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 #: 45381-C

October 25, 2013

Ms. Cathy Johnson, Housing Manager
Golden Horizons Assisted Living
800 Byron Godberson Drive
Ida Grove, IA 51445

RE: Final Complaint/Incident Investigation Report, Golden Horizons Assisted Living, Ida Grove, Iowa

Dear Ms. Johnson:

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. The Request for Reconsideration was reviewed and accepted in the area of Tenant Rights. The rule violation was removed; however, there were enough compelling issues present to identify a deviation from the requirements but they did not meet the standards for a regulatory insufficiency.

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 Johnson, Housing Manager
Golden Horizons Assisted Living
800 Byron Godberson Dr.
Ida Grove, Iowa 51445

Complaint/Incident Intake #:

45381-C

Date of Complaint/Incident Investigation:

September 30, 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:	21
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	22
TOTAL census of Assisted Living Program	22

Program History – The program received regulatory insufficiencies in the areas of Evaluations, Service Plans, Nurse Review, Staffing, Medications, Occupancy Agreement, Policy and Procedures, Record Checks, and Compliance with the Plan of Corrections, during this certification period.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged the Housing Manager treated staff members and tenants rudely and disrespectfully, making threatening statements.

- Monitoring Observation: The monitor interviewed four staff members (Staff #1, #2, #3 and #4). During interview, Staff #1, universal worker (UW), reported she had heard tenants talking about feeling they had been treated rudely by the Housing Manager. Staff #1 reported witnessing a conversation between Tenant #1 and the Housing Manager in early September 2013. Tenant #1 was upset about a trolley ride being 20 minutes late. Tenant #1 reportedly asked the Housing Manager to call to check on the trolley telling the Housing Manager it was her job. Staff #1 heard the Housing Manager respond reportedly telling Tenant #1 she wouldn't know what the Housing Manager's job was. Staff #1 felt the Housing Manager responded in a rude manner. Staff #1 also reported noting a tension between Tenant #2 and the Housing Manager. Staff #1 reported she had never witnessed any altercations between Tenant #2 and the Housing Manager but Tenant #2 had been vocal about feeling the Housing Manager had been treating him/her in a rude, disrespectful manner.

  During interview, Staff #2, certified nurse aide (CNA), reported she had never witnessed any rude or disrespectful treatment of tenants by staff or administration. Staff #2 reported she had heard Tenant #2 and the Housing Manager did not always see "eye to eye". Last week, Staff #2 was sitting in the common dining room area. She noted Tenant #2 was also in the area.

Staff #2 heard the Housing Manager, who was in her office with the door open ask another staff member if "her stalker was out there". Staff #2 believed the Housing Manager was referring to Tenant #2 due to the known tension between Tenant #2 and the Housing Manager. Staff #2 reported when the Housing Manager first came to the program her approach was not the same as the previous Manager with the tenants. Staff #2 believed things had gradually been improving.

During interview, Staff #3, UW, reported witnessing several tenants awaiting a trolley ride in early September. Staff #3 reported hearing Tenant#1 asking the Housing Manager to call to check on the trolley. Staff #3 reported witnessing the Housing Director speaking to the tenant in a rude manner. Staff #3 reported approximately two weeks ago she witnessed an altercation between the Housing Manager and Tenant #2. Tenant #2 was in the Housing Manager's office and the door was open. Tenant #2 and the Housing Manager were speaking to each other in raised voices. Tenant #2 used profanities when talking to the Housing Manager. The Housing Manager did not use profanities. Staff #3 did not hear anything that appeared to be threatening from either participant and did not witness any physical intimidation from the Housing Manager or Tenant #2. The Housing Manager told Tenant #2 to leave her office and Tenant #2 would not leave.

During interview, Staff #4, UW, reported in late August a group of staff members were sitting in the common dining room area eating lunch. Staff #4 reported tenants were also in the same area. Staff #4 reported the Housing Manager told her to "shut up". Staff #4 that she first believed the Housing Manager was serious but then she started laughing and Staff #4 realized she was only kidding. Tenant #2 was sitting in the area at the time and overheard the conversation. Staff #4 reported Tenant #2 approached the Housing Manager later in her office and told the Housing Manager she should not tell her staff members to "shut up". The conversation became heated between both participants. Staff #4 heard Tenant #2 cussing but did not ever hear the Housing Manager use any profanity. The Housing Manager told Tenant #2 to leave the office. Tenant #2 did leave the office. Staff #4 had noted a "personality conflict" since that time between Tenant #2 and the Housing Manager.

The monitor interviewed four tenants (Tenants #1, #2, #3 and #4). Tenant #1, an 83 year old cognitively intact tenant was admitted to the program on 5-1-12. During interview, Tenant #1 reported he/she enjoyed living at the program and felt the direct care workers were very kind and helpful. Tenant #1 reported when the new Housing Manager came to run the program about three months prior, the Housing Director did not introduce herself to the tenants or try to get to know the tenants. This made Tenant #1 feel the Housing Manager didn't care about them. Tenant #1 reported he/she had never felt the Housing Director had treated or spoke to him/her in a rude or disrespectful manner. Tenant #1 had never felt verbally or physically threatened by the Housing Manager. Tenant #1 believed the Housing Manager had been relating to the tenants in a better manner in the previous month or so.

Tenant #2, a 53 year old cognitively intact tenant was admitted to the program on 5-16-13. Tenant #2 experienced a stroke in the previous year, requiring temporary placement at the assisted living while rehabilitating to independence with activities of daily living. During interview, Tenant #2 reported he/she had had two altercations with the Housing Manager since the Manager's hire at the program.

Tenant #2 reported in late August 2013 he/she overheard the Housing Manager tell Staff #4 to "shut up". Tenant #2 reported all of the direct care workers were good employees and did not deserve to be spoken to in such a manner. Tenant #2 later went to the Housing Manager's office to speak with her about her treatment of the staff members. Tenant #2 reported feeling the Housing Manager got defensive and told Tenant #2 he/she should not be eavesdropping on staff conversations. Tenant #2 reported the conversation became heated and admitted to using profanity when speaking to the Housing Manager. Tenant #2 reported the Housing Manager did not use profanity during the conversation. Tenant #2 denied feeling verbally or physically threatened by the Housing Manager but felt that he/she could not express his/her own feelings or make comments to the Housing Manager.

Tenant #2 reported on September 10, 2013 the Housing Manager gave him/her a notice to begin charging 15.00 dollars every time a staff member needed to assist Tenant #2 with taking a shower. Tenant #2 reported that during August he/she had been having staff members allow him/her to do most of the bathing independently in an attempt to become independent with activities of daily living. Tenant #2 became upset about the changes in the fees for services. Tenant #2 reported telling the Housing Manager he/she no longer wanted to receive any assistance with activities of daily living from that day forward. Tenant #2 reported all he/she was willing to pay for was room/board and cable. Tenant #2 reported he/she and the Housing Manager's conversation turned heated. Tenant #2 reported he/she used profanities and said some things that were not very kind during the conversation. Tenant #2 reported the Housing Manager did not use profanity during the conversation. Tenant #2 denied feeling verbally or physically threatened by the Housing Manager during this altercation.

On 9-12-13, Tenant #2 reported his/her Power of Attorney for Financial Purposes arrived at the program, telling Tenant #2 the Housing Manager had called a meeting. Tenant #2 reported he/she felt like a child being tattled to his/her parent. Tenant #2 reported a meeting was held on 9-12-13 with the Housing Director, the program's temporary registered nurse (RN), Tenant #2 and Tenant #2's Power of Attorney for Financial Purposes. Tenant #2 reported the meeting consisted of changes to his/her service plan and a discussion about the altercations previously described between the Housing Manager and Tenant #2. Tenant #2's Power of Attorney for Financial Purposes had been activated on 10-10-12. The Power of Attorney for Financial Purposes was also identified as Tenant #2's Durable Power of Attorney for Health Care Decisions but this Power of Attorney had not been activated as Tenant #2 was cognitively intact and able to make his/her own health care decisions.

During interview, Tenant #2's Power of Attorney for Financial Purposes reported he/she was contacted by the Housing Manager to come to the program on 9-12-13 for a meeting to review Tenant #2's service plan for the 90 day review. The Power of Attorney reported he/she came to the meeting at the request of the Housing Manager. Tenant #2's service plan was reviewed and changes were made to stop all staff member assistance with showers, grooming, dressing and medications assistance per Tenant #2's request. After the service plan review, the Housing Manager discussed two previous altercations which had occurred between the Housing Manager and Tenant #2.

The Power of Attorney reported the Housing Manager had approached him/her on multiple other occasions to discuss the relationship between Tenant #2 and the Housing Manager. The Power of Attorney reported he/she had never approached the Housing Manager to discuss these issues and preferred to not discuss these issues and Tenant #2 was his/her own guardian. The Power of Attorney reported having many conversations with Tenant #2 after the Housing Manager's reports to try to deescalate the situation with very little success.

Tenant #3, a 65 year old cognitively intact tenant was admitted to the program on 12-28-12. During interview, Tenant #3 reported he/she had never been spoken to or treated in a rude or disrespectful manner by the Housing Manager. Tenant #3 denied feeling verbally or physically threatened by the Housing Manager. Tenant #3 denied witnessing rude or disrespectful treatment of other tenants by the Housing Manager.

Tenant #4, an 84 year old cognitively intact tenant was admitted to the program on 10-23-11. During interview, Tenant #4 reported he/she had never been spoken to or treated in a rude or disrespectful manner by the Housing Manager. Tenant #4 denied feeling verbally or physically threatened by the Housing Manager. Tenant #4 denied witnessing rude or disrespectful treatment of other tenants by the Housing Manager.

Tenants #1, #3 and #4 denied rude or disrespectful treatment by the Housing Manager. Tenants #1, #3 and #4 denied witnessing rude or disrespectful treatment of other tenants by the Housing Manager. Tenant #2 reported feeling he/she was spoken to in a rude and disrespectful manner by the Housing Manager on multiple occasions. Tenant #2 admitted to participating in a heated conversation with the Housing Manager on two occasions and admitted to using profanity and unkind comments during the conversation. Tenant #2 reported the Housing Manager did not use profanity during the conversations. Tenants #1, #2, #3 and #4 denied feeling verbally or physically threatened by the Housing Manager. Tenant #2 reported feeling the Housing Manager spoke rudely to her staff members; however, the Department of Inspections and Appeals does not investigate or have jurisdiction over personnel issues. The monitor found both Tenant #2 and the Housing Manager participated in heated arguments. Tenant #2 did not treat the Housing Manager respectfully during the conversations and the Housing Manager reacted to the disrespect in a rude manner. Tenant #2's use of profanity and his/her failure to leave the Housing Manager's office were factors in the escalation of the heated arguments.

The Housing Manager did not promote Tenant #2's autonomy by contacting a Power of Attorney for Financial Purposes to participate in decision making for health care reasons during the 90 day review of the service plan without Tenant #2's permission. The Housing Manager discussed Tenant #2's behaviors with The Power of Attorney for Financial Purposes on multiple occasions without Tenant #2's permission, failing to promote consideration and personal autonomy as Tenant #2 was his/her own guardian.

- While a deviation from the requirements of the rules was found, it did not meet the standards set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

During the course of the investigation, the monitor identified the following:

B. Evaluation

- Monitoring Observation: Tenant #5, an 85 year old was admitted on 8-27-13 with diagnoses of Early Alzheimer's Disease, Osteoarthritis and Hypertension. Tenant #5 answered four questions incorrectly on the program's Cognitive Ability Assessment completed on 8-27-13. The program's assessment requires the use of a Global Deterioration Scale (GDS) Assessment when a tenant answered five or more questions incorrectly. Tenant #5's clinical record contained a statement by the physician declaring Tenant #5 incapacitated and activating his/her durable power of attorney for health care decisions on 8-23-13.

  The program's Communication Book contained an entry, dated 8-27-13, notifying staff members that Tenant #5 had been admitted to the program and had early dementia and forgetfulness. The Communication Book contained an entry, dated 9-11-13, indicating Tenant #5 was missing from the building. Staff members went looking for Tenant #5, finding him/her at his/her previous residence across town. The Communication Book contained an entry, dated 9-22-13, indicating Tenant #5 went out of sight when walking. Staff members drove to find Tenant #5, finding him/her walking on the track at the local high-school approximately one block away.

  According to Nursing Progress Notes, dated 9-10-13, Tenant #5's family came and took Tenant #5's car from the program as a precaution due to his/her forgetfulness. Tenant #5 had been experiencing an increase in forgetfulness, losing the keys to his/her apartment on multiple occasions.

  According to the Nursing Progress Notes, dated 9-16-13, Tenant #5's family came to visit with the RN and the Housing Manager. Documentation indicated Tenant #5 had been experiencing more signs of confusion and becoming anxious around 4:00 PM daily. The program notified Tenant #5's physician who ordered an antianxiety medication to be given to Tenant #5 around supper time.

  The RN completed a functional and health assessment on 9-17-13, citing a change in Tenant #5's cognitive status as the reason for completion of the assessment. Tenant #5's clinical record did not include an assessment of Tenant #5's cognitive status on 9-17-13. The RN who completed the functional and health assessment was off on medical leave at the time of the on-site visit.

  During interview, Staff #1, UW, reported Tenant #5 had gone to his/her previous residence twice shortly after admission. Staff #1 indicated staff members did not know Tenant #5 had left the program grounds and found Tenant #5 at the residence after driving to look for him/her. Staff #1 reported Tenant #5 began going to the recreation center in town to walk supervised today with plans for staff to take Tenant #5 to the recreation center Monday through Friday mornings for supervised walks.

  During interview, Staff #3, UW, reported Tenant #5 had gone to his/her previous residence twice shortly after admission. Staff #3 indicated staff members did not know Tenant #5 had left the program grounds and found Tenant #5 at the residence after driving to look for him/her.

During interview, Staff #2, CNA, reported Tenant #5 was brought back to the program on Friday 9-27-13 by a female acquaintance after the acquaintance found Tenant #5 in the community confused and unsure of where to go.

On 9-30-13 at 3:00 p.m. during the on-site monitor's visit, Staff #5 reported Tenant #5 was off of the premises and believed him/her to be at the high-school walking on the track. At 3:40 p.m. the monitor noted Tenant #5 to be back. When visiting with Tenant #5, he/she reported going for a walk to the city's downtown area and then got a ride back to the program from a male acquaintance as he/she had gone too far and had sore toes. No staff members actually witnessed Tenant #5's return to the program.

Tenant #5's clinical record contained a Negotiated Risk Agreement, dated as signed on 9-30-13 by Tenant #5's family member. The Negotiated Risk Agreement indicated Tenant #5 experienced confusion and forgetfulness. Tenant #5 enjoyed going for walks and may get lost when on the walks or fall and be unable to summon assistance.

The Housing Manager and the temporary RN were unable to find documentation of completion of a cognitive evaluation at the time of the monitor's exit conference.

The RN failed to complete a cognitive evaluation for Tenant #5 after a noted change in cognitive status. Tenant #5 had gone from the program on at least four identified times, requiring staff members to either go looking for Tenant #5 or was brought back to the program by community members after being found in the community either confused or too far from the program to return independently. As the program had failed to complete a cognitive evaluation, the monitor was unable to determine the extent of Tenant #5's cognitive decline at the change of condition. The program would have been unable to determine if Tenant #5 was safe leaving the program unsupervised if they did not have a clear idea of Tenant #5's cognitive decline since admission to the program.

- 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))

C. Managed Risk Consensus Agreements

- Monitoring Observation: The program's Communication Book contained an entry, dated 8-27-13, notifying staff members that Tenant #5 had been admitted to the program and had early dementia and forgetfulness. The Communication Book contained an entry, dated 9-11-13, indicating Tenant #5 was missing from the building.

Staff members went looking for Tenant #5, finding him/her at his/her previous residence across town. The Communication Book contained an entry, dated 9-22-13, indicating Tenant #5 went out of sight when walking. Staff members drove to find Tenant #5, finding him/her walking on the track at the local high-school approximately one block away.

According to Nursing Progress Notes, dated 9-10-13, Tenant #5's family came and took Tenant #5's car from the program as a precaution due to his/her forgetfulness. Tenant #5 had been experiencing an increase in forgetfulness, losing the keys to his/her apartment on multiple occasions.

According to the Nursing Progress Notes, dated 9-16-13, Tenant #5's family came to visit with the RN and the Housing Manager. Documentation indicated Tenant #5 had been experiencing more signs of confusion and becoming anxious around 4:00 PM daily. The program notified Tenant #5's physician who ordered an antianxiety medication to be given to Tenant #5 around supper time.

During interview, Staff #1, UW, reported Tenant #5 had gone to his/her previous residence twice shortly after admission. Staff #1 indicated staff members did not know Tenant #5 had left the program grounds and found Tenant #5 at the residence after driving to look for him/her. Staff #1 reported Tenant #5 began going to the recreation center in town to walk supervised today with plans for staff to take Tenant #5 to the recreation center Monday through Friday mornings for supervised walks.

During interview, Staff #3, UW, reported Tenant #5 had gone to his/her previous residence twice shortly after admission. Staff #3 indicated staff members did not know Tenant #5 had left the program grounds and found Tenant #5 at the residence after driving to look for him/her.

During interview, Staff #2, CNA, reported Tenant #5 was brought back to the program on Friday 9-27-13 by a female acquaintance after the acquaintance found Tenant #5 in the community confused and unsure of where to go.

Tenant #5's clinical record contained a Negotiated Risk Agreement, dated as signed on 9-30-13 by Tenant #5's family member. The Negotiated Risk Agreement indicated Tenant #5 experienced confusion and forgetfulness. Tenant #5 enjoyed going for walks and may get lost when on the walks or fall and be unable to summon assistance. The family member signed the negotiated risk agreement but Tenant #5 did not sign the agreement.

- Regulatory Insufficiency: A consensus-based process to address specific risk situations. Program staff and the tenant shall participate in the process. The result of the consensus-based process may be a managed risk consensus agreement. The managed risk consensus agreement shall include the signature of the tenant and the signatures of all others who participated in the process. (IAC r. 481-69.31(2))