IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 44175-C

August 20, 2013

Mr. Marc Strohschein, Administrator
Senior Star at Elmore Place Assisted Living
4500 Elmore Avenue
Davenport, IA 52807

RE: Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report – Senior Star at Elmore Place Assisted Living, Davenport, IA

Dear Mr. Strohschein:

Enclosed is the **Final Complaint/Incident Investigation & Recertification Monitoring Evaluation 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 completed the review of your Plan of Correction (POC) in response to the **Preliminary Complaint/Incident Investigation & Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0295** with effective dates of **July 15, 2013** through **July 14, 2015**.

If you have any questions in regard to this certification, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report

Assisted Living Program: **Complaint/Incident Intake #:** 44175-C

Marc Strohschein, Administrator
Senior Star at Elmore Place Assisted Living
4500 Elmore Ave.
Davenport, IA 52807

Date of Monitoring Visit:

July 22 & 23, 2013

Monitor(s):

Hal L. Chase, RN BSN MPH

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 were provided by the Program at the time of the on-site.

General Population Program	
Number of tenants without cognitive disorder:	72
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	73
TOTAL census of Assisted Living Program	73

Tenant/Family Satisfaction Results – A community meeting was held with 67 tenants in attendance. Tenants reported they liked living at the Program. Housekeeping was completed to their satisfaction and the building and grounds were clean, safe and sanitary. Nursing services were available and staff responded to calls for assistance within 10 minutes. Staff knew what services to provide, were adequately trained and treated tenants with respect and dignity. Food was good with a variety of meats, vegetables and deserts offered throughout the week. There were enough activities offered throughout the day and week. Tenants reported they felt safe, made their own decisions and were generally satisfied with the Program and would recommend the Program to anyone.

Program History – The program received regulatory insufficiencies in the areas of Program Reporting to the Department, Evaluations, Service Plans and Nurse Review during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

A. Program Reporting to the Department

Complaint/Incident Allegation #44175-C: It was alleged Tenant #1 had eloped from the Program. Tenant #1 had crossed a busy intersection and was found in front of a retail store.

- Monitoring Observation: Tenant #1, an 84 year old, was admitted on 1-16-13 and had diagnoses of: Coronary Artery Disease, Depression, Memory Loss, Hypertension (HTN) and Hyperlipidemia. A Mini Mental Status Examination was completed on 2-14-13, with Tenant #1 scoring 29 out of 30, indicating normal cognition.

  Nurse's notes of 2-24-13 indicated Tenant #1 was "very" agitated and uncooperative with staff. Tenant #1 told staff he/she wanted to leave the facility. Tenant #1's family was called, came to the Program and met with Tenant #1. Family refused to take Tenant #1 home and Tenant #1 became more agitated.

  Tenant #1's physician was notified on 4-27-13, 5-8-13 and 6-6-13, of increased confusion, anxiousness and wandering. The Program requested and Tenant #1 was prescribed prn antipsychotics and anti-depressants.

Nurse's notes of 4-29-13 indicated Tenant #1's family notified Program staff Tenant #1 wanted to move out of the Program. On 4-29-13, Tenant #1 was tearful and reported he/she "just wants to go home."

On 5-8-13 the Program notified Tenant #1's physician Tenant #1 was found outside the entrance to the to the Program's corporate office (at the entrance to the Program and Elmore Ave.)

On 5-13-13 Tenant #1 continuously tried to walk off the property without notifying staff or family. Notes indicated Program staff met with and told family the Program was an assisted living facility and they were unable to control Tenant #1's coming and going off the property. Family reported they understood and were trying to make a decision whether placing Tenant #1 into memory care.

On 6-6-13 the Program notified Tenant's physician that Tenant #1 had increased anxiety and was wandering throughout the Program.

On 6-7-13 Tenant #1 was at the front desk with coat and purse and looking in for family in the parking lot. Tenant #1 was redirected back to his/her room. An incident report of 6-7-13 indicated staff found Tenant #1 on a "very" busy street, two blocks from the Program. Tenant #1 reported he/she was out getting deodorant from a store not located in the area he/she was going to.

Staff #2, #3 and #4 were interviewed and reported Tenant #1 was confused, disoriented, anxious and delusional. Each reported Tenant #1 had eloped from the Program on 5-8-13 and 6-7-13.

A cognitive evaluation completed on 2-14-13 indicated normal cognitive function. However, Tenant #1 demonstrated increased agitation, anxiety and confusion beginning 2-24-13 through 6-7-13. Tenant #1 reported to staff he/she wanted to leave the Program and was found off the Program's grounds on two separate occasions without the Program's knowledge. The Program did not report to the department when Tenant #1 had eloped on 5-8-13 and again on 6-7-13.

- 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))

B. Evaluation of Tenant

- Monitoring Observation: Five tenant files were reviewed. No issues were found with Tenants #3 and #4.

  Tenant #1's functional, cognitive and health evaluations of 2-14-13 indicated behavioral or safety issues and was independent with ambulation.

  Nurse's notes of 2-24-13 through 6-7-13 indicated increased agitation, anxiety, confusion and told staff he/she wanted to leave the Program.

Tenant #1's physician was notified on 4-27-13, 5-8-13 and 6-6-13, of increased confusion, anxiousness and wandering. The Program requested and Tenant #1 was prescribed prn antipsychotics and anti-depressants.

On 5-8-13 the Program notified Tenant #1's physician Tenant #1 was found outside the entrance to the to the Program's corporate office (at the entrance to the Program and Elmore Ave.)

On 5-13-13 Tenant #1 continuously tried to walk off the property without notifying staff or family. Notes indicated Program staff met with and told family the Program was an assisted living facility and they were unable to control Tenant #1's coming and going off the property. Family reported they were aware of this and was trying to make a decision of memory care placement.

On 6-7-13 Tenant #1 was at the front desk with coat and purse and looking in for family in the parking lot. Tenant #1 was redirected back to his/her room. An incident report of 6-7-13 indicated staff found Tenant #1 on a "very" busy street, two blocks from the Program. Tenant #1 reported he/she was out getting deodorant from a store not located in the area he/she was going to.

Tenant #1 demonstrated increased agitation, anxiety and confusion beginning 2-24-13 through 6-7-13. Tenant #1 reported to staff he/she wanted to leave the Program and was found off the Program's grounds on two separate occasions without the Program's knowledge.

The Program did not complete a functional, cognitive and health evaluation with a change in condition.

Tenant#2, a 91 year old, was admitted on 8-17-12 and had diagnoses of: HTN, Chronic Kidney Disease, History of Falls, Hyperlipidemia, and History of Laceration to Scalp, Osteoarthritis, Vertigo, History of Compression Fracture, and Degenerative Scoliosis of the Lumbar Spine.

Functional and health evaluations were completed on 7-19-13. A cognitive evaluation was last completed on 11-16-13, with Tenant #2 scoring 28 out of 30, which indicated normal cognition.

Tenant #2's nurse's notes of 6-14-13 indicated the Program requested an order for a urinalysis and culture and sensitivity due to Tenant #2's itching in the pubic area and an odor in his/her urine and vaginal area. On 6-21-13 Tenant #2's physician reviewed lab results and no new orders were written.

On 6-23-13 staff found Tenant #2 on the floor. Blood was noted on the back of Tenant #2's head and on the bathroom floor. Tenant #2 was transported to a hospital emergency department for treatment and admitted with a head laceration.

On 6-28-13 Tenant #2 returned to the Program. Six staples had been placed to the posterior (backside) of Tenant #2's head.

On 7-5-13 Tenant #2 was found by staff on the bathroom floor. Tenant #2 complained of lower back pain, but did not complain or discomfort during ambulation. Tenant #2 reported he/she lost her balance and slipped.

On 7-10-13 Tenant #2 complained of severe lower back pain. The Program notified Tenant #2's physician and an order for an x-ray was given.

On 7-16-13 a nurse review indicated evaluations needed to be completed. Functional and health evaluations were completed on 7-19-13, but a cognitive evaluation was not completed.

Nurse's notes of 6-14-13 through 7-10-13 indicated a significant change in condition. Tenant #2 had been scratching his/her pubic area and a strong odor of urine was present. Tenant #2 was hospitalized 6-23-13 through 6-28-13, initially complained of lower back pain on 7-5-13, then severe back pain and subsequent x-ray of the lower back on 7-10-13. Functional, cognitive and health evaluations were completed on 7-19-13, however, evaluations were not done prior when a change in condition existed.

Tenant #5, a 92 year old, was admitted on 12-22-10 and had diagnoses of: Diabetes Mellitus with Neuropathy, Hypothyroid Disturbance, HTN, Urosepsis, Bilateral Cataracts, history of a Hysterectomy and Hyperparathyroidism. A Global Deterioration Scale (GDS) was completed on 10-15-12 and staged Tenant #5 at three, which indicated mild cognitive impairment.

Nurse's notes of 5-23-13 indicated staff responded to a page from Tenant #5 and found him/her on the floor in the bathroom. Tenant #5 complained of right hip pain initially and later complained of left hip pain. Tenant #5 was transported to a local hospital emergency room for evaluation and treatment. The Program was notified Tenant #5 had fractured a right hip.

Nurse's notes of 7-11-13 indicated Tenant #5 returned from the hospital. Post discharge orders included the use of a wheel-chair and home health care for physical therapy, occupational therapy. Functional and health evaluations were completed, but a cognitive evaluation was not completed.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also 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 services professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

C. Service Plan

- Monitoring Observation: Five tenant files were reviewed. No issues were found with Tenants #3 and #4.

  Tenant #1's service plan of 2-14-13 indicated no behavioral or safety issues and was independent with ambulation.

  Nurse's notes of 2-24-13 through 6-7-13 indicated increased agitation, anxiety, confusion and told staff he/she wanted to leave the Program.

  Tenant #1's physician was notified on 4-27-13, 5-8-13 and 6-6-13, of increased confusion, anxiousness and wandering. The Program requested and Tenant #1 was prescribed prn antipsychotics and anti-depressants.

  On 5-8-13 the Program notified Tenant #1's physician Tenant #1 was found outside the entrance to the to the Program's corporate office (at the entrance to the Program and Elmore Ave.)

  On 5-13-13 Tenant #1 continuously tried to walk off the property without notifying staff or family. Notes indicated Program staff met with and told family the Program was an assisted living facility and they were unable to control Tenant #1's coming and going off the property. Family reported they were aware of this and was trying to make a decision of memory care placement.

  On 6-7-13 Tenant #1 was at the front desk with coat and purse and looking in for family in the parking lot. Tenant #1 was redirected back to his/her room. An incident report of 6-7-13 indicated staff found Tenant #1 on a "very" busy street, two blocks from the Program. Tenant #1 reported he/she was out getting deodorant from a store not located in the area he/she was going to.

  Tenant #1 demonstrated increased agitation, anxiety and confusion beginning 2-24-13 through 6-7-13. Tenant #1 reported to staff he/she wanted to leave the Program and was found off the Program's grounds on two separate occasions without the Program's knowledge.

  The Program did not establish interventions related to Tenant #1's increased confusion, anxiety, wandering and exit seeking.

  Tenant #2's service plan was updated on 7-19-13 and established interventions related to high risk for falls, toileting, ambulation and transfer and medication administration.

  Tenant #2's nurse's notes of 6-14-13 indicated the Program requested an order for a urinalysis and culture and sensitivity due to Tenant #2's itching in the pubic area and an odor in his/her urine and vaginal area. On 6-21-13 Tenant #2's physician reviewed lab results and no new orders were written.

On 6-23-13 staff found Tenant #2 on the floor. Blood was noted on the back of Tenant #2's head and on the bathroom floor. Tenant #2 was transported to a hospital emergency department for treatment and admitted with a head laceration.

On 6-28-13 Tenant #2 returned to the Program. Six staples had been placed to the posterior (backside) of Tenant #2's head.

On 7-5-13 Tenant #2 was found by staff on the bathroom floor. Tenant #2 complained of lower back pain, but did not complain or discomfort during ambulation. Tenant #2 reported he/she lost her balance and slipped.

On 7-10-13 Tenant #2 complained of severe lower back pain. The Program notified Tenant #2's physician and an order for an x-ray was given.

On 7-16-13 a nurse review indicated evaluations needed to be completed. Functional and health evaluations were completed on 7-19-13, but a cognitive evaluation was not completed.

Tenant #2's file indicated he/she received physical therapy beginning 7-10-13 for therapeutic exercise, gait, balance and transfer training. Tenant #2 also received wound care from an outside provider beginning 7-1-13 for post hospitalization wound care related to the head laceration of 6-23-13 and for a dorsal side right great toe stage three pressure ulcer.

The Program did not update the service with a change in condition existing prior to 7-19-13. The service plan of 7-19-13 indicated Tenant #2 received physical therapy but the service plan did not indicate Tenant #2 received wound care related to a head laceration and a Stagg three pressure ulcer to the right great toe.

Tenant #5's service plan was updated on 7-15-13, four days after Tenant #5 had returned from the hospital. The service plan was not supported by a cognitive evaluation.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluation conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service 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: The service plan shall be individualized and shall indicate, at a minimum: (a) The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

D. Nurse Review

- Monitoring Observation: Five tenant files were reviewed. No issues were found with Tenants #3 and #4.

Tenant #1's nurse's notes of 2-24-13 through 6-7-13 indicated increased agitation, anxiety, confusion and told staff he/she wanted to leave the Program.

Tenant #1's physician was notified on 4-27-13, 5-8-13 and 6-6-13, of increased confusion, anxiousness and wandering. The Program requested and Tenant #1 was prescribed prn antipsychotics and anti-depressants.

On 5-8-13 the Program notified Tenant #1's physician that Tenant #1 was found outside at the entrance to the to the Program's corporate office. On 5-13-13 Tenant #1 continuously tried to walk off the property without notifying staff or family.

On 6-7-13 Tenant #1 was at the front desk with coat and purse and looking in for family in the parking lot. Tenant #1 was redirected back to his/her room. An incident report of 6-7-13 indicated staff found Tenant #1 on a "very" busy street, two blocks from the Program. Tenant #1 reported he/she was out getting deodorant from a store not located in the area he/she was going to.

The Program did not complete a nurse review when Tenant #1 had left the Program on 5-8-13. A nurse review was completed on 6-7-13 after Tenant #1 had eloped. Family stayed with Tenant #1 until treatment was found.

A 90-day nurse review was completed on 5-13-13, but the nurse review indicated no change in condition despite incidents documented in nurse's notes of increased anxiety, confusion, wandering and two separate elopements.

Tenant #2's file indicated a 90-day nurse review was completed on 7-1-13 following a hospitalization for a fall and subsequent physical therapy. The nurse review indicated there was no significant change in Tenant #2's functional, cognitive or health status. The 90-day nurse review of 7-1-13 did not correctly assess the health status of Tenant #2.

- Regulatory Insufficiency: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r.481-69.27(1))

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. 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 monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r.481-69.27(1))

- Regulatory Insufficiency: 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)