IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 41151-I

November 13, 2012

Ms. Diana Niemeier, Executive Director
Village Ridge
365 Marion Blvd.
Marion, IA 52302

RE: Final Complaint/Incident Investigation Report, Village Ridge, Marion, Iowa

Dear Ms. Niemeier:

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:

Diana Niemeier, Executive Director
Village Ridge
365 Marion Blvd.
Marion, Iowa 52302

Complaint/Incident Intake #:

41151-I
41033-C

Date of Complaint/Incident Investigation:

October 23, 2012

Monitor(s):

Maribeth Freland RN
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 Definition	
Number of tenants without cognitive disorder:	29
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	35

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	16
Total Population of Program at time of on-site	16
TOTAL census of Assisted Living Program	51

Program History – The program received a regulatory insufficiency in the area of Activities during the May 2011, Recertification on-site.

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

A. Tenant Rights

Complaint/Incident Allegation: 41033-C- It was alleged the program allowed unauthorized visitors into the building without tenants' permission, resulting in the unauthorized visitors knocking on tenant doors unannounced.

- Monitoring Observation: The program's entrance doors were unlocked during the day time hours and were locked during the night. A call button was located at the front entrance to allow those seeking entrance to summon staff. The program's entrance had a sign posted stating "No soliciting." During interview, Staff #1, #2, #3 and #4, all direct care workers, reported the program entrance doors are locked at approximately 9:00 p.m. to prevent unauthorized entrance into the building and are unlocked from approximately 6:00 a.m. to 9:00 p.m., allowing free access to visitors. All four staff members reported receiving direction from administration to question all individuals not recognized by the program staff to determine the reason the person was in the building and to assist in directing the person to the desired location. All four staff members reported they would not allow access to and/or immediately contact administration should they identify a visitor who was unable to be directed to a specific business office or cite a specific tenant they wish to visit.

The monitors held a tenant meeting with Tenants #1, #2, #3, #4, #5 and #6, all cognitively intact tenants. The tenants reported feeling safe while residing at the program. All reported the entrance doors were locked in the evening and remain locked until sometime early morning. All six tenants denied ever seeing people who did not look like they belonged loitering in the building. All six tenants reported the program did not allow unauthorized solicitors into the building and denied ever being approached by unannounced visitors or have unknown individuals knocking on apartment doors. The tenants reported they have scheduled monthly tenant council meetings with the program administration. The tenants denied having any unscheduled tenant meetings in the previous few months. The tenants reported the program had never scheduled any group meetings to discuss supplemental insurances or meetings with other types of vendors.

The monitors reviewed the meeting minutes from all tenant council meetings held during July, August, September and October 2012. The meeting minutes did not address any issues related to unannounced visitors and did not address any issues with unwarranted solicitation. Tenants #2, #3, #4, #5 and #6 routinely attended the meetings reviewed by the monitors.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation: 41151-I- The program reported a tenant was injured while being transferred by a staff member without the use of a gait belt, resulting in the tenant's ankle being fractured.

- Monitoring Observation: The monitors reviewed the incident reports for the months of July, August, September and October 2012. The monitors reviewed the clinical records of Tenants #7, #8 and #9, all tenants who had experienced multiple falls during the months of incident report review. Tenant #7 experienced multiple falls without injury and was transferred to a higher level of care due to the increased falls. Tenant #9 was independent with ambulation and fell, resulting in a fractured arm.

  Tenant #8, an 88 year old, was admitted to the program on 2-16-08 with the diagnoses of: Alzheimer's Disease, Congestive Heart Failure, Diabetes, Hypertension, Osteoporosis and Renal Failure. Tenant #8 was admitted to hospice services on 4-9-12. Tenant #8 scored a 5 on the Global Deterioration Scale (GDS) completed on 4-9-12, indicating moderately severe cognitive decline. Tenant #8's service plan, dated 4-9-12, indicated Tenant #8 required stand by assistance of one staff member and the use of a walker when transferring and ambulating. On 9-6-12, Tenant #8 began using a hospital bed, which had the ability to be raised and lowered to allow easier access with Tenant #8 getting in and out of bed. On 9-19-12, Tenant #8 began experiencing increased stiffness, rigidity and discomfort with transfers. The program reported the changes to Tenant #8's physician. The physician ordered Tylenol 650 milligrams three times daily to alleviate the discomfort with transfers.

During interview, Staff #1, certified nursing assistant/occupational medication technician (CNA/OMT), reported she assisted Tenant #8 to transfer from the wheelchair to the bed on 9-29-12 at approximately 1:30 p.m. Staff #1 reported the bed was in the low position with bed rails lowered prior to the transfer. Staff #1 reported she did not place a gait belt around Tenant #8 as it was not included in the service plan to use a gait belt. Staff #1 placed Tenant #8's arms across her shoulders, assisted Tenant #8 to stand, pivoted Tenant #8 and Tenant #8 sat on the bed. When Tenant #8 sat down, Tenant #8 said "Ow". At that time, Staff #1 noted Tenant #8's foot had become caught on the underneath bed frame of the hospital bed. Staff #1 raised the bed and Tenant #8's foot was released. Staff #1 observed Tenant #8's ankle, noting no changes to Tenant #8's ankle or foot. Staff #1 assisted Tenant #8 with changing of incontinence product and perineal cleansing. Tenant #8 did not report any further discomfort. Staff #1 left Tenant #8 lying in bed. Staff #1 did not report the incident to the registered nurse (RN) as she did not believe Tenant #8 had been injured during the transfer.

On 9-29-12 at approximately 3:30 p.m., Staff #5, licensed practical nurse (LPN) and Staff #6, certified nursing assistant (CNA), put Tenant #8's socks and shoes on, noting no swelling or bruising to the feet or ankles. Tenant #8 did not stand well so was placed in a wheel chair and taken to the bathroom to toilet. After toileting, Tenant #8 did not stand well but voiced no discomfort.

On 9-29-12 during the evening shift, Staff #7, CNA, and Staff #8, CNA/OMT also assisted Tenant #8 to toilet and then assisted to bed for the night. Staff #7 and Staff #8 reported no difficulties during transfers and noted no swelling or discoloration to Tenant #8's feet or ankles when undressing Tenant #8.

On 9-30-12 at approximately 5:00 a.m. Staff #9, CNA/OMT, reported noting Tenant #8's left ankle appeared larger than the right ankle while repositioning Tenant #8. The ankle appeared to be discolored. Staff #9 summoned Staff #10, CNA, to look at Tenant #8's ankle. Staff #10 also noted Tenant #8's ankle to appear swollen and discolored. Staff #9 reported the swollen ankle to the oncoming shift during shift report at 6:00 a.m.

Program staff called Tenant #8's hospice nurse and reported Tenant #8's swollen ankle. The hospice nurse arrived at 10:20 a.m. and assessed Tenant #8's ankle, determining Tenant #8 required transport to the emergency room for x-ray. Tenant #8's x-rays showed a fracture through the distal fibula at the ankle joint. Tenant #8 returned to the program with a gel splint and ace wrap to the left ankle.

Tenant #8's service plan, dated 10-1-12, included the following changes to begin on 9-30-12: assistance of two staff members and use of a gait belt with all transfers as Tenant #8 could not bear weight on the left foot; wheel chair to be used for all mobility; bed baths instead of showers due to the inability of Tenant #8 to stand; no toileting in bathroom- changing of incontinence products and perineal cleansing to occur in bed.

The program administration held mandatory training related to transfer techniques when using a low bed and training on when to report incidents to the RN. Staff #1 received discipline for failing to report the incident to the program RN.

Tenant #8 had begun experiencing difficulties with transfers and ambulation prior to the incident on 9-29-12. Staff members did not observe any changes to Tenant #8's left ankle prior to 5:00 a.m. on 9-30-12. Staff reported the swelling and discoloration in a timely manner. The hospice nurse evaluated Tenant #8 as the hospice maintains professional management while Tenant #8 received hospice services. Tenant #8 received medical evaluation within six hours of the observation of injury indication. The program administration disciplined Staff #1 for not completing an incident report and failure to report the incident to the program RN. Staff education was completed following the incident. Tenant #8's service plan was updated to assure tenant safety following the injury.

- Regulatory Insufficiency: None noted.

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

C. Evaluation

- Monitoring Observation: Tenant #8's clinical record documented Tenant #8 fractured his/her ankle on 9-29-12. Tenant #8 experienced significant functional changes secondary to the fractured ankle, thereby requiring an evaluation of Tenant #8's health, functional and cognitive status. Tenant #8's clinical record lacked documentation of Tenant #8's cognitive status following identification of the significant change on 9-29-12. Staff #11, RN, reported she believed she had completed a GDS evaluation for Tenant #8 on 10-1-12 but failed to document the results of the evaluation.

  Tenant #9, an 80 year old, was admitted to the program on 8-18-12 with the diagnoses of Osteoarthritis and Alzheimer's Disease. Tenant #9 scored a 4 on the GDS completed on 8-6-12, indicating moderate cognitive decline. Tenant #9's clinical record lacked documentation of an evaluation of Tenant #9's health, functional or cognitive status within 30 days of admission to the program. Staff #11, RN, reported she was on vacation when Tenant #9 required a 30 day evaluation; therefore, the evaluations of Tenant #9's health, functional and cognitive status were not completed as required.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))