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Complaint/Incident Intake #:
47231-I
47226-C

March 3, 2014

Ms. Suzie Morgan, Administrator
Greenfield Manor Assisted Living
615 SE Kent Street
Greenfield, IA 50849

RE: Final Complaint/Incident Investigation Report, Greenfield Manor Assisted Living, Greenfield, Iowa

Dear Ms. Morgan:

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, following an investigation by DIA on **February 19, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plans, Nurse Review and Life Safety.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted to DIA within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

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:

Suzie Morgan, Administrator
Greenfield Manor Assisted Living
615 SE Kent Street
Greenfield, IA 50849

Complaint/Incident Intake #: 47231-I
47226-C

Date of Complaint/Incident Investigation:

February 19, 2014

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:	14
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	15
TOTAL census of Assisted Living Program	15

Program History – The program received Regulatory Insufficiencies in the areas of Evaluations, Service Plans, Nurse Review and Life Safety during this certification period.

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

A. Staffing

Complaint/Incident Allegation: It was alleged a tenant left the program without staff knowledge (#4722-C). The program reported Tenant #1eloped from the program (#47231-I).

- Monitoring Observation: The assisted living program was attached to the nursing home with a hallway. The program was a general population program and did not have a dementia unit. Each tenant was given a call pendant to use to request assistance if needed. The program reported the tenants as "high functioning" and not requiring a lot of care. Because the program was attached to the nursing home, the staff from the nursing home also provided medication assistance and bathing assistance as indicated in the assisted living service plans. During the overnight shift, the nursing home staff made rounds to the assisted living program twice. If apartment doors were unlocked, the staff member would open the door to check on the tenant. Doors to the assisted living program were locked which prevented entrance to the building. Persons would still be able to exit the building if needed. A key was required to gain entrance during the overnight shift.

  Iowa Administrative Code 481-69.29(4) indicates staff shall be awake and on duty 24-hours a day on site and in the proximate area. Staff is to check on tenants as indicated in the service plans.

  A review of Tenant #1's service plan dated 12-21-13 and updated 2-5-14 indicated Tenant #1 required checks twice during the night. The program provided documentation the checks were being completed as outlined in the service plan.

The program indicated staff members worked shifts of 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. The schedule confirmed the report that staff was available during the night shift. It was reported staff was awake at night.

The program was toured and it was possible to get from the attached nursing home to the assisted living section of the building in less than five minutes, which meets the requirement for staff to be in the proximate area.

Staff from the attached nursing home was in the proximate area and checked on Tenant #1 as per the service plan.

- Regulatory Insufficiency: None noted.

B. Evaluations

- Monitoring Observation: Tenant #1, a 91 year-old, was admitted on 11-25-13 and had diagnoses of: Hypertension, Hypothyroidism, Osteoarthritis, Renal Failure, Atrial Fibrillation, and Congestive Heart Failure.

  Pre-admission evaluations of function, cognition, and health were completed on 9-24-13. The pre-admission, health/functional assessment was unsigned but was identified by the program as having been completed by Staff #1, Licensed Practical Nurse (LPN). The cognitive evaluation dated 9-24-13, which indicated Tenant #1 had no cognitive impairment, was also completed by the LPN, Staff #1. Initial evaluations were not completed by a registered nurse (RN).

  Tenant #1 maintained a home out of state, and did not move into the program as anticipated. Tenant #1 moved into the program on 11-25-13. Evaluations of function, cognition, and health were completed on 11-25-13. The health/functional form was not signed, but was identified as completed by Staff #1, LPN. Staff #1 LPN completed the Global Deterioration Scale on 11-25-13 which indicated no cognitive impairment. Initial evaluations were not completed by an RN.

  Evaluations completed on 12-21-13, within 30 days of admission, continued to show Tenant #1 had no cognitive impairment.

  Nurse's notes dated 1-13-14 documented Tenant #1 was unable to process how to urinate into a graduate so that a urine sample could be collected. Tenant #1 required assistance with clothing during the process. On 1-14-13, Tenant #1 was seen by the healthcare provider for increased confusion, which Tenant #1 indicated had been occurring for three days. The provider's note indicated the urine test was normal. The healthcare provider documented Tenant #1was being monitored for transient mental changes.

  Nurse's notes dated 1-21-14 documented Tenant #1 had some confusion. The notes documented there were concerns regarding increased dementia and that a higher level of care was needed. Staff had reported it was difficult to assess Tenant #1 because the tenant was out with family often. A fax was sent to the physician regarding staff concerns with the increased confusion.

Tenant #1 exhibited a change of condition and staff determined Tenant #1 needed a higher level of care. Evaluations of function, cognition, and health were not completed when a change of condition was identified.

Notes of 1-21-14 indicated the program was setting up a meeting with the family to discuss Tenant #1's need for a higher level of care.

On 1-28-14, a 90-day assessment was completed. The forms indicated the assessment was completed for a change of condition. The health/functional form was unsigned but the program indicated the form had been completed by Staff #1 LPN. The cognitive evaluation was signed by Staff #1 LPN. An RN did not complete the health and cognitive evaluations for a significant change of condition.

On 1-28-14, Tenant #1 was staged between four and five on the Global Deterioration Scale (GDS) which indicated early to moderate dementia.

Nurse's notes dated 1-21-14 documented Tenant #1's normal behavior was to get up during the night. On 2-1-14, nurse's notes documented Tenant #1 reported going to the Legion to see a friend daily.

Nurse's notes dated 2-5-14 documented a staff member was paged to the assisted living program because Tenant #1 was confused and unable to find the apartment. An assessment note dated 2-5-14 documented the family was notified the program was concerned about Tenant #1's safety. According to the note, the family wanted to take Tenant #1 home, but the family was waiting for bathroom remodeling to be completed, the end of February, before taking Tenant #1 home. A GDS was completed and staged Tenant #1 at five, which indicated moderate dementia. The service plan was updated to include hourly checks for 24 hours, then checks three times daily and twice during the night.

Service log updates dated 1-21, 2-4, and 2-14-14 documented the program spoke to the family about discharge from the program. Documentation indicated the family did not want Tenant #1 to go to a nursing home, and the family could not take Tenant #1 home until bathroom remodeling had been completed. On 2-14-14, the family indicated Tenant #1 would move out in 1-2 weeks.

Notes of 2-6-14 documented Tenant #1 was confused and "not redirectable." Notes of 2-8-14 documented when Tenant #1 was asked about activities for the day, Tenant #1 reported he/she was going to walk to the Legion. Notes of 2-9-14 documented Tenant #1 was wearing the same clothes that had been on the previous day. Notes through 2-12-14 indicated Tenant #1 was not always oriented to person, place, or time.

Notes of 2-13-14 and timed at 12:30 a.m. documented Tenant #1 was wandering around in the hallways and was difficult to redirect. Staff #2 was interviewed. Staff #2 stated she worked the 6:00p.m. to 6:00 a.m. shift and had seen Tenant #1 walking in the hall only the one time of 2-13-14. Staff #2 checked on Tenant #1 twice a shift and always went into the room to see Tenant #1. Tenant #1 was awake at least one of the two checks each night that Staff #2 checked on Tenant #1

Staff #3, a housekeeper, stated Tenant #1 never walked the halls or went outside. Tenant #1 came out for lunch when the family brought Tenant #1 out.

Staff #4 was interviewed. Staff #4 indicated he worked the 6:00 p.m. to 6:00 a.m. shift. Staff #4 reported Tenant #1 stayed mostly in the apartment. Staff #4 had never seen Tenant #1 up walking in the halls during the overnight shift. Staff #4 checked on Tenant #1 twice a shift. Tenant #1 was always awake during one of the night checks. Usually, Tenant #1 had the lights and TV on, and would then go to bed but the lights and TV would still be on.

During the early morning of 2-17-14 at approximately 3:30 a.m., Staff #4 checked on Tenant #1 and observed Tenant #1 in bed with the covers pulled up. Staff #4 reported there was nothing unusual about the night.

At 5:30 a.m. on 2-17-14, Staff #5 came to work and entered the building in the attached nursing home. Staff #5's usual routine was to go to the assisted living portion of the building to unlock the doors. Staff #5 noted on 2-17-14 that it was cold and raining, and was checking the sidewalks for ice and spreading a deicer as she unlocked the doors. At approximately 5:40 a.m. Staff #5 reached the front entrance to the assisted living program. Upon unlocking the door, she found Tenant #1 lying on the ground, but was under the canopy of the building. Tenant #1 was parallel to the doors with the feet extending into the rocks. The upper body was lying on concrete. Tenant #1 had slippers, and one or both slippers were off. Tenant #1 was not wearing socks, but did have long pants, a shirt, and was wearing a quilted winter coat. Staff #5 did not recall if Tenant #1 had gloves. Blood was observed around Tenant #1's head. Staff #5 touched Tenant #1's cheeks which felt fine, but Staff #5 also stated she had been outside spreading the deicer and was not wearing her gloves. Tenant #1 made a noise, but Staff #5 was not able to understand what Tenant #1 was saying. Staff #5 went into the building and called for help. Staff #5 returned outside to Tenant #1 and put her coat over Tenant #1. Staff #5 observed the chain to the call pendant around Tenant #5's neck.

Staff #4 responded to the request for assistance. Staff #4 saw Tenant #1's walker tipped. Tenant #1 was lying on the back with the Staff #5's coat in place over Tenant #1. Tenant #1's feet were sticking out over the rocks. Staff #4 talked to Tenant #1 and Tenant #1 responded with incoherent speech. Tenant #1 was moving the legs, but Staff #4 was unable to determine if Tenant #1 had any pain. Staff #4 called for additional staff assistance and asked for 911 to be called. Staff #4 observed the blood around the head. Staff #4 checked Tenant #1's vital signs. Emergency personnel arrived and transported Tenant #1 to the hospital. Staff #5 reported it had started to snow by the time emergency personnel arrived.

According to the State Climatologist, the weather reporting station closest to Greenfield was in Creston. At 3:30 a.m. the temperature was 27 degrees with winds out of the southeast at 17 miles per hour (mph) resulting in a wind chill of 14 degrees. Skies were cloudy. At 5:35 a.m. the temperature was 30 degrees with winds out of the southeast at 12 mph resulting in a wind chill of 21 degrees. There was light freezing rain.

Documentation indicated Tenant #1 arrived at the local hospital with a body temperature of 89 degrees and was not responding verbally. A laceration was present on the back of the head. Heels to both feet were blue. There was concern a hip may have fractured. Tenant #1 was transferred from the local hospital to a regional medical center.

A family member was contacted by the monitor on 2-19-14. The family member reported Tenant #1 was getting along pretty well. Tenant #1 was alert and talking, and was getting out of bed. There was no fracture to the hip and the color was back into Tenant #1's feet.

Initial evaluations were not completed by an RN. Evaluations with changes of condition were not completed by an RN. Evaluations were not completed with a change of condition.

- Regulatory Insufficiency: A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. (IAC r. 481-69.22(1))

- Regulatory Insufficiency:. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also 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 when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

C. Service Plans

- Monitoring Observation: Pre-admission evaluations of function, cognition and health were completed for Tenant #1 on 9-24-13. The pre-admission service plan was dated and signed on 9-23-13. The service plan was not based on evaluations, which were documented as completed after the service plan.

  Tenant #1 maintained a home out of state, and did not move into the program as anticipated. Tenant #1 moved into the program on 11-25-13. Evaluations of function, cognition, and health were completed on 11-25-13. The initial service plan was dated and signed by the RN on 11-24-13.

The service plan was not based on evaluations, which were documented as completed after the service plan. The service plan was not signed by Tenant #1.

A 30-day assessment dated 12-21-13 documented Tenant #1 had a poor appetite. According to the service plan of 12-21-13, Tenant #1 was eating the majority of the meals prepared by dietary. A fax to the physician dated 1-10-14 documented Tenant #1 had a 6.5-pound weight loss in one week. The fax also noted Tenant #1 either ate in the apartment or was out with family. The fax also noted the food provided was less than nutritious.

Nurse's notes of 1-24, 1-25, and 1-26-14 documented the program was monitoring the amount of food Tenant #1 was eating with meals. The 90-day assessment dated 1-28-14 documented Tenant #1 had a 9-pound weight loss since admission. The nurse's notes of 1-28-14 documented Tenant #1 was given high calorie cookies from the kitchen. The service plan dated 12-21-13 and updated 1-28-14 did not include interventions for weight loss.

On 1-21-14, the program identified Tenant #1 had increasing dementia and required a higher level of care. Nurse's notes dated 1-21 to 1-28-14 documented Tenant #1 was confused, and not always oriented to person, place, and time. The service plan was not updated with the evaluations of 1-28-14 to include interventions for the confusion or interventions to meet the needs of Tenant #1 who required a higher level of care.

Service plans were not based on evaluations, were not signed by the tenant or legal representative, and did not meet the identified needs of the tenant.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1))

- Regulatory Insufficiency: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

D. Nurse Review

- Monitoring Observation: Nurse's notes dated 12-16-13 documented Tenant #1 had been with family and upon return, the family expressed concern Tenant #1 was congested. Notes of 12-18-13 indicated an antibiotic had been ordered for 10 days as well as a cough syrup. Notes of 12-19-13 documented Tenant #1 had coarse lung sounds and a harsh cough. A nurse review was not done upon completion of the antibiotic to determine the effectiveness of the medications or to indicate any adverse reactions to the medication.

A 30-day assessment dated 12-21-13 documented Tenant #1 had a poor appetite. According to the service plan of 12-21-13, Tenant #1 was eating the majority of the meals prepared by dietary. A fax to the physician dated 1-10-14 documented Tenant #1 had a 6.5-pound weight loss in one week. The fax also noted Tenant #1 either ate in the apartment or was out with family. The fax also noted the food provided was less than nutritious. A nurse review was not completed with the weight loss to document Tenant #1's health status and appropriate referrals and interventions.

- 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))

E. Life Safety

- Monitoring Observation: The program reported a census of 15 tenants; 14 were without cognitive impairment. Tenant #1 was identified as staged at five on the GDS which indicated cognitive impairment. The program was a general population program with no dementia unit. The doors were not required to be alarmed. The program was unable to provide documentation of a procedure related to missing persons.

- Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have: (b) Written procedures regarding appropriate staff response if a tenant with cognitive disorder or dementia is missing. (IAC r. 481-69.32(2)(b))