indicated the nurse completed a nurse review for an incident that occurred on 3-6-09, notes dated 4-20-09 indicated a nurse review was completed for an incident that occurred on 4-15-09, notes dated 5-12-09 indicated a nurse review was completed for an incident that occurred on 5-3-09, notes of 5-14-09 indicated a nurse review was completed for an incident that occurred on 5-13-09, notes of 5-17-09 indicated a nurse review was completed for an incident that occurred on 5-11-09 and notes of 5-19-09 indicated the program completed a nurse review for an incident that occurred on 5-14-09. An incident report of 5-3-09 indicated the tenant was found on the floor. Each incident reported was reporting the tenant was found on the floor by staff and at least two of the incidents reported the tenant sustained an abrasion and complained of pain. A nurse review was not completed in a timely fashion when a change in health status occurred.

- Regulatory Insufficiency: The program did not consistently 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. (25.30(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: It was alleged Tenant #1 required safety checks. The checks were not completed as scheduled and the tenant had falls. It was alleged documentation related to tenant checks was destroyed and the tenant did not have his/her pendant at the time of one of the falls. It was alleged the pendant was not returned to the tenant upon returning to the building.

Monitoring Observation: Tenant #1 was discharged on 7-1-09. According to an Incident Report, Tenant #1 was found on the floor on 6-27-09 at 8:50 a.m. The tenant had bruising, was slightly confused and had back pain. The tenant was sent to the ER and family, the nurse and the tenant's doctor were notified.

The service plan dated 6-3-09 indicated staff were to check the tenant every two hours during the night to ensure the tenant was wearing his/her pendant. The service plan also indicated staff were to check if the tenant was wearing the pendant during awake hours, twice during the day and during second shift. It also indicated staff were to check in the morning, early afternoon, late afternoon and after supper. According to a program record, the two hour checks throughout the night were documented as completed for the month of June, including the checks on 6-27-09, the night before the tenant was found on the floor at 8:50 a.m. Daily report sheets for the month of June, 2009, indicated the tenant was consistently checked three times on third shift. The Personal Emergency Response System (PERS) sheets between 6-27-09 at 12:00 a.m. and 6-28-09 at 11:59 p.m. were reviewed and indicated the tenant did not use the pendant to call for assistance related to the fall; however, the tenant's pendant was activated numerous times from 6-27-09 through 6-28-09. According to another program record, staff offered encouragement to the tenant to go to the dining room for all meals for morning and afternoon shifts. This was documented as completed for the morning shift on 6-27-09.

Staff #1 was interviewed and stated she worked third shift on 6-26-09 and 6-27-09. Staff #1 initialed on a program record that two hours checks were completed on third shift on 6-27-09. She stated third shift staff would check to make sure the tenant was wearing the pendant and would check on his/her location. The checks occurred at 12:00/12:30 a.m., 2:00/2:30 a.m. and 4:00/4:30 a.m. The tenant was visualized and staff documented the checks on the Activities of Daily Living (ADLs) sheet. Staff #1 stated checks were completed appropriately for the tenant and the tenant did not have any falls when she worked on third shift.

Staff #2 was interviewed and stated that on 6-27-09 she was a new employee and she did not remember the tenant. Staff #2 initialed on a program record, that she offered encouragement for the tenant to go to the dining room for the morning meal on 6-27-09.

Staff #3 was interviewed and had worked first shift on 6-27-09. Staff #3 stated staff checked the tenant to ensure he/she was wearing the pendant and to do a safety check. She stated staff check on all tenants that do not come out for meals. Staff #3 stated Staff #4 called her on 6-27-09 regarding the fall with the tenant. She responded to the call and found the tenant lying face down on the floor with dried bowel movement on his/her buttocks and foot. The tenant was not wearing the pendant, according to the staff. Staff

#3 stated the tenant did not have any injuries or pain and did not tell staff how long he/she had been on the floor. Staff #3 did not know when the previous check was completed on the tenant. She stated they kept the tenant comfortable until the ambulance arrived and she cleaned up the bathroom and the tenant. The tenant returned on 6-27-09 and staff started documenting each check on a checklist. The tenant required more assistance and used the pendant frequently upon his/her return. Staff #3 stated staff did not record the checks on her shifts until right before the tenant was discharged.

Staff #4 was interviewed and had worked first shift on 6-27-09. Staff #4 stated she found the tenant on the bathroom floor when she went to administer medications. The tenant had bruising on his/her tailbone and had bowel movement on him/her. The tenant did not tell staff how long he/she had been on the floor and did not use his/her pendant to call for assistance. Staff #4 stated the tenant went to the hospital and returned.

A new service plan was developed on 6-27-09, after the fall and ER visit. The service plan dated 6-27-09 indicated: staff were to check the tenant every two hours during the night to ensure the tenant was wearing his/her pendant and to document exact times the tenant was checked, staff were to check if the tenant was wearing the pendant, during awake hours, twice during the day and second shift, staff were to check in the morning, early afternoon, late afternoon and after supper and staff were to check the tenant every two hours and place the call light on the tenant with a verbal reminder of the importance.

According to a checklist, the tenant was checked on 15 times on 6-28-09 from 1:51 a.m. to 8:00 a.m. and staff checked to make sure the tenant was wearing the pendant. According to a Resident Sign Out Log, the tenant was signed out of the program on 6-28-09 at 8:40 a.m. and returned at 11:30 a.m.

According to an Incident Report dated 6-28-09, family found the tenant on the floor on 6-28-09 at 1:30 p.m. The tenant had a swollen lip on the right side, a chipped tooth and bruising on the left fingers. The tenant was sent to the ER and the nurse and tenant's doctor were notified.

Staff #5 was interviewed and had worked first shift on 6-28-09. Staff #5 stated the tenant went out with family and came back around lunch time where she saw the tenant in the dining room. The tenant asked to go back to his/her room and Staff #5 took the tenant back and asked if the tenant needed to use the restroom or if he/she wanted to sit in the recliner. The tenant declined, according to staff. Staff #5 stated she had several pages go off and told the tenant she would be back briefly. Approximately ten minutes later she heard, over the radio, about the tenant's fall and responded. Staff stayed with the tenant until medics arrived. The tenant did not have any visible injuries or complaints of pain. Staff #5 stated she initialed on the checklist at 12:30 p.m. when she saw the tenant in the dining room but did not check if the tenant was wearing a pendant as stated on the service plan. Family or tenants take the pendants off and on and sign themselves in and out of the building. Staff #5 stated the tenant left every Sunday and family usually signed the tenant in and out and transferred the pendant.

Staff #4 stated on 6-28-09 the tenant went out to church and came back at lunch time. The tenant went back to his/her apartment and approximately 20 minutes later family found the tenant on the floor. The tenant went to the hospital after the fall.

The Executive Director (ED) stated tenants are told they do not like them to leave the program with the pendants due to the replacement costs; however, tenants can leave them in the room, can leave with them or can put them in the basket. There is not a formal monitoring of signing in and out or of what pendants are in the basket. The ED stated the program prefers and recommends that tenants leave the pendants; however, it is not required and there is not a written policy related to it. The ED stated it had not come to her attention that tenant checks were not completed.

According to a program document, the nurse was no longer employed by the program.

- Regulatory Insufficiency: The program did not consistently provide sufficient trained staff available at all times to fully meet tenant's identified needs. (25.33(1))

E. Structural requirements – The structure of the program shall be designed and operated to meet the needs of the tenants. The buildings and grounds shall be well-maintained, clean, safe and sanitary.

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

Monitoring Observation: During the on-site on 7-29-09 monitors made a visual inspection of the dementia unit. In the kitchen a sharp knife was found in an unlocked cupboard and a toaster was plugged into an outlet to the left of the kitchen sink.

- Regulatory Insufficiency: The program did not consistently have buildings and grounds that are well-maintained, clean, safe and sanitary. (25.40 (1)(b))

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

Complaint Allegation: It was alleged a tenant's physician orders were accidently shared with another facility and were not kept confidential.

Monitoring Observation: An interview was conducted with the Administrator who stated she had spoken with the RN, who is no longer with the program, and the RN had inadvertently copied information from another tenant's file and gave it to Tenant # 1's family. The family gave the documents to the new facility that Tenant #1 moved into.

- Regulatory Insufficiency: The program did not protect all records from loss, damage and unauthorized use. (25.27(3))

Dated this 23rd day of October, 2009.