IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: **40153-I**
40193-C
40548-C

October 11, 2012

Mr. Travis Senters. Director
Meadowview Memory Care Village
3005 F Avenue NW
Cedar Rapids, IA 52405

RE: Final Complaint/Incident Investigation Report, Meadowview Memory Care Village, Cedar Rapids, Iowa

Dear Mr. Senters:

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 Insufficiency, DIA accepts the POC.

If you have any questions in regard to 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:

Travis Senters, Director
Meadowview Memory Care Village
3005 F Ave. NW
Cedar Rapids, IA 52405

Complaint/Incident Intake #: 40153-I
40193-C
40548-C

Date of Complaint/Incident Investigation:

September 11, 12 & 13, 2012

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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:	1
Number of tenants with cognitive disorder:	46
Total Population of Program at time of on-site	47
TOTAL census of Assisted Living Program	47

Program History – The program received a regulatory insufficiency in the area of Other (non notification of an elopement) during the October 31, 2011, Recertification on-site. During the Incident Investigation (38076-I) of February 29 and March 1, 2012, the program received regulatory insufficiencies in the areas of Staffing and Life Safety.

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

A. Program Reporting to the Department

Complaint/Incident Allegation #40153-I: The Program reported a tenant became combative during cares resulting in a tenant and staff member sustaining bruises and skin tears.

- Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7).

  Tenant #1, a 95 year old, was admitted on 11-30-10 and diagnoses include: Dementia, Diabetes Mellitus Type II, Hypertension (HTN) Hypothyroidism, Coronary Artery Disease, Macular Degeneration, Arthritis, Pacemaker, History of Pneumonia and History of Urinary Tract Infections (UTIs). Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #1 received Hospice services.

  According to Nurse's Notes dated 7-28-12, the overnight shift reported Tenant #1 was combative with cares. Staff #1 showed Staff #3 scratches with sloughed skin on left upper inner arm. Tenant #1 had two small skin tears on right wrist/forearm, large bruise covering left posterior hand and bruising with swelling to left anterior wrist. Pain was noted on palpation and range of motion was within normal limits without any complaints of pain. Tenant #1's family member was notified, Hospice was aware and the Director of Nursing (DON) was aware. Vital signs were taken; Temperature 96.6, pulse 60, respirations 20 and blood pressure 158/90. A urine culture was received. Results were given to Hospice who called Tenant #1's doctor. A new order was received for Rocephin 1 gm injection daily times ten days.

According to a service plan completed on 7-30-12, when Tenant #1 exhibited verbal or physical aggression staff would encourage social interaction with other tenants. Staff could also attempt redirection to play balloon volleyball, go for a walk, offer a drink or encourage rest. If redirection attempts were unsuccessful, staff would notify Tenant #1's family member who would come in to sit with Tenant #1. Staff could also call Hospice. If Tenant #1 became combative, talk to Tenant #1 about family and any memories Tenant #1 had to help Tenant #1 calm down. If that did not work, staff were to make sure Tenant #1 was in a safe place, walk away and get another staff to assist if needed.

Staff #1 said at approximately 5:00 a.m. she went into Tenant #1's room and asked if Tenant #1 could go to the bathroom as the bedding was wet. Tenant #1 didn't say anything but got up and went into the bathroom and sat on the toilet. Staff #1 moved Tenant #1's walker and attempted to remove Tenant #1's brief when Tenant #1 started to claw, slap and patted the sink with Tenant #1's palm. When Tenant #1 reached over the walker, Tenant #1's right arm hit the walker bar. Staff #1 said Tenant #1 clawed Staff #1's left upper arm two times. Staff #1 said she asked Tenant #1 to please not do that and took Tenant #1's hand and moved it away. Staff #1 told Tenant #1 she was going to leave and put the walker back in front of Tenant #1. Tenant #1 continued to try to hit Staff #1, reaching over the walker. Staff #1 left the room and came back every 10 minutes to check on Tenant #1. Tenant #1 was sitting quietly on the toilet at each subsequent check. At each point Staff #1 would ask Tenant #1 if Tenant #1 wanted to get off the toilet. Staff #1 did this for 40 minutes and at that point Tenant #1 said yes and agreed to have the brief changed. Tenant #1 did not want to return to bed and wanted to sit in a chair.

Staff #2 indicated on 7-28-12 at approximately 9:30 a.m. she went to give Tenant #1 a shower and she noticed a bruise on top of the left hand, then a 4 inch long raised bruise on the underside of the left wrist. She called the nurse into the room to show her the bruises. Staff #2 said she went to give Tenant #1's shower and noticed a bruise on the wrist and hand. The underside of the left wrist was raised and continued to grow. Tenant #1 was not able to say how it occurred. Staff #2 reported it to Staff #3. Staff #2 said when she had come in the overnight staff, Staff #1, seemed "angry" and kept saying Tenant #1's name. Staff #1 had fingernail indentions and scratches on the upper arm.

According to Staff #3 when she arrived for work, Staff #1 told her Tenant #1 was resistive and combative to cares. Staff #1 showed Staff #3 scratches on her underarm. Staff #3 checked Tenant #1's blood sugar and gave Tenant #1 medications between 6:00 and 6:30 a.m. and did not see any bruising. Staff #2 assisted Tenant #1 for a shower after breakfast and called Staff #3. At that time Staff #3 saw a large swollen bruise about 3 inches long by 2 inches wide on Tenant #1's posterior arm. Staff #3 notified Tenant #1's family member around 9:30 a.m. Staff #3 said maybe there was a small bruise on top of the right hand. Staff #3 called the Hospice Nurse to assess. Tenant #1's family member refused offers to put an icepack on Tenant #1's arm. When asked about Staff #1's demeanor, Staff #3 said Staff #1 seemed a little irritated about the situation.

The DON said she was called on Saturday and told Tenant #1 had a bruise on Tenant #1's arm and Tenant #1 had been combative on third shift. On Monday she observed a rectangular bruise on the left and a bruise on the top of the right hand. Staff #1 said she was changing Tenant #1's protective undergarment and Tenant #1 became combative. Staff #1 put the walker in front of Tenant #1, left the room and checked on Tenant #1 to ensure Tenant #1 was safe. She said Tenant #1 had the walker in front of Tenant #1, a sink to the right side, another bar on the wall and cabinet right in front of the toilet. The DON said there were no witnesses besides Tenant #1 and Staff #1. She said no grab marks were observed. Staff #1 had scratches and bruises on the left inner arm and did not require medical attention. The DON did not suspect any abuse had occurred. She said Staff #1 was working on the other side of the building until everything was figured out.

According to the Director, on 7-30-12, the DON informed him of the situation that occurred on 7-28-12 regarding Tenant #1. He did not feel the situation was abusive. He said he did not think anything could have been done differently as Staff #1 removed herself from the situation. He stated Tenant #1 was someone who had a pattern of UTIs. There were no witnesses to the incident.

The Hospice Nurse who was on call the weekend the incident occurred was interviewed. She was not Tenant #1's primary nurse but had seen Tenant #1 quite a bit. She was called and asked to come out and visit. She made a visit around supper time and Tenant #1 was at the table. There was a bruise on Tenant #1's left wrist and she measured and marked the bruise. Tenant #1 was not able to recall how it happened. Tenant #1 did not have any complaints of pain. She said it was quite a long bruise and she assessed the bruise. She did not have any concerns that abuse had occurred.

Tenant #1 was interviewed and said people treated Tenant #1 well and were nice. Observation of Tenant #1's bathroom where the incident occurred revealed a high rise toilet seat on the toilet with bars on both the right and left side. If seated on the toilet, a counter was on the right and a bar on the left wall. A cabinet was in front of toilet along the left side wall.

The Director and DON stated they did not suspect any abuse. The Director and the DON stated there was no one who was a harm to self or others.

An Incident Report Form was completed related to the incident. The Program notified the Department appropriately. Photographs of Tenant #1 and Staff #1 injuries were taken. Those pictures were provided to the monitors.

Tenant #1's service plan provided interventions when Tenant #1 displayed behaviors which included to make sure Tenant #1 was in a safe place, walk away and get another staff to assist if needed. At the time of the incident there was another staff working and Staff #1 did not have the other staff attempt to provide cares after Tenant #1 became combative. While a deviation from 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.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation #40548-C: It was alleged the Program was short staffed on weekends which resulted in some of the tenants being neglected.

- Monitoring Observation: Staff schedules were reviewed from July 1 through September 8. The same number of staff (personal caregivers) was scheduled on the weekends as during the weekdays. Review of Program Staffing Plans indicated staffing was adjusted based on the number of tenants.

  According to Staff #1, #2, #3, the DON and the Director, staff scheduled on the weekends is the same as during the week. Staff #2 said a staff member had quit and it took about two weeks to replace the staff member but the nurse helped. The Director stated there were more call offs for weekend shifts but replacement staff were called to fill the open shifts. Staff #1, #3, the Director and the DON said there was enough staff to meet the needs of the tenants. Staff #1 and #3 said no tenants or their family members had complained of a lack of help due to not having a sufficient number of staff.

  A family interview indicated staff treated tenants appropriately and received the cares needed.

  According to the Program's Staffing policy, the Program shall employ sufficient trained staff to be available to meet the tenant's identified needs.

  Review of Program staff schedules, policy review and staff and family interviews indicated staffing was scheduled the same on weekends as on weekdays.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #40548-C: It was alleged some certified nurse aides (CNAs) were aggressive in their interactions with tenants, forcing tenants to stand by and pulling up the tenants by their armpits.

- Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). The files indicated service plans addressed the type of assistance tenants needed with transfers and ambulation.

  Tenant #5, a 74 year old, was admitted on 3-1-06 and diagnoses include: HTN, Dementia-Alzheimer's, Degenerative Arthritis and Depressive Disorder. Tenant #5 was staged at a six on the GDS, which indicated severe cognitive decline. According to a service plan dated 6-29-12, Tenant #5 was independent with ambulation without the use of an assistive device.

  Tenant #6, an 81 year old, was admitted on 5-12-09 and diagnoses include: Severe Dementia, History of Peptic Ulcer Disease, Gastro Esophageal Reflux Disease, Osteopenia, Osteoarthritis, Anemia, Anxiety, Depressive Disorder and Frequent

UTIs. Tenant #6 was staged at a six on the GDS, which indicated severe cognitive decline. According to a service plan dated 8-20-12, Tenant #6 had a history of falls, ambulated and self-transferred independently without devices. Staff was to provide stand by assistance if Tenant #6 was noted to be unsteady. Staff was to provide increased assistance as needed.

Staff #1, #2, #3, #4, the DON and the Director said CNAs were not aggressive in forcing tenants to stand. Staff #1, #2, #4, the DON and the Director said tenants are not forced to stand when they don't want to stand. Staff #2 said tenants were not assisted to stand by being pulled up under the armpits. She said a gait belt could be used and the gait belts were available to staff. Staff #3 said sometimes if a tenant was wet or soiled they might be resistive to standing. Staff #3 and #4 said tenants were not assisted to stand by being pulled up under the armpits. The DON said had not seen nor had it been reported to her that tenants were assisted to stand by being pulled up under the armpits. The Director said staff was supposed to put their arms under the tenant's arms if assistance was needed to get up. Gait belts could also be used to assist tenants. A family interview indicated staff treated tenants appropriately and received the cares needed.

A CNA Orientation Checklist indicated a variety of categories including a category for CNA job routines. A statement from the Delegating Nurse indicated transfers and ambulation delegations fell under CNA job routines. Such delegations were discussed and visually observed with all staff. Staff files were reviewed (Staff #1, #5, #6, #7 and #8). Staff had training on CNA job routines including transfers and ambulation.

According to the Program's Staffing Policy, the Director of the Assisted Living and DON will be responsible for the direction of tasks and training of employees in the assisted living.

Review of tenant files, interviews, policy review and staff files did not identify any concerns with inappropriate transfer technique, tenants being forced to stand or staff being aggressive with tenants.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #40548-C: It was alleged some staff did not toilet tenants on the weekend.

- Monitoring Observation: Tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). The files reviewed did not indicate any issues with tenants not being toileted. The service plans addressed the type of assistance needed with toileting and incontinence care.

  Tenant #3, a 64 year old, was admitted on 3-12-12 and diagnoses include: Dementia, Depression, Hypocholesterolemia and Left Elbow Olceanon Bursitis. Tenant #3 was staged at a six on the GDS, which indicated severe cognitive decline. According to a service plan completed on 8-17-12, Tenant #3 was incontinent of urine and of bowels and Tenant #3 was constipated at times. Staff to check on Tenant #3 and assist with

changing protective undergarments when soiled as Tenant #3 will not. Staff to cue Tenant #3 to use the bathroom before and after meals; in A.M., at bedtime two times per night and as needed. Staff to assist Tenant #3 with perineal care after each incontinent episode and in A.M. and P.M.

Tenant #5's file was reviewed. According to a service plan dated 6-29-12, Tenant #5 was occasionally incontinent of bowel and was incontinent of bladder frequently. Tenant #5 wore protective products and staff assisted with changing the protective undergarments. Staff assisted Tenant #5 routinely to use the restroom after meals, at bedtime, one time during the night and as needed. Tenant #5 at times was noted to be tearful and hold the abdomen which could be an indication Tenant #5 needed to toilet for a bowel movement. Staff was to complete perineal care twice daily and as needed. Tenant #5 also self toileted at times. Tenant #5 had a history of UTIs and staff was to report any burning, discomfort or foul odor of urine to the nurse.

Tenant #6's file was reviewed. According to a service plan dated 8-20-12, Tenant #6 was incontinent of bowel and bladder with occasional episodes of continence on the toilet. Tenant #6 wore incontinent products for protection and staff was to change products as often as needed. Staff was to observe Tenant #6 picking at continence brief or pants, rubbing stomach or standing alone in corners, as that was often a cue the continence product was soiled. When staff observed the behavior staff was to offer toileting. Tenant #6 was routinely offered toileting needs before and after meals, before bedtime and as needed. Staff was to provide perineal care twice daily and as needed.

Staff #1, #2, #3, #4, the DON and the Director said tenants were toileted as needed. A family interview indicated staff treated tenants appropriately and received the cares needed.

Staff files were reviewed (Staff #1, #5, #6, #7 and #8). Staff had training on incontinence care.

Review of tenant files, interviews and staff files indicated there were no concerns regarding lack of toileting assistance provided to tenants.

- Regulatory Insufficiency: None noted.

C. Criteria for Admission and Retention

Complaint/Incident Allegation #40193-C: It was alleged a tenant was combative and sustained injury.

- Monitoring Observation: Tenant files (Tenants #1, #2, #3, #4, #5, #6 and #7) were reviewed. The files revealed several tenants had behaviors including Tenant #1, #3, #4 and #6.

  Tenant #1's file was reviewed. According to Nurse's Notes dated 7-28-12, the overnight shift reported Tenant #1 was combative with cares. Staff #1 showed Staff

#3 scratches with sloughed skin on Staff #1's left upper inner arm. Tenant #1 had two small skin tears on right wrist/forearm, large bruise covering left posterior hand and bruising with swelling to left anterior wrist. Pain was noted on palpation and range of motion was within normal limits without any complaints of pain. Staff #3 called the Hospice Nurse to assess. Tenant #1's service plan provided interventions when Tenant #1 displayed behaviors which included to make sure Tenant #1 was in a safe place, walk away and get another staff to assist if needed.

Tenant #3's file was reviewed. According to an Incident Report Form dated 8-29-12, Tenant #3 was helped into bed when Tenant #3 became agitated and pushed the CNA. According to the Nurse's Notes dated 8-29-12, staff was assisting Tenant #3 with P.M. cares and helping to bed. Staff went to readjust the pillows under Tenant #3's head when Tenant #3 shoved staff in the stomach. Tenant #3 did not appear agitated and went to sleep. Tenant #3's service plan reflected behaviors and interventions related to the behaviors.

Tenant #4, a 90 year old, was admitted on 9-1-10 and diagnoses include: HTN, Dementia/Alzheimer's, Depression, Lower Back Pain and Closed Head Injury from fall. Tenant #4 was staged at a six on the GDS, which indicated severe cognitive decline. According to Nurse's Notes dated 8-23-12, Tenant #4 was up this morning, difficult with morning cares. Aggressive behavior was directed towards another tenant by Tenant #4. According to the service plan updated on 8-23-12, if staff noticed Tenant #4 feeling agitated while in the halls, try and walk with Tenant #4 for a few minutes to help avoid altercations with other tenants. According to Nurse's Notes, dated 9-7-12, Tenant #4 was up this morning, resistive to care and taking medications. Tenant #4 had a bruise on right upper forearm and right hip. No recent fall had been reported.

Tenant #6's file was reviewed. According to an Incident Report Form, on 8-27-12 at 3:50 p.m. a bath aide was giving Tenant #6 a shower when Tenant #6 became violent and kicking and spitting. Tenant #6 lost Tenant #6's balance and was stabilized by the bath aide. When bath aide caught Tenant #6 her name badge caused a scrape on Tenant #6's back. The incident was reported to the nurse, the doctor and family. Nurse's Notes dated 8-27-12 indicated Tenant #6 received a superficial scrape on back near the shoulder blade. There was no pain or discomfort noticed at that time. There were five entries in Nurse's Notes from 8-28-12 through 8-30-12 regarding the scrape on Tenant #6's back. Vitals were obtained; there were no signs or symptoms of discomfort or infection. Tenant #6's service plan reflected behaviors and interventions related to the behaviors.

Review of tenant files, incident reports and interviews indicated Tenants #1, #3, #4 and #6 were combative at times. Tenants #1 and #6 sustained injuries. Incident reports were completed and service plans reflected interventions for behaviors.

- Regulatory Insufficiency: None noted.

D. Other

Complaint/Incident Allegation #40548-C: It was alleged concerns had been brought to management regarding the lack of staffing on weekends and nothing had been done.

- Monitoring Observation: Staff #1, #2, #3 and #4 said they could take concerns to management and felt management followed up on their concerns. Staff #1, #3, the Director and the DON said there was enough staff to meet the needs of the tenants. Staff #1 and #3 said no tenants or their family members had complained of a lack of help due to not having a sufficient number of staff.

- Regulatory Insufficiency: None noted.

E. Tenant Documents

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

- Monitoring Observation: The Program's Medication Management Policy indicated if medication reminders, supervision, or administration was delegated to the Program by the tenant or the tenant's legal representative the following procedures would be followed: including a medication reconciliation sheet would be used to document medications and or treatments which were delegated to the Program and performed by health care staff. Tenants #6 and #7 had medications administered by the Program. The table below represents physician ordered treatments not completed or not documented as completed. Medication Administration Records (MARs) were reviewed from July 2012 and August 2012 indicated the following:

TENANT	TREATMENT	DATE/TIME	CHARTING ON MAR
TENANT #6	Health supplement by mouth three times daily	8-26-12 at 1:00 p.m.	Not initialed as given and percentage consumed not recorded
TENANT #6	Compression stockings daily; on every morning and off every afternoon	8-30-12 p.m.	Circled on the front of the MAR and no explanation on the back of the MAR
TENANT #6	Compression stockings daily; on every morning and off every afternoon	7-5-12 a.m. and p.m.	Circled on the front of the MAR and no explanation on the back of the MAR
TENANT #6	Compression stockings daily; on every morning and off every afternoon	7-6-12 a.m. and p.m.	Circled on the front of the MAR and no explanation on the back of the MAR
TENANT #7	Elevate legs 20 minutes twice daily	8-29-12 a.m.	Not initialed as completed
TENANT #7	Elevate legs 20 minutes twice daily	8-30-12 a.m.	Not initialed as completed
TENANT #7	Compression stockings; on in a.m. and off in p.m.	8-30-12 p.m.	Circled on the front of the MAR and no explanation on the

			back of the MAR

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception. (IAC r. 481-69.25(1)(i))