IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #'s:
46535-M
47204-C

March 14, 2014

Mr. Marcus Strohschein, Executive Director
Senior Star at Elmore Place Assisted Living
4500 Elmore Avenue
Davenport, IA 52807

RE: Final Complaint/Incident Investigation Report, Senior Star at Elmore Place Assisted Living, Davenport, Iowa

Dear Mr. Strohschein:

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 3, 26 and 27, 2014.** The Report notes a Regulatory Insufficiency in the area(s) of: Service Plans.

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:

Marcus Strohschein, Executive Director
Senior Star at Elmore Place Assisted Living
4500 Elmore Avenue
Davenport, IA 52807

Complaint/Incident Intake #: 46535-M
47204-C

Date of Complaint/Incident Investigation:

February 3, 26 and 27, 2014

Monitor(s):

Stephanie Cummins, MA

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:	70
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	70
TOTAL census of Assisted Living Program	70

Program History – The program received regulatory insufficiencies in the areas of Program Reporting to the Department, Evaluations, Service Plans and Nurse Review 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 #47204-C: It was alleged a tenant was not resuscitated due to not having access to a tenant's file.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6).

  According to an Acknowledgement of Receipt of the Advance Directives Information Sheet, Tenant #5 did not have an Out-of-Hospital Do Not Resuscitate Order. Review of Tenant #5's file indicated Tenant #5 had an incident and staff attempted to resuscitate.

  Tenant #5, an 83 year old (at the time of Tenant #5's death), was admitted on 5-5-12 and diagnoses included: Chronic Obstructive Pulmonary Disease (COPD), Insulin Dependent Diabetes Mellitus, Coronary Artery Disease (CAD), Glaucoma and Hypertension (HTN). Tenant #5 was discharged on 7-15-12. Tenant #5 scored a 29 on the Mini Mental Status Examination (MMSE), which indicated normal to very mild impairment. According to Nurse's Notes dated 7-15-12 at 7:35 p.m. a nurse was paged to Tenant #5's apartment. Tenant #5 was non-responsive (pulse was 81 and oxygen saturation was 83). Tenant #5 was non-responsive to sternal rub and was very pale. The nurse asked Tenant #5's spouse if the spouse wanted Cardiopulmonary Resuscitation (CPR) started and the spouse said yes. Tenant #5 was lowered from the chair to the ground with the assistance of a direct care staff and chest compressions were started. The front desk notified a medic.

The medic and firemen arrived while the nurse was doing chest compressions and took over. The family and the Assistant Director of Nursing (ADON) were notified. Tenant #5 was transported to the hospital via medic. According to Nurse's Notes dated 7-15-12 Tenant #5's spouse returned from the hospital and said Tenant #5 died at the hospital.

The Director of Memory Care was interviewed. She was one of the ADONs at the time of the 7-15-12 incident. She said Tenant #5's spouse called and said Tenant #5 was sitting at the table in the apartment and was fine and then became unresponsive. A licensed practical nurse (LPN) responded, lowered Tenant #5 to the ground and asked Tenant #5's spouse if she could initiate CPR and the spouse said yes. The Director of Memory Care said there were no concerns with the situation and all staff had access to the medication rooms. She said there were no issues with the availability of the records. She said there was no delay in the attempts to resuscitate Tenant #5. Counseling was provided to staff and she said it was very sudden with Tenant #5. The Director of Memory Care was not sure who was on-call when the incident occurred.

Interviews were completed with Staff #1, #2 and #3 (LPNs). Staff #1, #2, and #3 did not report any outcomes or issues related to resuscitation of tenants and not having access to needed information.

The Director of Assisted Living, Assistant Director of Assisted Living #1 and Assistant Director of Assisted Living #2 did not report any outcomes or issues related to resuscitation of tenants and staff not having access to needed information.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation #46535-M: The Program reported a tenant had medications missing.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6). Tenant #6 had missing medications.

  Tenant #6, a 96 year old, was admitted on 10-7-11 and diagnoses included: Back Pain, Osteopenia, Hypokalemia, HTN, CAD and Abdominal Aortic Aneurysm. According to the service plan, Tenant #6's family set up medications in medication planners and Tenant #6 administered independently.

  According to an Incident Report Form-Health Services Residents, the date of the incident was 12-10-13 and the time was approximately 9:30 a.m. The incident description indicated on 12-5-13 Tenant #6's family member thought Tenant #6 had missing medications. Upon checking into it a camera was placed and upon review it was noted an employee was handling the medication reminders.

According to the Director of Assisted Living's statement, with consent of Tenant #6 and Tenant #6's family a monitor was placed in the area of the medications. On 12-10-13 the monitor was checked and there was nothing on it and all the medications were still in the medication reminders. After breakfast the medications were missing from the medication reminder boxes. Upon checking the monitor it was noted by the Director of Assisted Living, the Assistant Director of Assisted Living #1 and the Assistant Director of Assisted Living #2 that allegedly Staff #4 had taken the medications the morning of 12-10-13 while Tenant #6 was at breakfast. Tenant #6 and Tenant #6's family was notified that medications were missing and the police department was notified. Police arrived and spoke with Staff #4 and Staff #4 allegedly admitted to taking the pills. Staff #4 was terminated.

An incident report was completed and the Program reported the incident to the Department.

A mandatory dependent adult abuse investigation was initiated on 2-3-14. The investigation was ongoing.

- Regulatory Insufficiency: None noted.

C. Criteria for Admission and Retention

Complaint/Incident Allegation #47204-C: It was alleged tenants exceeded the level of care.

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6).

  Staff #1 said Tenant #1 was a two person transfer 20 to 25% of the time and could bear weight. Staff #1 said Tenant #2 was a two person transfer 30 to 40% of the time and could bear weight. Staff #1 did not identify any tenants who had eloped, who were unmanageably incontinent, who were a routine two person transfer or who exceeded the level of care.

  Staff #2 said Tenant #2 sometimes took two people for transfers and said it was 20 to 40% of the time. Staff #2 said Tenant #2 was weight bearing. Staff #2 did not identify any tenants who had eloped, who were unmanageably incontinent, who were a routine two person transfer or who exceeded the level of care.

  Staff #3 did not identify any tenants who had eloped, who were unmanageably incontinent, who were a routine two person transfer or who exceeded the level of care.

  The Director of Assisted Living did not identify any tenants who had eloped, who were unmanageably incontinent, who were a routine two person transfer or who exceeded the level of care. The Director of Assisted Living said Tenant #2 could bear weight and it depended on Tenant #2's motivation.

Tenant #2 was appropriate for the Program as long at Tenant #2 wanted to be. Tenant #2 was not a routine two person transfer and physical therapy (PT) was working with Tenant #2.

The Assistant Director of Assisted Living #1 did not identify any tenants who had eloped; however, Tenant #4 had hallucinations and would come out of the apartment into the hall but not outside the building. Tenant #4 had past traumatic events. The Assistant Director of Assisted Living #1 did not identify any tenants that were unmanageably incontinent. She said Tenant #3 had a big episode and it was an isolated incident. She did not identify any tenants that were a routine two person transfer. She said Tenant #1 was weight bearing, could transfer self at times and could stand on the scale. Tenant #1 had a motorized scooter. Tenant #1 was appropriate for the level of care and was not exceeding any criteria; however, a close eye was being kept on Tenant #1.

The Assistant Director of Assisted Living #2 did not identify any tenants who had eloped or who were unmanageably incontinent. None of the tenants required a routine two person transfer. Tenant #2 transferred with a two person assist 40 to 50% of the time. Interventions for Tenant #2 included pain medications and PT. The Program was working with family, the doctor and PT.

Tenant #1, a 90 year old, was admitted on 8-21-10 and diagnoses included: Status/Post Cerebral Vascular Accident with Left Sided Weakness. Tenant #1 scored a 26 on the MMSE. According to a nurse review completed on 2-12-14, Tenant #1 used a motorized scooter for mobility and was able to use it independently. Tenant #1 needed assistance with transferring with one person, dressing, bathing, grooming and toileting. Tenant #1 had a fair to poor appetite and Tenant #1's weight had slowly declined over the last few months. Tenant #1 continued to make progress with therapy and remained the same with activities of daily living. The service plan reflected Tenant #1 was a high risk for falls. The service plan reflected staff assisted Tenant #1 with transferring to a motorized wheelchair. The service plan reflected Tenant #1 had PT services.

Tenant #2, an 89 year old, was admitted on 8-25-11 and diagnoses included: Weakness, Osteoporosis, Back Pain, HTN, Alzheimer's Disease, Constipation, Diabetes, Hyperlipidemia, Anxiety, Insomnia, Atrial Fibrillation, Dementia, Depression and Nausea. Tenant #2 scored a 29 on the MMSE, which indicated normal to very mild impairment. A nurse review dated 2-10-14 indicated Tenant #2 had a decline with transfers per staff. Tenant #2 had difficulty standing for transfers and knees buckled with one to one assist. Tenant #2 had more difficulty in the morning with transfers and improved throughout the day. Evening staff stated Tenant #2 usually required one assist with transfers and toileting. According to a nurse review dated 2-24-14, Tenant #2 was evaluated by PT on 2-24-14 for transfers and core strengthening. Information per PT at that time was Tenant #2 had 50 % needing encouragement to work with PT and 50% requiring more strength for Tenant #2 to meet goals. The service plan indicated staff was to provide one to one assist with two to one stand by if needed for toileting or two to one for safety if needed. The service plan also reflected PT services.

Tenant #3, a 92 year old, was admitted on 11-27-11 and diagnoses included: Legally Blind, Hypothyroidism, Hyperlipidemia, Skin Cancer, Anxiety and COPD. Tenant #3 was discharged on 1-17-14. According to Nurse's Notes from 12-13-13 to 1-5-14 Tenant #3 had episodes of bladder and bowel incontinence, forgot where the toilet or bathroom was located and had frequent pendant calls. On 1-7-14 a medic was called for medical transport due to agitation and forgetfulness. Tenant #3 returned from the hospital with orders to start Bactrim DS one tablet by mouth twice daily for seven days. Nurse's Notes dated 1-11-14 indicated Tenant #3 was on an antibiotic for a Urinary Tract Infection (UTI) with no adverse reactions noted. Tenant #3 was discharged on 1-17-14.

Tenant #4, an 83 year old, was admitted on 3-29-12 and diagnoses included: Dementia, Stroke and HTN. Tenant #4 scored a 28 on the MMSE, which indicated normal to very mild impairment. Tenant #4 was discharged on 1-23-14. Nurse's Notes dated 1-9-14 indicated Tenant #4 was tearful and said Tenant #4's friend was putting oil on Tenant #4 to keep Tenant #4 from burning in the fire and the oil was making Tenant #4's underpants dissolve. Nurse's Notes dated 1-16-14 indicated Tenant #4 left the Program via medic. Tenant #4 had been tearful all morning, hiding under her blankets stating that Tenant #4's friend was trying to kill Tenant #4. According to Nurse's Notes dated 1-16-14 a psychological evaluation was completed and Tenant #4 returned to the Program. A Urinalysis came back positive and Tenant #4 had a new order for Ciprofloxacin 250 milligram by mouth twice daily for five days. The service plan reflected Tenant #4 had a traumatic childhood experience of a house burning down and the neighbor children caught in the house. When Tenant #4 had a UTI the fears were exacerbated. Tenant #4 was discharged on 1-23-14.

Review of tenant files indicated Tenants #3 and #4 were discharged. Tenant #1 did not exceed the level of care. Tenant #2 did require a two person assist with transfers with a percentage of time that varied per staff. Tenant #2 could bear weight, at times could transfer with one person and there were interventions such PT and pain management.

- Regulatory Insufficiency: None noted.

D. Other

Complaint/Incident Allegation #47204-C: It was alleged tenant files were locked up in offices. It was alleged there were concerns regarding what was documented.

- Monitoring Observation: According to a document regarding a new system, charts were kept in the offices of the Assistant Director of Assisted Living #1 and the Assistant Director of Assisted Living #2. Binders were placed at each nurses station which contained the information needed to send a tenant out if needed and contact information. Copies could be made if needed. If something needed charted to see one of the Assistant Directors of Assisted Living as much of the documentation should consist of nurse reviews. If a fall occurred the incident report was to be completed and family/doctor was to be notified. If an order needed to be changed it was requested staff spoke with one of the Assistant Directors of Assisted Living first.

It was requested if an order came back to make them aware and if they were there to see them before writing it. If one of them was not available to write the order as before and one of them would complete a nurse review in place of a nurse's note. Not many faxes should be sent over the weekend, most doctors were not usually available over the weekend and if it was an emergency to call them. If a conversation was had with someone that one felt needed to be charted leave a voicemail or note which stated who one talked with, about what and the date and time and it would be followed up with a nurse review. It was a new system and they wanted to make sure communication was good from shift to shift and person to person, according to the document.

Staff #1, #2 and #3 were interviewed. They did not voice any concerns regarding the new system and access to information to their job.

Staff #1 said the face sheet, history and physical, code status and legal representative information was kept in two binders with no issues to access of the information identified. Staff #1 said an incident report was completed if there was an incident. She did not complete actual charting in the files and the Assistant Director of Assisted Living #1 and the Assistant Director of Assisted Living #2 completed the charting. The files were kept in the offices. She charted unusual occurrences in the communication log. Staff #1 did not voice any concerns regarding doctor's orders.

Staff #2 said the communication log was used to chart different things. Licensed staff had not been charting a lot in the files. Staff #2 said there was no effect with staff and the care to tenants. She said the files were kept in the offices of the Assistant Directors of Assisted Living. If they were not there the front desk had a key and she estimated it would take less than five minutes to have access to the files. Staff #2 said staff had access to the information needed to their job. Staff #2 said there was information kept in the nurse's station including face sheets and insurance information. Staff #2 did not voice any concerns regarding doctor's orders.

Staff #3 said staff had access to the information need to their job. The files were kept in the office of the Assistant Director of Assisted Living #1 and after hours a key was left at the front desk. Staff #3 said staff could access the files pretty quickly. She said information such as face sheet, legal representative contact, code status and insurance information was available in the medication rooms. Staff #3 said there were no issues with the new system and communication was better. Staff #3 did not voice any concerns regarding doctor's orders.

The Assistant Director of Assisted Living #1 said there were no issues with staff and access to information needed to do their jobs. She said the process was changed to promote communication and it occurred in the middle of February. She said tenant files used to be kept in the nurses station and now were kept in her office and the Assistant Director of Assisted Living #2's office. Keys were at the front desk and there was always someone to get the keys. She said with the doctor orders the difference was they were trying to get staff to come to them regarding a new order so they were aware of things that might be a nurse review situation. She said there were also repeat faxes to the doctor. She said transfer packets were kept in the nurses stations. She said direct care staff documented in the communication log and licensed staff could document in the log or the report sheet.

The Assistant Director of Assisted Living #2 said there were no issues with staff access to information needed to do their jobs. Staff could quickly access the records and she estimated within five minutes and there was no prior approval required. Staff might let her know after if they were in her office. She said direct care staff used a communication log to document and licensed staff used 24 hour sheets and the communication log. Licensed staff might also document on a nurses note. She would review the nurse's note and determined if a nurse review was needed. She said it was a trial system.

The Director of Assisted Living said there were no issues with staff access to information needed to do their jobs. Staff could quickly access the records. For emergency purposes there were packets made for everyone that had face sheets, code status and legal representative. If staff needed the tenant file and the offices were locked the keys were at the front desk and there was no prior approval required. He met with staff face to face and went through the different process. It was to have a main person overseeing things, to be more efficient and not to send out duplicate faxes. In regards to the expectation for documentation, direct care staff used communication sheets and licensed staff used communication sheets and report sheets. In regards to doctor's orders licensed staff needed to talk to the Assistant Director of Assisted Living #1 and the Assistant Director of Assisted Living #2 regarding orders. The order was put in a folder in the medication rooms and it was reviewed and filed by the Assistant Director of Assisted Living #1 and the Assistant Director of Assisted Living #2. The Director of Assisted Living said staff had not been restricted from documenting events that occurred.

- Regulatory Insufficiency: None noted.

E. Service Plans

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

- Monitoring Observation: Six tenant files were reviewed (Tenants #1, #2, #3, #4, #5 and #6).

Tenant #1's file was reviewed. According to a nurse review dated 2-12-14, Tenant #1 had a fair to poor appetite and Tenant #1's weight had slowly declined over the last few months. According to a fax to the doctor Tenant #1's July weight was 92 pounds and was 80 pounds in December. The Assistant Director of Assisted Living #1 said Tenant #1's weight was down to 75 pounds in February. The service plan was updated on 2-12-14 and reflected two falls in the past quarter, appetite was fair to poor and Tenant #1's weight had slowly declined over the past few months. The doctor was aware. Tenant #1's appetite had improved over the last few weeks per family. The most recent cognitive evaluations were completed on 10-22-13 and 6-28-13. The most recent Functional Assessment Results was completed on 6-28-13. A nurse review was completed on 2-12-14. The service plan was updated on 2-12-14 regarding Tenant #1's appetite and weight loss; however, evaluations were not completed. The service plan was not based on evaluations.

Tenant #2's file was reviewed. A nurse review dated 2-10-14 indicated Tenant #2 had a decline with transfers per staff. Tenant #2 had difficulty standing for transfers and knees buckled with one to one assist. Tenant #2 had more difficulty in the morning with transfers and improved throughout the day. Evening staff stated Tenant #2 usually required one assist with transfers and toileting. According to a nurse review dated 2-24-14, Tenant #2 was evaluated by PT on 2-24-14 for transfers and core strengthening. Information per PT at that was Tenant #2 had 50 % needing encouragement to work and with PT and 50% requiring more strength for Tenant #2 to meet goals.

Tenant #2's service plan was updated on 12-31-13 and reflected staff to assist one to one with transfers. The service plan also reflected staff to assist Tenant #2 to the toilet/encourage Tenant #2 to use the pendant prior to activity. Tenant #2 was to walk to the toilet as much as possible per encouragement. The service plan was updated on 1-9-14 and reflected staff needed to check on Tenant #2 for toileting schedule and if Tenant #2 required assistance with anything else at that time for safety precautions. The service plan was updated on 1-16-14 and indicated staff was to allow Tenant #2 extra-time when taking medications to alleviate symptoms of nausea. Staff was to report if any increase in nausea or vomiting occurred. The service plan was updated on 2-10-14 and reflected staff was to provide one to one assist with two to one stand by if needed for toileting or two to one for safety if needed. The updated service plan dated 2-24-14 identified the need for a Physical Therapy evaluation and admission for transfers and core strengthening. The most recent cognitive evaluation was completed on 5-3-13. The Functional Assessment Results was last completed on 5-3-13. Nurse reviews were completed on 2-24-14, 2-10-14, 1-9-14 and 12-31-13. A 90 day nurse review was completed on 1-16-14. The service plan was updated; however, was not based on evaluations.

Review of tenant files indicated service plans were not based on evaluations.

- 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))