IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Complaint Intake: #28450-C

August 2, 2010

Gary Tiemeyer, Administrator
Heritage Court
1499 Office Park Road
West Des Moines, IA 50265-6500

RE: Final Complaint Investigation Report, Heritage Court, West Des Moines, Iowa

Dear Mr. Tiemeyer:

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Final Complaint Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515-281-5003.

Sincerely,

Connie Schaffer

Connie Schaffer
Certification Coordinator - Central/Eastern Iowa
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #:** **28450-C**

Gary Tiemeyer, Administrator
Heritage Court
1499 Office Park Road
West Des Moines, IA 50265-6500

Date of Investigation:

June 23, 2010

Monitor(s):

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 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 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 investigation on-site visit was conducted at Heritage Court on June 23, 2010. In preparing this report, the following information was considered:

Current Program Census

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

Current number of tenants without cognitive disorder:	20
Current number of tenants with cognitive disorder:	1
Total Population:	21

Dementia Specific Program (DSP)* – Not applicable.

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

Program History – There have been substantiated Regulatory Insufficiencies in the areas of Evaluation of Tenant and Service Plan during this recertification period.

On-Site Incident and Monitoring Evaluation – The monitor made the observations detailed in the following areas.

A. Evaluation of Tenant

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

- Monitoring Observation: Tenant #1's service plan dated 1-12-10 directed for contact guard assist with toileting as needed. The Nurse's Notes dated 2-16-10 to 5-7-10 documented open areas on the tenant's coccyx area, which were treated with four different treatments and multiple instances of incontinence. The clinical record lacked documentation of completion of cognitive, functional and health evaluations completed after 1-12-10.

  Tenant #2's service plan dated 2-24-10, directed for supervision by staff with ambulation, toileting and tenant to use walker or cane and assist of one to transfer. The cognitive evaluation completed 2-24-10 documented a score of 23/30, which indicated mild cognitive impairment. The Nurse's Notes dated 3-23-10 to 4-6-10 documented multiple instances of incontinence and cognitive level. The clinical record lacked documentation of completion of cognitive, functional and health evaluations completed after 2-24-10.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Service Plan

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

- Monitoring Observation: Tenant #1's service plan dated 1-12-10 directed for contact guard assist with toileting as needed. The Nurse's Notes dated 2-16-10 to 5-7-10 documented open areas on the tenant's coccyx area which were treated with four different treatments and multiple instances of incontinence, however the clinical record lacked evidence of updates to the service plan to meet the current needs of the tenant.

  Tenant #2's service plan dated 2-24-10, directed for supervision by staff with ambulation, toileting and tenant to use walker or cane and assist of one to transfer. The cognitive evaluation completed 2-24-10 documented a score of 23/30 which indicated mild cognitive impairment. The Nurse's Notes dated 3-23-10 to 4-6-10 documented multiple instances of incontinence and functional ability; however, the clinical record lacked evidence of updates to the service plan to meet the current needs of the tenant.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and

shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))

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

C. Nurse Review

- Monitoring Observation: Tenant #1, a 100 year old, was admitted 2-5-08 with diagnoses of: Peripheral Vascular Disease, Atrial Fibulation, Hypertension (HTN) and Depression. The service plan dated 1-12-10 directed for contact guard assist with toileting as needed.

  The Nurse's Notes contained the following entries:
  2-16-10 New order received for Calmoseptine topical to areas with pericare three times a day
  3-02-10 Bottom continues to have some red areas and a small open area.
  3-02-10 Received new order for skin prep and Duoderm to red area on coccyx.
  3-04-10 Noticed Duoderm rolled off and a small amount of blood on bottom.
  3-06-10 Small amount of blood on undergarment and a small spot forming on the Left.
  3-18-10 Tenant's area on bottom continues to be open.
  3-19-10 Received order to continue Duoderm for one more week.
  3-20-10 Staff assisted with pericare due to bowel movement (BM) smears.
  3-21-10 Tenant had many times BM incontinent in undergarment.
  3-26-10 Received order for Butt cream twice a day.
  4-04-10 Staff found small amount of BM on undergarment and then found open area forming on the right side.
  4-05-10 Tenant continues on Butt cream, noted to have start of small open area
  4-12-10 Tenant's area continues to be open.
  4-17-10 Staff assisted with undergarment four times and pericare for BM smears found two open areas and red spot on right side.
  4-22-10 Tenant continues to have open area on bottom.
  4-24-10 Received order for Critic Acid paste to two weeks three times a day.
  5-06-10 Tenant's bottom healing, still open but looking better.
  5-07-10 Continue Critic Acid paste three times a day for two more weeks.

  The clinical record lacked documentation of completion of a nurse review for changes in the tenant's condition that continued over a three month period.

  Tenant #2, an 88 year old, was admitted 2-7-07 with diagnoses of: Dementia, Osteoporosis, Depression, and Hyperlipidemia. The Nurse's Note dated 2-18-10 indicated a new diagnosis of Urinary Tract Infection and Sciatica. Evaluations were completed and a service plan updated with a significant change 2-24-10. The service plan directed for supervision by staff with ambulation, toileting and tenant to use walker or cane and assist of one to transfer. The cognitive exam completed 2-24-10 documented a score of 23/30, which indicated mild cognitive impairment.

  The Nurse's Notes contained the following entries:
  3-23-10 Tenant could hardly walk in from outside

3-25-10 Tenant had BM on the floor in front of the recliner
3-26-10 10:10 a.m. Tenant had BM in pants
3-26-10 1:30 p.m. Tenant had BM in pants and said he/she did not need to call for help and didn't know how
3-30-10 Could hardly move from wheelchair to toilet and back, PRN pain pill given
3-31-10 Tenant was coming out of his/her room without pants on with only shirt and undergarment
4-02-10 Tenant had BM all over hands and bathroom and refused to let staff check bottom
4-06-10 Tenant found lying in middle of bedroom floor, tenant does not remember falling down.
4-06-10 Nurse and social worker met with tenant's family and advised that due to change in activities of daily living status and cognitive deficits, the tenant does not meet assisted living requirement any longer.

The clinical record lacked documentation of completion of a nurse review for changes in the tenant's condition.

- **Regulatory Insufficiency:** To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

D. Staffing

Complaint Allegation: It was alleged a tenant transferred to another facility and upon admission, was diagnosed with a fracture of the superior pubic ramus.

Monitoring Observation: Three files were reviewed including two tenants who had been discharged. According to record review and interviews, no negligent care was found.

- Regulatory Insufficiency: None noted.

Dated this 2nd day of August, 2010.