IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:

42231-M
42115-I

April 11, 2013

Ms. Cathy Hughes, Executive Director
Senior Star at Elmore Place Assisted Living
4500 Elmore Avenue
Davenport, IA 52807

RE: Final Complaint/Incident Investigation Report, Senior Star at Elmore Place Assisted Living, Davenport, Iowa

Dear Ms. Hughes:

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 515/281-4116 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:

Cathy Hughes, Executive Director
Senior Star at Elmore Place Assisted Living
4500 Elmore Avenue
Davenport, IA 52807

Complaint/Incident Intake #: 42231-M
42115-I

Date of Complaint/Incident Investigation:

March 6, 2013 to March 13, 2013

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.

General Population Program	
Number of tenants without cognitive disorder:	75
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	75
TOTAL census of Assisted Living Program	75

Program History – There were substantiated Regulatory Insufficiencies found during this certification period for Service Plan, Medications, Staffing and Nurse Review.

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

A. Policies and Procedures

Complaint/Incident Allegation #42231-M: The Program reported a staff member allegedly took a tenant's medication and gave it to another staff member.

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #1, a 93 year old, was admitted on 12-3-11 and diagnoses included: Parkinson's Disease, Enlarged Prostate and Frequent Urinary Tract Infections. Tenant #1 had a physician's order dated 9-5-12 for Acetaminophen 500 mg two tablets (1000 mg) by mouth at bedtime. Tenant #1 also had a physician's order dated 1-6-12 for as needed Acetaminophen 500 mg two tablets (1000 mg) by mouth every six hours as needed for pain. According to the Nurse's Notes dated 1-6-13 at 10:50 a.m., Tenant #1 was admitted to the hospital. A nurse at the hospital did not share the admitting diagnosis due to the American Health Insurance Portability and Accountability Act regulations. Tenant #1 returned to the Program on 1-9-13 at 5:45 p.m. accompanied with a family member. Tenant #1 was not at the Program at the time of the incident.

  According to the information submitted by the Program, on 1-8-13 Staff #1 allegedly gave Tylenol from Tenant #1's as needed medication and gave it to Staff #2. The police were contacted and interviewed witnesses and Staff #1. The allegation of dependent adult abuse was reported to the Department. An incident report was not completed related to the incident.

  According to the former Assisted Living (AL) Director, Tenant #1 was not informed of the alleged theft of Tenant #1's Acetaminophen medication.

According to the Program's Incident Report Policy, the responsible person was an employee who witnessed or responded to an incident. The action was to report any potential liability incident involving a tenant, guest, employee, company vehicle or company property. The proper incident report form was to be completed and given to the supervisor immediately. Incidents to be reported included allegations of assault or abuse, allegations of theft, extortion or mismanagement of money and any other incident which could have potential for a liability claim. The Program did not complete an incident report regarding the incident.

Per review of Tenant #1's file, investigation materials, policies and interviews, an incident report was not completed related to the allegation of dependent adult abuse.

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

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #2, a 64 year old, was admitted on 9-4-12 and diagnoses included: Diabetic Neuropathy, Adjustment Disorder, Colon Perforation and Narcolepsy. Tenant #2 was discharged on 1-8-13. Tenant #2 scored a 26/29 on the Mini Mental Status Examination (MMSE). Nurse's Notes dated 9-12-12 indicated Tenant #2 had slid off the edge of the bed and said it was too tall. Nurse's Notes dated 11-21-12 indicated Tenant #2 was observed sitting on the floor beside the bed. Tenant #2 tried to get out of bed, felt weak and Tenant #2 lowered self to the floor.

  According to the Program's Employee Handbook policy on Improper Payments and Gifts, the Program prohibited the solicitation, appearance, offer or payment to any person or organization of any bribe, kickback or similar consideration of any kind, including money, services or goods or favors. Because tenants often asked employees to accept things they were tossing away, employees could ask the Executive Director (ED) for permission, in advance of accepting any item. Monetary gifts from tenants must have Main Office approval. This policy was in effect whether the item was accepted for personal use, the use of others, as a donation and/or for the use of the Community.

  According to a written statement provided by the ED, on or about 2-6-13, Tenant #2's family was moving Tenant #2's possessions out of the apartment. She received a call from the AL front desk asking if she knew anything about Tenant #2's new pillow top mattress. She told them, no. With investigation it was found that Staff #1 (who was no longer employed at the Program) had been talking with Tenant #2 and Tenant #2 was having trouble with the new mattress/bed set, which Tenant #2 could not get into bed due to the height of the bed. Staff #1 said she had a thinner mattress and there was a trade. The ED did not know who initiated the idea. It was never brought to her attention and she did not give permission. This was reported to the former AL Director by some of the staff members. The Program offered to replace the mattress but Tenant #2's family declined. To the ED's knowledge, no money exchanged hands between Tenant #2 and Staff #1.

  Per review of Tenant #2's file, review of policies, an interview and written statement, the Employee Handbook policy on Improper Payments and Gifts was not followed.

Policies were not followed regarding the completion of incident reports and the gift policy.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2))

B. Other

Complaint/Incident Allegation #42115-I: The Program reported a tenant had personal possessions missing, including checks and cash.

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #3, a 95 year old, was admitted on 8-11-10 and diagnoses included: Hypertension, Hyperlipidemia, Syncope due to Neurogenic Syncope and Osteoporosis. Tenant #3 scored a 28/29 on the MMSE.

  According to an Incident Report dated 12-17-12, Tenant #3 had 10 checks and approximately $35.00 in cash missing. The date of the incident was 12-16-12 at 8:15 a.m. and the location of the incident was Tenant #3's apartment. It was reported on 12-17-12 to the former AL Director by Tenant #3's family.

  According to information the Program submitted, Tenant #3 also had checks missing in September 2012.

  The Program completed an investigation which included interviewing staff and staff statements were collected. An incident report was completed and the Department was notified.

  Interviews were conducted with the ED, the former AL Director, Tenant #3 and Tenant #3's family. At the time of the investigation it could not be determined what occurred regarding the missing checks and cash.

  Tenant #3 reported nothing else was missing since that time. Tenant #3 felt safe but did lock the door when Tenant #3 was out of the apartment.

  According to a written statement provided by the ED, in reviewing some incident reports, she found reports for Tenants #4, #5 and #6, who had reported to the former AL Director they had missing money. The former AL Director reported this to the ED and they discussed the situation together. None of the tenants had an exact time line and they were vague in when and where they had the money. It spanned over a couple of weeks to a couple of days. The ED asked the former AL Director to follow up on these reports and see if she could resolve this. They were out of town at a conference at the time and the ED instructed the former AL Director if these were not resolved, they would need to be reported to State.

The former AL Director was no longer with the company and the ED could not find any notes in the file as to the resolution of the incidents reported.

The former AL Director was interviewed and indicated she had followed up regarding Tenant #3, #4 and #5 and there had been no evidence to indicate the money was stolen.

Per review of Tenant #3's file, review of investigation materials and interviews at the time of the investigation, it could not be determined what occurred regarding the missing personal property.

- Regulatory Insufficiency: None noted.