IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 40116-C

September 17, 2012

Ms. Nancy Ketcham, Director
Riverview Terrace Assisted Living
1501 St. Luke Drive
Spencer, IA 51301

RE: Final Complaint/Incident Investigation Report, Riverview Terrace Assisted Living, Spencer, Iowa

Dear Ms. Ketcham:

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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident 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 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint/Incident Intake #:** 40116-C

Nancy Ketcham, Director
Riverview Terrace Assisted Living
1501 St. Luke Drive
Spencer, IA 51301

Date of Complaint/Incident Investigation:

August 8, 2012

Monitor(s):

Hal L. Chase, RN BSN MPH
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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	59
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	63
TOTAL census of Assisted Living Program	63

Program History – The program received regulatory insufficiencies in the areas of Evaluation, Service Plan, Staffing, Nurse Review, Tenant Documents, Policy and Procedures during this certification period.

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 investigation, the following information was obtained:

- Monitoring Observation: The service coordinator and Staff #1, #2 and #3 were interviewed. Staff #3 reported Tenant #5 eloped from the Program on 8-5-12.

  Tenant #5, an 83 year old, was admitted on 1-22-11 and had diagnoses of: Gastro Esophageal Reflux Disease, Arthritis, Barrettes Esophagus, Diverticulitis, Tremors, Osteoporosis, Sciatica, Diastolic Dysfunction and Anemia. A cognitive evaluation was completed on 7-5-12, with Tenant #5 scoring 24 out of 30 on a mini mental status exam, which indicated normal cognition.

  Personal Service Assistant (PSA) notes of 8-5-12 indicated Staff #3 told Tenant #5 to head up for supper and Tenant #5 agreed. When Staff #3 went to the dining room Tenant #5 was not present. Staff #3 documented she didn't see Tenant #5 in the hall, so she went outside and saw Tenant #5 heading up the road. Staff #3 directed Tenant #5 back to the Program.

  Staff #3 was interviewed by a monitor and reported the evening of 8-5-12 she had checked on Tenant #5 around 2:00 p.m. – 2:15 p.m. and found Tenant #5 in his/her apartment. Staff #3 administered medications to Tenant #3 sometime between 4:45 p.m. and 5:00 p.m. Tenant #5 asked if it was time for supper and Staff #3 told Tenant #5 it wasn't time for supper but Staff #3 would come back when it was time to go to supper. At approximately 5:15 p.m. Staff #3 saw Tenant #5 walking into the elevator to go upstairs for supper.

Staff #3 left and assisted another tenant to the dining room and began to assist with supper when she noticed Tenant #5 was not in the dining room.

Staff #3 proceeded to look in the hallway adjacent to the dining room and didn't see Tenant #5. Staff #3 walked outside and saw Tenant #5 walking southeast of the Program, across the Program's parking lot driveway toward the public sidewalk. The distance to the sidewalk from the Program was greater than 100 feet from the front entrance of the Program. Staff #3 asked Tenant #5 where he/she was going and Tenant #5 reported he/she wasn't sure why he/she was outside and reported "I'm thinking I am going home." Weather data indicated the high temperature for the day was 77 degrees Fahrenheit, sunny and with no precipitation. Staff #3 reported Tenant #5 was appropriately dressed; wearing a shirt, shorts and socks and tennis shoes. Staff #3 escorted Tenant #5 back to the Program and into the dining room for supper. After supper Staff #3 escorted Tenant #5 back to his/her apartment.

The Program did not complete an incident report when Tenant #5 eloped from the Program.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists; however the dates of the rule violation precede the programs plan of correction date.

- Regulatory Insufficiency: None noted.

B. Tenant Rights

Complaint/Incident Allegation: It was alleged Program staff did not knock before entering tenants' apartments.

- Monitoring Observation: During the onsite investigation, a monitor independently observed staff assisting tenants. Staff was observed knocking on tenants' doors prior to entering their apartments.

  Tenants' #1, #2 and #3 were interviewed and each reported staff consistently knocked before entering their apartments. The service coordinator and Staff #1 and #2 were interviewed and reported staff routinely knocked before entering a tenant's apartment.

  Complaint/Incident Allegation: It was alleged tenants have to wait outside the dining room until the dining room is ready.

- Monitoring Observation: The service coordinator was interviewed and reported the dining room was open to tenants one-half hour before the meal was served. During that time kitchen staff was preparing the meal, staff was placing tableware and silverware at each table. Once this was done, the doors to the dining room were open for seating. Tenants' #1, #2 and #3 were interviewed and reported they had no issue with the dining room not being accessible until one-half hour before each meal. Tenants knew it took time to prepare for each meal.

Complaint/Incident Allegation: It was alleged the Program sold a television belonging to a tenant without his/her permission.

- Monitoring Observation: The Director was not onsite during the investigation, but was interviewed by phone. The Director reported she had no knowledge of a television being sold without a tenants' permission. The service coordinator and maintenance supervisor were interviewed and had no knowledge property belonging to tenants was sold without a tenants' permission. The service coordinator reported the Program accepted donations from tenants and family members of items they no longer wanted and held an annual rummage sale. The money received from this rummage sale was used to support various projects and events. The service coordinator reported the Program didn't keep records of items donated including who had donated and what items had been donated.

  Four tenants were interviewed. Tenants' #1, #2 reported they had not been asked to donate and have not donated items to the Program. Tenant #3 reported he/she had an "old big TV" and it was suggested by the Director Tenant #3 get a new television. Tenant #3 received a new television and the old television was removed and placed in the Program's garage. Tenant #3 reported he had not donated the television and believed the television was possibly sold at the rummage sale but he/she hadn't received the money from the sale of the television.

  Records were not kept of the items donated and who had donated the items.

- Regulatory Insufficiency: All tenants have the following rights, (1) to be treated with consideration, respect and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

C. Program Reporting to the Department

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #5's nurse's notes of 5-29-12 indicated Tenant #5 had increased confusion. Nurse's notes of 5-31-12 indicated Tenant #5 was treated with antibiotics for a urinary tract infection (UTI) for seven days. Nurse's notes of 6-12-12 through 7-29-12 indicated Tenant #5 had increased confusion, walked up and down halls looking for family, needed staff assistance to find his/her apartment and set off exit door alarms while attempting to look for family and wanting to go home.

  PSA notes of 7-11-12 through 7-30-12 indicated Tenant #5 was very confused and refused staff assistance with cares. Staff reported it was "impossible to keep track of" Tenant #5 and Tenant 35 refused to stay in one place. Tenant #5 was upset and wanted to go home. On 7-26-12, at approximate 2:20 a.m., Tenant #5 was found in the whirlpool room. On 7-30-12, at approximately 4:15 a.m., Tenant #5 was found on the second floor near the service coordinator's desk, which was near the front entrance.

  PSA notes of 8-5-12 indicated Staff #3 told Tenant #5 to head up for supper and Tenant #5 agreed. When Staff #3 went to the dining room Tenant #5 was not present.

Staff #3 documented she didn't see Tenant #5 in the hall, so she went outside and saw Tenant #5 heading up the road. Staff #3 directed Tenant #5 back to the Program.

Staff #3 was interviewed by a monitor and reported the evening of 8-5-12 she had checked on Tenant #5 around 2:00 p.m. – 2:15 p.m. and found Tenant #5 in his/her apartment. Staff #3 administered medications to Tenant #3 sometime between 4:45 p.m. and 5:00 p.m. Tenant #5 asked if it was time for supper and Staff #3 told Tenant #5 it wasn't time for supper but would come back when it was time to go to supper. At approximately 5:15 p.m. Staff #3 saw Tenant #5 walking into the elevator to go upstairs for supper. Staff #3 left and assisted another tenant to the dining room and began to assist with supper when she noticed Tenant #5 was not in the dining room.

Staff #3 proceeded to look in the hallway adjacent to the dining room and didn't see Tenant #5. Staff #3 walked outside and saw Tenant #5 walking south east of the Program, across the Program's parking lot driveway toward the public sidewalk. The distance to the sidewalk from the Program was greater than 100 feet from the front entrance of the Program. Staff #3 asked Tenant #5 where he/she was going and Tenant #5 reported he/she wasn't sure why he/she was outside and reported "I'm thinking I am going home." Weather data indicated the high temperature for the day was 77 degrees Fahrenheit, sunny and with no precipitation. Staff #3 reported Tenant #5 was appropriately dressed; wearing a shirt, shorts and socks and tennis shoes. Staff #3 escorted Tenant #5 back to the Program and into the dining room for supper. After supper Staff #3 escorted Tenant #5 back to his/her apartment. . Staff #3 reported Tenant #5 may have been outside for approximately 20 minutes.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available, when a tenant elopes from a program. (IAC r.481-67.4(4))

D. Evaluation

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Five tenant files were reviewed. Tenant #1's, #2's, #3's and #4's files revealed no issues.

  Tenant #5's nurse's notes of 5-29-12 indicated Tenant #5 had increased confusion. Nurse's notes of 5-31-12 indicated Tenant #5 was treated with antibiotics for a urinary tract infection for seven days. Nurse's notes of 6-12-12 through 7-29-12 indicated Tenant #5 had increased confusion, walking up and down halls looking for family, needing staff assistance to find his/her apartment, setting off exit door alarms attempting to look for family and wanting to go home.

  PSA notes of 7-11-12 through 7-30-12 indicated Tenant #5 was very confused and refused staff assistance with cares. Staff reported it was "impossible to keep track of" Tenant #5 and Tenant #5 refused to stay in one place. Tenant #5 was upset and wanted to go home. On 7-26-12, at approximate 2:20 a.m., Tenant #5 was found in the whirlpool room.

On 7-30-12, at approximately 4:15 a.m., Tenant #5 was found on the second floor near the service coordinator's desk, which was near the front entrance.

Tenant #5's file indicated functional, cognitive and health evaluations were completed on 7-5-12 and 7-11-12. Evaluations completed did not include an evaluation of Tenant #5's behavior as described in the nurse's notes and PSA notes described above.

PSA notes of 8-5-12 indicated Staff #3 told Tenant #5 to head up for supper and Tenant #5 agreed. When Staff #3 went to the dining room Tenant #5 was not present. Staff #3 documented she didn't see Tenant #5 in the hall, so she went outside and saw Tenant #5 heading up the road. Staff #3 directed Tenant #5 back to the Program.

The Program did not complete evaluations after Tenant #5 eloped from the Program on 8-5-12, to determine if a significant changed occurred and to make any changes to services.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists; however the dates of the rule violation precede the programs plan of correction date.

- Regulatory Insufficiency: None noted.

E. Service Plans

During the course of the investigation, the following information was obtained:

Monitoring Observation: Tenant #5's service plans of 7-5-12 indicated Tenant #5 needed assistance with activities of daily living, (ADLs), including stand by assistance with ambulation.

Tenant #5's nurse's notes of 5-29-12 indicated Tenant #5 had increased confusion. Nurse's notes of 5-31-12 indicated Tenant #5 was treated with antibiotics for a urinary tract infection for seven days. Nurse's notes of 6-12-12 through 7-29-12 indicated Tenant #5 had increased confusion, walking up and down halls looking for family, needing staff assistance to find his/her apartment, setting off exit door alarms attempting to look for family and wanting to go home.

PSA notes of 7-11-12 through 7-30-12 indicated Tenant #5 was very confused and refused staff assistance with cares. Staff reported it was "impossible to keep track of" Tenant #5 and Tenant 35 refused to stay in one place. Tenant #5 was upset and wanted to go home. On 7-26-12, at approximate 2:20 a.m., Tenant #5 was found in the whirlpool room. On 7-30-12, at approximately 4:15 a.m., Tenant #5 was found on the second floor near the service coordinator's desk, which was near the front entrance.

PSA notes of 8-5-12 indicated Staff #3 told Tenant #5 to head up for supper and Tenant #5 agreed. When Staff #3 went to the dining room Tenant #5 was not present.

Staff #3 documented she didn't see Tenant #5 in the hall, so she went outside and saw Tenant #5 heading up the road. Staff #3 directed Tenant #5 back to the Program.

Tenant #5's service plan was not updated to reflect interventions related to the increased confusions, history of a UTI, inability to find his/her apartment, wandering and exit seeking as described above.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists; however the dates of the rule violation precede the programs plan of correction date.

- Regulatory Insufficiency: None noted.

F. Nurse Review

During the course of the investigation, the following information was obtained:

Monitoring Observation: PSA notes of 8-5-12 indicated Staff #3 told Tenant #5 to head up for supper and Tenant #5 agreed. When Staff #3 went to the dining room Tenant #5 was not present. Staff #3 documented she didn't see Tenant #5 in the hall, so she went outside and saw Tenant #5 heading up the road. Staff #3 directed Tenant #5 back to the Program.

Staff #3 reported she did not report the incident to a nurse. Nurse's notes did not indicate a nurse review was completed related to the incident. The Program nurse reported she had not completed a nurse review.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists; however the dates of the rule violation precede the programs plan of correction date.

- Regulatory Insufficiency: None noted.

G. Life Safety

Complaint/Incident Allegation: It was alleged it took several days for the Program to replace a burnt out light bulb in a tenant's kitchen.

- Monitoring Observation: The service coordinator reported PSA's would replace light bulbs and repair minor things if they could. If they couldn't fix, repair or replace something that was broken in a tenant's apartment they would notify her and she would request maintenance staff to respond. The maintenance supervisor reported his staff would often replace light bulbs if care staff couldn't reach the burnt out bulb. Maintenance staff would be called by the service coordinator when needed and a requisition would be placed for work to be done.

Tenant #1, #2, #3 reported no concerns related to the replacement of lights or repairs made by PSA's and maintenance staff. PSA's and maintenance staff would quick to respond to their needs.

- Regulatory Insufficiency: None noted.