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 #: 46312-C

December 16, 2013

Ms. Tonia Olsen, Manager
Cedar Vale
100 Poppe Lane
Nashua, IA 50658

RE: Final Complaint/Incident Investigation Report – Cedar Vale, Nashua, IA

Dear Ms. Olsen:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of December 10, 2013, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding 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 #:** 46312-C

Tonia Olsen, Manager
Cedar Vale
100 Poppe Lane
Nashua, IA 50658

Date of Complaint/Incident Investigation:

December 10, 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:	17
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	19
TOTAL census of Assisted Living Program	19

Program History – The program received a regulatory insufficiency during the Recertification visit of April 4, 2013 in the area of Dementia Specific Education. During the Complaint Investigation (45466-C) of September 2013, the program received a regulatory insufficiency in the area of Structural.

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

A. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged the Program admitted a tenant who required a higher level of care.

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #1, a 90 year old, was admitted on 10-28-11 and diagnoses included: History of Breast Cancer-Bilateral Mastectomy, Chronic Anxiety, Osteoporosis, Degenerative Arthritis, Hypertension (HTN), Hypothryoidism, Palpitations and Congestive Heart Failure (CHF). According to a service plan dated 10-21-13, Tenant #1 was independent with mobility with the use of a wheeled walker. Medications were set up weekly in a medication planner for Tenant #1's self-administration. Tenant #1 was independent with all Activities of Daily Living (ADLs). According to the Nurse's Notes dated 12-6-13, staff reported Tenant #1 pushed pendant, reported became weak and fell to knees and couldn't catch breath. Blood pressure was 192/86 and pulse was 99. Tenant #1 was transported via ambulance to the hospital. According to the Nurse, Tenant #1 was hospitalized with pneumonia and would be re-assessed prior to readmission to the Program.

  Tenant #2, a 93 year old, was admitted on 8-8-09 and diagnoses included: Polycythemia Vera, Syncope Episodes, Status Post Myocardial Infarction (MI)-1/2010, CHF with Chronic Edema and HTN. Tenant #2 was staged at a four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. According to a service plan dated 11-22-13, Tenant #2 was independent with mobility with the use of a four wheeled walker. Medications were administered by staff

according to physician orders. Tenant #2 was independent in ADLs with staff assistance with bathing three times weekly.

Tenant #3, a 97 year old, was admitted on 11-26-13 and diagnoses included: Dementia, HTN, History of Breast Cancer (Right), MI, Hypercholesterolemia, Anemia, Depression, Gastric Esophageal Reflux Disease and Renal Insufficiency. According to a service plan dated 11-26-13, Tenant #3 was independent with mobility with the use of a four wheeled walker with staff to provide reminders as needed. Medications were set up in weekly medication planners with staff to administer from planner until pre-filled bubble packs arrived. Staff assisted with showers three times per week and staff prompts was provided as needed for ADL's. Tenant #3 was independent with continence care with staff provided reminders every four hours.

Staff #1 stated Tenant #1 independently completed all cares and was independent with medications. Tenant #2 received medication assistance, assistance with showers and was confused at times. In the mornings, Staff #1 woke up Tenant #3 and assisted with dressing. Tenant #3 was independent in brushing hair and teeth, received medication assistance, assistance with showers, was independent in toileting and reminders to change hygiene pads. Tenant #3 had not had any falls since admission and was not exit seeking.

Staff #2 stated Tenant #3 was cued every four hours for toileting. Tenant #3 went to the bathroom independently every two hours, was independent in ambulating to meals. Tenant #3 dressed self, received bathes three times a week with staff assistance and attended activities. She stated Tenant #3 had lots of visitors, had no falls and was not exit seeking. Tenant #3's family took Tenant #3 out for church and holidays.

The Nurse stated she had more concerns recently with Tenant #1, who was currently hospitalized with pneumonia due to respiratory issues. Tenant #1 wanted to return to the Program and an assessment would be needed before being re-admitted. She stated Tenant #2 was not exit seeking and she had no concerns with Tenant #2's GDS level. Tenant #2 could be confused at times and it worked for Tenant #2 to live at the Program at this time. Tenant #3 toileted self and would sometimes need prompting every three hours while awake. Tenant #3 received assistance with showers, housekeeping and laundry and medication administration. Tenant #3 did not wander, did not go into other tenant rooms, was appropriate with peers, recognized other long time tenants and was very happy to be back at the Program. Tenant #3 enjoyed playing cards and attended activities.

The Manager stated Tenant #1 had a sharp memory and the Program set up medications which Tenant #1 took independently. She stated they didn't do a whole lot for Tenant #1. Tenant #2 received assistance with medication administration and showers. Tenant #2 was independent in ambulation and received reminders for meals. Tenant #2 loved to play Bingo. Tenant #3 received assistance getting into and out of the shower and help washing Tenant #3's back. Medication assistance was provided, reminders to get up and for toileting. Tenant #3 was independent in dressing self and getting ready for bed. Tenant #3 always used a walker and did not forget to use it. Tenant #3 was independent with ambulation, meals and activities.

The Manager stated when Tenant #3 previously was discharged from the Program, Tenant #3 did not exceed level of care.

Tenant #3 was interviewed and stated staff helped with anything Tenant #3 wanted. Tenant #3 stated he/she was independent with toileting, grooming, eating and activities. Tenant #3 stated assistance was needed with dressing and showers. Tenant #3 stated he/she made his/her own decisions. Tenant #3 used a personal help call button and staff came right away, Tenant #3 had pushed it one time. Tenant #3 stated he/she liked living at the Program, played 500 cards and was the scorekeeper. Tenant #3 stated he/she was "tickled to death" to be back at the Program, being there was home. Tenant #3 liked to attend church and used a walker independently. Tenant #3 stated living at the Program allowed friends to make local phone calls on the telephone instead of dialing long distance, which allowed Tenant #3 to receive more calls. Tenant #3's apartment was clean and neat; Tenant #3 was dressed appropriately and was well groomed.

The monitor observed Tenant #3 at 11:40 a.m. enjoying a private holiday lunch with family. At 12:55 p.m. Tenant #3 ambulated independently from the bathroom to the living room using Tenant #3's walker. At 1:50 p.m., Tenant #3 was observed opening Tenant #3's apartment door, entered the hallway with walker and ambulated to the living room and sat down on a sofa until ambulating to the dining room to play Bingo at 2:00 p.m.

Staff #1, #2, the Nurse and the Manager stated there was enough staff to meet the needs of the tenants and there were no tenants who exceeded the level of care for assisted living. The Nurse and the Manager stated Tenant #3 was appropriate to live at the Program.

A policy titled Admission and Discharge Criteria Policies was provided. The policy included Admission Criteria, Discharge Criteria and the need for a nurse assessment completed to assess the tenant's ability to perform specified activities of daily living before move-in.

Review of tenant files, policy review and interviews with Tenant #3, Staff #1, #2, the Nurse and Manager did not identify any tenants who exceeded level of care.

- Regulatory Insufficiency: None noted.