IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Incident Intake: 30787-I

November 8, 2010

Mr. Gary Shebeck, Administrator
Newton Village Inc.
122 North 5th Avenue West
Newton, IA 50208

RE: Final Incident Investigation Report, Newton Village, Inc., Newton, Iowa

Dear Mr. Shebeck:

Enclosed is the **Final Incident 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 **Preliminary Incident 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 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #: 30787-I**

Gary Shebeck, Administrator
Newton Village Inc.
122 North 5th Ave. West
Newton, IA 50208

Date of Incident Investigation:

October 11, 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 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:

An on-site visit was conducted at Newton Village Inc. on October 11, 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:	32
Current number of tenants with cognitive disorder:	2
Total Population of GPP:	34

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

Total Population of DSP:	10
Total Census of ALP:	44

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

Program History – There were no regulatory insufficiencies found during this certification period.

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

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

A. Evaluation of Tenant

Monitoring Observation: Tenant #1, a 90 year old, was admitted to assisted living on 12-2-09 with diagnoses of: Dementia, Hypercholestermia, and Osteoporosis. The Global Deterioration Scale (GDS) dated 9-22-10 documented the tenant at 4 which indicates moderate cognitive decline. The tenant was transferred to a secured dementia unit 9-25-10. A nurse review completed 9-22-10 documented the tenant was confused and had fallen outside The nursing progress note dated 5-14-10 documented the tenant left the assisted living unit after reporting he/she was going for a walk but did not return until staff went after him/her. At this time the program implemented one hour checks. Another note on 5-18-10 documented the program planned to try the tenant in a day program in the secured unit. The clinical record contained documentation of a clinic referral dated 5-19-10 which indicated the tenant had demonstrated increased confusion and some wandering. The clinical record lacked evidence of completion of cognitive, health or functional evaluations for significant changes in condition.

Tenant #2, an 87 year old was admitted 5-30-09 with diagnoses of: Depression, Dementia, Arthritis, and Dyslipidemia. The Mini Mental State Exam (MMSE) completed 6-29-09 documented a score of 23 of 30 which indicated mild cognitive impairment. The GDS was 3 which also indicated mild cognitive decline. The clinical record lacked evidence of completion of annual cognitive, health and functional evaluations.

Tenant #4, a 90 year old, was admitted 8-22-08 with diagnoses of: HTN, Hypercholesteremia, and Arthritis. The service plan from 9-17-08 had been updated 2-23-10 with directions for minimal assist with ambulation due to vision and 8-11-10 with directions for total staff medication administration. The clinical record lacked evidence of completion of annual cognitive, health and functional evaluations during 2009.

- 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. Criteria for Exclusion of Tenant

Incident Allegation: The program reported a tenant eloped from the program on 9-21-10 and was found to have fallen on the property and sustained a fractured wrist.

Monitoring Observation: The clinical record for Tenant #1 contained a GDS assessment of 5 completed 8-17-10 which indicated a moderately severe cognitive decline. The tenant had an incident of leaving the program and failing to return independently on 5-14-10. The clinical record did not document another incident until 9-21-10 in which the tenant left the building after 6:30 pm. and was found outside in the rain on the side walk of the property. The tenant had not taken their walker, had fallen, and sustained a fractured wrist. A cognitive and functional assessment was completed and the tenant was transferred to a secured unit. The tenant had not left the building independently for over four months. The program reported the incident appropriately on 9-22-10.

- Regulatory Insufficiency: None noted

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

C. Service Plan

Monitoring Observation: The service plan for Tenant #1 was completed and signed by the registered nurse 2-26-10. The service plan lacked the signatures of the tenant or responsible party.

The clinical record for Tenant #1 contained a GDS assessment of 5 completed 8-17-10 which indicated a moderately severe cognitive decline. The tenant had an incident of leaving the program and failing to return independently on 5-14-10. According to nursing notes, the program implemented one hour safety checks and planned to try the tenant in a day program in the secured unit. The program did not update the service plan to include these interventions.

Cognitive, health and functional evaluations were completed for Tenant #2 after 30 days of occupancy on 6-29-09. The clinical record lacked evidence of completion of annual cognitive, health and functional evaluations. The clinical record also lacked evidence that an annual service plan had been developed with the change to program administration of medications which was implemented 5-28-10.

Tenant #3, an 86 year old, was admitted 2-19-10 with diagnoses of: Dementia, Depression, Diabetes, Hypertension, (HTN) and Hycholesteremia. The service plan completed, signed by the registered nurse and dated 2-12-10 contained no signatures of the tenant or tenant's legal representative either with the initial service plan or 30 day updated service plan.

Tenant #4, a 90 year old, was admitted 8-22-08 with diagnoses of: HTN, Hypercholesteremia, and Arthritis. The service plan from 9-17-08 had been updated 2-23-10 with directions for minimal assist with ambulation due to vision and 8-11-10 with directions for total staff medication administration. The clinical record lacked evidence of completion of annual cognitive, health and functional assessment during 2009. The clinical record also lacked a service plan developed with the tenant and signed by the tenant and/or tenant's legal representative.

- 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))

- Regulatory Insufficiency: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional 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. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26 (2))

D. Nurse Review

Monitoring Observation: The clinical record for Tenant #1 contained a MMSE dated 11-24-09 which documented the tenant scored 27/30 indicating no cognitive impairment. A GDS assessment completed 8-17-10 documented the tenant at 5 which indicated a moderately severe cognitive decline. The tenant had an incident of leaving the program and failing to return independently on 5-14-10. According to nursing notes, the program implemented one hour safety checks and planned to try the tenant in a day program in the secured unit. The program did not complete a nurse review in May 2010 when the changes to the service plan were attempted or August 2010 when the nurse documented a dramatic decline in cognition.

The clinical record for Tenant #4 included documented falls on 8-8, 9-3, 9-17, and 10-10-10. The clinical record lacks documentation of a nurse review to assess the tenant's health status to make recommendations and/or referrals for multiple falls.

- 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))

Dated this 8th day of November, 2010.