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INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
47663-C

April 28, 2014

Mr. Fredrick Killian, Executive Director
Waterford Assisted Living
1325 Coconino Road
Ames, IA 50014

RE: Final Complaint/Incident Investigation Report, Waterford Assisted Living, Ames, Iowa

Dear Mr. Killian:

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 21, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plans 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/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 #:** 47663-C

Fredrick Killian, Executive Director
Waterford Assisted Living
1325 Coconino Road
Ames, IA 50014

Date of Complaint/Incident Investigation:

April 21, 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:	57
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	58
TOTAL census of Assisted Living Program	58

Program History – During the Recertification and Complaint Investigation (42340-C) conducted on February 12 and 13, 2013, the program received regulatory insufficiencies in the areas of evaluation and service plan.

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

A. Program Reporting to the Department

Complaint/Incident Allegation: It was alleged an elopement was not reported to the department.

- Monitoring Observation: Iowa Administrative Code 481-67.4(4) requires tenant elopements be reported to the department. IAC 481-67.1 defines elopement as a tenant who has impaired decision-making ability leaving the program without the knowledge or authorization of staff. Impaired decision-making ability is defined as lack of capacity to make safe and prudent decision as determined by the program nurse or means having a Global Deterioration Scale (GDS) score of four or above.

  Incident reports were reviewed for the months of January through April of 2014 . An incident report dated 1-30-14 and timed 7:20 p.m. documented Tenant #1 was outside and staff directed Tenant #1 back into the building. The incident report documented Tenant #1 was having hallucinations about little girls in the apartment. The incident reported the nurse (RN) was called and 15 minute checks were started.

  There were no other incident reports related to tenants being outside of the building.

  The clinical record for Tenant #1 was reviewed. Tenant #1, a 92 year-old, was admitted on 10-16-13 and had diagnoses of: Hypertension, Hypothyroidism, Macular Degeneration, History of Stroke, Carotid Artery Stenosis, Diabetes, Hallucinations, and Atrial Fibrillation. Cognitive screenings completed by the RN on 1-10, 2-1, 3-14-14 indicated no cognitive impairment. A different cognitive screening tool dated

4-11-14 was documented as completed during Tenant #1's hallucination. Tenant #1 had no errors in ten questions which indicated intact intellectual functioning.

A physician order sheet dated 3-20-14 documented Tenant #1 was reported to have left the program unnoticed. The resident care notes did not contain documentation of the reported event. The RN was interviewed and stated Tenant #1 signed out of the program and reported going to an assisted living program (ALP) adjacent to Waterford to visit friends. Tenant #1 had previously resided at the other ALP. The RN reported Tenant #1 had on a coat and had taken oxygen. According to the RN, the family had encouraged Tenant #1 to visit friends at the other program. An incident report was not completed as it was a cognitively well tenant who chose to visit friends. The RN reported Staff #1 and #2 were working and phoned the RN after returning Tenant #1 to the program to verify the tenant had friends at the other program, which the RN verified.

Staff #1 was interviewed and stated she did not recall the date, but a short time after supper the program received a phone call from the neighboring ALP to report Tenant #1 was at that program. Staff #1 reported Tenant #1 signed self out of the building. Staff #1 stated she went to the ALP. Tenant #1 had on a sweatshirt, pants, and shoes, had oxygen and was using a walker and reported visiting with friends. Staff #1 reported Tenant #1 was not hallucinating at the time. Staff #1 reported hourly checks were instituted after Tenant #1 returned to the program.

Staff #2 reported she did not recall the date, but it was about 7:30 p.m. that Staff #2 was notified Tenant #1 was at the ALP. Staff #2 reported Tenant #1 had been hallucinating earlier in the day but was getting better and was being checked every half-hour. Staff #2 had checked on Tenant #1 at about 7:00 p.m. Staff #2 went to the ALP and found Tenant #1 was wearing a sweater, pants, shoes, was using oxygen, and the walker. Tenant #1 had previously lived at the ALP and seemed confused as to why Tenant #1 needed to return to the Waterford. Tenant #1 reported going to the ALP to visit friends. Staff #2 did not recall whether or not Tenant #1 signed self out of the building. Staff #2 reported Tenant #1 had not been wandering and had not left the building before or since. Staff #2 reported the RN was notified and Tenant #1 was checked throughout the night following return to the Waterford.

The ALP was observed to be located on the same side of the street as the Waterford with parking lots and sidewalk adjoining the programs.

Tenant #1 had no documentation of cognitive impairment as indicated by cognitive screening tools utilized by the program. Tenant #1 did not meet the definition of cognitively impaired which would have required reporting of the incident.

- Regulatory Insufficiency: None noted.

B. Evaluation

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

- Monitoring Observation: The resident care notes documented Tenant #2 had been taken to the hospital and returned to the program on 3-18-14. The notes documented Tenant #2 was hospitalized for a Transient Ischemic Attack. Upon return to the program Tenant #2 had weak, unsteady gait. Physical Therapy was scheduled to work with Tenant #2. Evaluations and the service plan of 3-18-14 documented Tenant #2 required assistance of two persons with ambulation and required staff to transfer Tenant #2 by wheelchair to and from meals and activities. The RN reported Tenant #2 required the assist of two persons for ambulation for less than 21 days. Evaluations were not completed with a change of condition, improvement in mobility.

  Resident care notes dated 4-7-14 documented Tenant #2 had been having trouble swallowing pills over the previous two days. The notes documented Tenant #2 needed to take the pills one at a time and very slowly. No choking was noted. The physician was notified. Evaluations were not completed with a change of condition.

  Tenant #3, an 85 year-old, was admitted on 4-21-06 and had diagnoses of: Borderline Personality Disorder, Partial Epilepsy, Autoimmune Encephalitis, Diabetes Mellitus Type II, Atherosclerotic Cerebrovascular Disease, and Psychosis secondary to Partial Status Epilepticus. Resident care notes of 1-27-14 which documented a late entry for 1-26-14 revealed Tenant #3 became unresponsive, was shaking and not responding except for a few words. Tenant #3 was transported to the hospital and admitted. According to physician's notes, Tenant #3 had not experienced a seizure since 2012. Tenant #3 returned to the program on 1-31-14. Notes documented Tenant #3 had changes to medications for seizures. When Tenant #3 returned to the program, evaluations were not completed with a change of condition, hospitalization with medication changes.

  Notes of 2-1 14 documented Tenant #3 was stuttering and not making sense while on the phone to a family member. The RN documented staff checked on Tenant #3 throughout the day. Evaluations were not completed with a change of condition which required an increase in services from program staff.

  Notes of 2-4-14 documented Tenant #3 was admitted to the hospital. The program reported Tenant #3 was discharged from the program on 3-22-14 to a higher level of care.

  Tenant #4, a 91 year-old, was admitted on 12-27-07 and had diagnoses of: Atrial Fibrillation, Hypertension, Osteoarthrosis, and Anxiety. Resident care notes dated 1-6-14 documented Tenant #4 experienced left-sided weakness, confusion, slurred speech, and unsteady gait. According to the notes, Tenant #4 was admitted to the intensive care unit of the local hospital with bleeding on the brain. Tenant #4 returned to the program on 3-4-14.

  Notes of 3-17-14 as a late entry for 3-15-14 documented Tenant #4 fell and sustained a laceration to the back of the head. Tenant #4 was transported to the emergency room and returned to the program on the same day with staples to the laceration on the back of the head. According to the discharge instructions from the hospital, Tenant #4 sustained a concussion, defined as a hit to the head hard enough to injure the brain. According to the notes, staff was instructed to check on Tenant #4 every

two hours. Evaluations were not completed for a change of condition, a tenant with a history of a brain bleed who sustained a concussion and laceration to the head and required changes to services.

- 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. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant exceeded criteria for retention at the program.

- Monitoring Observation: The program was asked to provide incident reports, communication sheets, and unlabeled staff communication sheets to the monitor. The documents were reviewed as provided. Unlabeled staff communication sheets dated the end of March 2014 documented Tenant #2 was a two-person assist. The RN stated staff transferred information forward for one week on the unlabeled staff communication sheets.

  Staff #3 and #4 were interviewed. Both were staff that had worked directly with tenants. Neither Staff #3 nor #4 identified Tenant #2 as requiring two persons for assistance.

  Clinical records were reviewed for Tenants #1, #2, #3, and #4. No issues related to exceeding criteria for retention were identified for Tenants #1, #3, or #4.

  Tenant #2, an 85 year-old, was admitted on 11-24-11 and had diagnoses of: Dementia, Autoimmune Hepatitis, Hypertension, Anemia, and Chronic Kidney Disease. On 3-18-14, Tenant #2 had four errors on the cognitive screening tool which indicated mild intellectual impairment. The resident care notes documented Tenant #2 had been taken to the hospital and returned to the program on 3-18-14. The notes documented Tenant #2 was hospitalized for a Transient Ischemic Attack. Upon return to the program Tenant #2 had weak, unsteady gait. Physical Therapy was scheduled to work with Tenant #2.

  In an interview with the RN, she reported Tenant #2 required assistance of two persons for a short period of time, but had improved. Physical Therapy notes dated 3-27-14 documented Tenant #2 had improved functional mobility and required minimal assistance.

  Tenant #2 did not exceed criteria for retention in an assisted living program. No other tenants were identified as exceeding criteria for retention.

- Regulatory Insufficiency: None noted.

D. Service Plans

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

- Monitoring Observation: Tenant #1 had episodes of hallucinations. Evaluations were completed on 3-14-14 following hospitalization for Congestive Heart Failure, Urinary Tract Infection, and a possible reaction to Lorazepam given for hallucinations. Resident care notes dated 3-18-14 documented Tenant #1 was on hourly checks. A review of the service plan of 3-14-14 did not identify Tenant #1 was receiving frequent checks. The service plan did not meet the identified needs of Tenant #1. Notes of 4-11-14 documented Tenant #1 was again hallucinating. The notes documented staff were instructed by the RN to check on Tenant #1 hourly throughout the night. The service plan of 4-11-14 did not identify Tenant #1 was to be on hourly checks. The service plan did not meet the identified needs of Tenant #1.

  The resident care notes documented Tenant #2 had been taken to the hospital and returned to the program on 3-18-14. The notes documented Tenant #2 was hospitalized for a Transient Ischemic Attack. Upon return to the program Tenant #2 had weak, unsteady gait. Physical Therapy was scheduled to work with Tenant #2. Evaluations and the service plan of 3-18-14 documented Tenant #2 required assistance of two persons with ambulation, and required staff to transfer Tenant #2 by wheelchair to and from meals and activities. The RN reported Tenant #2 required the assist of two persons for ambulation for less than 21 days. The service plan was not updated with the change in services required.

  Resident care notes dated 4-7-14 documented Tenant #2 had been having trouble swallowing pills over the previous two days. The notes documented Tenant #2 needed to take the pills one at a time and very slowly. The RN stated the staff was not allowing enough time for Tenant #2 to take the pills. The service plan was not updated to direct the staff to allow Tenant #2 to take pills one at a time and very slowly. The service plan did not meet the identified needs of Tenant #2.

  The current service plan for Tenant #3 was dated 5-21-13. The corresponding evaluations indicated "annual." A review of the service plan indicated Tenant #3 had psychosis secondary to partial status epilepticus, but did not identify behaviors staff would witness that would let staff know Tenant #3 was experiencing a seizure. The service plan did not identify interventions for a seizure. The service plan did not identify Tenant #3 was to be checked throughout the day as indicated in the resident care notes of 2-1-14. The service plan did not meet the identified needs of Tenant #3.

  Tenant #4 was admitted to the hospital on 1-6-14 following bleeding on the brain. Tenant #4 returned to the program on 3-4-14. According to the resident care notes Tenant #4 had left-sided visual neglect. The service plan identified Tenant #4 had left-sided visual neglect, but did not identify interventions for staff to use when working with Tenant #4 with the left-sided visual neglect.

Tenant #4 sustained a laceration following a fall on 3-15-14. Staples were used to close the laceration. The service plan did not identify the care of the staples and/or wound to the back of the head.

Resident care notes dated 3-17-14 as a late entry for 3-15-14 documented staff was to check on Tenant #4 every two hours upon return from the hospital following a fall with head injury. The service plan was not updated to indicate the two-hour checks, or signs/symptoms to be reported to the nurse following a head injury.

- 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))

E. Nurse Review

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

- Monitoring Observation: Tenant #1 had an evaluations completed for a change in condition on 1-10-14. The resident care notes documented medications were changed, and daily weights and blood pressures were to be checked. The notes also documented Tenant #1 had increased fluid retention, 4+ pitting edema, increased shortness of breath, and increased confusion and hallucinations. There was no further documentation of Tenant #1's physical health. A nurse review was not completed to assess and document Tenant #1's health status and monitor progress following medication changes. Tenant #1 was admitted to the hospital with a diagnosis of Congestive Heart Failure on 3-11-14.

  Evaluations were completed on 4-11-14 for Tenant #1 for a change of condition. A nurse review was not completed with the change of condition. There was no documentation of a medication review for Tenant #1 who was administered medications by the program.

  The resident care notes documented Tenant #2 had been taken to the hospital and returned to the program on 3-18-14. The notes documented Tenant #2 was hospitalized for a Transient Ischemic Attack. Upon return to the program Tenant #2 had weak, unsteady gait. Physical Therapy was scheduled to work with Tenant #2. Evaluations and the service plan of 3-18-14 documented Tenant #2 required assistance of two persons with ambulation and required staff to transfer Tenant #2 by wheelchair to and from meals and activities. The RN reported Tenant #2 required the assist of two persons for ambulation for less than 21 days. A nurse review was not completed for a change of condition, improvement of mobility which resulted in fewer staff required for ambulation.

  A nurse review was documented as completed on 12-31-13. The nurse review of 12-31-13 did not document a review of medications. There was no documented 90-day nurse review after 12-31-13 for Tenant #2

Tenant #3 returned to the program after hospitalization for seizures, which last occurred in 2012. Tenant #3 returned with changes to medications. The resident care notes dated 1-31-14 documented Tenant #3 was reported to exhibit confusion while hospitalized. Notes of 2-1-14 documented Tenant #3 was stuttering and no making sense. A nurse review was not completed with a change of condition which resulted in increased services, checking Tenant #3 throughout the day.

Tenant #4 returned to the program on 3-4-14 following hospital and post-hospital care for a brain bleed. A nurse review was not completed to include a review of medications following a change of condition.

Tenant #4 sustained a concussion following a fall. A nurse review was not completed to include assess and document Tenant #4's health status, or a review of medications with a change of condition which resulted in a change of services, two-hour checks.

- 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))