IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
47122-I
47327-I

April 29, 2014

Ms. Vonnie Potter, Executive Director
Windsor Manor Indianola
608 South 15th Street
Indianola, IA 50125

RE: Final Complaint/Incident Investigation Report, Windsor Manor Indianola, Indianola, Iowa

Dear Ms. Potter:

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 31, April 1, 22 and 24, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation and Service Plan.

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 #:** 47122-I & 47327-I

Vonnie Potter, Executive Director
Windsor Manor Indianola
608 South 15th Street
Indianola, IA 50125

Date of Complaint/Incident Investigation:

March 31, 2014 & April 1, 22 and 24 2014

Monitor(s):

Margaret Kaltefleiter, RN MS
Wendy Kuhse, RN BS

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:	25
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	29
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	7
TOTAL census of Assisted Living Program	36

Program History – During the Recertification and Incident Investigation (40288-I) of Sept. 2012, the program received a regulatory insufficiency in the area of Structural Requirements. During the October 2013 Incident Investigation (45090-I) the program did not receive any regulatory insufficiencies.

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

A. Other

Complaint/Incident Allegation #47122-I: The Program reported Tenant #1 was assisted to the bathroom and subsequently fell and suffered a hip fracture.

- Monitoring Observation: Five tenant files were reviewed.

  Tenant #1, a 74 year old, was admitted on 12-17-13 and diagnoses include: Diabetes, Type II, Hypertension (HTN), Hyperlipidemia, Osteoporosis, Gastro-Esophageal Reflux Disease (GERD), Hypothyroidism, Depression, Dementia, Vitamin B Deficiency, Glaucoma, History of Gout, Hypercalcemia, and Chronic Kidney Disease, Stage II. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit.

  According to Tenant #1's functional and health assessment dated 12-11-13, Tenant #1 ambulated with a walker and/or self-propelled with a wheelchair. The assessment indicated Tenant #1 was able to stand independently. According to Tenant #1's functional and health assessment dated 01-22-14 Tenant #1 used a wheelchair for ambulation and mobility.

According to the service plan dated 01-22-14 Tenant #1 was independent with an assistive device/walker and indicated Tenant #1 used a wheelchair, which Tenant #1 propelled for the majority of Tenant #1's transportation needs. Tenant #1 was able to stand independently but had gotten weaker.

According to an Incident and Accident Form dated 01-25-14 at 10:00 p.m., Staff #2 assisted Tenant #1 with using the restroom and one of the other tenant's family asked a question and needed assistance and Staff #2 stepped out of Tenant #1's room for a split second and heard Tenant #1 fall. Staff #2 indicated Tenant #1 got up and turned around to clean the toilet and lost Tenant #1's footing and fell. Tenant #1stated Tenant #1 hit head and hip. Staff #2 notified the Executive Director (ED), Tenant #1's family and called 911.

Staff #2 was interviewed and stated on the evening of 01-25-14 Staff #2 assisted Tenant #1 to use the bathroom. Staff #2 stated Tenant #1 became agitated and told Staff #2 to "get the hell out of here". Staff #2 stated Tenant #1 often was in the bathroom five to ten minutes, so Staff #2 stepped just outside Tenant #1's apartment, but was still able to visualize Tenant #1 in the bathroom. Staff #2 stated another tenant's family required Staff #2's assistance and Staff #2 stepped away from Tenant #1's doorway for about five minutes. Staff #2 stated when returning to Tenant #1's apartment Staff #2 heard a loud noise and entered Tenant #1's apartment to find Tenant #1 on the floor in the bathroom.

Staff # 3 was interviewed and stated at about 10:00 p.m. Staff #2 was talking to a tenant's family in the kitchen of the dementia unit. Staff #3 stated a thud was heard and she responded to Tenant #1's apartment and arrived first at the scene. She stated Tenant #1 had fallen and was sitting with Tenant #1's back against the wall with one knee bent and the other leg straight out. Staff #3 stated Tenant #1 was wearing a tee-shirt and protective undergarments. She stated Tenant #1 complained of hip pain but did not appear to be in pain. She always liked to be with Tenant #1 while toileting and stated that the task sheet indicated Tenant #1 required stand by assistance (SBA). Staff #3 stated SBA meant staff was to be with the tenant when the tenant used the bathroom. Staff #3 stated she would step into the outer room to keep a visual on Tenant #1. Staff #3 stated possibly Tenant # 1 used a walker and had fallen one time before.

The Executive Director (ED) was interviewed and was aware of Tenant #1's fall on 02-25-14. The ED stated Tenant #1 used a walker for assistance to ambulate outside Tenant #1's apartment. The ED also stated Tenant #1 was a very private person with toileting and Staff #2 was able to visualize Tenant #1 until another tenant's family called Staff #2 to assist them.

According to a nurse review dated 01-28-14, Tenant #1 had been sent to the emergency room for evaluation and treatment where Tenant #1 was diagnosed with a hip fracture. Tenant #1 received surgical repair of the fracture and was transferred to a skilled nursing facility for rehabilitation.

An incident report was completed and the Department was notified.

Review of Tenant #1's file, interviews with Staff #2, Staff #3, the ED and review of the incident report indicated Tenant #1 was independent in ambulation, had fallen and suffered an injury.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47327-I: The Program reported Tenant #2 stated a female fondled and kissed Tenant #2 on two separate occasions.

- Monitoring Observation: Tenant #2, a 76 year old, was admitted on 12-6-13 and diagnoses include: Dementia, Chronic Obstructive Pulmonary Disease and HTN. Tenant #2 was staged at a six on the GDS which indicated severe cognitive decline. Tenant #2 resided in the dementia unit.

  According to an Incident and Accident Form dated 2-8-14 at 2:00 p.m., Tenant #2's family reported to Staff #2 and another staff that Tenant #2 stated a lady came into Tenant #2's room at night and tried to kiss Tenant #2 on the lips and was grabbing at the chest. Staff #2 and the other staff talked with Tenant #2 who gave a vivid description of what the person looked like. Tenant #2's description was a very ugly woman who had short black hair and glasses with no teeth. Tenant #2 was very shaken up and got choked up when talking and was crying. Staff #2 notified the ED about the situation, completed the Incident and Accident Form and tried to make Tenant #2 feel safe.

  Per Tenant #2's family request, Tenant #2 was interviewed. When the monitor entered the dementia unit, Tenant #2 was asking Staff #2 for cigarettes. Staff #2 told Tenant #2 only one cigarette was available at a time. Tenant #2 questioned whose rule it was that the number of cigarettes was limited. Staff #2 suggested Tenant #2 join the monitor outside for the interview. Tenant #2 stated Tenant #2 loved living at the Program at first, and was happy until Tenant #2 met Staff #2 who had just brought Tenant #2 outside, because Staff #2 stole Tenant #2's cigarettes. Tenant #2 stated no one had done anything inappropriate; the rest of the staff was nice. It was just Staff #2 who took Tenant #2's cigarettes and denied it. Tenant #2 stated there was just one girl who had fondled Tenant #2, had felt Tenant #2's breasts, but Tenant #2 pushed the girl away. Tenant #2 couldn't remember any details about the incident and there had been no issues since.

  According to a Program Investigation document, the Program had an overnight staff, Staff #3, who had dark brown hair, wore glasses and did not have top teeth. The ED questioned Staff #3 on the cares she provided to Tenant #2 on the overnight shift. Staff #3 said Tenant #2 was very independent and she did not assist Tenant #2 in anyway other than hourly checks. Tenant #2 would get upset with Staff #3 at times. Tenant #2 would ask for three cigarettes at a time and Staff #3 would tell Tenant #2 she would give one and help light it. Tenant #2 would walk away and not talk to Staff #3 for a long time. Staff #3 found a cigarette in Tenant #2's apartment and asked Tenant #2 if Tenant #2 had a lighter and smoked in the apartment. Tenant #2 became very agitated with Staff #3. The ED asked Staff #3 to deliver cookies to the dementia unit and have coffee with the tenants so the ED could observe Tenant #2's reaction to Staff #3. Staff #3 offered the tenants cookies and sat at the table with

several tenants. Tenant #2 would not take a cookie from Staff #3 but did not appear uncomfortable with Staff #3 being there. Staff #3 spent 20 minutes with the tenants and Tenant #2 appeared to be content during this time.

Staff #2 was interviewed and stated Tenant #2's family stated Tenant #2 needed to talk to her. Tenant #2 gave a description of someone who wore glasses, had short black hair, missing teeth, sounded and looked like a man and was ugly. Tenant #2 indicated this person touched Tenant #2's breast, kissed Tenant #2 on the mouth and attempted to touch Tenant #2's private area. Tenant #2 started getting choked up and cried. Tenant #2's family stated Tenant #2 had reported this previously but the family did not take it seriously. Staff #2 called the ED. Staff #2 stated this occurred one and one half or two months ago and Tenant #2 had not spoken of it since. Staff #2 reported Tenant #2 got upset with other staff regarding cigarettes. If Tenant #2 got mad at a staff, Tenant #2 made up stories about that staff.

Staff #3 was interviewed and stated Tenant #2 was very demanding and quickly forgot things such as when Tenant #2 had a cigarette one minute and afterwards asked for another one. When Tenant #2 asked for something Tenant #2 wanted it immediately and didn't want to wait. Tenant #2 got agitated if Tenant #2 had to wait and would then talk ugly to you. Staff #3 denied any inappropriate behavior and stated she had never hugged or kissed Tenant #2.

The Heath Care Coordinator (HCC) was interviewed and stated Tenant #2's allegations at first surprised her because Tenant #2 was very refined and gracious. The HCC started to observe Tenant #2 interacting with others and observed Tenant #2 became easily agitated. She checked Tenant #2's Medication Administration Record and wondered if too many evening medications were ordered. Tenant #2's Trazadone was discontinued and Tenant #2 seemed to mellow out. Soon Tenant #2 started to have short triggers of anger again and pointed fingers at others. When Tenant #2 was angry with someone it was because cigarettes were not provided and Tenant #2 would accuse the person of something. The HCC met with Staff #3 and shared Tenant #2's allegations of a tall, thin, person with no teeth, dark hair and ugly coming in the middle of the night. Tenant #2 didn't know if the person was a male or female. Staff #3 denied all allegations. The HCC stated Staff #3 was a very good caregiver. The HCC took Staff #3 to the dementia unit with a tray of cookies to see how Tenant #2 would respond when Tenant #2 saw Staff #3. Tenant #2 had no reaction.

The ED was interviewed and stated she received a call from staff indicating Tenant #2 had told Tenant #2's family about inappropriate behaviors. She instructed staff to complete an incident report. The next morning she spoke with Tenant #2's family and she and the HCC interviewed Tenant #2 and she notified the Department. Staff #3 was taken off the dementia unit schedule during the Program's investigation. The ED took the allegation seriously and followed up on a daily basis and noticed Tenant #2's confusion and would receive different information from Tenant #2. Tenant #2 had medication changes as some medications could cause hallucinations. After the medication changes, Tenant #2 leveled out but recently started getting mad again and made comments about suing the ED. She stated Staff #3 was a very good employee, had worked at the Program several years ago and left, returned about one year ago.

Staff #3 was very considerate and professional. Staff #3 denied the allegations, was tearful and responded appropriately.

An incident report was completed and the Department was notified.

Review of Tenant #2's file, interviews with Tenant #2, Staff #2, Staff #3, HCC and ED and review of the incident report indicated Tenant #2 had a history of making false accusations against staff when Tenant #2 was unhappy about a situation that had just occurred.

- Regulatory Insufficiency: None noted.

B. Evaluation

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

- Monitoring Observation: Five tenant files were reviewed.

  Tenant #2's file was reviewed. According to Nurses Notes dated 2-11-14 at 1:30 p.m., Tenant #2 had expressed a woman had walked into Tenant #2's room at night and touched Tenant #2. Upon questioning, Tenant #2 stated Tenant #2 couldn't tell who it was because it was night time and dark. According to Nurses Notes dated 3-21-14 at 5:30 p.m., Tenant #2's family reported Tenant #2 stated someone had tried to touch Tenant #2. Tenant #2 started being more aggressive mainly due to wanting cigarettes and talked about being touched when Tenant #2's anger escalated. Functional, cognitive and health evaluations were not completed as needed with significant change.

  Tenant #3, an 85 year old, was admitted on 12-1-13 and diagnoses include: HTN, Dementia, Rapid Atrial Rhythm and History of Colitis/Diverticulitis. Tenant #3 was staged at a six on the GDS which indicated severe cognitive decline. Tenant #3 resided in the dementia unit. According to Nurses Notes dated 1-22-14 at 4:00 p.m., Tenant #3 had increased confusion and tested positive for a Urinary Tract Infection (UTI). An antibiotic (ATB) was ordered. According to Nurses Notes dated 3-11-14, an order for a urinalysis (UA) was obtained and Tenant #3 was started on an ATB for seven days for a UTI. According to Nurses Notes dated 3-20-14, the HCC assessed Tenant #3's right foot and ankle and noted increased swelling, ecchymosis, increased darker purple/blue. Tenant #3 had increased pain when palpated outer ankle, able to move toes without pain. Tenant #3 continued to walk with a walker although favored right foot. The HCC encouraged Tenant #3's family to have X-Rays taken. A Clinic Document dated 3-21-14 indicated Tenant #3 had a non-displaced fracture of the right fifth metatarsal. Ice three times a day; Naproxen 250 mg. with food twice a day and as needed for pain/swelling; wear hard soled shoe when up and walking around; may use ace wrap or ankle stirrup if desired. According to the Nurses Notes dated 3-21-14, Tenant #3's family brought in a hard soled Velcro foot covering to wear with the splint or ace wrap. Functional, cognitive and health evaluations were not completed as needed with significant change.

Review of tenant files indicated functional, cognitive and health evaluations were not completed as needed for tenants with significant change.

- 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

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

- Monitoring Observation: Five tenant files were reviewed.

  Tenant #2's file was reviewed. The HCC was informed by staff Tenant #2 started being more aggressive mainly due to wanting cigarettes and talked about being touched when Tenant #2's anger escalated. Tenant #2's service plan was not updated to reflect Tenant #2's behaviors and interventions for behaviors. Tenant #2's service plan did not reflect the identified needs of the tenant.

  Tenant #3's file was reviewed. According to Nurses Notes dated 1-22-14 at 4:00 p.m., Tenant #3 had increased confusion and tested positive for a UTI. An ATB was ordered. According to Nurses Notes dated 3-11-14, an order for a UA was obtained and Tenant #3 was started on an ATB for seven days for a UTI. A Clinic Document dated 3-21-14 indicated Tenant #3 had a non-displaced fracture of the right fifth metatarsal. Ice three times a day; Naproxen 250 mg. with food twice a day and as needed for pain/swelling; wear hard soled shoe when up and walking around; may use ace wrap or ankle stirrup if desired. According to the Nurses Notes dated 3-21-14, Tenant #3's family brought in a hard soled Velcro foot covering to wear with the splint or ace wrap. Tenant #3's service plan was not updated to reflect the orders when antibiotics were started and discontinued, the non-displaced fracture and application of the splint and ace wrap. Tenant #3's service plan did not reflect antibiotics, fracture of the fifth metatarsal or a splint and ace wrap. Tenant #3's service plan did not reflect the identified needs of the tenant.

  File reviews for Tenant's #2 and #3 indicated service plans were not individualized and did not indicate the identified needs and preferences for assistance.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preference for assistance. (IAC r. 481-69.26(4)(a).