IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 32060-C

March 3, 2011

Sally Hill, RN Director
Senior Star at Elmore Place Memory Care
4504 Elmore Avenue
Davenport, IA 52807

RE: Final Complaint Investigation Report, Senior Star at Elmore Place Memory Care, Davenport, Iowa

Dear Ms. Hill:

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

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

Assisted Living Program: **Complaint Intake #: 32060-C**

Sally Hill, RN Memory Care Director
Senior Star at Elmore Place Memory Care
4504 Elmore Avenue
Davenport, IA 52807

Date of Investigation:

January 25, 2011

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 Senior Star at Elmore Place Memory Care on January 25, 2011. In preparing this report, the following information was considered:

Current Program Census:

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:	12

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

Program History – The program received regulatory insufficiencies in the areas of service plan and staffing during the August 31 and September 1, 2009, on-site.

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

A. Occupancy Agreement

Complaint Allegation: It was alleged the program did not follow the occupancy agreement pertaining to discharge of a tenant.

- Monitoring Observation: The program discharged five tenants in the past three months. Two tenants left per tenant choice, two tenants died and one tenant was involuntarily discharged. Three of the five discharged tenant files were reviewed.

  Tenant #1, an 84 year old, was admitted on 7-6-10 and diagnoses include: Dementia, Hypertension (HTN), Gout, Gastroesophageal Reflux Disease (GERD), Congestive Heart Failure (CHF), Arthritis and History of Prostate Cancer. The tenant was staged at a four to five on the Global Deterioration Scale (GDS), which indicated moderate to moderately severe cognitive decline. The tenant was discharged on 1-1-11 per tenant choice. A 30 day written notice was given to the program by the tenant's family. According to a Move In/Move Out Data Entry Form, notice was given on 11-18-10 and the tenant moved out on 1-1-11. According to the occupancy agreement, a 30 day notice was required when the tenant terminated the occupancy agreement. The occupancy agreement was appropriately followed related to the discharge.

  Tenant #2, an 87 year old, was admitted on 1-15-10 and diagnoses include: Hearing Loss, Macular Degeneration, Dementia, HTN, Coronary Artery Disease (CAD), Agitation, Hypokalemia, Hyperlipidemia and Anxiety. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. The tenant was discharged on 12-13-10. According to a Move In/Move Out Data Entry Form, notice was given 12-3-10 and the tenant was an involuntary discharge. The tenant's move out date was 12-13-10. The occupancy agreement indicated the program could terminate the agreement at any time by giving a 10 day written notice if the tenant was engaged in behavior that was a potential threat to the tenant's mental and/or physical health or safety or to the mental and/or physical safety of others in the community. The occupancy agreement indicated the program would work with the responsible party and/or healthcare professional to ensure a safe and orderly transfer. The tenant had a legal representative that was enacted by the tenant's physician. A letter dated 12-1-10 was sent to the legal representative that indicated due to aggressive behaviors a 10 day involuntary discharge notice was given and the 10 day notice would end on 12-10-10. The letter provided the Ombudsman's information and a copy of the internal appeals process. A letter dated 12-8-10 indicated because the involuntary discharge notice was not received until 12-3-10 the date was extended until 12-13-10. The letter indicated the program would assist in locating other placement and enclosed a list of communities to best meet the tenant's needs. The occupancy agreement was appropriately followed related to the discharge.

  Tenant #3, a 94 year old, was admitted on 7-31-09 and diagnoses include: Osteoporosis, Pacemaker, Mild Dementia and Mild CHF. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. According to a Move In/Move Out Data Entry Form, the tenant died, notice was given on 11-30-10 and the move out date was listed as 12-1-10. The occupancy agreement indicated in the event a tenant was transferred permanently to an outside facility because the tenant required higher level of care or upon death, the tenant could terminate the occupancy

agreement with the minimum financial responsibility of seven days after vacating the residence and all personal belonging had been removed. According to a Move In/Move Out Data Entry Form, the move out date was 12-1-10 and the pro-rate period was from 12-1-10 to 12-7-10. The occupancy agreement was appropriately followed related to the discharge.

- Regulatory Insufficiency: None noted.

B. Evaluation of Tenant

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

- Monitoring Observation: Tenant #2's file was reviewed.

  Tenant #2 was discharged due to aggressive behaviors. A 10 day discharge letter sent to the tenant's legal representative indicated the tenant had been physically and verbally aggressive towards tenants and staff and required one to one attention to monitor the tenant's behaviors and prevent any harm to the tenant or others. Nurse's Notes from 11-17-10 to 12-10-10 and Incident/Accident Reports, indicated the tenant had increased aggression and had physically and verbally aggressive behaviors. According to Nurse's Notes dated 11-25-10, the tenant came down for supper and asked staff a question. Staff replied to the question and the tenant threw a vase toward the staff. The vase went between the staff and another tenant and burst all over the floor. There was glass on the plates, on the table and all over the floor, according to notes. On 12-2-10, the tenant told a staff "I want to kill you" according to the notes. The service plan was updated to reflect increased agitation with physical aggression, wandering into another tenant's apartment, one to one staffing and the discontinuation of the one to one staffing. Evaluations were not completed as needed with a significant change.

- 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 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))

C. Criteria for Exclusion of Tenants

Complaint Allegation: It was alleged a tenant had behaviors and was discharged without appropriate interventions. It was alleged other tenants had behaviors.

- Monitoring Observation: Staff #1, #2 and #3 were interviewed and did not identify any current tenants that exceeded the appropriate level of care. Staff #1, #2 and #3 did not identify any current tenants that were physically or verbally aggressive. The Director did not identify any current tenants that exceeded the appropriate level of

care. Review of two current tenant records indicated the tenants did not exceed the appropriate level of care.

Three discharged tenant files were reviewed. Review of Tenant #1 and #3's file indicated the tenants did not exceed the appropriate level of care.

Tenant #2 was discharged due to aggressive behaviors. A 10 day discharge letter sent to the tenant's legal representative indicated the tenant had been physically and verbally aggressive towards tenants and staff. The letter also indicated one to one attention to monitor the tenant's behaviors and prevent any harm to the tenant or others was needed. Nurse's Notes from 11-17-10 to 12-10-10 and Incident/Accident Reports, indicated the tenant had increased aggression and had physically and verbally aggressive behaviors. An order was received to increase the tenant's Seroquel 25 mg by mouth from twice daily to three times daily started on 11-30-10. A urinalysis (UA) was ordered and came back negative. The tenant's potassium was drawn on 12-10-10 and was in the normal range. According to a Psychological Report, a request was made by the tenant's physician for a psychological consultation regarding the tenant's behavior. The report indicated a few weeks before Thanksgiving the tenant had displayed increasingly aggressive behavior toward staff and tenants. The tenant had visual hallucinations and paranoid thinking. The tenant displayed wandering behavior and an increase in the lack of impulse control. The report indicated the tenant had suffered significant decline in cognitive functioning in comparison to one year ago. The report indicated the tenant was not currently an appropriate candidate for the program due to the aggression posed to both tenants and staff.

The Department is not involved in the reasons for discharge of a tenant if the program initiates discharge. The Department has regulations to ensure the occupancy agreement was followed pertaining to discharge. The Department also has regulations pertaining to involuntary transfers to ensure the program follows appropriate regulations related to involuntary transfer.

- Regulatory Insufficiency: None noted.

D. Tenant Documents

Complaint Allegation: It was alleged confidentiality of tenant records was not upheld.

- Monitoring Observation: Staff #1, #2 and #3 had signed confidentiality and non-compete agreements. The Director and Staff #1 stated tenant confidentiality was upheld. Tenants #1, #2 and #3 had signed release of information forms. The Director stated a representative from another program had come to assess Tenant #2 and the tenant's legal representative had informed the nurse in advance of the visit. The Director stated the release of information allowed other programs to view records; however, the release of information form for Tenant #2 was reviewed and it did not cover the release of information to another program.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: Authorizations for the release of information, if any. (IAC r. 481-69.25(1)r.)

E. Program Initiated Involuntary Transfer

Complaint Allegation: It was alleged involuntary transfer protocol was not followed and assistance with alternative placement was not offered. It was alleged a tenant was required to have additional staffing.

- Monitoring Observation: Three discharged files were reviewed. Tenant #1 moved out per tenant choice and Tenant #3 died. Tenant #2 was involuntarily transferred.

  Tenant #2's file was reviewed. Nurse's Notes dated 11-26-10 indicated the Director spoke with the Interim Executive Director regarding concerns with the tenant's increased aggressive verbal and physical behaviors towards tenants and staff. Due to concerns for the safety of the tenant and others the tenant would be involuntarily discharged, according to the notes. The tenant's legal representative was notified and voiced understanding for the reasons of discharge. The legal representative also needed to provide one to one supervision, according to the notes. A letter dated 12-1-10 was sent to the legal representative that indicated due to physically and verbally aggressive behaviors and an incident where the tenant had a bowel movement in an inappropriate place in another tenant's apartment, a 10 day involuntary discharge notice was given and the 10 day notice would end on 12-10-10. The letter indicated if placement was not found within the 10 day notice the tenant would be able to remain until placement was found provided the legal representative had 24 hour one to one supervision and was actively looking for placement. The letter provided the Ombudsman's information and a copy of the internal appeals process. Program records noted the Ombudsman's involvement throughout the involuntary transfer process. The tenant's physician was also notified of the involuntary transfer. A letter dated 12-7-10 from the legal representative, indicated the transfer was appealed and the one to one staffing services were removed during the appeal process. A letter from the program to the legal representative dated 12-8-10, indicated because the involuntary discharge notice was not received until 12-3-10 the discharge date was extended until 12-13-10. The tenant exceeded the criteria for retention due to being a danger to self or others, according to the letter. The letter indicated the necessity of transfer if the tenant became unsafe per the occupancy agreement. The letter indicated the program would assist in locating other placement and enclosed a list of communities to best meet the tenant's needs. The involuntary transfer protocol was followed appropriately.

  Nurse's Notes dated 11-27-10 indicated the legal representative was responsible for the one to one staffing costs and the legal representative understood that arrangement. A letter dated 12-1-10 sent to the legal representative, indicated the need for one to one attention to monitor the tenant's behavior and prevent any harm to self or others. A letter dated 12-7-10 from the legal representative, indicated the transfer was appealed and the one to one staffing services were removed during the appeal process. A letter was sent to the legal representative dated 12-8-10, which indicated due to the cancellation of the one to one staffing the staff had responded and placed one of the program's staff with the tenant one to one. The letter indicated they did not provided staffing at that level and there would be a charge to the tenant's account at a rate of $18.50 per hour. The Director stated the one to one care was a stipulation

for the tenant to have 10 days for transfer and the one to one supervision could have been family.

- Regulatory Insufficiency: None noted.

F. Service Plan

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

- Monitoring Observation: Tenant #2's file was reviewed. Tenant #2's service plan was updated on 11-17-10 to reflect increased agitation with physical aggression. The service plan was also updated to include an incident where the tenant wandered into another tenant's room and pulled on the tenant's nightgown. The service plan was updated on 11-26-10 and 11-27-10 to identify a staffing agency was providing one to one care. The service plan was updated on 12-7-10 to reflect the staffing agency was discontinued. The tenant's service plan was last signed the legal representative on 8-16-10. The service plan was not signed appropriately.

- Regulatory Insufficiency: If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. (IAC r. 481-69.26(3)(a))

Dated this day 4th day of March, 2011.