IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 38953-I

May 18, 2012

Mr. Jack Collins, Administrator
Walnut Ridge
1701 Campus Drive
Clive, IA 50325

RE: Final Complaint/Incident Investigation Report – Walnut Ridge, Clive, IA

Dear Mr. Collins:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of May 16, 2012, 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 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Jack Collins, Administrator
Walnut Ridge
1701 Campus Dr.
Clive, Iowa 50325

Complaint/Incident Intake #:

38953-I

Date of Complaint/Incident Investigation:

May 16, 2012

Monitor(s):

Maribeth Freland RN
Joyce Kix RN

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:	39
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	40

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	17
Total Population of Program at time of on-site	17
TOTAL census of Assisted Living Program	57

Program History – The program received the following regulatory insufficiencies as the result of the January 12, 18 and 19, 2011 Recertification and Complaint (32548-C) on site: Evaluation, Criteria for Exclusion of Tenants, Service Plan, Medications, Nurse Review, Staffing, Tenant Rights and Other, (non-notification of elopement).

During the Recertification Revisit and Complaint Investigation (32548-C) of April 14th 2011 on-site, the program received regulatory insufficiencies in the areas of: Tenant Rights and Other (not following plan of correction).

The program received regulatory insufficiencies in the areas of: Evaluation, Service Plan, Medications, Nurse Review, Staffing, Tenant Rights, Program Notification to the Department and Plan of Correction during the April 26 and 27 and May 3, 4, 5, 2011, Second Recertification Revisit and Complaint and Incident Investigation (33811, 33653, 33852). The program was fined $8,000.

The program received regulatory insufficiencies in the areas of Medications and Plan of Correction during the August 1 and 2, 2011, Third Recertification Revisit, Revisit to Complaints (33811-CR, 33653-CR and 33852-M).

The program received regulatory insufficiencies in the areas of Service Plan and Nurse Review during the January 31 through February 1, 2012 Complaint Investigation (37357-C).

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

Criteria for Admission and Retention

Complaint/Incident Allegation: It was reported a tenant fell while unattended by staff members, resulting in a fractured ankle.

- Monitoring Observation: The monitors reviewed the program's incident reports for the previous three months and reviewed the clinical records of Tenants #1, #2 and #3.

  Tenant #1, an 85 year old, was admitted to the program on 8-5-11 with the diagnoses of: Dementia, Chronic Aortic Stenosis, Diabetes, Chronic Stage 3 Kidney Disease, Hypertension, Coronary Artery Disease and Irritable Bowel Syndrome. Tenant #1 resided in the program's general population area until 4-23-12 when Tenant #1 moved into the program's memory care unit. Tenant #1 scored a 5 on the Global Deterioration Scale, completed on 4-4-12, which indicated moderately severe cognitive decline. The program moved Tenant #1 into the memory care unit when Tenant #1 began experiencing increased confusion and wandering.

  The evaluation and service plan, dated 4-4-12, indicated Tenant #1 was independent with eating, transfers, grooming and dressing. Tenant #1 ambulated independently with a walker and required standby assistance with bathing. Tenant #1 was continent of bladder but had occasional incontinence of bowel due to irritable bowel syndrome. When Tenant #1 experienced a bout of irritable bowel, he/she required staff member assistance with bathing and cleaning up following incontinent stools. The program used routine staff member safety checks to monitor Tenant #1's needs as he/she could not use a call system due to Tenant #1's cognitive decline.

  The clinical record indicated Tenant #1 fell in his/her apartment on 4-28-12, resulting in a fractured ankle. Tenant #1 had not experienced any falls prior to the 4-28-12 fall. The incident report indicated staff members had been in Tenant #1's apartment approximately 15 minutes prior to the fall to complete a safety check. Tenant #1 was safe at that time. Approximately 15 minutes later, staff members heard Tenant #1 calling for help. Tenant #1 had ambulated to his/her bathroom and undressed in an independent attempt to cleanse following an incontinent bowel movement. Tenant #1 fell, fracturing his/her ankle. While hospitalized, Tenant #1 was diagnosed with acute renal failure and severe aortic stenosis. Tenant #1 died at the hospital without ever returning to the program.

  The program had a system in place to monitor Tenant #1 for needs and assure safety. Staff members had been in Tenant #1's apartment 15 minutes prior to the incident, determining Tenant #1 to be safe. Tenant #1 had not experienced any falls prior to this incident. Tenant #1 was independent with ambulation, grooming and dressing. Tenant #1 attempted to clean up him/herself following an incontinent episode and fell in the process. The monitors determined Tenant #1 had not exceeded assisted living level of care.

  Tenant #2 resided in the program's general population area and experienced an incident with a motorized wheelchair on 4-18-12. Tenant #2 was cognitively intact and independent with all personal care tasks. The program was not required to report this incident to the Department of Inspections and Appeals (Department). The monitors identified no level of care issues related to Tenant #2.

Tenant #3 resided in the program's memory care unit, exhibited moderately severe cognitively decline and experienced multiple falls during February, March and April 2012. None of the falls resulted in serious injury and did not require reporting to the Department. The program was trying various interventions to adequately address Tenant #3's falls. The monitors identified no level of care issues related to Tenant #3.

- Regulatory Insufficiency: None noted.