IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
45642-C
45929-C

November 18, 2013

Ms. Deborah Slusarczyk, Manager
Willow Pointe Senior Living
17396 Kingbird Avenue
Mason City, IA 50401

RE: Final Complaint/Incident Investigation Report, Willow Pointe Senior Living, Mason City, Iowa

Dear Ms. Slusarczyk:

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 #:** 45642-C, 45929-C

Deborah Slusarczyk, Manager
Willow Pointe Senior Living
17396 Kingbird Avenue
Mason City, IA 50401

Date of Complaint/Incident Investigation:

November 4 & 5, 2013

Monitor(s):

Margaret Kaltefleiter, RN MS

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:	15
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	17
TOTAL census of Assisted Living Program	17

Program History – The program received regulatory insufficiencies in the areas of Criteria for Admission and Retention of Tenants and Transportation during the April 2013 Recertification on-site.

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

A. Staffing

Complaint/Incident Allegation #45929-C: It was alleged a staff put tissue on a tenant's sore legs resulting in the legs being infected.

- Monitoring Observation: The Manager stated there were no tenants with wounds but did identify Tenants #1 and #2 as tenants who received skin treatments.

  Tenant #1, a 76 year old, was admitted on 1-29-10 and diagnoses included: Anemia, Depression, Hypertension (HTN), Urinary Incontinence, Benign Prostatic Hypertrophy (BPH), Vitamin Supplement, Peripheral Edema, Diabetes Mellitus, Insulin Dependent Type II, Hyperlipidemia, Chronic Obstructive Pulmonary Disease, Constipation, Arthritis and Insomnia. According to the Medication Administration Record (MAR) Tenant #1 had an order dated 12-10-12 to apply Mepilex to coccyx as needed for broken skin. According to the Nurse's Notes dated 10-10-13, Tenant #1 returned from a doctor's appointment with a new order for EPC Cream to coccyx daily. On 10-11-13, Tenant #1 expressed concern over the EPC Cream order because of the use of the Mepilex patches and the increased cost of the patches if removed daily to apply the EPC Cream. A fax was sent to the Physician. According to the Nurse's Notes dated 10-15-13 as a 90 Day Nurse Review, Tenant #1 had an ongoing skin issue on coccyx which Mepilex was used for. Tenant #1 did not sleep in bed but sitting in recliner. This added to coccyx issues along with incontinence. A recent order was received that included trying EPC cream nightly and leaving Mepilex off. This would be started on the next bath day. According to the Nurse's Notes dated 10-28-13, a new order was received, reviewed and noted for EPC cream and Mepilex.

The Manager stated Tenant #1 had a crack between the butt cheeks when Tenant #1 moved in and it was due to incontinence, being continually moist and the area was never open to the air. The treatment had been changed recently to EPC Cream at bedtime and after Tenant #1's bath. There was an order for Mepiflex as needed.

Tenant #2, a 63 year old, was admitted on 10-1-09 and diagnoses included: Dependent Edema, Type II Diabetes Mellitus, Essential HTN, Hyperlipidemia, Uric Acid Kidney Stone, Depression, Hirsutism, Morbid Obesity, Osteoarthritis of Right Knee, Cerebral Palsy, Obstructive Sleep Apnea and History of Physical and Emotional Abuse. According to the Nurse's Notes dated 9-6-13, Tenant #2's shins were red but no open areas. The shins looked improved from a few months ago. According to the Nurse's Notes dated 9-17-13 compression stockings were reinitiated and Tenant #2 declined to have them applied. The MAR reflected Compression Hose, knee high, were placed on each morning and taken off at bedtime. During the month of October, Tenant #2 refused the application of the Compression Hose on October 1, 3,5,10,11,19,20 and 25th. The MAR reflected Bacitracin Antibiotic Ointment applied to affected area as needed and to cover with dressing.

The monitor observed the removal of the Compression Hose on 11-4-13 at 5:30 p.m. The shin area of each lower leg revealed bright red areas. No open areas, weeping or blisters were noted. The Manager measured the reddened areas. The right lower leg measured 13 centimeters (cm) long by 4.6 cm wide. The left lower leg measured 8.3 cm long by 3.8 cm wide. Tenant #2 stated Tenant #2's physician did not know what caused the redness.

Tenant #2 stated there was one time when Staff #5 put a piece of tissue on each reddened area over the ointment before putting on the stockings. After Staff #5 put on the tissue she asked Tenant #2 if that was okay and Tenant #2 said, sure. Staff #5 told Tenant #2 she did not have any Telfa pads to use. That night when Staff #4 removed the stockings, the tissue had stuck a little bit. Staff #4 was able to remove the tissue. Tenant #2 stated she did not have an infection in the legs due to the tissue but a sore did break open. That sore has since healed.

Staff #5 was interviewed and stated she had provided wound treatment for Tenant #2. She stated she believed there was one time when she applied tissue on Tenant #2's legs but Tenant #2 wanted it. Staff #5 stated afterwards there was a note in the communication book that stated someone put tissue on Tenant #2's wound and not to do that again. Staff #5 stated she had not done that since.

Staff #4 stated there was one time she found tissues on Tenant #2's legs. The tissues were sticking to the legs; there was one tissue on each leg. They used to use Telfa on the legs but they quit using anything. Staff #4 removed the tissues slowly from the bottom to the top using Bacitracin as needed. Staff #4 stated Tenant #2 told her Staff #5 applied the tissues. Staff #4 stated the tissues did not cause any infection in the legs. Staff #4 stated she documented what she found in the communication book and the Manager wrote a note that no one was to use tissues on the wounds again.

The Manager stated Tenant #2 had an ongoing issue on the legs for a long time. Bacitracin was applied to the reddened areas and it was covered with a Telfa dressing. The Manager stated she was not aware of any staff putting tissue on Tenant #2's legs.

The Manager was not able to produce the communication book page that reflected the note regarding the tissue placed on Tenant #2's legs.

A Nurse Delegation was completed and signed by Staff #5 on 3-28-13 for Medication Pass and Treatments. Treatments included dressing of skin tears, covering of dressings with a shower, covering of dialysis ports prior to showering and application of any protective covering.

Review of tenant files, interviews with Tenant #2, staff and the Manager revealed Tenants #1 and #2 received skin care treatments and Tenant #2 did have tissue placed on Tenant #2's legs. The tissue did not cause any infection to the skin.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #45929-C: It was alleged a tenant fell resulting in a head injury and was not taken to the emergency room (ER) in a timely manner.

- Monitoring Observation: A review of Incident Reports was completed. An incident report reflecting a tenant with a head injury was identified for Tenant #5.

  Tenant #5, a 92 year old, was admitted on 10-10-10 and diagnoses included: BPH, HTN, Dyslipidemia, Osteopenia, Compression Fracture, Osteoarthritis, Atrial Fibrillation, Congestive Heart Failure, Coronary Artery Disease, Coronary Vascular Disease, Gastric Esophageal Reflux Disease, Hearing Loss, History of Depression, Diverticulosis, Anemia, History of Myocardial Infection, History of Coronary Artery Bypass Graft, Carotid Stenosis and Abdominal Aortic Aneurysm. According to an Incident/Accident Report dated 10-19-13 at 11:55 a.m., Tenant #5 stated Tenant #5 was getting up off the sofa and feet got tangled up and Tenant #5 fell. Tenant #5 hit head on an electric heater. The floor was clean and dry and free of debris. Footwear had heel backs cut. Tenant #5 was assisted to standing with the help of two. Tenant #5 denied any discomfort. A two inch abrasion, scrape to lower back of head in the hair line was noted. Minimal drainage was noted at that time. Tenant #5 declined an offer of an ER consultation. At 2:15 p.m. Tenant #5 was taken to the ER due to head wound bleeding increased.

  According to the Nurse's Notes dated 10-19-13 at 11:55 a.m., the Manager was summoned to Tenant #5's apartment and found Tenant #5 sitting on floor in front of recliner with knees drawn up to chest. Tenant #5 was alert and oriented to person, place and time. Tenant #5 stated, "I'm ok. My feet got tangled up underneath me and I lost my balance sitting down on floor. I bumped my head on the heater." Furniture was askew in the room. Tenant #5 was assisted to standing by two staff members, able to bear weight equally. Tenant #5 verbalized no complaints of discomfort. No external rotation of either lower extremity noted. An abrasion of two inches on back lower right area of head with small amount of bleeding was noted. Tenant #5 declined a need for an ambulance. Pupils were equal and reactive to light, grips were equal. The area on back of head was cleaned and left open to air. Tenant #5 had poor supporting shoes on with backs cut out. Tenant #5 was encouraged to wear better fitting shoes and use a walker for stability. Tenant #5 stated would try to

comply. Phone call was placed to Tenant #5's family to inform of the fall and a fax was sent to Tenant #5's physician.

The Manager was interviewed and stated after the fall Tenant #5 took a nap, which was Tenant #5's normal routine, to nap after each meal. Later a staff asked the Manager to look at Tenant #5's head as it was bleeding due to Tenant #5 rubbing Tenant #5's head. The abrasion appeared to start to open. There was approximately a quarter size area of bloody drainage on the pillow. At 2:15 p.m. the Manager transported Tenant #5 to the ER.

The 24 Hour Assessment section on the Incident/Accident Report dated 10-20-13 at 10:00 a.m. indicated Tenant #5 had six staples to the back of Tenant #5's head intact. Some bluish, purple discoloration was noted surrounding the staple line. Tenant #5 denied discomfort. Pupils were equal and reactive to light and grips were equal. Gait was steady and Tenant #5 was using a cane.

Review of Tenant #5's file, incident reports and a Manager interview indicated Tenant #5 had a fall which resulted in an injury to the head. Treatment was provided as directed by Tenant #5 and as needed.

- Regulatory Insufficiency: None noted.

B. Tenant Rights

Complaint/Incident Allegation 45642-C: It was alleged a dietary staff yelled at a tenant.

- Monitoring Observation: The Manager identified Tenants #1, #2, #3 and #4 as tenants who routinely played card games.

  According to the Manager, on Sunday, 9-15-13, around 11:45 a.m. two friends of Tenant #2 were visiting. Tenant #2 was eating lunch when one of the friends started to remove a table cloth and decorations from one of the dining room tables. The Manager and Staff #1 asked the visitor what he/she was doing. The visitor started to yell that a large table for six people was needed to play cards. The table was going to be used at 2:00 p.m. for a scheduled activity so the Manager offered to put two tables together in the dining room or a large round table was available in the day room. The visitor replied that they just wouldn't play cards. The other visitor started to curse and yelled a list of profanities. Tenant #2 witnessed the situation and later apologized to the Manager for the visitor's actions.

  Tenants #1, #2, #3, #4 and the two visitors went to the activity room and played cards there. The next day the Manager called the Long Term Care Ombudsman and informed her of the situation. The Manager stated that Staff #1 did not yell. She stated she felt she handled the situation the best way she could at the time.

  Tenant #2 was interviewed and stated Tenant #2 had never witnessed any staff yell, including Staff #1. Tenant #2 stated there was one time when one of the tables was undressed without asking Staff #1, thus it was Tenant #2's fault. Staff #1 used a loud

voice at that time when asking Tenant #2 what Tenant #2 was doing but Staff #2 did not yell.

A community meeting was held with 15 tenants and 1 family member. The tenants stated staff treated them good, had not yelled at them and used pleasant voices.

Tenant #3 was interviewed and stated Tenant #3 played cards with Tenants #1, #2 and #4. Once in a great while friends of Tenant #2 played cards with them. Tenant #3 stated he/she had never heard Staff #1 get upset about anything and couldn't imagine Staff #1 getting that way. Tenant #3 stated Staff #1 and Tenant #4 teased each other. Tenant #3 stated staff definitely treated tenants with respect.

Tenant #4 was interviewed and stated Tenant #4 played cards with Tenants #1, #2 and #3. Tenant #4 stated Tenant #4 never had any problems with staff. Tenant #4 admitted joking around with Staff #1 and other tenants, stating it might sound like fighting if someone else heard it. Tenant #4 stated staff treated Tenant #4 well and with respect. Tenant #4 stated one time a visitor moved a table cloth and Staff #1 told the visitor not to do that since the table was set up for a meeting. Staff #1 did not yell at the visitor and they still got to play cards in the activity room.

Staff #2 stated she had never heard any staff yell at a tenant. Staff #3 stated she had not witnessed any staff yell at tenants. Staff #4 stated she had not heard any staff yell at a tenant.

Results of a community meeting and individual interviews with tenants, staff and the Manager indicated staff did not yell at tenants.

- Regulatory Insufficiency: None noted.

C. Transportation

Complaint/Incident Allegation #45642-C: It was alleged several tenants were unable to access the Program's van requiring them to pay for transportation without reimbursement from the Program.

- Monitoring Observation: The Manager stated the Program had a van that was available for shopping trips and outside activities. The Program did not charge tenants when riding the van and the Program did not reimburse tenants for transportation fees as free transportation was available if chosen.

  According to a Program document, the Program had a van that could be used for transportation provided the tenant was able to get into the van as it was not handicap accessible. The van did not have a running board, thus a step stool was needed to gain access to the seat of the van. The Manager indicated there were currently two tenants (Tenants #1 and #2) who were unable to get into the van. Other transportation services were available for use provided by the county. The county transportation charged $2.00 each way for a trip. Tenants with Medicaid funding were able to access transportation that was free of charge. Tenants were informed upon admission of the available transportation that came to the Program.

According to a policy on Transportation, the Program would provide transportation for shopping needs of the tenants and to provide opportunity for trips through the activity program. Every tenant transported would have a seat with an adequate seat belt in the vehicle.

A community meeting with 15 tenants and one family member was held. The tenants stated the Program had a van but some tenants were not able to get into it as the step was too high. Other transportation was available. A handicap bus had a lift. Free transportation was available to all for doctors' appointments. There was transportation available for those with a Medicaid number if three days' notice was given. The tenants reported shopping trips were canceled if enough tenants did not sign up. Staff #4 stated three tenants needed to sign up in order to take the van on a shopping trip.

Tenant #1 was interviewed and stated when Tenant #1 moved into the Program, Tenant #1 had a car and drove self when wanting to go somewhere. Tenant #1 was able to get in and out of the car and didn't need to use the van. Tenant #1 was not currently able to get into a car. Tenant #1 stated Tenant #1 knew Tenant #1's limitations. Tenant #1 had no problems with the Program not providing transportation services for Tenant #1.

Tenant #2 was interviewed and stated Tenant #2 never used the van for transportation when Tenant #2 moved into the Program. No transportation was promised to Tenant #2. Tenant #2 was not able to get into the van as the step to get in was too high. Tenant #2 stated other transportation was available for Tenant #2.

Review of Program policy, a tenant community meeting and interviews with tenants, staff and the Manager indicated several choices of transportation were available.

- Regulatory Insufficiency: None noted.

D. Service Plans

During the course of the onsite investigation, the following information was obtained:

- Monitoring Observation #45642-C, #45929-C: Tenant files were reviewed for Tenants #1, #2, #3, #4 and #5.

  Tenant #1's file was reviewed. According to the Nurse's Notes dated 10-15-13 as a 90 Day Nurse Review, Tenant #1 had an ongoing skin issue on coccyx which Mepilex was used for. Tenant #1 did not sleep in bed but sat in a recliner. This added to coccyx issues along with incontinence. A recent order was received that included trying EPC cream nightly and leaving Mepilex off. Tenant #1's service plan did not reflect the ongoing skin issue with the coccyx; treatments, incontinence and Tenant #1's choice to sleep in a recliner. Tenant #1's service plan did not reflect Tenant #1's identified needs.

Tenant #2's file was reviewed. Tenant #2's service plan indicated Tenant #2 needed assistance washing the back, legs and groin area and drying under abdominal apron. Tenant #2 was independent with hygiene, dressing and undressing and needed help with shoes and socks. Staff would notify nurse of swelling, redness or complaints of tightness in legs. The service plan did not reflect the application and removal of compression stockings and treatment to the reddened areas on the shins. Tenant #2's service plan did not reflect Tenant #2's identified needs.

Tenant #5's file was reviewed. Tenant #5 had Incident/Accident Reports completed for falls on 8-14-13, 10-19-13 and 10-26-13. The service plan was not updated to reflect Tenant #5's tendency for falls or interventions regarding fall prevention. Tenant #5's service plan did not reflect Tenant #5's identified needs.

Review of tenant files indicated service plans did not reflect the identified needs of the tenants.

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