IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
45219-C

October 17, 2013

Ms. Carrie Stone, Interim Administrator
Homestead Assisted Living
2501 W. State Street
Mason City, IA 50401

RE: Final Complaint/Incident Investigation Report, Homestead Assisted Living, Mason City, Iowa

Dear Ms. Stone:

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: **Complaint/Incident Intake #: 45219-C**

Carrie Stone, Interim Administrator
Homestead Assisted Living
2501 W. State Street
Mason City, IA 50401

Date of Complaint/Incident Investigation:

September 25, 2013

Monitor(s):

Lori Miner, RN BSN

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:	30
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	32
TOTAL census of Assisted Living Program	32

Program History – During the April 8, 2013 recertification visit the program received regulatory insufficiencies in the following areas: Evaluation, Service Plan, Tenant Documents and Food Service.

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

A. Evaluation

Complaint/Incident Allegation: It was alleged tenants had strokes and were not evaluated which resulted in a decline in the tenants' health.

- Monitoring Observation: The program was asked to provide documentation of tenants who had been hospitalized and those that had been discharged in the last six months. Staff interviews were also conducted to identify tenants. Four tenant files were reviewed.

  Tenant #1, an 89 year-old, was admitted on 7-16-12 and had diagnoses of: Hypercholesteremia, Colon Cancer, Hypertension, Osteoporosis, Compression Fracture and Falls. On 4-1-13, Tenant #1 scored 22 of 30 on the Mini-Mental State Examination (MMSE) which indicated mild impairment. Evaluations of function, cognition, and health were completed on 4-1-13 following a diagnosis of disk compression in the back which resulted in back pain. The program provided more assistance for activities of daily living following the evaluations according to the nurse's notes. The service plan of 4-1-13 was based on the evaluations of the same date.

  Nurse's notes of 4-8 and 4-11-13 indicated Tenant #1 was found on the floor but sustained no injuries. Nurse reviews were completed following the incidents and the physician was notified by fax of the incidents. Physical Therapy (PT) began visits on 4-26-13 for strengthening. Tenant #1 was identified as needing assistance with transfers and ambulation. The service plan of 4-1-13 identified Tenant #1 required staff assist with ambulation and transfers and would call for assistance when needed.

Beginning with nurse's notes dated 5-23-13, documentation by the Registered Nurse (RN) indicated Tenant #1 refused staff assist with transfers and ambulation. PT services continued. Tenant #1 was discharged from PT on 6-3-13 as progress had plateaued.

On 6-4-13 the RN documented an attempt to set up a meeting with Tenant #1, family, and the RN to discuss a managed risk agreement. Both Tenant #1 and the family refused a meeting. Documentation of 6-17-13 indicated staff members continued to attempt to assist Tenant #1 with activities of daily living, ambulation, and transfers. The former program administrator discussed the need for assistance with ambulation and transfers with Tenant #1 on 6-17-13. It was agreed that PT would be asked to evaluate Tenant #1 again. According to the RN, the former program administrator also discussed possible discharge from the program with Tenant #1 if safety could not be maintained. PT evaluated Tenant #1 on 6-19-13 and indicated Tenant #1 demonstrated unsafe practice and required assistance with ambulation and transfers. A nurse review of 6-28-13 indicated Tenant #1 was to meet with the physician the following week.

Nurse's notes dated 6-30-13 documented Tenant #1 was found sitting on the floor at approximately 6:15 a.m. with slurred speech, left sided weakness, and drooling. Tenant #1 was transported to the hospital via ambulance. Documentation at 2 p.m. indicated Tenant #1 had a stroke. Tenant #1 was transferred from the hospital to another facility on 7-3-13 and was discharged from the program on 8-26-13.

The clinical record documented ongoing assessments of Tenant #1's condition.

Tenant #2, a 92 year-old, was admitted on 11-30-12 and had diagnoses of: Hypertensions and Chronic Airway Obstruction. Tenant #2 scored 25 of 30 on the MMSE dated 9-13-13 which indicated intact intellectual functioning. A 90-day nurse review was completed on 7-5-13 which indicated Tenant #2 was independent with transfers and ambulation.

Nurse's notes dated 9-11-13 documented Tenant #2 sustained a fall with injury. A nurse review documented the RN's assessment of the tenant at the time of the injury. Tenant #2 was transported to the hospital via ambulance. An incident report was completed. The physician was notified of the incident.

Tenant #2 was diagnosed with facial fractures. Tenant #2 returned to the program on 9-13-13. The RN completed evaluations of function, cognition, and health on 9-13-13. Nurse's notes of 9-16 through 9-19-13 documented continuing evaluation of Tenant #2's condition.

Tenant #2 was independent with transfer and ambulation when a fall with fractures occurred on 9-11-13. Evaluations of function, cognition, and health were completed after hospitalization. Ongoing evaluation of Tenant #2's condition was completed for almost a week after return to the program.

Tenant #3, a 93 year-old, was admitted on 4-23-11 and had diagnoses of: Systolic Congestive Heart Failure, Pulmonary Hypertension, Hypertension, and

Hypothyroidism. Evaluations of function, cognition, and health were completed on 4-6-13. Tenant #3 scored 26 of 30 on the MMSE which indicated intact intellectual functioning. A service plan was created on 4-6-13 and was based on evaluations. Tenant #3 was independent with activities of daily living and the program administered medications. Faxes to the physician dated 4-5, 4-8, and 4-12-13 documented communication to the physician about low blood pressures, following the physician's guidelines to be notified if the blood pressure was less than 140 systolic for more than two days.

Staff #1 was interviewed and stated she was working in the kitchen at the time Tenant #3 complained of numbness on the left side and something wrong with the leg. Staff #1 stated staff members working with Tenant #3 were directed to elevate Tenant #3's leg and to check vital signs.

The Activity Director was interviewed and stated Tenant #3 attended activities and one day Tenant #3 reported his/her legs felt funny. After exercise class which was 11:15 a.m., Tenant #3 reported to the Activity Director not being able to feel his/her legs. The Activity Director stated she reported the information to the RN.

Nurse's notes completed by the RN dated 4-18-13 and timed 11:50 a.m. indicated Tenant #3 complained of right knee pain, numbness, and the joint "locking up." Tenant #3 sat in the dining area with the leg elevated. Tenant #1 was assisted by one staff to move to the dining room for the noon meal. In an interview, the RN stated Tenant #3 appeared to have a "Charlie horse" in his leg, and the RN observed Tenant #3 ambulate with a steady gait. The RN indicated Tenant #3 reported feeling better. Nurse's notes dated 4-18-13 and timed at 2:00 p.m. documented Tenant #3 had knee pain "off and on."

Nurse's notes dated 4-18-13 and timed 5:55 p.m. indicated staff called the RN to report Tenant #3 was on the floor, alert and oriented, clear speech, without pain or dizziness, no pain with range of motion to the joints and no apparent injury. Staff reported to the RN that Tenant #3 had muscle weakness in the legs when being transferred from the floor to feet to bed. An ambulance was called to assist with the transfer. Tenant #3 was then taken to the hospital.

Nurse's notes dated 4-19-13 documented the RN phoned the hospital. Hospital staff indicated tests were still being run and no diagnosis had been determined. Nurse's notes dated 5-22-13 indicated family moved out Tenant #3's belongings and Tenant #3 was discharged from the program.

In an interview with the RN, she stated the family informed her Tenant #3 was diagnosed with a stroke but does not recall the date she was informed.

The clinical record for Tenant #3 documented the RN's ongoing assessment and communication with the physician regarding medication and low blood pressure. On 4-18-13, Tenant #3 began to complain of knee pain and numbness in the leg. Nurse's notes documented the RN's follow-up with Tenant #3 during the course of the day. Documentation indicated no diagnosis had been confirmed by the following day.

Tenant #4, an 84 year-old, was admitted on 12-18-12 and had diagnoses of: Hypertension and Diabetes. Tenant #4 scored 27 of 30 on the MMSE which indicated intact intellectual functioning.

According to the service plan of 3-13-13, Tenant #4 was independent with bathing. According to the nurse's notes and an incident report 8-16-13, Tenant #4 was in the bathroom when staff checked at 7:15 a.m. Tenant #4 reported passing out and was sitting on the bathroom floor. Tenant #4 denied pain, but did indicate legs felt numb. An ambulance was called and Tenant #4 was transported to the hospital. Physical Therapy notes of 9-6-13 documented Tenant #4 was admitted to the hospital on 8-16-13 for a left-sided stroke.

Evaluations of cognition, and health were completed by the RN on 8-30-13. A functional assessment was completed on 9-3-13 and the service plan was updated. Tenant #4 returned to the program on 9-3-13 with an order for Physical Therapy to evaluate and treat for balance and gait deficits.

On 9-4-13 Tenant #4 was found on the floor twice even though the service plan indicated toileting every two hours. The physician was notified via fax of both falls.

Physical Therapy began visits post-stroke on 9-6-13. On 9-6-13 according to an incident report and nurse's notes, Tenant #4 was found on the floor. Tenant #4 was transported to the hospital for evaluation and returned to the program in less than 24 hours.

Nurse's notes dated 9-9-13 through 9-24-13 documented by the RN indicated changes to insulin, a review of Tenant #4's gait, drops in Tenant #4's blood sugar and communication with the physician. On 9-22-13, Tenant #4 slid out of bed. The room was rearranged to secure the bed against the wall.

Tenant #4 was found on the floor on 8-16-13, was transported to the hospital and diagnosed with a stroke. Upon return on 9-3-13, the nurse's notes documented the RN's ongoing review of Tenant #4's condition.

- Regulatory Insufficiency: None noted.

B. Nurse Review

During the course of the investigation, the following was noted:

- Monitoring Observation: Nurse reviews were completed for Tenant #1 on 4-1 and 6-28-13. According to the service plan of 4-1-13, the program administered medications to Tenant #1. The nurse reviews did not document whether or not Tenant #1 experienced adverse reactions to the medications, or that medications were administered consistent with the orders.

A 90-day nurse review was completed for Tenant #2 on 7-5-13. The program administered medications according to the nurse review. The nurse review did not document whether or not Tenant #2 experienced adverse reactions to the medications, or that medications were administered consistent with the orders.

A nurse review was completed for Tenant #3 on 4-6-13. The program administered medications according to the nurse review. The nurse review did not document whether or not Tenant #3 experienced adverse reactions to the medications, or that medications were administered consistent with the orders. Tenant #3 was discharged from the program in May 2013.

A nurse review was completed for Tenant #4 on 3-13-13. According to the service plan of 3-13-13, the program administered medications to Tenant #4. The nurse review did not document whether or not Tenant #4 experienced adverse reaction to the medications, or that medications were administered consistent with the orders.

A 90-day nurse review was not completed in July 2013 for Tenant #4.

Nurse reviews were not completed every 90 days and did not document a review of adverse reactions or administration of medications consistent with orders.

- 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; and (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))