IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
46903-C

April 9, 2014

Mr. Derrick Johnson, Manager
Courtyard Estates at Hawthorne Crossing
601 Hawthorne Crossing Drive SE
Bondurant, IA 50035

RE: Final Complaint/Incident Investigation Report, Courtyard Estates at Hawthorne Crossing, Bondurant, Iowa

Dear Mr. Johnson:

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 **April 1, 2 and 3, 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/emailed to DIA to my attention 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 515/281-7039 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 #:** 46903-C

Derrick Johnson, Manager
Courtyard Estates at Hawthorne Crossing
601 Hawthorne Crossing Drive SE
Bondurant, IA 50035

Date of Complaint/Incident Investigation:

April 1, 2, and 3, 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:	12
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	14
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	21
TOTAL census of Assisted Living Program	35

Program History – During the recertification visit of June 24, 2013, the Program received regulatory insufficiencies in the areas of: Food Service, Dementia Specific Education and Transportation.

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

A. Medications

Complaint/Incident Allegation: It was alleged medications were not given as ordered.

- Monitoring Observation: Clinical records including medication administration records (MARs) and physician orders were reviewed for three tenants, #3, #4, and #5.

  Tenant #3, an 87 year-old, was admitted on 6-1-12 and had diagnoses of: Alzheimer's Dementia, Shortness of Breath, History of Hip Replacement, Congestive Heart Failure, and Subconjunctival Hemorrhages to Eye. Tenant #3 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. Tenant #3 resided in the dementia unit. A review of the clinical record indicated Tenant #3 was on a blood thinner and several changes were made to the order over the months of December 2013 through March 2014. Changes to medications including the blood thinner were accurately reflected on the MARs. MARs documented the medications were given as ordered.

  Tenant #4, an 82 year-old, was admitted on 3-29-12 and had diagnoses of: Alzheimer's Dementia, Osteoarthritis, Hypertension, Gastroesophageal Reflux Disease, Depression, Anxiety, and Insomnia. Tenant #4 was staged at five on the GDS which indicated moderately severe cognitive decline. Nurse's notes dated 7-18-

13 documented the family requested Namenda, an anti-Alzheimer's medication, be held, and the medication had not been held. Notes of 8-19-13 documented an error with the Namenda. Namenda was to have been changed from 20 milligrams (mg) daily to 10 mg daily. A medication error occurred. The clinical record documented changes were made to reflect the orders.

Nurse's notes documented follow-up with the physician on 7-19, 7-25, and 8-13-13 to report Tenant #4's response to medications. Nurse's notes documented the physician updates were decreased to "as needed."

Tenant #5, an 88 year-old, was admitted on 2-1-14 and had diagnoses of: Chronic Kidney Disease with an Arterio-Venous Fistula, Hypertension, Diabetes, Arthritis, and Congestive Heart Failure. On 2-5-14 Tenant #5 had no errors on the cognitive screening tool which indicated no cognitive impairment. Tenant #5 resided in the general population. MARs were reviewed for February and March 2014. Changes to medications were accurately reflected on the MARs. MARs documented the medications were given as ordered.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation: It was alleged staff moved a tenant after a fall when the tenant should not have been moved.

- Monitoring Observation: Incident reports documented Tenant #3 fell or nearly fell on two occasions, 2-6-14 and 3-24-14. Tenant #3 was transported to the hospital for pain on both occasions. There was no documentation to suggest Tenant #3 was moved inappropriately.

  An incident report dated 9-3-13 and timed 12:30 p.m. documented staff observed Tenant #4 to have a bruised and swollen arm. The incident report documented Tenant #4 had been observed earlier in the day and no injury had been observed to the arm. Nurse's notes of the same date documented no fall occurred. Nurse's notes documented Tenant #4 was observed and the arm worsened. Tenant #4 was sent to the hospital on 9-5-13. Tenant #4 returned from the hospital with a diagnosis of a broken elbow. Nurse's notes documented Tenant #4 had bruising and swelling to the arm and was resistant to the ice and elevation as ordered by the physician. On 9-7-13, Tenant #4 was sent to the hospital after Tenant #4 began to complain of pain and was unable to move the fingers of the affected arm. Tenant #4 was treated for a fluctuating blood pressure and treated with surgery to the arm. Tenant #4 returned to the program on 9-20-13.

  Notes of 9-21-13 documented Tenant #4 was continuously moving the arm and was dressing and undressing self and not allowing staff to assist. The RN documented

concern over injury to the arm and the need for re-evaluation by the physician. Family was to take Tenant #4 to the physician's office the following day.

Incident reports and nurse's notes dated 10-2-13 documented Tenant #4 was found sitting on the toilet with a bump to the head and complaining of leg and arm pain. Staff #1, who was no longer employed at the program at the time of the onsite visit, and Staff #2 were interviewed. Each indicated they had observed Tenant #4 in the apartment about 15 minutes prior to finding Tenant #4 on the toilet. The RN was notified. The RN and Staff #1 and #2 reported a search of the apartment revealed blood spots on the pillowcase on the bed and on the floor in the bedroom. Staff #1 and #2 reported Tenant #4 had been wearing front button shirts following the September 2013 arm injury. Staff #1 reported there was blood on the shirt and Staff #1 reported removing the shirt and applying a clean front-button shirt. Tenant #4 was transported to the hospital via ambulance and did not return to the hospital.

There was no observed and documented fall prior to Tenant #4's fractured elbow. Tenant #4 was not moved from the toilet following observation of a bump to the head and Tenant #4's complaint of leg pain.

Incident reports dated 2-14 and 2-19-14 documented Tenant #5 was found on the floor. Vital signs were checked and emergency services were contacted. There was no documentation to suggest Tenant #5 was moved inappropriately.

Staff #2, #3, #4, #5, and #6, direct care staff, were interviewed and reported a tenant would not be moved following a fall.

- Regulatory Insufficiency: None noted.

C. Service Plans

Complaint/Incident Allegation: It was alleged service plans were not followed and did not meet tenant needs.

- Monitoring Observation: The service plan was reviewed for Tenant #3. The service plan dated 3-27-14 was based on evaluations completed on the same date. Task sheets were completed appropriately and documented personal cares were completed. Tasks on the task sheets were not completed on the days Tenant #3 was at the hospital. The task sheets documented staff offered Tenant #3 a shower three times and Tenant #3 refused each time. Task sheets indicated Tenant #3 was offered a shower on a day not previously scheduled or assisted Tenant #3 with a sponge bath.

  The service plan was reviewed for Tenant #4. Evaluations were completed on 9-18-13, prior to the return to the program following the diagnosis of fractured elbow. The health evaluation documented Tenant #4 had a four inch surgical incision on the left elbow. The service plan did not identify Tenant #4 had a wound or staff interventions for the wound including observation of changes which would require notification to the nurse.

Tenant #4 had a diagnosis of left elbow fracture. The service plan did not include interventions for the fracture to include not using the arm for blood pressure checks which were listed on the task sheets to be completed monthly.

The service plan did not meet the identified needs of Tenant #4.

The task sheets indicated Tenant #4 sometimes refused showers. The task sheet instructed staff to repeatedly offer showers and if refusal continued, a shower was to be attempted the next day. A sponge bath was to be completed if showers were refused repeatedly.

The task sheet also noted Tenant #4 liked to pack items, and toothbrush and toothpaste was secured. Task sheets were completed appropriately and documented personal cares were completed. Tasks on the task sheets were not documented as completed on days Tenant #4 was not at the program.

Tenant #4's task sheet documented Tenant #4, a person with dementia, was to be reminded the spouse was deceased. The entry indicated a lack of understanding of dementia care.

Nurse's notes documented the following for Tenant #5 had legs that were weeping and required betadine and leg wraps. Redness was observed in the sacral area. On 2-19-14 Tenant #5 hit a toe on a chair which resulted in a loose toenail and bleeding. Notes of 2-19-14 also documented blood sugars were low in the morning for Tenant #5, a diabetic. Tenant #5 returned to the program on 2-19-14. On 2-20-14 Tenant #5's condition deteriorated according to the nurse's notes and Tenant #5 was sent to the hospital for evaluation. Evaluations were completed on 3-21-14 and Tenant #5 returned to the program on 3-24-14. On 3-27-14, Tenant #5 was again sent to the hospital for decline, but returned to the program on the same day. On 3-29-14, Tenant #5 was transferred to a higher level of care.

The service plan of 2-19-14 documented Tenant #5 was diabetic but did not identify Tenant #5 had low blood sugars in the morning and that staff should be aware of symptoms of hypoglycemia. The service plan did not identify legs were weeping, dressing changes, care of the dressings during bathing. The service plan did not identify a reddened sacral area and interventions for skin care and observations to be made to the nurse. The service plan did not identify Tenant #5's arterio-venous fistula and staff direction, such as not the checking the blood pressure on the side of the fistula. The service plan of 3-27-14 did not identify interventions for skin and wound care or observations, and arterio-venous fistula care or interventions.

The service plan did not meet the needs of Tenant #5.

Observations were made in the dementia unit on all three days of the monitoring visit. Staff were observed checking on tenants and providing cares. Documentation sheets were reviewed. Hourly checks were not documented prior to completion. Tenants were observed to be neat and clean and free of odor. Apartments were entered with permission when interviewing Tenants #1, #2, and Family #1. Apartments were neat and clean. Tenants #1, #2, and Family #1 verbalized no concerns of cares given to either self or family member.

The dementia unit was generally neat and clean. Staff members were observed changing linens and doing laundry.

Service plans did not meet identified needs of Tenants #4 and #5.

- 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. Activities

Complaint/Incident Allegation: It was alleged regularly scheduled activities were not held.

- Monitoring Observation: The program provided activity calendars for April 2014 for both the general population area and the dementia unit. During the onsite visit of April 1, 2, and 3, activities were observed to be held in both the general population area and dementia unit as scheduled on the calendars. Additional activities including a birthday party and ball toss were observed. Tenants who usually resided in the dementia unit were accompanied to activities in the general population.

  Tenants #1 and #2 were interviewed. Tenants #1 and #2 were reported by the program to be cognitively well and resided in the dementia unit with spouses who had cognitive impairment. Family #1 was also interviewed. All three reported activities were held as scheduled and there were no problems identified with activities. It was reported a new activity directed was hired one to two months ago, and the activities had improved.

  The program held activities as scheduled on the activity calendar. Tenants and family were interviewed and identified no problems with activities.

- Regulatory Insufficiency: None noted.