IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 32835-C

August 8, 2011

Mary Jo Pipkin, Executive Director
Keystone Cedars Assisted Living
6325 Rockwell Drive NE
Cedar Rapids, IA 52402

RE: Final Complaint Investigation Report – Keystone Cedars Assisted Living, Cedar Rapids, IA

Dear Ms. Pipkin:

Enclosed is the **Final Complaint Investigation Report** from the on-site monitoring visit of July 27, 2011, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding 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 Complaint Investigation Report

Assisted Living Program:

Complaint Intake #: 32835-C

Mary Jo Pipkin, Executive Director
Keystone Cedars Assisted Living
6325 Rockwell Dr. NE
Cedar Rapids, IA 52402

Date of Investigation:

July 27, 2011

Monitor(s):

Margaret Kaltefleiter, RN MS

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 Keystone Cedars Assisted Living on July 27, 2011. 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:	71
Current number of tenants with cognitive disorder:	0
Total Population of GPP:	71

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

Total Population of DSP:	15
Total Census of ALP:	86

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

Program History – The program has not received 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. Other

Complaint Allegation: It was alleged the Program failed to provide proper care and follow-up after an incident with injury.

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #1 (the Tenant), a 94 year old, was admitted on 1-4-11 and diagnoses include: Eczema, Coronary Artery Disease, Hypertension, Edema, Chronic Obstructive Pulmonary Disease, Gastric Esophageal Reflux Disease, Benign Prostatic Hyperplasia and Depression. According to the Nurse's Notes, an entry dated 2-1-11 indicated that staff and the Nurse reported an incident that occurred on 1-31-11. At 4:15 p.m., the Tenant's family member paged staff that entered the room and found the Tenant lying on his/her back on the bathroom floor. The Tenant stated he/she blacked out and fell to the floor and hit his/her head. Active Range of Motion (AROM) was completed and the Tenant stated his/her head hurt. Staff assisted the Tenant to a standing position and walked the Tenant to a recliner. Upon examination, a small bump was found on the back of the Tenant's head. The Tenant stated a feeling of dizziness after falling but denied any dizziness once seated in the recliner.

Ice was applied to the bump on the head. The Nurse assessed the Tenant and staff was instructed to monitor the Tenant and notify the Nurse of any changes. On 2-1-11 at 8:30 a.m., the Tenant's doctor called and requested transfer to the emergency room (ER) for follow-up. The Tenant's family was notified and the Tenant was transferred via ambulance. The Tenant suffered a thoracic fracture.

Tenant #2 (the Tenant), an 80 year old, was admitted on 11-1-10 and diagnoses include: Atrial Fibrillation, Hypertension, Increased Lipids, Peripheral Vascular Disease, Osteoporosis, Lower Back Pain, Myelocytic Leukemia, History of Pacemaker and Coumadin Therapy. According to the Nurse's Notes, an entry on 4-12-11 at 9:30 a.m., staff reported responding to a page and found the Tenant lying on his/her right side on the bathroom floor with a walker tipped over next to the Tenant. Staff assisted the Tenant up and into a wheelchair. The Tenant was unable to bear weight on the right leg and a skin tear to the right arm was also noted. AROM was performed, the Tenant complained of right hip pain, and was not able to move the right leg. The Tenant requested transport to the ER for an evaluation. The Tenant suffered a fractured hip.

Tenant #3 (the Tenant), a 93 year old, was admitted on 12-18-08 and diagnoses include: Mild Dementia, Poor Hearing, Lower Pedal Edema and History of Pleural Effusion. According to the Nurse's Notes, an entry on 3-14-11 at 9:00 a.m., staff reported that on 3-12-11 at 8:30 a.m., the Tenant called staff and stated he/she had fallen and hit his/her head. When staff entered the apartment, the Tenant was in the bathroom attempting to stop bleeding on his/her head. AROM was completed. The Tenant had a quarter sized bump with a small half inch scrape on the right temple area and a two inch laceration above the left eye. The Tenant was taken to a local medical center and returned with four sutures over the left eye. Staff was instructed to perform two hour visual checks for 24 hours.

An Incident/Accident Report was completed for Tenant #1, #2 and #3. Each report included a description of the incident, actions taken; instructions/actions followed and nurse review/follow up. Each report included information regarding notification of the physician via fax, as well as notification of the Tenant's family. The Nurse stated it is the responsibility of a staff nurse to document all incidents in the tenant's record once the incident report is completed. The Nurse stated all incident reports are faxed to the physician.

Three employee files were reviewed. The Caregiver Skills Checklist reflected Staff #1, #2 and #3 completed training on the Procedure for Incident Reporting.

Staff #1, #2, #3 and the Nurse stated there was enough staff to meet the needs of the tenants. Staff #1stated the Nurse was available and on call 24 hours per day, seven days a week. Staff #2 stated the Nurse was available whenever needed and whenever there was a fall, a nurse aide responded to the call and then called a medication aide to assist the tenant. Vital signs and AROM are completed and any visible injury was noted. Staff assisted the tenant off the floor and to a chair or bed and the Nurse was contacted. She stated if it was after normal working hours she would call the Nurse, unless the tenant was cognitively alert and stated he/she was okay, then she would wait until the next morning to contact the Nurse.

- Regulatory Insufficiency: None Noted.

Dated this 2nd day of August, 2011.