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INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
46754-C

March 18, 2014

Mr. Steven Mohr, RN Manager
Wel-Cov Assisted Living at Alta
705 W. 7th Street
Alta, IA 51002

RE: Final Complaint/Incident Investigation Report, Wel-Cov Assisted Living at Alta, Alta, Iowa

Dear Mr. Mohr:

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 **March 10, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plan and Nurse Review.

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:

Steven Mohr, RN Program Director
Wel-Cov Assisted Living at Alta
705 W. 7th Street
Alta, IA 51002

Complaint/Incident Intake #: 46754-C

Date of Complaint/Incident Investigation:

March 10, 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:	32
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	34
TOTAL census of Assisted Living Program	34

Program History – The program received regulatory insufficiencies in the area of Food Service, 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: It was alleged a dog bit a tenant.

- Monitoring Observation: Incident reports were reviewed from October 2013 to present. There was no documentation a tenant was bit by a dog. The Monitor interviewed Staff #1, #2, and #3. Staff #1 reported the former nurse brought in a puppy that scratched Tenant #1. Staff #1 was not sure how long ago the incident happened. Staff #2 heard Tenant #1 was bitten by a dog. Staff #3 reported Tenant #1 came out of the apartment with blood on the hand and reported the puppy bit the hand. A bandage was applied to the area.

  The Program Director was interviewed and stated a tenant was scratched by the puppy's claw, but the puppy had grown and was trained and presented no problem. The Program Director did not recall when the incident occurred.

  Tenant #1 was interviewed and stated he/she had been playing with a puppy brought in by the Former Nurse. Tenant #1 stated the puppy's tooth caught on skin on the hand and did not bite. Tenant #1 did not recall when the incident occurred and reported the skin healed with no infection. Tenant #1 reported the puppy had grown into a dog that did not bite and was well trained. Tenant #1 reported he/she liked the interaction with the dog and welcomed it.

  Nurse's notes documented Tenant #3 enjoyed the company of the dog.

- Regulatory Insufficiency: None noted.

B. Evaluation

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #2, an 88 year-old, was admitted on 7-9-08 and had diagnoses of: Dizziness, Hypertension, Atrial Fibrillation, Osteoarthritis, Gait Instability, and Mild Dementia

  Nurse's notes dated 12-13 and 12-19-13 documented Tenant #2 had a swollen left leg with pitting edema. Edema wear was placed on the legs. Tenant #2 went to the physician's office and returned with orders for an antibiotic for 10 days and water pills. There was no documentation of the reason for the medications and no documentation of Tenant #2's health status.

  Notes of 1-3-14 documented Tenant #2 went to see the physician for follow-up. Tenant #2 returned to the program with orders to follow-up again in three weeks. The physician was to be notified of weight gain or shortness of breath. There was no documentation of Tenant #2's health status. There was no documentation as to whether or not the antibiotics ordered on 12-19-13 were effective.

  Physician's documentation of 1-24-14 documented Tenant #2 was seen for follow-up of pneumonia and leg swelling. Evaluations were not completed with a change in condition which resulted in new medications and follow-up visits with the physician.

  Tenant #4, a 92 year-old, was admitted on 7-23-07 and had diagnoses of: Anemia, Congestive Heart Failure, Dementia, Diabetes, and Hypertension. On 2-19-13 Tenant #4 was staged at four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. Nurse's notes dated Tenant #4 had a declining condition and arrangements were made for a hospice referral. Evaluations were not completed with a change of condition.

  Tenant #5, a 75 year-old, was admitted on 1-23-13 and had diagnoses of: Parkinson's Disease, Hypertension, and Dementia. Tenant #5 was staged at three on the GDS which indicated mild cognitive decline. The 24-hour shift report for the night shift dated 11-15 /11-16-13 documented Tenant #5 was on hands and knees in bed and could not lay down and requested staff assistance to do so. Staff documented Tenant #5 could not roll over in bed. Staff documented Tenant #5 could not do anything without assistance.

  The 24-hour report dated 11-17/11-18 documented Tenant #5 went into the bathroom and urinated on the floor and said someone made a mess.

  The 24-hour report dated 11-18/11-19-13 documented Tenant #5 had to be dressed completely by a staff member and could not stand up straight.

  The 24-hour report dated 11-22/11-23 documented Tenant #5 paged for assistance to get to the bathroom. Tenant #5 could not get up by self or walk by self.

  The 24-hour report dated 11-23/11-24-13 documented staff took 15 minutes to get Tenant #5 from the bathroom to the bed. Tenant #5 was very confused.

A fax to the physician dated 11-25-13 requested and increase in medication due to increased incontinence.

The evaluations and service plan current as of November 2013 was dated 2-21-13. The evaluations indicated Tenant #5 was independent with all activities of daily living except bathing. Tenant #5 had no behaviors documented.

During the month of November 2013, Tenant #5 exhibited a change of condition resulting in increased assistance with activities of daily living and exhibited confusion. Evaluations were not completed with a change of condition.

Nurse's notes dated 12-26-13 documented Tenant #5 verbalized wanting to commit suicide. The notes indicated a family member came to the program and the family notified the physician. Medication was adjusted and a referral made to a mental health counselor. Evaluations were not completed with a change of condition.

- 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

Complaint/Incident Allegation: It was alleged service plans didn't meet tenants' needs.

- Monitoring Observation: Nurse's notes dated 12-13-13 indicated edema wear was put on Tenant #2's legs. Nurse's notes dated 1-3-14 documented Tenant #2's physician was to be notified of a weight gain or shortness of breath. The use of the edema wear continued. The service plan current at the time of the notations was a plan dated 2-12-13. The service plan was not updated to include the use of the edema wear, directions for staff members to report Tenant #2's weight gain or shortness of breath to the nurse. The service plan did not meet the identified needs of Tenant #2.

  Tenant #3, an 87 year-old, was admitted on 3-10-11 and had diagnoses of: Hypertension, Anxiety, Asthma, and Chronic Obstructive Pulmonary Disease. The physician order sheet dated July 2013 indicated orders were given on 5-29-13 which indicated Tenant #3 was to have high protein snacks twice a day for weight loss. The orders also indicated Tenant #3 used oxygen at three liters at bedtime. The functional assessment dated 2-19-13 indicated Tenant #3 was legally blind. The service plan dated 2-19-13 used oxygen but did not indicate the liter flow. The service plan indicated weight was stable and did not identify interventions for weight loss as documented in the 5-29-13 physicians order. The service plan did not meet the identified needs of Tenant #3.

On 1-8-14 the physician ordered Physical Therapy. Nurse's notes of 1-9-14 indicated PT was to start on 1-10-14. The service plan was not updated with outside service providers.

Nurse's notes dated 10-23-13 indicated Tenant #4's condition had declined. Evaluations of function, cognition, and health were completed on 2-19-13. The evaluations and service plan of the same date indicated Tenant #4 was independent with toileting and self-managed minimal incontinence. The evaluation also indicated Tenant #4 exhibited signs of anxiety or agitation four to six times a week.

A 24-hour shift report dated 10-9-13 documented Tenant #4 needed to be encouraged to wear incontinence products because underwear was wet "quite a bit." The 24-hour report dated 10-11-13 documented Tenant #4 was combative.

The Monitor interviewed Staff #1 and #3. Both stated they assisted Tenant #4 with toileting. The service plan dated 2-19-13 did not indicate interventions for anxiety or agitation as identified in the evaluations. The service plan was not updated to include staff assistance with toileting and management of incontinence products. The service plan did not identify the liter flow of the oxygen used at night.

Evaluations and a service plan and an updated service plan were completed on 2-21-14 for Tenant #4. The service plan did not identify the liter flow of the oxygen used at night. The service plan did not identify staff assistance with toileting and incontinence products as identified by two staff members. The evaluation of 2-21-14 indicated Tenant #4 showed signs of anxiety or agitation daily. The service plan did not identify interventions for anxiety or agitation.

The service plans of 2-19-13 and 2-21-14 did not meet the identified needs of Tenant #4. The service plan dated 2-21-14 was not signed by the nurse, the tenant or legal representative on the date of the onsite visit, 3-10-14.

The July 2013 Physician Order Sheet documented Tenant #5 required the use of a CPAP machine at night. The service plan did not identify the use of the machine. Tenant #5 began to require staff assistance with activities of daily living beginning in November 2013 according to documentation in 24-hour reports. Staff #1 and #3 reported Tenant #5 required significant time and required help with "everything." Tenant #5 was also reported to exhibit behaviors that required redirection including wandering and exit-seeking. Tenant #5 verbalized wanting to commit suicide on 12-26-13. The service plan indicated Tenant #5 was independent with all activities of daily living except bathing. The service plan was not updated with interventions for a tenant verbalizing a desire to commit suicide. The service plan of 2-21-13, current at the time of the incidents, was not updated to meet the identified needs of Tenant #5.

Evaluations were completed on 2-21-14 for Tenant #5. Evaluations indicated Tenant #5 exhibited signs of anxiety and agitation, resisted cares, and showed signs of a reversal of the sleep cycle that required staff attention. The service plan did not identify interventions related to behaviors Tenant #5 exhibited. The service plan did not identify the use of the CPAP machine. The service plan was not based on evaluations and did not meet the identified needs of Tenant #5.

The service plans of 2-21-13 and 2-21-14 did not meet the identified needs of Tenant #5. The service plan dated 2-21-14 was not signed by the nurse, the tenant or legal representative on the date of the onsite visit, 3-10-14.

Tenant #6, a 92 year-old, was admitted on 11-5-08 and had diagnoses of: Panic Attacks and Dementia. On 9-24-13, Tenant #6 was staged at five on the GDS which indicated moderately severe cognitive decline. Nurse's notes dated 7-3-13 documented Tenant #6 experienced panic and anxiety issues. The evaluation of 10-7-14 documented Tenant #6 showed signs of anxiety four to six times a week. Nurse's notes of 10-24-13 documented Tenant #6 went to see a healthcare provider and medication was adjusted because of daily panic attacks. The service plan of 10-7-13 did not identify interventions for daily panic attacks. The service plan was not based on evaluations and did not meet identified needs of Tenant #6.

The functional assessment dated 10-7-13 documented Tenant #6 needed supervision with toileting and was frequently incontinent. The Monitor interviewed Staff #1 and #3. Both stated Tenant #6 was on a toileting schedule. The service plan dated 10-7-13 indicated Tenant #6 self-managed toileting and incontinence. The service plan was not based on evaluations and did not meet the identified needs of Tenant #6

Service plans were not based on evaluations and did not meet identified tenant needs.

- 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))

D. Nurse Review

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1, an 88 year-old, was admitted on 8-16-09 and had diagnoses of: Heart Disease, Hypertension, Peripheral Neuropathy, and Long-term Anticoagulant Therapy. Nurse's notes of 10-16, 11-5, 11-26, and 12-20-13 documented Tenant #1 was seeking treatment for back problems.

  The service plan dated 4-5-13 documented Tenant #1 was independent with activities of daily living but required assistance from the nurse to have medications set up in the planner which Tenant #1 then self-administered.

  The program provided health-related care to Tenant #1. A nurse review was not completed every 90 days to assess and document the health status of Tenant #1.

  Nurse's notes were reviewed from 10-26-13 through 2-26-14. The entries had dates and signatures of the nurse completing the entry, but the entries were not timed.

The service plan dated 2-13-13 documented Tenant #2 required bathing assistance and the program administered medications. The program provided personal and health-related care to Tenant #2. A nurse review was not completed every 90 days to assess and document the health status of Tenant #2. A nurse review was not completed every 90 days to monitor for adverse reactions to medications, to ensure prescription medications were administered consistent with the orders.

Nurse's notes were reviewed for Tenant #2 from 8-13-13 through 2-24-14. The entries had dates and signatures of the nurse completing the entry, but the entries were not timed.

The service plan dated 2-19-13 documented Tenant #3 was independent with activities of daily living but required assistance from the nurse to have medications set up in the planner which Tenant #3 then self-administered. Staff members were to check to see that Tenant #3 actually took the medications.

The program provided health-related care to Tenant #3. A nurse review was not completed every 90 days to assess and document the health status of Tenant #3.

Nurse's notes dated 12-9-13 documented Tenant #3 had congestion, saw a physician and was ordered an antibiotic. There was no documentation as to whether or not the antibiotic was effective. A nurse review was not completed with a change of condition.

Nurse's notes were reviewed for Tenant #3 from 9-3-13 through 3-4-14. The entries had dates and signatures of the nurse completing the entry, but the entries were not timed.

The service plan dated 2-19-13 documented Tenant #4 required staff to assist with the application of edema wear and bathing, and staff administered medications.

The program provided personal and health-related care to Tenant #4 and administered medications. A nurse review was not completed every 90 days to assess and document the health status for Tenant #4. A nurse review was not completed every 90 days to monitor for adverse reactions to medications, to ensure prescription medications were administered consistent with the orders.

Nurse's notes were reviewed for Tenant #4 from 7-29-13 through 2-12-14. The entries had dates and signatures of the nurse completing the entry, but the entries were not timed.

The service plan dated 2-21-13 documented Tenant #5 required staff to assist with bathing, and staff administered medications.

The program provided personal and health related care to Tenant #5 and administered medications. A nurse review was not completed every 90 days to assess and document the health status for Tenant #5. A nurse review was not completed every 90 days to monitor for adverse reactions to medications, to ensure prescription medications were administered consistent with the orders.

Nurse's notes were reviewed for Tenant #5 from 10-24-13 through 2-11-14. The entries had dates and signatures of the nurse completing the entry, but the entries were not timed.

Nurse's notes dated 3-4-14 documented Tenant #6, a 92 year-old with cognitive impairment was experiencing vomiting and had diarrhea. An antiemetic was ordered by the physician. As of the monitor's visit of 3-10-14 a nurse review had not been completed to document Tenant #6's progression of the illness or response to medication. A nurse review was not completed with a change of condition.

The service plan of 10-7-13 documented Tenant #6 required staff assistance with dressing, bathing and staff administered medications.

The program provided personal and health related care to Tenant #6 and administered medications. A nurse review was not completed every 90 days to assess and document the health status for Tenant #6. A nurse review was not completed every 90 days to monitor for adverse reactions to medications, to ensure prescription medications were administered consistent with the orders.

Nurse's notes were reviewed for Tenant #6 from 9-24-13 through 3-4-14. The entries had dates and signatures of the nurse completing the entry, but the entries were not timed.

- 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; and (IAC r. 481-69.27(3))

- Regulatory Insufficiency: To provide the program with written documentation of the activities under the service plan, as set forth in rule 481—69.26(231C), showing the time, date and signature. (IAC r. 481-69.27(4))

E. Structural Requirements

Complaint/Incident Allegation: It was alleged a dog urinated on the dining room floor of the program.

- Monitoring Observation: Staff #1, #2, and #3 interviews revealed the following. Staff #1 reported a puppy came to work with the Former Nurse. Staff #1 reported the puppy urinated in the nurse's office. Staff #1 reported she observed the nurse clean up the urine and use a spray. Staff #1 reported the dog was here every day for a while. Staff #1 reported the puppy had grown up and was no longer a problem. Staff #1 also reported visitors brought in pets who on occasion had defecated on the carpet. The visitor cleaned and the staff applied carpet spray. The incident occurred two months or more ago.

  Staff #2 reported the Former Nurse's dog urinated in the nurse's office. Staff #2 reported observing the Former Nurse clean the carpet.

  Staff #3 reported the Former Nurse's dog urinated on the floor in the nurse's office and the dining room. The floor was cleaned afterwards. The dog was at the program about two months. The Former Nurse was reported to bring the dog to the program to see some of the tenants even though she was no longer employed by the program.

  The Program Director reported he gave permission for the Former Nurse to bring the puppy into the program. The Program Director thought the tenants would enjoy the dog. The Program Director reported the puppy had accidents but had grown into a trained dog. According the Program Director, the corporate office received a complaint about a dog in the program. After the complaint was received, changes were made at the program to include no dogs allowed in the dining room. When a dog was brought in, the dog was taken through the hallways and the dining room was avoided. The dog was to be leashed.

  The Program Director reported there was no policy regarding staff members and pets, but there was a policy for tenants. The policy for tenants indicated pets were allowed, must be kept on a leash, and were not permitted in the common areas. Pet owners were to maintain the dwelling unit and keep the environment clean and sanitary.

  The monitor walked the hallways, the dining room, the private dining room, and nurse's office. There was no odor of urine. No dogs were observed to be at the program during the onsite visit.

  The program was kept clean and sanitary.

- Regulatory Insufficiency: None noted.