IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

August 9, 2010

Complaint Intake #: 28794-C

Ms. Lisa Crawford, Director
Assisi Village Assisted Living
1001 Assisi Drive
Dubuque, IA 52001-1312

RE: Final Initial Certification Monitoring Evaluation & Complaint Investigation Report, Assisi Village Assisted Living, Dubuque, IA

Dear Ms. Crawford:

Enclosed is the **Final Initial Certification Monitoring Evaluation & 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. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC and certification of Assisi Village Assisted Living will continue.

Enclosed you will find the Assisted Living Program Certificate **S0301** with effective dates of **November 9, 2009** through **November 8, 2011**. This certificate is to be posted in the building for public viewing.

If you have any questions regarding this certification, please contact me at 515/281-5721.

Sincerely,

Tamara Halvorson

Tamara Halvorson
ASB Lead Certification Coordinator
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Initial Certification Monitoring Evaluation & Complaint Investigation Report

Assisted Living Program:

Complaint Intake #: 28794-C

Lisa Crawford, Director of Assisi Village
Assisi Village Assisted Living
1001 Assisi Drive
Dubuque, IA 52001-1312

Date of Investigation/Monitoring Visit:

July 13 & 14, 2010

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. 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 & initial monitoring evaluation on-site visit was conducted at Assisi Village Assisted Living on July 13 & 14, 2010. In preparing this report, the following information was considered:

Current Program Census

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

Current number of tenants without cognitive disorder:	16
Current number of tenants with cognitive disorder:	0
Total Population:	16

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.**

Tenant/Family Satisfaction Results – A community meeting with eight tenants was held. The tenants did not have any concerns with housekeeping, laundry or maintenance. Staff went above and beyond and asked the tenants how they wanted things done. The tenants described staff as warm, enthusiastic, excellent and well trained. There were sufficient staff to meet their needs and staff answered calls for assistance quickly. One tenant requested staff spend more down time with tenants. They stated the quality of the food was good; however, there was not a variety of foods served at the noon meal. The food temperature at times needed improvement. The tenants received an activity calendar and there were sufficient activities available. They enjoyed Bingo, music, movies, outings and one on one activities with staff. They felt safe and felt they were making their own decisions. The tenants stated they were getting the services expected when they signed the occupancy agreement. They were aware if they needed more care they might have to move to a higher level of care. The tenants were aware of their rights and stated tenant rights were respected and no one had their tenant rights violated. The nurse was available as needed. They described the environment as warm and caring. They requested the program be larger in size so more tenants could move in. They were satisfied with the program and would recommend it to others.

Program History – There were no substantiated Regulatory Insufficiencies found during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

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

A. Occupancy Agreement

Complaint Allegation #28794-C: It was alleged a tenant was discharged and appropriate notification of transfer was not given.

- Monitoring Observation: Four discharge files were reviewed.

  Tenant #1, a 91 year old, was admitted on 11-19-09 and diagnoses include: Hypotension, Hypoglycemia and Dementia Alzheimer's Type. The tenant was staged at five on the Global Deterioration Scale (GDS), which indicate moderately severe cognitive impairment. The tenant was discharged on 12-19-09. According to Nurse's/Care Notes dated 12-8-09 the tenant was observed having a grand-mal-seizure activity. The tenant was taken by ambulance to the hospital. Notes dated 12-10-09 indicated the tenant's doctor felt the tenant was not appropriate for assisted living. Notes dated 12-11-09 indicated the tenant was admitted to the care center for two weeks of Physical Therapy (PT). On 12-18-09 the tenant's family made a decision to keep the tenant at the care center. The program did not initiate transfer and the program was not required to give notification.

  Tenant #2, an 83 year old, was admitted on 11-10-09 and diagnoses include: History of Recent Fracture Right Upper Extremity (RUE), History of Spinal Compression Fracture and Mild Alzheimer's Type Dementia. The tenant was discharged on 1-28-10. According to Nurse's/Care Notes dated 12-16-09 the tenant was admitted to the hospital on 12-16-09 with a diagnosis of early pneumonia. The tenant was transferred to a skilled unit at the care center for a two week period. According to notes dated 1-7-10 the decision was made (tenant/tenant's family) to have the tenant remain at the care center. The program did not initiate transfer and the program was not required to give notification.

  Tenant #3, a 94 year old was admitted on 11-12-09 and diagnoses include: Diabetes, Hypertension (HTN), Gastroesophageal Reflux Disease (GERD), Atrial Fibrillation, Asthma, Hypercholesterolemia and Senile Dementia. The tenant was discharged on 3-18-10. According to Nurse's Notes/Care Notes the tenant was admitted to the hospital on 2-15-10. According to notes dated 2-18-10 the tenant's doctor felt the tenant should go to skilled care following discharge from the hospital. On 2-19-10 the tenant was admitted to the care center skilled unit. The tenant was assessed on 3-11-10 and was staged at four to five on the GDS. The program had discharge criteria in the occupancy agreement that included not admitting or retaining tenants that scored a four or above on the GDS. Previously the tenant had not scored at a four or above on the GDS. On 3-11-10 the RN/AL Director met with the tenant and also met with the tenant's spouse and informed them the assessments indicated the tenant was not appropriate for the program. The tenant verbalized sadness, but stated "I understand", according to notes. The RN/AL Director met with the tenant's family and explained the tenant did not meet the continued stay criteria. The family was upset that the tenant and his/her spouse could not stay together at the program. On 3-16-10, the RN/AL Director met with another family member and explained the assessment findings and the family member verbalized understanding and indicated the family was in discussion regarding the tenant and his/her spouse. According to notes, the tenant was to be discharged from skilled unit on 3-18-10; however, the

tenant could remain at the care center until other placement was found if the tenant was not going to remain at the care center after discharge from skilled. According to notes the tenant was discharged from the care center on 3-19-10 to independent living and family wished to keep the tenant and spouse together at all costs. According to the RN/AL Director a written 30 day notification of discharge was not given to the tenant. The RN/AL Director stated she had concerns regarding the tenant's safety and the return to the program. A written 30 day notice was not given to the tenant or the tenant's legal representative regarding discharge from the program.

Tenant #4, a 92 year old, was admitted on 11-12-09 and diagnoses include: Atrial Fibrillation, Anemia, Hypothyroidism, Hyperlipidemia, Glaucoma and Cataracts. The tenant was discharged on 3-19-10. According to Nurse's/Care Notes dated 3-16-10 the tenant and family were making plans to move due to the tenant's spouse not meeting retention criteria. The tenant moved out with his/her spouse. The tenant was not discharged by the program; the tenant elected to move with his/her spouse to another facility. The program was not required to give notification.

- Regulatory Insufficiency: An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to copy originally delivered are made. (231C.5(1))

B. Program Initiated Involuntary Transfer

Complaint Allegation: It was alleged a tenant was discharged and appropriate involuntary transfer protocol was not followed.

- Monitoring Observation: Four discharge files were reviewed.

Tenant #1's file was reviewed. According to Nurse's/Care Notes dated 12-8-09 the tenant was observed having a grand-mal-seizure activity. The tenant was taken by ambulance to the hospital. Notes dated 12-10-09 indicated the tenant's doctor felt the tenant was not appropriate for assisted living. Notes dated 12-11-09 indicated the tenant was admitted to the care center for two weeks of PT. On 12-18-09 the tenant's family made a decision to keep the tenant at the care center. The program did not initiate transfer and the tenant did not contest the transfer. The involuntary transfer protocol was not required.

Tenant #2's file was reviewed. According to Nurse's/Care Notes dated 12-16-09 the tenant was admitted to the hospital on 12-16-09 with a diagnosis of early pneumonia. The tenant was transferred to a skilled unit at the care center for a two week period. According to notes dated 1-7-10, the decision was made (tenant/tenant's family) to have the tenant remain at the care center. The program did not initiate transfer and

the tenant did not contest the transfer. The involuntary transfer protocol was not required.

Tenant #3's file was reviewed. According to Nurse's Notes/Care Notes the tenant was admitted to the hospital on 2-15-10. According to notes dated 2-18-10 the tenant's doctor felt the tenant should go to skilled care following discharge from the hospital. On 2-19-10 the tenant was admitted to the care center skilled unit. The tenant was assessed on 3-11-10 and was staged at four to five on the GDS. The program had discharge criteria in the occupancy agreement that included not admitting or retaining tenants that scored a four or above on the GDS. Previously the tenant had not scored at a four or above on the GDS. On 3-11-10 the RN/AL Director met with the tenant and also met with the tenant's spouse and informed them the assessments indicated the tenant was not appropriate for the program. The tenant verbalized sadness, but stated "I understand", according to notes. The RN/AL Director met with the tenant's family and explained the tenant did not meet the continued stay criteria. The family was upset that the tenant and his/her spouse could not stay together at the program. On 3-16-10, the RN/AL Director met with another family member and explained the assessment findings and the family member verbalized understanding and indicated the family was in discussion for both the tenant and his/her spouse. According to notes, the tenant was to be discharged from skilled unit on 3-18-10; however, the tenant could remain at the care center until other placement was found if the tenant was not going to remain at the care center after discharge from skilled. According to notes the tenant was discharged from the care center on 3-19-10 to independent living and family wished to keep the tenant and spouse together at all costs. According to the RN/AL Director, initially the transfer was a voluntary transfer and then became an involuntary transfer. She stated the program did not initiate the involuntary transfer process once the transfer became an involuntary transfer. The appropriate involuntary transfer protocol was not initiated regarding the tenant's transfer.

Tenant #4's file was reviewed. According to Nurse's/Care Notes dated 3-16-10 the tenant and family were making plans to move due to the tenant's spouse not meeting retention criteria. The tenant moved out with his/her spouse. The tenant was not discharged by the program; the tenant elected to move with his/her spouse to another facility. The program did not initiate the tenant's transfer and involuntary transfer protocol was not required.

- Regulatory Insufficiency: If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: the program shall notify the tenant or tenant's representative, in accordance with the occupancy agreement, of the need to transfer the tenant and of the reason for the transfer and shall include the contact information for the tenant advocate. The program shall immediately provide to the tenant advocate, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. Pursuant to statute, the tenant advocate shall offer the notified tenant or tenant's legal representative assistance with the program's internal appeal process. The tenant or tenant's legal representative is not required to accept the assistance of the tenant advocate. If,

following the internal appeal process, the program upholds the transfer decision, the tenant or tenant's legal representative may utilize other remedies authorized by law to contest the transfer. (IAC r. 481-69.24(1)(a-d)

C. Other

Complaint Allegation #28794-C: It was alleged tenant rights were not upheld.

- Monitoring Observation: A community meeting with eight tenants was held. The tenants described staff as warm, enthusiastic, excellent and well trained. There were sufficient staff to meet their needs and staff answer calls for assistance quickly. They felt safe and felt they were making their own decisions. The tenants stated they were getting the services expected when they signed the occupancy agreement. They were aware if they needed more care they might have to move to a higher level of care. The tenants were aware of their rights and stated tenant rights were respected and no one had their tenant rights violated. They were satisfied with the program and would recommend it to others. They described the environment as warm and caring.

  Staff #1 and Staff #2 stated tenant rights were respected and none of the tenants had their tenant rights violated.

  The Director and the RN/AL Director stated that tenant rights were respected and if a tenant was not physically in the building the tenants retained their tenant rights.

  Four current tenant files and four discharged tenant files were reviewed. All of the tenants had a signed acknowledgement of the tenant rights, discharge criteria and the handbook.

- Regulatory Insufficiency: None noted.

Dated this 9th day of August, 2010.