IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

March 1, 2010

Incident: #27062-I
#26156-I
#26587-I
Complaint Intake: #26527-C

Christina Bricker, Housing Director
Summit Pointe Senior Living Community
3505 English Glen Ave.
Marion, IA 52302-4711

RE: Final Incident and Complaint Investigation Report, Summit Pointe Senior Living Community, Marion, IA

Dear Ms. Bricker:

Enclosed is the **Final Incident and Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2009) and Iowa Administrative Code, chapters 481- 67 and 69, pertaining to monitoring, civil penalties, complaints and incidents regarding assisted living programs. **No Regulatory Insufficiencies were identified.**

If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Christina Bricker, Housing Director
Summit Pointe Senior Living Community
3505 English Glen Ave.
Marion, IA 52302-4711

Incident Intake #: 27062-I
26156-I
26587-I
Complaint Intake#: 26527-C

Date of Incident Investigation:

January 25 and 26, 2010

Monitor(s):

Stephanie Cummins, MA
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. IAC r. 481-67.10(5). 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 481 IAC - chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:
A complaint and incident investigation on-site visit was conducted at Summit Point Senior Living Community on January 25 and 26, 2010. In preparing this report, the following information was considered:

Current Program Census:

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

Current number of tenants without cognitive disorder:	98
Current number of tenants with cognitive disorder:	5
Total Population of GPP:	103

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

Total Population of DSP:	12
Total Census of ALP:	115

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

Program History – The program has had a substantiated Regulatory Insufficiency in the area of medications this certification period.

The June 15 and 16, 2009 Incident Investigation resulted in no Regulatory Insufficiencies.

The October 15, 2008 recertification visit resulted in a Regulatory Insufficiency in the area of Medications.

On-Site Monitoring Evaluation – The monitors made the observations detailed in the following areas.

A. Criteria for exclusion of Tenants

Incident Allegation # 27062: The program reported a tenant had a couple of episodes and the program attempted to implement a managed risk.

Monitoring Observation: Tenant #1, 81 years old, was admitted on 2-1-08 with diagnoses of: Macular Degeneration, Vitamin B-12 Deficiency, Depression, Hypertension (HTN) and Benign Prostatic Hypertrophy (BPH). The tenant utilized an electric wheelchair for ambulation.

According to the Housing Director, the first incident occurred on 11-27-09 and the second incident occurred on 12-15-09.

According to an interview with Staff #9, the Activity Director, approximately two months ago Tenant #1 entered the kitchen from the dining room while Staff #9 was in the kitchen. Staff #9 stepped in front of the tenant and told the tenant he/she could not be in that area and the tenant stated he/she would run staff over. All staff moved out of the way after the tenant said he/she would run them over. The tenant then moved toward the cook and discussed the issue regarding his/her food and then left the kitchen.

According to an interview with Staff #4, sometime between Thanksgiving and Christmas, Tenant #1 entered the kitchen regarding a food order. The tenant was yelling and argumentative but did not bump the wheelchair into anyone. Staff #4 stated the tenant did not harm or endanger anyone; however, the tenant was constantly rude and complaining.

According to an interview with Staff #10, he was present in the kitchen when the tenant entered the room and showed the cook that the order was incorrect. Staff tried to stop Tenant #1 from entering. The tenant did not harm anyone or actually run the scooter into people.

According to an interview with Staff #11, she entered the kitchen after the tenant had already entered the kitchen. Staff tried to stand in front of the tenant's wheelchair to stop the tenant; however, the tenant had an aggressive demeanor but did not bump into anyone. She stated that if she had continued to try to stop the tenant, she didn't know what the tenant would have done.

Staff #7 stated the tenant verbally put her down and she tried to avoid him/her but she was not afraid of the tenant.

According to a Resident Occurrence Report dated 12-15-09, Tenant #1 drove his/her wheelchair into the dining room and circled the first table until he/she found an unused coffee cup. Staff #9, the Activity Director, saw the tenant was upset and offered to help with the cup. The tenant declined and ran his/her electric chair into Tenant #4's wheelchair.

According to Staff #9's written statement, she entered the dining room on 12-15-09 because she observed Tenant #1 traveling at a reckless speed in his/her motorized

wheelchair in an occupied tenant dining room. According to the statement, the tenant's body language indicated that the tenant was angry about something. Staff #9 said she entered the dining room because she was afraid a staff member or other tenant would be verbally or physically abused by the tenant and his/her wheelchair. The tenant told her no one would get him/her the correct coffee cup so she offered to get one. According to an interview with Staff #9, the tenant refused assistance and started to leave, hitting Tenant #4's wheelchair several times. Staff #9 stepped in front of Tenant #1's wheelchair and asked him/her to back up because he/she was hitting Tenant #4's chair. She asked the nurse to check on Tenant #4 but she observed no physical injuries. Staff #9 stated the tenant did not harm any other tenants; however, he/she was a disruption to the dining room. She stated the tenant did not physically harm staff; however, was verbally abusive to staff.

Tenant #4 was discharged from the program on 12-31-09 and could not be interviewed.

Two tenants were interviewed and stated that several months ago a tenant was not pleased about what he/she received from the kitchen. The tenant went into the kitchen in his/her motorized wheelchair but did not run into anyone. They indicated administrative staff listened to their concerns and they did not have any significant complaints regarding the food.

According to a managed risk agreement signed by the Housing Director on 12-17-09, the cause of concern was the tenant's behavior toward staff and tenants; for example, running his/her electric wheelchair into other tenants and yelling and threatening to run over staff. The plan indicated the tenant would not have verbal outbursts with staff or use his/her electric wheelchair inappropriately which could cause harm to himself/herself or others or damage program property. The agreement stated that if the behaviors continued, the program would issue a 30-day notice for the tenant to leave the facility. The agreement also stated the tenant would not enter any unauthorized rooms such as the kitchen. The tenant refused to sign the managed risk agreement when it was initially presented to the tenant and again when it was presented on 1-5-10 in the presence of the Ombudsman, Housing Director and Staff #9.

A review of Tenant #1's file and staff interviews indicated the tenant did not exceed the appropriate level of care. The tenant gave notice to the program and voluntarily moved out of the program on 1-23-10.

- Regulatory Insufficiency: None noted.

B. Medications

Incident Allegation 26587-I: It was reported by the program that Tenant #3's narcotic count was off. According to the count, there were to be three syringes of ABH cream (a compounded mixture of Ativan, Benadryl and Haldol). The program reported when the narcotic count was completed, there were only 2.8 milliliters (ml) remaining rather than 3.0 ml. The syringes were delivered by the pharmacy on 11-9-09.

Monitoring Observation: Tenant #3, 85 years old, was admitted on 8-15-08 and diagnoses include: Dementia, Acute Renal Failure and Diabetes. The tenant was staged at a six on the Global Deterioration Scale (GDS) which indicated severe cognitive

decline. The tenant resided in the dementia unit. ABH cream was ordered .1 ml as needed on 11-9-09. According to pharmacy records, four syringes of one ml each were delivered on 11-9-09 equaling 40 doses. According to the Medication Administration Records (MARs) there were 18 doses administered from 11-12-09 to 12-7-09 leaving 22 doses. According to documentation of destruction, the total number of doses destroyed was 22. The monitor reconciled the doses delivered with doses administered and destroyed and all doses were accounted for. Currently, the program orders only one syringe and documents accordingly at the current time. The program reported the potential theft to the police department and the Department of Inspections and Appeals appropriately.

- Regulatory Insufficiency: None noted.

C. Food Service

Complaint Allegation # 26527-C: It was alleged there was not adequate fresh bread, silverware, dishes and salt and pepper shakers. It was alleged that sack lunches had replaced many meals.

Monitoring Observation: A community meeting was held with 50 tenants present. The tenants reported fresh bread was available and they had adequate utensils, dishes and condiments. The tenants indicated that sack lunches were not served often and they had no concerns.

The program had a food license which was issued 12-7-09 and expired on 12-12-2010.

Staff #3, the Food Service Director, was certified as a food safety manager effective 12-4-2007. Staff #4, #5, #6, #7, and #8 had current appropriate sanitation and safe food handling training.

According to Staff #3, the bread is delivered frozen and is servable, sack lunches are rarely served and since he had been there they had only been served two times. He stated there had been no complaints regarding sack lunches and the tenants were notified in advance of the menu change. Staff #3 stated that salt and pepper were always available and more cups and silverware had been ordered.

The monitors requested a sample meal and tested the bread for freshness. It was found to be soft and edible.

- Regulatory Insufficiency: None noted.

D. Staffing

Complaint Allegation #26527-C: It was alleged that the program was short staffed.

Monitoring Observation: A community meeting was held with 50 tenants present. The tenants indicated there were enough staff and staff treated them well; however, there had been a lot of staff turnover.

- Regulatory Insufficiency: None noted.

E. Structural requirements

Complaint I #26527-C: It was alleged the windows and heating system needed repair and/or replaced and that water was a problem in the basement.

Monitoring Observation: Maintenance logs were reviewed from 10-29-09 through 1-21-10. All issues were documented as resolved. The log revealed approximately 15 complaints regarding heat and four regarding windows. According to Staff #2, the Maintenance Director, there had been approximately 15 to 20 work orders regarding windows and heat and 100% were related to the windows not being latched appropriately. One tenant apartment on the north side of the building had issues with the window and the program is attempting to resolve the problem; however, the window supplier is out of business. According to Staff #2, there have been no actual issues with the boilers and no issues with the heating system. He stated that if a room was cold, it was usually because a window was not closed properly. Staff #2 stated the basement had been dry recently, but showed the monitors where water had entered the building previously. He indicated water comes down the seams and the building contractor was involved regarding replacement of the siding. Staff #2 stated there was a prompt response to work orders. The monitors observed the basement/garage and electrical area to be dry. The windows the monitors observed did not have a draft when they were closed properly.

A community meeting was held with 50 tenants present. They reported that maintenance issues were addressed promptly. Four tenants indicated they had problems with the windows but the majority did not report concerns. The tenants indicated the heat was adjusted appropriately and the thermostats worked. The tenants reported there was still water in the basement when it rains.

- Regulatory Insufficiency: None noted.

F. Other

Complaint Allegation # 26527-C: It was alleged that the lounge and private dining area were not accessible to tenants.

Monitoring Observation: A community meeting was held with 50 tenants present. The tenants reported the lounge and dining rooms were available to them upon reservation. Staff #3, the Food Service Director, stated the lounge and small dining room were available for tenants use upon request.

- Regulatory Insufficiency: None noted.

Incident Allegation #26156-I: The program reported a tenant had money missing. It was reported a tenant had $270.00 on 10-12-09 and discovered the money missing on 10-21-09. It was reported the tenant kept the money in his/her walker and felt the money was taken during the hours of sleep.

Monitoring Observation: Tenant #2, 94 years old, was admitted on 9-12-09 and diagnoses include: Skin Cancer, Tremors, Hyperlipidemia, Hyperthyroidism, Gastric Reflux, Depression and Glaucoma.

According to a written statement from Staff #1, the tenant reported to him on 10-21-09 that on 10-11-09 the tenant withdrew $300.00 from the bank, gave $30.00 to a family member and placed the remaining $270.00 in a bank envelope in the pocket of his/her walker. On 10-21-09, the tenant discovered the envelope and $270.00 gone. According to Staff #1's statement, the tenant did not have any nursing services and no one should have been in his/her apartment without permission. The tenant reported he/she never had the walker out of sight unless sleeping at night.

The Housing Director provided a written statement which indicated Tenant #2 reported to Staff #1 on 10-21-09 that he/she had money missing. The tenant is alert and oriented and manages his/her own affairs. The tenant was encouraged to make a police report but declined to do so. According to the statement, the tenant felt the theft had happened while sleeping at night. The tenant takes a sleeping pill at night and is a sound sleeper. The Housing Director indicated she conducted an internal investigation.

Tenant #2 was interviewed and stated he/she took $300.00 out of the bank and gave $30.00 to a family member leaving $270.00. The next time he/she checked, the money was gone. The tenant reported he/she kept the money inside a pocket inside the walker and out of sight. The tenant reported he/she kept the apartment door locked and he/she did not require any nursing services, therefore, staff had no reason to come into his/her apartment. Staff cleaned the apartment one time per week. The tenant reported that if staff enter his/her apartment when he/she is not there, they leave a note. The tenant reported he/she takes a sleeping pill at night and said the money had to have been taken during the night. The tenant received the money back in a rent concession from the program. The tenant reported no other items have since been missing and he/she feels safe in the program.

According to documentation from the engineering company and monitor observation, security cameras were installed in the program. According to the Housing Director, drug testing started for all employees on 12-8-09 and was completed by 12-11-09. The Housing Director indicated they now conduct pre-employment drug testing, post-accident drug testing and with reasonable cause. The program hired a special investigations company regarding the thefts at the program.

According to program records and a master key list, multiple persons had access. The monitors were unable to determine the date and time the alleged theft occurred and therefore could not identify a specific perpetrator.

- Regulatory Insufficiency: None noted

Incident Allegation # 27062-I: The program reported a tenant and tenant's family voiced concerns regarding the tenant's rights and alleged that provocation of the tenant constituted potential abuse. The tenant had concerns regarding the building and grounds, staffing, food service and tenant rights. During the process of attempting to resolve the issues, the family and tenant alleged that the tenant's rights were violated.

Monitoring Observation: A community meeting was held with 50 tenants in attendance. Tenants felt the staff respected their rights and treated them well. The program allowed

tenants to post documents in approved areas and tenants felt that leadership staff listened to their concerns. They would recommend the program to friends and family.

Staff #9 was interviewed and indicated Tenant #1 put up signs all over the building and a lot of them were negative. Staff #9 stated he/she took down some of the signs and discussed with the tenant why the signs were removed. She stated the tenants could post anything on a resident board. According to weekly announcement information for the week of 11-8-09, tenants were allowed to place flyers anytime on the resident board with their name posted on the bottom of the flyer. The announcement indicated the dining room doors and windows would be kept clear of flyers to minimize clutter.

According to the Housing Director, the first incident occurred on 11-27-09.

According to an interview with Staff #9, the Activity Director, approximately two months ago, Tenant #1 entered the kitchen from the dining room while Staff #9 was in the kitchen. Staff #9 stepped in front of the tenant and told the tenant he/she could not be in that area and the tenant stated he/she would run staff over. All the staff moved out of the way after the tenant said he/she would run them over. The tenant then moved toward the cook and discussed the issue regarding his/her food and then left the kitchen.

According to an interview with Staff #4, between Thanksgiving and Christmas, Tenant #1 entered the kitchen regarding a food order. The tenant was yelling and argumentative but did not bump the wheelchair into anyone. Staff #4 stated the tenant did not harm or endanger anyone; however, was constantly rude and complaining.

According to an interview with Staff #10, who was present in the kitchen when the tenant entered the room, the tenant wanted to show the cook that the order was incorrect. Staff tried to stop Tenant #1 from entering. The tenant did not harm anyone or actually run the scooter into people.

According to an interview with Staff #11, she entered the kitchen after the tenant had already entered the kitchen. Staff tried to stand in front of the wheelchair to stop the tenant. The tenant had an aggressive demeanor; however, did not bump into anyone. She stated that if she had continued to try to stop the tenant, she didn't know what the tenant would have done.

Staff #7 stated the tenant verbally put her down and he/she tried to avoid him/her but he/she was not afraid of the tenant.

According to a Resident Occurrence Report dated 12-15-09, Tenant #1 drove his/her wheelchair into the dining room. The tenant circled the first table until he/she found an unused coffee cup. Staff #9, the Activity Director, saw the tenant was upset and offered to help with the cup. According to the report, the tenant said "no" and ran his/her electric chair into Tenant #4's wheelchair.

According to Staff #9's written statement, he/she entered the dining room on 12-15 because he/she observed Tenant #1 traveling at a reckless speed in his/her motorized wheelchair in an occupied tenant dining room. According to the statement, the tenant's body language indicated that the tenant was angry about something. Staff #9 said he/she entered the dining room because he/she was afraid a staff member or other tenant would

be verbally of physically abused by the tenant and his wheelchair. The tenant told her no one would get him a coffee cup so she offered to get one. According to an interview with Staff #9, the tenant refused assistance and started to leave, hitting Tenant #4's wheelchair several times. Staff #9's statement indicated she stepped in front of Tenant #1's wheelchair and asked him/her to back up because he/she was hitting Tenant #4's chair. Staff #9 stated she asked the nurse to check on Tenant #4 but she observed no physical injuries. She stated the tenant did not harm any other tenant; however, he/she was a disruption to the dining room. She stated the tenant did not physically harm staff either; however, was verbally abusive to staff.

Tenant #4 was discharged from the program on 12-31-09.

Two tenants were interviewed. They stated several months ago a tenant wasn't happy about what he/she received from the kitchen. The tenant went into the kitchen in his/her motorized wheelchair but did not run into anyone. They indicated the program administrative staff listened to their concerns and they did not have any significant complaints regarding the food.

According to a managed risk agreement signed by the Housing Director on 12-17-09, the cause of concern was regarding the tenant's behavior toward staff and tenants; for example, running his/her electric wheelchair into other tenants and yelling and threatening to run over staff. The plan indicated the tenant would not have verbal outbursts with staff or use his/her electric wheelchair inappropriately, which could cause harm to himself/herself or others or damage program property. The agreement stated that if the behaviors continued, the program would issue a 30-day notice for the tenant to leave the facility. The agreement also stated the tenant would not enter any unauthorized rooms such as the kitchen. The tenant refused to sign the managed risk agreement when it was initially presented to the tenant and again when presented on 1-5-10 in the presence of the Ombudsman, housing director and Staff #9.

According to an interview with the Housing Director, a managed risk was prepared and the tenant was called for permission to meet with him/her which the tenant gave. The housing director indicated he/she and the nurse met with the tenant in his/her room to discuss the managed risk. She stated the tenant got frustrated and they left the tenant's apartment and put a copy of the managed risk in the tenant's mailbox. The housing director advised the tenant he/she would follow-up in a couple of weeks. According to the housing director, he/she met with the tenant, the activity director and the Ombudsman again on 1-5-10. The housing director indicated the tenant's rights were upheld and there were prompt and appropriate responses to his/her concerns. The housing director indicated there were no ill health effects to the tenant per her knowledge; however, there were no nursing services provided for the tenant.

The program updated the tenant's service plan to reflect behaviors identified on the managed risk agreement and staff interventions regarding these behaviors. The tenant declined to sign the service plan. The tenant gave notice to the program and voluntarily moved out of the program on 1-23-10.

- Regulatory Insufficiency: None noted.

Dated this 1st day of March, 2010.