IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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**Complaint/Incident Intake #:**
**43475-C**

June 11, 2013

Ms. Jill Scott, Manager
Windsor Manor Webster City
1401 Wall Street
Webster City, IA 50595

**RE: Final Complaint/Incident Investigation Report, Windsor Manor Webster City, Webster City, Iowa**

Dear Ms. Scott:

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 515/281-7039 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:**

Windsor Manor Webster City
Jill Scott, Manager
1401 Wall St.
Webster City, IA 50595

**Complaint/Incident Intake #:**

43475-C

**Date of Complaint/Incident Investigation:**

May 6, 2013

**Monitor(s):**

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: | 25 |
| Number of tenants with cognitive disorder: | 2 |
| Total Population of Program at time of on-site | 27 |
| **Dementia-Specific Program by Dedication** | |
| Number of tenants without cognitive disorder: | 0 |
| Number of tenants with cognitive disorder: | 7 |
| Total Population of Program at time of on-site | 7 |
| **TOTAL census of Assisted Living Program** | 34 |

**Program History** – The program received a regulatory insufficiency in the area of staffing during the September 2012 Complaint Investigation (40935-C).

**Complaint/Incident Investigation** – The Complaint/Incident investigator made the observations detailed in the following areas:

**A. Tenant Rights**

Complaint/Incident Allegation: It was alleged that a tenant sustained a bruise when a staff member attempted to keep them seated on the toilet.

- Monitoring Observation: Incident reports for the prior three months were reviewed. Clinical records for Tenant #1, #2 and #3 were reviewed.

  Tenant #1, a 71 year old, was admitted 7-30-09 and currently resided in the memory care unit with diagnoses of: Hypertension (HTN), Dementia, Osteoporosis, Depression and Hyperlipidemia. The Nurse's Notes dated 4-8-13 documented Tenant #1 had a Global Deterioration Score (GDS) of "6" which indicated severe cognitive decline. The program provided shift Report Sheets written by the unlicensed staff which documented Tenant #1 had a black and blue finger identified on 5-1-13. The monitor also observed Tenant #1 to have a healing bruise under his/her right eye on 5-6-13. The clinical record lacked documentation of an incident in which the bruise to the finger or the eye occurred.

  Tenant #2, an 85 year old, was admitted 3-28-09 and currently resided in the memory care unit with diagnoses of: Diabetes, HTN, Dizziness, Alzheimer's and Osteoporosis. The GDS completed 3-28-13 documented a score of "6" which indicated severe cognitive decline. The program provided an Incident/Accident

report dated 4-17-13 which documented Tenant #2 was found on the floor face down. The report indicated the parts of Tenant #2's body impacted were face and shoulder. According to the clinical record Tenant #2 took Plavix (a blood thinner) and 81 milligrams of aspirin daily. Both medications would intensify bruising. Nurse's Notes dated 4-18-13 documented notification to the physician and assessment of bruising to Tenant #2's left shoulder and side.

Staff #1 and #2, certified nurse aides, were interviewed. Both denied knowledge of staff interactions with tenants which would result in unidentified bruising. Although there was a lack of documentation regarding all incident occurrences, there was no evidence that tenants were intentionally restrained.

Regulatory Insufficiency: None noted

**B. Nurse Review**

Complaint/Incident Allegation: It was alleged that a tenant sustained an injury that was not assessed by the nurse and the family was not notified of a fall which resulted in injury.

- Monitoring Observation: The program provided shift Report Sheets written by the unlicensed staff which documented Tenant #1 experienced bloody stools on 4-26, 4-27 and 4-28-13. The report sheets also documented Tenant #1 had a black and blue finger identified on 5-1-13. On 5-4-13 the report sheets documented Tenant #1 had been wearing adult briefs and was struggling to eat, requiring lots of assistance. The Report Sheets are normally read by the nurse and then destroyed and not kept as a part of the clinical record. The clinical record lacked evidence of an assessment completed by a nurse for any of the above noted changes in health and functional abilities.

  The program provided an incident report dated 5-5-13 completed by unlicensed staff which documented Tenant #2 fell in the bathroom of the apartment at 6:23 p.m. striking his/her upper back and head. The form indicated the family had been notified but not the physician. The clinical record lacked documentation of completion of an assessment by a nurse. The Manager reported the program's RN was on vacation and a nurse from another facility was taking call. On 5-6-13 at approximately 3:00 p.m. a nurse arrived at the facility to complete assessments.

  Regulatory Insufficiency: If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

**C. Staffing**

Complaint/Incident Allegation: It was alleged that staff in the memory care unit are often busy and can't observe what is going on elsewhere.

- Monitoring Observation: Observations were completed by the monitor at various times during the on-site 5-6-13. At no time were the tenants of the memory care unit left unsupervised.

  Regulatory Insufficiency: None noted

**D. Other**

Complaint/Incident Allegation: It was alleged that unsafe items were left unsecured and cognitively impaired tenants could potentially have access.

- Monitoring Observation: A tour of the memory care unit was completed and no sharp or potentially dangerous items were available for cognitively impaired tenants.

  Regulatory Insufficiency: None noted.

The following information was identified during the investigation completed 5-6-13.

**E. Evaluation**

- Monitoring Observation: The most recent functional and health evaluations completed for Tenant #1 were dated 12-16-11. The Nurse's Notes dated 4-8-13 documented Tenant #1 had a Global Deterioration Score (GDS) of "6" which indicated severe cognitive decline. The program provided shift Report Sheets written by the unlicensed staff which documented Tenant #1 experienced bloody stools on 4-26, 4-27 and 4-28-13. The report sheets also documented Tenant #1 had a black and blue finger identified on 5-1-13. On 5-4-13 the report sheets documented Tenant #1 had been wearing adult briefs and was struggling to eat, requiring lots of assistance. The clinical record contained a signed service plan dated 10-17-12 but lacked evidence of comprehensive evaluations of cognitive, health and functional abilities to base that service plan on. The clinical record also lacked evidence of completion of evaluations with the above mentioned changes in health and functional abilities of Tenant #1.

  Tenant #3, an 87 year old, was admitted to the memory care unit 3-25-13 with diagnoses of HTN, Senile Dementia, Spinal Stenosis and Osteoarthritis. The clinical record contained a three page form for comprehensive functional, cognitive and health status. This form was dated 4-19-13 and signed by the RN but was totally blank of any assessment or comment completed by the nurse. The required cognitive, functional and health evaluations for 30 days after occupancy were not completed.

  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))

**F. Service Plans**

- Monitoring Observation: The most recent functional and health evaluations completed for Tenant #1 were dated 12-16-11. The Nurse's Notes dated 4-8-13 documented Tenant #1 had a Global Deterioration Score (GDS) of "6" which indicated severe cognitive decline. The program provided shift Report Sheets written by the unlicensed staff which documented Tenant #1 experienced bloody stools on 4-26, 4-27 and 4-28-13. The report sheets also documented Tenant #1 had a black and blue finger identified on 5-1-13. On 5-4-13 the report sheets documented Tenant #1 had been wearing adult briefs and was struggling to eat, requiring lots of assistance. The clinical record contained a signed service plan dated 10-17-12 but lacked evidence of comprehensive evaluations of cognitive, health and functional abilities to base that service plan on. The clinical record also lacked evidence of completion of changes to the service plan with interventions for the above mentioned changes in health and functional abilities of Tenant #1

  The program provided an Incident/Accident report for Tenant #2 dated 4-17-13 which documented Tenant #2 was found on the floor face down. The report indicated the parts of Tenant #2's body impacted were face and shoulder. The Nurse's Notes in the clinical record dated 4-18-13 documented that a facsimile had been received from the physician regarding a fall. On 4-22-13 the physician ordered to discontinue the blood thinner Plavix and apply a bandage daily to the open wound. Tenant #2 was seen at the program by a nurse practitioner on 5-2-13 and antibiotic and warm compresses were ordered for a diagnosis of early cellulitis. The service plan dated 3-28-13 lacked inclusion of interventions of covering the open wound or applying warm compresses. The Medication Administration Record (MAR) and the Task Sheet for Tenant #2 lacked inclusion of directions for staff to complete the above mentioned tasks.

  Tenant #3 was admitted to the memory care unit 3-25-13. The clinical record lacked evidence of completion of a preliminary service plan prior to the tenant taking occupancy.

  Report Sheets completed by unlicensed staff documented Tenant #3 had urinated and defecated on the floor on 4-26 and 5-5-13 and complained of right leg pain on 4-26, 4-27, 4-28, 5-1 and 5-4-13. The notes also documented Tenant #3 was agitated on the verge of aggression and taking clothing off on 4-28. The service plan dated 4-19-13 lacked specific interventions to address reports of pain and/or behaviors.

  Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))

Regulatory Insufficiency: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

Regulatory Insufficiency: The service plan shall be individualized and shall indicate the tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)a)

**G. Tenant Documents**

- Monitoring Observation: The undated program Policy and Procedure for Incident Reports directed, staff members were to immediately notify the Nurse/Manager if a tenant becomes ill, has fallen, their behavior is abnormal, or any unusual event occurs. An incident report is to be completed by the Health Care Coordinator, Manager or person in charge for documentation purposes.

  The shift Report Sheet completed by unlicensed personnel dated 5-1-13 documented Tenant #1 had a black and blue finger. The program was unable to provide documentation of a completed incident report.

  The monitor observed Tenant #1 to have a healing bruise under his/her right eye on 5-6-13. The clinical record lacked documentation of a nursing assessment and the program was unable to provide an incident report to explain how the injury to the eye occurred or when it had happened.

  Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record). (IAC r. 481.69.25(1) o.)