IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 36400-I

November 17, 2011

Ms. Laura Hansen, RN Clinical Manager
Elm Crest Retirement Community
2104 12th Street
Harlan, IA 51537

RE: Final Complaint/Incident Investigation Report – Elm Crest Retirement Community, Harlan, IA

Dear Ms. Hansen:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of November 1, 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 515/281-4116.

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/Incident Investigation Report

Assisted Living Program:

Complaint/Incident Intake #: 36400-I

Laura Hansen RN, Clinical Manager
Elm Crest Retirement Community Assisted Living
2104 12th Street
Harlan, IA 51537

Date of Complaint/Incident Investigation:

November 1, 2011

Monitor(s):

Lori Miner, RN BSN

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:	26
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	29
TOTAL census of Assisted Living Program	29

Program History – The program has regulatory insufficiencies during this certification period in the areas of Evaluation of Tenant and Service Plan.

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

A. Structural Requirements

Complaint/Incident Allegation: The program reported Tenant #1 was bitten by a bat in the Tenant's apartment.

- Monitoring Observation: Tenant #1 (the Tenant), an 87 year-old, was admitted on 12-28-09 and had diagnoses of: Diabetes Type II, Congestive Heart Failure, Osteoarthrosis, and Hypertension. The Tenant had errors on the cognitive screening tool, but not enough to trigger staging on the Global Deterioration Scale. Resident notes dated 10-24-11 revealed the Tenant thought a leaf was stuck on the curtain of the apartment, and the Tenant brushed it down. According to a Staff #1, the Tenant was scheduled to have blood drawn by a lab technician from the hospital. The lab technician reported to the staff member that Tenant #1 was "playing with a bat." Staff #1 went to the apartment to find a bat on the arm of the couch with the Tenant in a chair nearby. It was reported the Tenant was "alert and fine." The staff member caught the bat and sealed it in a container. The Tenant was noted to have a small bite on his finger. According to Staff #1, the Tenant reported he/she had been bitten. The bite was washed with antibacterial soap, and hand sanitizer was applied. Staff #1 notified her supervisor, the nurse. The event was documented in an incident report which followed program policy.

  The Tenant went to the medical clinic for a tetanus shot. The bat was taken to a local veterinary clinic which submitted the bat to the State Hygienic Laboratory for rabies testing. The results, which were negative, were returned on 10-27-11.

  The Tenant was observed during the onsite visit. When asked about the bite, the Tenant responded that he/she was "OK."

A tour of the Tenant's apartment was taken. There were no bats observed in the apartment. The apartment had no obvious points of entry for a bat. It was noted there was a freshly painted area on the ceiling of the bathroom, approximately two feet by two feet. In an interview with the maintenance director, he indicated there had been a hole in the bathroom ceiling for a month. It had been noted that the ceiling was wet. To locate the source of the water, a hole had been cut into the ceiling approximately 18 x 18 inches. A leak had been discovered in the plumbing above. After the plumbing had been fixed, the hole had been left open to allow the area to adequately dry. The maintenance director indicated the hole could not have been the source of entry for the bat as there were no areas that went to the outside from the space that was opened. The hole was repaired on 10-28-11. The maintenance director stated a "bat company" was present two days after the incident occurred; no bats were found. The maintenance director and nurse knew of no other bat problems.

- Regulatory Insufficiency: None noted.