IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 31913-C

January 28, 2011

Ms. Alecia Grove, Executive Director
Garden View Senior Community
800 Darby Drive
Monona, IA 52159

RE: Final Complaint Investigation Report, Garden View Senior Community, Monona, Iowa

Dear Ms. Grove:

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 **Preliminary 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 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #: 31913-C**

Alecia Grove, Executive Director
Garden View Senior Community
800 Darby Drive
Monona, IA 52159

Date of Investigation:

December 22, 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 on-site visit was conducted at Garden View Senior Community on December 22, 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 of GPP:	16

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

Total Population of DSP:	6
Total Census of ALP:	22

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

Program History – The program did not receive any regulatory insufficiencies 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. Evaluation of Tenant

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

- Monitoring Observation: Tenant #2, a 71 year old, was admitted on 3-28-10 with diagnoses of: Hypothyroidism, Dementia, Vitamin Deficiency and Alcoholism. The tenant was discharged from the program. According to Progress Notes, Aricept was started on 9-24-10. According to Progress Notes dated 10-5-10, the tenant's doctor was updated regarding concerns. On 10-20-10 notes indicated behaviors continued and the tenant tended to space staff out when he/she did not want to listen. Notes of 11-5-10 indicated the tenant was obsessed with preparing for Thanksgiving. The tenant's family did take him/her out and the tenant insisted on buying a turkey. The tenant took the turkey out of the freezer and put it into the refrigerator thinking Thanksgiving was in a few days. Progress Notes dated 11-10-10 indicated the tenant wanted to go to the grocery store to buy pie filling for pies. The tenant did not have an oven or stove in the apartment. Notes dated 11-11-10 indicated family was aware of behaviors and the tenant called family members during the night with no concept of time. The notes indicated the tenant's doctor was making an appointment for the tenant to be seen by a geriatric psychologist. On 11-16-10 the tenant started to walk out of the building to go to the grocery store. The tenant was informed he/she could not go by himself/herself and there was no need to go at that time. An hour later the tenant walked outside past staff and was asked to return. The tenant returned but was not happy, according to notes. On 11-17-10 at 3:00 p.m. the tenant walked out the front door of the building and when asked to return the tenant refused. Staff followed the tenant and the local police were notified. The police met the tenant and staff and escorted the tenant back to the program. The tenant's family and doctor were notified. The tenant went to a geriatric psych unit on 11-18-10.

  An update on the tenant's behaviors was sent to the tenant's doctor on 10-5-10. The update indicated the tenant was stubborn about things and would tune staff out if they asked him/her to do something or not to do something. The tenant put his/her fist up to a staff person when the tenant did not want to comply with a simple request. The tenant pushed another tenant back to the other tenant's apartment and proceeded to help the other tenant out of the wheelchair despite being told numerous times not to assist. The nurse reported there had been no improvements since Aricept was started. The nurse wondered since the tenant was not drinking, was eating better and taking medications that a behavior problem was more visible. The drinking was a form of "self-medication" and was not as obvious, according to the update to the tenant's doctor. The family wondered if besides the dementia, the tenant was also obsessive compulsive. The tenant was discharged from the program on 11-19-10. The reason for discharge included irrational thinking and unsafe practice when leaving the building. The last cognitive evaluation was completed on 4-28-10 and that time the tenant was staged at no or mild impairment. Health and functional evaluations were last updated on 9-28-10. Evaluations were not completed as needed.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive, and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with a

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 when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Program Initiated Involuntary Transfer

Complaint Allegation: It was alleged a tenant was inappropriately discharged. It was alleged a tenant was discharged because of administrative staff favoritism.

- Monitoring Observation: There were two tenants discharged in the past three months. The program reported there had not been any involuntary discharges in the past three months.

  Tenant #1, a 94 year old, was admitted on 7-22-05 with diagnoses of: High Blood Pressure, Macular Degeneration, Irregular Heart Beat, Anemia and Incontinence. The tenant resided in the Dementia Unit and was discharged 10-18-10. The tenant was transferred to the hospital due to possible stroke. The tenant was transferred to a nursing home after hospitalization. The tenant expired, according to a program document.

  Tenant #2 was discharged on 11-19-10. The tenant was transferred per doctor's phone request for an examination. Due to the tenant's recent behaviors and lack of an available apartment in the Dementia Unit at the program, it was not advisable for the tenant to return. The tenant moved to another facility.

  The Executive Director stated the tenant went to the front door and told her he/she was going downtown. The Executive Director estimated it was a one and a half to two mile walk. The told the tenant he/she could not go and it was too far. The tenant was wearing a light spring jacket at the time. The tenant told her he/she was going and to go to hell. The tenant left and the Executive Director followed the tenant. She told the nurse where she was going and had her call the police. The police arrived and brought the tenant back to the program. The tenant's family and doctor were notified. The doctor said to immediately discharge the tenant to a psych ward. The Executive Director met the tenant's legal representative at the courthouse to have the tenant committed; however, there was no a judge available. Family stayed with the tenant overnight, per the program's request. The next day the tenant voluntarily went to the geriatric psych unit for approximately 10 days. The Executive Director met with the tenant's family on 11-19-10 and explained the tenant was beyond the criteria and the Dementia Unit was full. She stated the family voiced understanding. The tenant was admitted to another facility.

  The nurse stated the tenant decided to go to the grocery store and was told not to go; however, refused and left. The Executive Director followed the tenant and the nurse called the police. The tenant asked the police to take him/her to the grocery store. The police brought the tenant back and the tenant's doctor was notified. The doctor was going to order a committal to a psych unit; however, a judge was not available. The tenant's doctor felt it was the fastest way to handle the situation, according to the

nurse. The tenant's family stayed with the tenant that night and the tenant agreed to go to the psych unit the next day.

The tenant's doctor wrote a letter for the transfer of the tenant to a secured institution dated 11-17-10. The letter was sent to the county courthouse and to the hospital for a committal. The letter indicated for the tenant's safety the tenant should be committed to an institution with sufficient security.

Review of the tenant's occupancy agreement indicated the tenant signed the agreement on 3-28-10. The agreement indicated a tenant could be transferred from assisted living for more appropriate care upon less than thirty (30) day notice when the tenant's health status or behavior constitutes a substantial threat to the health or safety of the tenant, other tenants or others and the service included in the tenant agreement could not be safely provided by the program.

The Executive Director indicated the tenant met the criteria for immediate discharge and was a harm to himself/herself. The nurse indicated the tenant was a harm to himself/herself. The Executive Director stated all tenants were important and tenants were discharged based on criteria and not favoritism. The nurse stated there was not any favoritism.

The Executive Director indicated the tenant was found to be beyond the policy criteria on 11-19-10. At a meeting on 11-19-10 with the tenant's legal representative and another family member, it was explained the tenant was beyond the level of care as indicated in the occupancy agreement. A letter to that effect was drafted on 11-30-10 and stored with the tenant's mail. The tenant's mail was collected in the Executive Director's office per family request. The legal representative was notified that the tenant's mail, including the letter and some personal items were in the office. As of 12-22-10 those items remained in the office.

DIA is not involved in the discharge of a tenant if the program initiates discharge. DIA has regulations to ensure the occupancy agreement was followed pertaining to discharge. DIA also has regulations pertaining to involuntary transfers to ensure the program follows appropriate regulations related to involuntary transfer. The program did not have any involuntary transfers at the time of the complaint investigation. Tenant #1 was a voluntary transfer due to level of care. Tenant #2 was not an involuntary transfer and the occupancy agreement was followed.

- Regulatory Insufficiency: None noted.

C. Tenant Documents

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

- Monitoring Observation: Tenant #2's file was reviewed. On 11-17-10 at 3:00 p.m. the tenant walked out the front door of the building and when asked to return the tenant refused. Staff followed the tenant and the local police were notified. The police met the tenant and staff and escorted the tenant back to the program. The tenant's family and health care provider were notified. The tenant went to a geriatric

psych unit on 11-18-10. An incident reported was not completed related to the incident.

- Regulatory Insufficiency: All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. (IAC r. 481-67.21(1)(e))

D. Service Plan

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

- Monitoring Observation: Tenant #2's file was reviewed. According to Progress Notes, Aricept was started on 9-24-10. According to Progress Notes dated 10-5-10, the tenant's doctor was updated regarding concerns. On 10-20-10 notes indicated behaviors continued and the tenant tended to space staff out when he/she did not want to listen. Notes of 11-5-10 indicated the tenant was obsessed with preparing for Thanksgiving. The tenant's family did take him/her out and the tenant insisted on buying a turkey. The tenant took the turkey out of the freezer and put it into the refrigerator thinking Thanksgiving was in a few days. Progress Notes dated 11-10-10 indicated the tenant wanted to go to the grocery store to buy pie filling for pies. The tenant did not have an oven or stove in the apartment. Notes dated 11-11-10 indicated family was aware of behaviors and the tenant called family members during the night with no concept of time. The notes indicated the tenant's doctor was making an appointment for the tenant to be seen by a geriatric psychologist. On 11-16-10 the tenant started to walk out of the building to go to the grocery store. The tenant was informed he/she could not go by himself/herself and there was no need to go at that time. An hour later, the tenant walked outside past staff and was asked to return. The tenant returned but was not happy, according to notes. On 11-17-10 at 3:00 p.m. the tenant walked out the front door of the building and when asked to return the tenant refused. Staff followed the tenant and the local police were notified. The police met the tenant and staff and escorted the tenant back to the program. The tenant's family and doctor were notified. The tenant went to a geriatric psych unit on 11-18-10.

  An update on the tenant's behaviors was sent to the tenant's doctor on 10-5-10. The update indicated the tenant was stubborn about things and would tune staff out if they asked him/her to do something or not to do something. The tenant put his/her fist up to a staff person when the tenant did not want to comply with a simple request. The tenant pushed another tenant back to the other tenant's apartment and proceeded to help the other tenant out of the wheelchair despite being told numerous times not to assist. The nurse reported there had been no improvements since Aricept was started. The nurse wondered since the tenant was not drinking, was eating better and taking medications that a behavior problem was more visible. The drinking was a form of "self-medication" and was not as obvious, according to the update to the tenant's doctor. The family wondered if besides the dementia, the tenant was also obsessive compulsive. The tenant was discharged from the program on 11-19-10. The reason for discharge included irrational thinking and unsafe practice when leaving the building. The service plan was not updated as needed and did not reflect the tenant's behaviors and interventions related to the behaviors.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3))

Dated this 28th day of January, 2011.