IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 34794-CR2
34822-CR2
34948-CR2

March 26, 2012

Ms. Kara Bernsee, Administrator
Silvercrest at Woodlands Creek Assisted Living
12605 Woodlands Parkway
Clive, IA 50325

RE: Final Complaint/Incident Revisit Investigation Report, Silvercrest at Woodlands Creek Assisted Living, Clive, Iowa

Dear Ms. Bernsee:

Enclosed is the **Final Complaint/Incident Revisit 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/Incident Revisit 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 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Kara Bernsee, Administrator
Silvercrest at Woodlands Creek Assisted Living
12605 Woodlands Parkway
Clive, IA 50325

Complaint/Incident Intake #: 34794-C R2
34822-C R2
34948-C R2

Date of Complaint/Incident Investigation:

February 15 & 16, 2012

Monitor(s):

Hal L. Chase, RN BSN MPH
Lori Miner, RN BSN
Ann Martin, RN
Rose Boccella, MA

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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	46
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	53

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	13
Total Population of Program at time of on-site	14
TOTAL census of Assisted Living Program	67

Program History – The program received regulatory insufficiencies in the areas of: Tenant Documents, Service Plan, Medications, Nurse Review, Staffing, Policies and Procedures, Life Safety and Structural during the Complaint and Incident Investigation of July 2011.

During the Complaint Revisit (34794-C, 34822-C, 34948-C) of November 29 and 30 and December 1, 2, 4 and 4, 2011, the program received regulatory insufficiencies in the areas of: Policy and Procedure, Medications, Level of Care, and Structural.

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

A. Policies and Procedures

During the course of the onsite complaint investigation revisit of November 29-30, December 1-2, 4-5, 2011, the Program received a regulatory insufficiency for not following the policies and procedures related to staff present and in charge at the time of an incident of 8-24-11. The Program did not prepare and sign the incident report. Staff present during the incident and who witnessed the incident did not complete witness statements.

The program's Plan of Correction (POC) of 12-30-12 indicated nursing staff would be re-educated on the facility's policy and procedure regarding filling out incident reports.

- Monitoring Observation: Program documentation reviewed indicated the Program initiated a new incident report form for staff to use. This form indicated the staff person who completed the report and actions taken, including notifying the Program nurse, physician, and emergency personnel if activated. All nursing staff were retrained on the Program's policy of completing an incident report; including but not

limited to staff who were in charge at the time of the incident and other staff present during the incident completing written statements.

Program documentation indicated four incidents occurred between 12-30-11 and 2-15-12. Each incident report was completed by staff who witnessed and/or participated in the incident.

- Regulatory Insufficiency: None noted.

B. Medications

During the course of the onsite complaint investigation revisit of November 29-30, December 1-2, 4-5, 2011, the Program received a regulatory insufficiency for not providing training in medication administration for Staff #30. Staff #30 had not applied support hose to Tenant #24. Staff #30 was observed leaving medications and not watching Tenant #25 take his/her medications.

Monitoring Observation: Nine tenant files were reviewed. Tenants' #9, #11, #15, #21, #25, #35, #36, and #37 medication administration records (MARs) were reviewed beginning January 1, 2012 through February 15, 2012 and no medication errors were noted. Three medication passes were observed and no errors were noted.

The Program provided documentation of re-training on medication administration to Staff #30. Tenant #24's MAR indicated the support hose were not applied on 2-15-12 as Tenant #24 refused them. Tenant #24 was observed on 2-16-12 without support hose. A review of the MAR for 2-16-12 indicated support hose had been applied. Two staff members, #23 and #30, indicated Tenant #24 had changed clothing following an "accident." Staff #23 and #30 also indicated Tenant #24 often took off the hose and other clothing. In an interview, Tenant #24 did not know if the support hose were on and stated the hose caused discomfort to the feet.

On 2-16-12 Tenant #25 was observed using a motorized wheelchair, going to the dining room with a cup of pills in hand. The Operations Manager accompanied Tenant #25 to the dining room and observed Tenant #25 taking the medications. A review of the service plan indicated staff members were to encourage Tenant #25 to take the medications in the apartment prior to going to the dining room, which the Operations Manager did. The Operations Manager indicated Tenant #25 had not been seen leaving the pills on the dining room table. Tenant #25, as compared to the previous monitoring visit, was noted to be seated at a different table for the noon meal. The Program provided documentation which indicated the tenants seated at the current table were not cognitively impaired.

Tenant #34, an 85 year-old, was admitted on 1-9-12 and had diagnoses of: Alzheimer's Disease, Atrial Fibrillation, Aortic Stenosis, and Depression. Tenant #34 resided in the dementia unit of the program. A Global Deterioration Scale (GDS) of 1-27-12 staged Tenant #34 at four, which indicated moderate cognitive impairment.

Tenant #34's service plan of 1-27-12 indicated the Program administered medications. Tenant #34's initial medication admission orders of 1-9-12 indicated Clonazepam 0.5mg – one tablet twice daily as needed (prn) for severe anxiety. The Program requested

clarification of the medication admission orders as Tenant #34's spouse reported giving Clonazepam 0.5 mg ½ tablet twice daily. The physician directed the Program to continue the regimen of medication as the spouse had been doing.

A physician order of 1-25-12 indicated Clonazepam 0.5mg ½ tablet prn for severe agitation (no more than one additional dose in a 24-hour period in addition to Clonazepam 0.5mg ½ twice daily. Clinical notes of 1-27-12 indicated Tenant #34 had made statements of self-harm. Hospital medical records indicated Tenant #34 was seen at a hospital emergency room related to statements of self harm, and returned the same day. Discharge orders included the following: Clonazepam 0.5mg – one tablet twice daily prn for severe anxiety and Rivastigmine 9.5mg – one patch every 24-hours.

Clinical notes of 1-31-12 indicated the Program spoke to the physician's nurse regarding the medication list sent home with Tenant #34 on 1-27-12. The program did not take any action to obtain the order for Rivastigimine until 1-31-12, when the program confirmed the order with the physician's nurse. Rivastigimine patches were to be mailed to the Program and to allow seven days to arrive.

On 2-10-12, the Program sent, by fax, confirming medications to be given by the Program. The list of medication included Clonazepam 0.5mg tablet, give ½ tab = 0.25mg tablet twice daily and Clonazepam 0.5mg – given ½ tablet daily as needed – no more than one additional dose in a twenty-four period. The physician signed the medication list and faxed it back to the Program on 2-13-12.

MARs for 1-10-12 through 2-16-12 indicated Tenant #34 received Clonazepam 0.5mg ½ tablet 0.25mg twice daily. MARs for February 2012 indicated Clonazepam 0.5mg – ½ tablet daily prn, no more than one additional dose per 24-hour period in addition to 0.5mg tablet twice daily. February 2012 MARs indicated Tenant received an additional 0.5mg tablet on 2-1-12, 2-2-12, 2-5-12, and 2-8-12.

The Program gave Tenant #34 Clonazepam 0.25mg tablet twice daily from 1-10-12 through 2-16-12 twice daily when the physician's order was to give Clonzaepam 0.5 mg tablet twice daily prn for agitation. The Program didn't administer Clonazepam as ordered; however, while this was a deviation from the requirements of the rules, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.

C. Criteria for Admission and Retention

During the course of the onsite complaint investigation revisit of November 29-30, December 1-2, 4-5, 2011, the Program received a regulatory insufficiency for retaining Tenant #21 who was chronically sexually aggressive and displayed behavior that placed another tenant at risk.

- Monitoring Observation: Nine tenant files were reviewed: #9, #11, #15, #21, #25, #34, #35, #36 and #37. Program records indicated no issues related to exceeding criteria and retention.

Tenant #21 was discharged from the Program on 12-27-11.

- Regulatory Insufficiency: None noted.

D. Structural Requirements

During the course of the onsite complaint investigation revisit of November 29-30, December 1-2, 4-5, 2011, the Program received a regulatory insufficiency for having a cleaning chemical with corrosive properties attached to a mop sitting adjacent to a housekeeping cart unattended in the dementia unit hallway.

- Monitoring Observation: Staff #16 was no longer employed by the Program. The Program provided documentation of staff providing environmental safety walk-throughs. During the onsite visit of 2-15-12 and 2-16-12 two walk-throughs were done of the secured dementia unit. No chemicals or carts with chemicals were observed. Nine staff were interviewed: #2, #4, #17, #30, #33, #43, #44, #45, and #46. All staff interviewed indicated knowledge that chemicals needed to be locked up.

  During the course of the interview regarding knowledge of chemicals, Staff #2 volunteered two tenants who resided in the secured dementia unit, #37 and #38, had laundry detergent in their apartments. During the course of a medication pass, Tenant #37's apartment was entered. No tenants were in the apartment at that time. A monitor was accompanying Staff #44. Upon questioning about laundry detergent in the apartment, Staff #44 walked through the open door from the living room to Tenant #37's bedroom, opened an unlocked closet in Tenant #37's bathroom, and a laundry detergent was found. The bottle indicated an ingredient was calcium chloride. The bottle was labeled "keep out of the reach of children" and "if swallowed, call poison control center." A second bottle, carpet cleaner, was also found. It too was labeled "keep out of reach of children." Staff #44 proceeded to get medications from the apartment and take them to Tenant #37 who was in the dining room of the secured dementia unit.

  Tenant #37 an 89 year-old, was admitted on 11-15-10 and had diagnoses of: Intractable Back Pain, Atrial Fibrillation, Parkinson's, and Hypertension (HTN). On 2-3-12 Tenant #37 was staged at three on the GDS which indicated mild cognitive decline.

  Tenant #37 resided in the secured dementia unit and shared an apartment with Tenant #11, who was not in the apartment at the time of medication pass. The apartment had a central living room with a bedroom on either side. Tenant #11 had access to the bedroom/bathroom area occupied by Tenant #37. The laundry detergent and carpet cleaner were in an unlocked bathroom closet.

  Tenant #11, an 83 year-old, was admitted on 4-27-10 and had diagnoses of: Partial Colectomy for polyps, Dementia, Transient Ischemic Attack (TIA), HTN, Hyperlipidemia, and Venous Stasis. On 1-25-12 Tenant #11 was staged at five on the GDS which indicated moderately severe cognitive decline.

The second tenant identified was Tenant #38, a 91 year-old, admitted on 1-26-11 and had diagnoses of: Chronic Obstructive Pulmonary Disease, Hyponatremia, HTN, Colitis, Dementia, History of TIA, and Osteoarthritis. On 1-23-12 Tenant #38 was staged at three on the GDS which indicated mild cognitive decline. Staff #2 indicated Tenant #38 kept the apartment door locked. Tenant #38 resided in a single apartment with no other tenants, in the secured dementia unit.

Chemicals were left unlocked in the secured dementia unit in an apartment in which a cognitively impaired tenant resided.

- Regulatory Insufficiency: The building and grounds shall be well-maintained, clean, safe and sanitary. (IAC r.481-69.35(1)(b))