IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
45121-C

October 21, 2013

Ms. Pam Wells, Director
Glenwood Place Assisted Living
2907 S. 6th Street
Marshalltown, IA 50158

RE: Final Complaint/Incident Investigation Report, Glenwood Place Assisted Living, Marshalltown, Iowa

Dear Ms. Wells:

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. The Request for Reconsideration has been denied due to the doors in question being propped open without staff supervision thereby disengaging the alarm system.

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:

Pam Wells, Director
Glenwood Place Assisted Living
2907 S. 6th St.
Marshalltown, Iowa 50158

Complaint/Incident Intake #:

45121-C

Date of Complaint/Incident Investigation:

September 5 and 9, 2013

Monitor(s):

Maribeth Freland 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:	29
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	29
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	12
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	15
TOTAL census of Assisted Living Program	44

Program History – The program received regulatory insufficiencies in the areas of Policy and Procedures, Transportation, Evaluations, Service Plans, Program Reporting to the Department, Medications, Staffing, Food Service and Dementia Specific Education during this certification period.

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

A. Medications

Complaint/Incident Allegation: It was alleged medications were missing from tenants medication bubble packs.

- Monitoring Observation: During interview, the Registered Nurse (RN) reported she identified two Tramadol tablets were missing from both Tenant #4 and Tenant #5's medication bubble packs when changing medications over for the new month on 8-24-13. Both Tenant #4 and Tenant #5 took Tramadol, a non-narcotic analgesic, on a scheduled basis and on an as needed basis for pain. The RN completed an investigation into the four missing Tramadol tablets and was unable to determine the medication was actually missing. The RN questioned if the pills may have been mistakenly taken from the scheduled bubble pack when giving a Tramadol on an as needed basis. At the time, the program did not count Tramadol at each shift change so the RN could not determine when the Tramadol was actually taken from the bubble packs.

The RN initiated counting all Tramadol administered to tenants by staff members at each shift change, requiring one staff member from the off going and one staff member from the oncoming shifts to count the Tramadol together and document the amount remaining in the bubble packs at shift change. The Tramadol shift counts for both Tenant #4 and Tenant #5 had been correct since 8-30-13.

The RN held a mandatory emergency in-service to initiate the counting of Tramadol and to review the importance of reporting missing medications immediately upon observing the discrepancy on 8-30-13.

The program was not required to count Tramadol. The RN initiated the counting of Tramadol to keep an accurate count of the medication after the four unaccounted for tablets were identified. The RN held an in-service to review medication protocols with staff members and no further tablets had been identified as missing.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation: It was alleged the program did not have enough staff members working to meet the program's identified tenant to staff member ratio without requiring staff members to work overtime.

- Monitoring Observation: The program identified planned scheduling to result in an ideal staff/tenant ratio was to have two universal workers in the general population area and one universal worker in the memory care unit on the day and evening shifts and one universal worker in both the general population area and in the memory care unit on the overnight shift.

  The monitor reviewed the program's staff schedules, noting each day, evening and night shift for both the general population area and the memory care unit had the program identified staffing numbers as described above for each shift in June, July, August and September 2013.

  The program's list of previous employees who had either resigned or were terminated from employment with the program documented four universal workers (Staff #5, #6, #7 and #8) left employment in July, August and September 2013. Staff #5 resigned on 9-4-13, Staff #6 resigned on 8-21-13, Staff #7 resigned on 8-16-13 and Staff #8 resigned on 7-9-13.

  During interview, Staff #1, #2, #3 and #4, all universal workers, reported three universal workers (Staff #5, #6 and #7) left employment with the program in August and September 2013. All three employees worked either the evening or the overnight shift. Employees had been asked to voluntarily fill extra positions due to the staff member resignations. All four universal workers indicated when others did not voluntarily pick up extra work hours; the program administration activated mandatory overtime to assure all shifts were covered.

All four universal workers reported all shifts were filled and denied any shifts did not have the program indicated tenant/staff ratio as identified above. All indicated no more than two shifts were required to be worked simultaneously by any one employee.

The program administration had been conducting interviews for universal worker positions and had just hired one new universal worker.

The program staffed every shift as identified as planned adequate staffing numbers. Staff members were required to work overtime, either voluntarily or mandatory; however, the Department of Inspections and Appeals does not have jurisdiction over fair labor standards. The program administration was currently interviewing in an attempt to replace the universal workers who had resigned from the program.

- Regulatory Insufficiency: None noted.

C. Service Plans

Complaint/Incident Allegation: It was alleged a tenant experienced multiple falls and the registered nurse did not add interventions onto the tenant's service plan addressing the falls.

- Monitoring Observation: The monitor reviewed the program's incident reports for June, July, August and September 2013. Three tenants experienced more than one fall (Tenants #1, #2 and #3). The monitor reviewed the clinical records of all three tenants.

  Tenant #1 experienced two falls in July 2013, one fall in August 2013 and fell out of bed twice in September 2013. Tenant #1's service plan included interventions specific to Tenant #1's falls.

  Tenant #2 experienced one fall in June 2013 and two falls in July 2013. Tenant #2's service plan included interventions specific to Tenant #2's falls.

  Tenant #3 experienced three falls in July 2013. Tenant #3's service plan included interventions specific to Tenant #3's falls.

- Regulatory Insufficiency: None noted.

D. Structural Requirements

Complaint/Incident Allegation: It was alleged staff members assisted program tenants with personal care tasks such as toileting and then assisted with tasks in the kitchen area, posing a contamination risk.

- Monitoring Observation: The program utilized universal workers, whose job description included assisting tenants with personal care tasks, medication administration, housekeeping services and helping in the kitchen or with serving meals to tenants.

During interview, Staff #1, #2, #3 and #4, all universal workers, reported they routinely assisted tenants with personal care tasks, administered tenant medications, performed housekeeping duties as needed and helped in the kitchen and/or with serving tenant meals as needed.

The monitor observed the lunch meal on 9-5-13, noting Staff #2, #3 and #4 assisted with serving tenants and helping tenants through the salad bar. All three staff members washed their hands and put on aprons prior to assisting with serving of the noon meal. The monitor did not note any observable soiling on Staff #2, #3 or #4's clothes.

Universal workers are commonly used in assisted living programs. All staff members utilized an apron to cover his/her clothing and washed his/her hands prior to working in the kitchen area or prior to assisting tenants with food, thereby, avoiding any potential food contamination.

- Regulatory Insufficiency: None noted.

E. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged staff members were required to routinely transfer tenants with two person assistance.

- Monitoring Observation: The program did not identify any tenants requiring a two-person transfer. During interview, Staff #1, universal worker who worked primarily in the program's secured memory care unit, reported there were no tenants residing in the memory care unit who required two-person transfers. During interview, Staff #4, a universal worker who routinely worked in the general population unit, reported there were no tenants residing in the general population area who required a two-person transfer. During interview, Staff #2 and #3, both universal workers who worked primarily in the general population area, reported Tenant #1 required two-person transfer assistance on occasion when he/she became too weak or tired to stand well. Both universal workers indicated the two-person transfer was used to assure staff and tenant safety during the transfer due to Tenant #1's unreliable weakness. Both universal workers indicated Tenant #1 stood easily and transferred with the assistance of one staff member in the early part of the day but began to get tired and weak at the end of the day, at times requiring the second person to transfer.

  Tenant #1's service plan indicated Tenant #1 required the assistance of one staff member to transfer and ambulate. The service plan indicated Tenant #1 did get tired later in the day and was to utilize a wheelchair if weak or tired to prevent falls or injury.

  The monitor was not able to identify any tenants residing at the program who routinely required the assistance of two staff members to transfer.

- Regulatory Insufficiency: None noted.

The following insufficiency was identified during the course of the investigation:

F. Life Safety

- Monitoring Observation: The program had 17 apartments dedicated to dementia specific care. The program's memory care unit was secured with an alarm system to prevent unauthorized exit from the unit. Each outside exit doors and each door leading into the general population area of the building had alarms connected to the program's pager system. Each door had a code pad that staff members were required to input a numerical code to temporarily deactivate the alarm system to allow authorized exit from the unit. Each door was equipped with a 15 second egress bar, which, when pushed continuously, would activate the alarm to the pager system, sound audibly and then release after 15 seconds to allow exit from the unit in an emergent situation. If any of the doors in the memory care unit were opened either without input of the numerical code or by pushing on the door until the 15 second egress released the door, the alarm system would send a message to pagers carried by staff members alerting them to the unauthorized exit and the system identified which door alarmed.

  During the on-site visit at 8:45 a.m., the monitor noted two tenants who resided in the general population area opened the two sets of double doors going into the secured memory care unit and propped each door open using a magnetic piece at the top of the door. When the monitor told the tenants the doors needed to remain shut as they were alarmed, the two tenants reported they are always propped open to allow them to "walk the square" for an hours each day between 8:30 a.m. and 9:30 a.m. every day. The monitor observed the doors to the unit from 8:45 a.m. until 9:10 a.m. when Staff #2, universal worker, came through the doors. Staff #2 stated "these doors are supposed to be shut" and then shut both sets of double doors.

  During interview, the program Director reported both sets of double doors between the memory care unit and the general population area are always propped open for one hour each morning per tenant request to allow tenants in the general population area to walk the perimeter of the building. The Director believed this to be okay because no tenants residing in the apartments where the secured doors were located currently had a GDS score of four or above.

  During interview, the Assistant Director reported both sets of double doors between the memory care unit and the general population area are always propped open for one hour each morning per tenant request to allow tenants in the general population area to walk the perimeter of the building. The Assistant Director also reported many activities occur in a room located within the secured memory care unit prior to lunch and many tenants resided in the secured memory care unit who are not cognitively impaired. The doors are usually propped open before each meal to allow these tenants to leave their apartments or the activity and go to meals without having to open the heavy doors while ambulating with walkers and canes.

The program had been disengaging the alarm system when allowing the doors to the secured memory care unit to be propped open without staff member supervision of the area.

- Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. (IAC r. 481-69.32(2))