IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

February 18, 2010

Complaint #26534-C

Monica Hunter, Administrator/Marketing Director
MeadowView Memory Care Village
3005 F Ave NW
Cedar Rapids, IA 52405-2944

RE: Final Complaint Investigation Report, MeadowView Memory Care Village, Cedar Rapids, IA

Dear Ms. Hunter:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) and the Request for Reconsideration in response to the complaint investigation Report dated December 14, 15 and 16, 2009. Based on the information provided, DIA denies the Request for Reconsideration as it relates to Nurse Review. Although Nurse Review was completed on November 30, 2009, several changes occurred after November 30, 2009 that required further Nurse Review. These changes included but were not limited to; lethargy, shortness of breath, the tenant found lying on the floor, the tenant moaning, refusing medications and ending with the tenant hospitalized with Delirium and a Urinary Tract Infection. The Plan of Correction is accepted.

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 #: 26534-C**

Monica Hunter, Administration/Marketing Director
Meadowview Memory Care Village
3005 F Ave NW
Cedar Rapids, IA 52405-2944

Date of Investigation:

December 14, 15 and 16, 2009

Monitor(s):

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 Meadowview Memory Care Village on December 14, 15 and 16, 2009. In preparing this report, the following information was considered:

Current Program Census:

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):	39
Current number of tenants without cognitive disorder:	2
Total Population:	41

***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 this certification period in the areas of: Service Plans and Other (not fully implementing the Plan of Correction).

The June 30, 2008 complaint investigation revisit resulted in a discontinuation of the sanctions and issuance of a standard certificate. There were no Regulatory Insufficiencies.

The May 8 & 9, 2008 complaint investigation revisit resulted in a fine of $2,500.00 and sanctions that include: a Conditional Certification, admit up to eight tenants per month and submission of monthly nurse reviews.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. 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.

Complaint Allegation: It was alleged a tenant was hospitalized following a fall and had not had anything to eat or drink for four to five days. It was alleged a tenant had a urinary tract infection (UTI) and became septic.

Monitoring Observation: Four tenant files were reviewed.

Tenant #1, 86 years old, was admitted on 6-16-08 and diagnoses include: Constipation, Diabetes Mellitus Type II, Gastroesophageal Reflux Disease (GERD), Arthritis, Coronary Artery Disease (CAD) with Aortic Stenosis and Mitral Regurgitation, Hypertension (HTN), Osteoporosis, History of Prostate Cancer, Hypothyroidism, UTI, Weakness, Dementia, Alzheimer's Disease and Mental Status Change. The tenant was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. According to Nurse's Notes dated 9-15-09, the tenant was transferred to the ER for evaluation and treatment. According to notes dated 9-17-09, the tenant was admitted to the hospital with a diagnosis of Pneumonia and returned to the program on 9-21-09. The tenant was transferred to a SNF on 9-22-09 and returned to the program on 11-17-09. On 11-25-09 a UA and C & S was ordered. The culture was positive for a UTI and a new order for Macrobid, 100 mg, twice daily for seven days was issued. On 12-4-09, notes indicated the antibiotics were completed; however, the tenant still complained of burning while urinating. An order was requested for a follow up UA with C & S and for the tenant to begin Tetracycline, 500 mg by mouth, twice daily for 10 days. On 12-7-09 notes indicated the antibiotic was discontinued due to the UA and C & S being returned negative. A review of Nurse's Notes and a review of the Meal and Watch Checklist indicated the tenant consistently came out for meals. Nurse's notes indicated on 11-22-09, the tenant refused a meal. Nurse Review was completed appropriately as needed with changes.

Tenant #2, 88 years old, was admitted on 9-23-09 and diagnoses include: Hyperlipidemia, Hyponatremia, Dementia, Delirium, Osteoporosis, Glaucoma, Arthritis and Anxiety. The tenant was staged at a four on the GDS, which indicated moderate cognitive decline. According to Nurse's Notes the tenant was hospitalized, due to behavioral issues, on 9-24-09 and returned to the program on 10-6-09. According to notes dated 12-1-09, a new order was received for a UA with C & S. The UA was negative and no new orders were received. The Nurse's Notes and the Meal and Watch Checklist indicated the tenant consistently came out for meals. Nurse Review was completed appropriately, as needed with changes.

Tenant #3, 91 years old, was admitted on 9-12-09 and diagnoses include: Depression, Anxiety, Osteoarthritis, Dementia and GERD. The tenant was staged at a five on the GDS, which indicated moderate cognitive impairment. According to Nurse's Notes dated 11-29-09 at 8:35 p.m., the tenant refused to come out for a meal. The tenant was sleeping in bed and denied pain or discomfort. The tenant's temperature was 99.6° F. and a scheduled Tylenol was given. When staff later checked on the tenant he/she was up in the room, had made the bed and was sitting in the chair. Food and soup were offered and

the tenant declined. On 11-30-09 at 8:35 a.m. a fax was sent to the tenant's doctor requesting a UA with C & S due to the tenant's increased confusion. Cognitive, health and functional evaluations were completed on 11-30-09 related to the increased confusion. On 11-30-09 orders were received for a UA with C & S to be obtained with a straight catheter, for a Cortisol level, CBC and Hg Alc. The UA was obtained due to the tenant's increased confusion, slow ambulation and unsteady gait. Staff were providing SBA due to the tenant's unsteadiness. The tenant's face was drawn and grimacing was noted when the tenant talked with staff. The tenant complained of general malaise and was resting. On 12-1-09, the lab and UA results were returned and faxed to the tenant's doctor for any new orders. Staff #1, #2 and the nurse indicated the UA was negative. The nurse indicated the UA was not significant; however, there was some rare bacteria but not very much. No treatment was ordered. Notes dated 12-1-09 at 1915, indicated the tenant was laying in his/her room all shift and ate approximately 50 % of his/her supper in the apartment. According to notes dated 12-2-09, the tenant was observed lying on the floor at 4:15 a.m.; however, there were no injuries reported and no complaints of pain. Notes dated 12-2-09 indicated the tenant did moan when adjusting him/herself in bed. Notes dated 12-2-09 at 12:45 p.m., indicated the tenant was in bed the entire shift, refused both meals, the lunch tray in the room was untouched, the tenant was very lethargic and he/she gave only short responses to questions asked. On 12-2-09 at 1:20 p.m. the tenant's doctor acknowledged notification of the fall and requested to see the tenant and to have the tenant bring a current medication list. The tenant was taken out of the program at 3:35 p.m. for an appointment with the doctor. Per the tenant's family member, the tenant was admitted to the hospital with a diagnosis of Sepsis. Hospital records indicated the final diagnoses included: Escherichia coli UTI, Delirium secondary to UTI, Osteoarthritis and Dementia with Agitation. The records indicated the tenant appeared septic; however, sepsis was later disproved. The tenant was weak, dry and did require fluids. Nurse review was completed on 11-30-09; however, several changes occurred from 12-1-09 to 12-2-09 and nurse review was not completed with those changes. According to notes from 12-1-09 to 12-2-09 when the tenant left for the doctor appointment and subsequent hospitalization, the tenant was laying in his/her room all shift, was found on the floor, was moaning when adjusting his/herself in bed, refused meals and was very lethargic. Nurse review was not completed as needed. The Meal and Watch Checklist indicated on 11-30-09, that the tenant came to the dining room for the lunch meal. On 12-1-09 and 12-2-09 the sheets indicated the tenant received room trays for lunch and dinner. Nurse's Notes dated 12-1-09 indicated the tenant ate 50% of his/her supper in the tenant's apartment. Staff #1 stated the tenant was voiding as evidenced by obtaining a sample for the UA. She stated if the tenant refused to come out for meals, tray meals were served. She stated there were no issues with the tenant not eating or drinking until 12-2-09, the day the tenant went to the doctor's appointment. Staff #2 stated on 11-30-09 the tenant came out to the dining room for the evening meal with SBA from staff. She stated on 12-1-09 the tenant refused the evening meal and staff took a tray to the tenant. The tenant did not want soup but staff took him/her cereal, water and juice and he/she ate 50% of that meal. Staff #2 stated she was removing four to five empty glasses from the tenant' room and the tenant did void. The nurse observed the tenant walking to supper during this time period and stated the tenant did not come out a couple of times for lunch and breakfast; however, tray meals were offered. Staff #4 stated on 12-1-09, the tenant was served a room tray and refused soup. She brought the tenant cereal, coffee and cranberry juice. The tenant ate 50% of the cereal and drank all of the juice. The nurse stated on 12-2-09 the tenant did not come out for meals.

However, during the time the tenant was sick the nurse indicated he/she was eating and drinking but she did not document it.

Tenant #4, 80 years old, was admitted on 9-10-09 and diagnoses include: Alzheimer's Disease, Osteoporosis, Chronic Obstructive Pulmonary Disease (COPD), Osteoarthritis, Vitamin Deficiency, Asthma and HTN. The tenant was staged at a five on the GDS, which indicated moderately severe cognitive decline. According to Nurse's Notes dated 12-5-09, the tenant requested to go to the hospital. The tenant was admitted for observation of the COPD. The tenant returned to the program on 12-7-09. Notes dated 12-10-09 indicated the tenant was very unsteady on his/her feet. The tenant's doctor indicated the program was to observe the tenant. On 12-14-09 the tenant's doctor ordered the program to continue to observe the tenant and to call in seven days with a progress report. Nurse's notes and the Meal and Watch Checklist indicated the tenant did not come out to meals and received tray meals in his/her apartment. The tenant was staying in his/her apartment more, was very sleepy and was unsteady. Notes indicated the tenant was drinking fluids well, requested ice cream for a snack and received room trays. Nurse review was completed appropriately, as needed with changes.

- Regulatory Insufficiency: The program did not assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress on previous recommendations if there are changes in health status. (321-IAC r. 25.30(3)).

B. 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 had bruises.

Monitoring Observation: Four files were reviewed.

Tenant #1's file was reviewed. The notes did not identify any bruises.

Tenant #2's file was reviewed. The notes did not identify any bruises.

Tenant #3's file was reviewed. According to Nurse's Notes dated 11-28-09, a large violet bruise was observed on the tenant's lower back and upper buttock area. The tenant denied pain or discomfort, was moving per usual and was unable to explain how he/she received the bruise or when it happened. The tenant's doctor and family were notified of the bruise. Hospital records dated December 3, 2009, indicate the tenant had multiple bruises of varying ages and of an unclear source. Staff #1 and #2 indicated tenants had not been physically or verbally harmed by staff.

Tenant #4's file was reviewed. According to Nurse's Notes dated 12-9-09, the tenant approached staff in the hallway and reported he/she had just tripped on the carpet and fell. The tenant had skin tears to the left elbow and left knee. The family and doctor were notified. The areas were cleansed and steri - strips were applied.

The program had previously reported suspected dependent adult abuse regarding Tenant #3. These allegations were investigated on October 27 and 28, 2009 by the Department

in regard to the lack of Dementia-Specific training for staff. A Regulatory Insufficiency was issued; however, dependent adult abuse was not confirmed.

- Regulatory Insufficiency: None noted.

Dated this 18th day of February, 2010.