IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 35461-C

October 13, 2011

Ms. Gayla Gilliland, Manager
Windsor Manor Assisted Living
608 East 15th
Indianola, IA 50125

RE: I. Final Complaint/Incident Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Gilliland:

I. Final Complaint/Incident Investigation – Windsor Manor Assisted Living, Indianola, IA

Enclosed is the **Final Complaint/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. The Report notes Regulatory Insufficiencies in the area(s) of: Staffing and Dementia Specific Education. **Windsor Manor Assisted Living** ("Program") is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

II. Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order in the amount of three hundred twenty five dollars ($325) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on October 6, 2011, has been reviewed and will constitute the final POC related to the on-site visit of September 1 and 2, 2011.

The Request for Reconsideration regarding Nurse Review has been accepted.

The Request for Reconsideration regarding Staffing has been denied.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Gayla Gilliland, Manager
Windsor Manor Assisted Living
608 East 15th
Indianola, IA 50125

Complaint/Incident Intake #:35461-C

Date of Complaint/Incident Investigation:

September 1 and 2, 2011

Monitor(s):

Lori Miner, RN BSN
Hal Chase, RN BSN MPH

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	21
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	25
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	6
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	8
TOTAL census of Assisted Living Program	33

Program History – The program received a regulatory insufficiency in the area of Staffing during this certification period.i

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Tenant Rights

Complaint/Incident Allegation: It was alleged tenant rooms were dirty, and chairs and mattresses were soiled with urine and feces.

- Monitoring Observation: Staff #1 and #2 were interviewed and indicated tenant apartments were cleaned weekly and as needed. Staff # 1, #2, and #3 indicated no beds, mattresses, chairs, or couches were soiled with urine or feces. No mold or mildew was present on furniture. Staff #10 was interviewed and indicated housekeeping staff cleaned apartments as quickly as possible after urinary or fecal accidents. All apartments received 30 minutes of housekeeping services weekly. The Operations Manager revealed it was not routine for housekeeping to clean under the beds.

  A meeting was held with eight tenants. Tenants reported apartments were cleaned weekly.

  Three tenant apartments in the dementia unit were observed. No mattresses were observed to have mold or mildew. No soiling of mattresses or chairs was noted in the tenant apartments. Chairs and couches were observed in the common area of the dementia unit; there were no stains noted. No odor was noted in the common area.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged there were incidents between tenants that resulted in injury.

- Monitoring Observation: The Program was asked to provide incident reports for six months. Incident reports documented three events between tenants. Tenant #1 (the Tenant), was admitted on 2-27-08 and had diagnoses of: Alzheimer's Dementia, Esophageal Reflux, Hypertension (HTN), History of Alcohol Abuse, Fragile Skin, Chronic Dry Eyes, and History of Falls. The Tenant was staged at four on the (Global Deterioration Scale (GDS), which indicated moderate cognitive decline. The Tenant resided in the secured dementia unit. On 2-26-11, Tenant #1 touched Tenant #4. Tenant #4 held on to Tenant#1. Tenant #1 lost balance and fell. No injuries were documented to either tenant. On 6-22-11, Tenant #1 held up a fist to Tenant #2. Tenant #1 pushed Tenant #2 and both fell. Tenant #1 had a skin tear to the elbow; no injuries were documented to Tenant #2. Tenant #1 was transported to the hospital for further evaluation. On 7-8-11, Tenant #1 walked up and hit Tenant #4 several times. No injuries were noted to either tenant. Tenant #1 was transported to the hospital for further evaluation.

  Staff #2 indicated Tenant #1 would bump arms "a lot" which resulted in bruising. Staff #7 indicated Tenant #1 would bump into objects and walls which resulted in bruised arms.

  There were no incidents between tenants observed during the onsite visit.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation: It was alleged there was not enough staff in the dementia unit. It was alleged staff were unprofessional.

- Monitoring Observation: Staff #1 and #2 indicated there were two staff scheduled in the general population on the day and evening shift and one staff on the night shift. One staff person was scheduled for each shift in the dementia unit. A person was available from the general population to assist as needed. A review of the staff schedule for the month of August, as well as the master schedule, revealed the staffing pattern as identified by staff.

  A meeting was held with eight tenants who indicated they were treated kindly and with respect.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged staff were not trained.

Staff #1, a Certified Nursing Assistant (CNA) hired as a Universal Worker (UW), was interviewed and revealed that nurse-delegation training was done by video and

peers. Staff #1 demonstrated competency with vital signs and transfer only. Staff #7, a UW, was trained by other staff to do cares. The Nurse sat down with Staff #7 and reviewed the skills checklist and talked about Activities of Daily Living. It was revealed after two weeks working with a peer, when the Nurse thought staff was ready, staff was cleared to provide cares independently.

Training records were reviewed for Staff #3, a UW hired 11-13-09. Thirty-one tasks were documented as delegated on 11-19-10 including showers, whirlpool bath, incontinence care, vital signs, ambulation with walker, oral, skin, and nail care, shampoo, inhaler and nebulizer assistance, hyper- and hypoglycemia, blood sugar testing, suppositories, eye and ear drops, narcotics counts, and five other tasks related to medications. Staff #4, hired 2-24-11 as a UW, had 28 tasks delegated on 3-3-11. Staff #5, hired 7-26-11 as a UW, had 15 tasks delegated on 8-12-11. Staff #6, hired 7-13-10 as a UW, had 16 tasks delegated on 11-11-10. Staff #7, hired 4-25-11 as a Universal Worker, had 16 tasks delegated on 5-6-11 and 16 tasks related to medications and blood sugars delegated on 6-3-11. Staff #8, hired on 8-13-10 as a UW, had 31 tasks delegated on 11-11-10.

The Nurse stated she has used a group session for training, and that staff verbalized steps to perform tasks. Staff was not observed performing all tasks.

The delegation process, which includes direct observation of staff performing tasks, was not followed.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

C. Involuntary Discharge

Complaint/Incident Allegation: It was alleged a tenant was involuntarily discharged from the program and procedures were not followed for discharge.

- Monitoring Observation: The Program provided a list of tenants who had left the program; four tenants were noted to have left in the last three months. Two of the four tenant files were reviewed. Tenant #1 (the Tenant), was admitted on 2-27-08 and had diagnoses of: Alzheimer's Dementia, Esophageal Reflux, Hypertension (HTN), History of Alcohol Abuse, Fragile Skin, Chronic Dry Eyes, and History of Falls. The Tenant was staged at four on the (Global Deterioration Scale (GDS), which indicated moderate cognitive decline. The Tenant resided in the secured dementia unit.

  Staff #2 and #7 reported the Tenant was aggressive and combative at times. On 6-22-11, Tenant #1 approached Tenant #2 by shaking a fist. Tenant #1 eventually pushed Tenant #2 and both fell. Tenant #1 was transported to the hospital for evaluation. Medications were adjusted, and the Tenant returned to the Program.

  On 6-23-11, a 15-day corrective action notice was given to the Tenant's legal representative by the Program. The notice revealed if the Tenant was unable to

correct the behavior of increased physical aggression towards other tenants after the 15 days, a 30-day notice to transfer would be given. The Program rescinded the 15-day corrective action on 7-8-11, because the Tenant had responded to the medication adjustments, no further behavioral episodes were displayed, and the Tenant was easily redirected.

On the afternoon of 7-8-11, the same day the corrective action notice had been rescinded, the Tenant walked to Tenant #4 and hit the him/her several times in the face. The Tenant was given medication and redirected to stay away from Tenant #4. The Tenant was transported to the hospital for further evaluation.

There was no documentation in the chart that indicated the Tenant or legal representative had been given a discharge notice. Documentation in the chart revealed the Program had discussed options for a higher level of care with the Tenant's legal representative. Documentation of 7-15-11 revealed the legal representative had decided on long-term care placement when the Tenant was discharged from the hospital. The Tenant no longer resides at the Program.

The Operations Manager, the Nurse, and the Manager stated the Tenant could have returned to the Program after hospitalization, however, a 30-day notice would have been given if the Tenant had returned.

The social worker at the hospital was contacted. She indicated the Tenant required a higher level of care and family did not want the Tenant to return to the program.

Tenant #5 (the Tenant), an 83 year-old, was admitted on 2-25-08 with diagnoses of: Angina, Diabetes Mellitus, Arthritis, HTN, Gastroesophageal Reflux Disease, and Hypothyroidism. There was no documentation in the chart to indicate the Tenant had been given a discharge notice. Documentation of 8-1-11 indicated the Tenant had moved out over the weekend. The Tenant no longer resides at the Program.

- Regulatory Insufficiency: None noted.

D. Food Service

Complaint/Incident Allegation: It was alleged food was served cold in the dementia unit.

- Monitoring Observation: The Program was noted to have a current food license that expires 11-16-11. The last food inspection was completed on 4-19-11 with no errors in compliance related to food temperatures. Hot hold and reheating temperatures were noted to be "ok." Staff #9, kitchen staff, stated food was prepared in the kitchen, food temperatures were checked in kitchen and put into containers and taken to the dementia unit. The temperature of the food was again checked in the dementia unit and served from there.

  Staff #1 and #7 reported food was served hot in the dementia unit.

  A meeting was held with eight tenants who reported food was served hot.

At 11:55 a.m. on 9-1-11 the meal cart was wheeled from the kitchen to the dementia unit. The tenants were already seated at the table. The food temperature was checked prior to serving. The menu consisted of a Reuben sandwich, baked potato, and cooked vegetables. After the tenants were served, both monitors sampled the foods and found them to be hot.

- Regulatory Insufficiency: None noted.

E. Dementia-Specific Education

Complaint/Incident Allegation: It was alleged staff was not trained to work in the dementia unit.

- Monitoring Observation: Staff #3 was hired 11-13-09 as a UW. Six hours of dementia training was documented on 11-16-09; two hours of training on 2-14-10. Staff # 4 was hired 2-24-11 as a UW. Six hours of dementia training was documented on 3-18-11. Staff #6 was hired as a UW on 7-13-10 with six hours of dementia training on 7-23-10, two hours on 8-19-10 and two hours on 2-3-11. Staff #8 was hired 8-13-10 as a UW with six hours of dementia training on 8-13-10 and two hours on 2-3-11. Staff did not have eight hours of dementia training within 30 days of hire or annually.

- Regulatory Insufficiency: All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. (IAC r. 481-69.30(1))

Dated this 12th day of September, 2011.