IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
47892-A
48704-C

June 12, 2014

Ms. Diana Smith, Manager
Arlington Place of Red Oak
800 East Ratliff Road
Red Oak, IA 51566

RE: Final Complaint/Incident Investigation Report, Arlington Place of Red Oak, Red Oak, Iowa

Dear Ms. Smith:

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 **May 14, 15, 19, 20 and June 2, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Policies and Procedures and Program Reporting to Department.

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 515/281-4116 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:

Diana Smith, Manager
Arlington Place of Red Oak
800 East Ratliff Road
Red Oak, IA 51566

Complaint/Incident Intake #: 47892-A
48704-C

Date of Complaint/Incident Investigation:

May 14, 15, 19, 20 and June 2, 2014

Monitor(s):

Stephanie Cummins, MA
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:	22
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	25

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	7
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	9
TOTAL census of Assisted Living Program	34

Program History – There were regulatory insufficiencies in the areas of Policies and Procedures and Program Reporting to the Department during this recertification period.

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

A. Policies and Procedures

Complaint/Incident Allegation: It was alleged a tenant was in the private dining room and refused to move and staff physically removed the tenant from the room.

- Monitoring Observation: Review of a Program incident investigation summary identified Tenant #1 was involved in an alleged incident with staff.

  Tenant #1, a 98 year old, was admitted on 1-27-10 and diagnoses include: History of Asthma, Colon Cancer with Colon Resection, Complete Heart Block with pacemaker placement, Osteoarthritis, Osteoporosis, History of Compression Fracture, and History of Cellulitis. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit.

  According to the service plan dated 4-14-14, Tenant #1 ambulated with a walker when Tenant #1 was outside the apartment. Tenant #1 transferred independently and used a walker in the halls without the need for assistance. Tenant #1 ambulated independently without a walker inside the apartment. If staff witnessed Tenant #1 ambulating in the halls without the walker staff should assist in getting the walker for Tenant #1. The service plan indicated Tenant #1 was forgetful and needed/requested reminders and occasional prompts from staff.

The service plan also identified Tenant #1 at times would refuse a whirlpool. Tenant #1's family requested that staff alert the family to talk to Tenant #1 and then staff could re-approach Tenant #1 regarding taking a whirlpool.

According to the Nurse's Notes dated 4-24-14 at 6:00 p.m. Tenant #1 had been discharged from the hospital and could return to the Program. The Nurse's Notes indicated Tenant #1 remained independent with mobility with use of a wheeled walker. According to an Incident Report dated 4-24-14, Tenant #1 was unwilling to transfer from the wheelchair to the Program van to return to the Program. The report indicated a local transit company was called to transport Tenant #1 back to the Program while remaining in the wheelchair.

According to an Incident Report dated 5-18-14, Tenant #1 refused to take Tenant #1's evening (8:00 p.m.) medications. Staff re-approached and Tenant #1 continued to refuse stating, "Just leave me alone, I'm fine."

According to Staff #1's statement, Tenant #1 was sitting in the dementia unit and Tenant #1 decided Tenant #1 did not want to stay in the dementia unit. Staff #1 attempted to redirect Tenant #1 but Tenant #1 was insistent on leaving. Staff #1 followed Tenant #1 for safety as Tenant #1 was using a walker and was unsteady on Tenant #1's feet. Tenant #1 stopped by the private dining room, walked into the room and sat down in a chair at the table. Other staff was arriving for an employee meeting so Staff #1 asked other staff to keep an eye on Tenant #1 while she returned to the dementia unit. At 2:00 p.m. when the employee meeting was about to begin Staff #1 came to the meeting and saw other staff trying to redirect and the Healthcare Coordinator (HCC) asking Tenant #1 to move into the wheelchair. Tenant #1 was "noncompliant and over stimulated by all of the encouragements." Tenant #1 refused to move and was not responding to staff encouragements. Tenant #1 said no and Tenant #1 did not want to move and became very angry and agitated. The HCC and Manager instructed Staff #1 to assist in transferring Tenant #1 from the chair into the wheelchair. Staff #1 was on the left side and followed the direction of the HCC to grab under Tenant #1's arm. The Manager grabbed the back of the pants pulling Tenant #1 up from the chair. Tenant #1 dug Tenant #1's feet into the ground and screamed, "Help! Call the cops!" The HCC pushed the wheelchair backwards due to the fact Tenant #1 would not lift Tenant #1's feet (dragging). Tenant #1 grabbed the door frame on the way out and said, "Help!" again. The HCC brought Tenant #1 a cup of coffee and Tenant #1 threw the cup of coffee at her. Tenant #1 was breathing heavy, Tenant #1's head was bobbing and was swearing under Tenant #1's breath. Tenant #1 was also throwing punches at any staff member that came near.

According to the HCC's statement, prior to the employee meeting scheduled on 4-10-14 at 2:00 p.m. Tenant #1 walked into the private dining with a walker and one of the staff sat Tenant #1 at the table and gave Tenant #1 a cup of coffee. Just prior to the meeting the HCC determined due to the fact that so many people would be in the small space Tenant #1 should be encouraged to move from the dining room. The private dining room got very warm when several people were in attendance and the doors were closed for privacy. Tenant #1 was reluctant to be moved but was resistive to cares frequently and had to be approached sometimes several times. As the meeting was getting started the HCC instructed Staff #1 to bring the wheelchair in and they would assist Tenant #1 to the wheelchair.

The HCC got on the right side and placed her arm under Tenant #1's arm and instructed Staff #1 to do the same of the left side. The Manager stood behind the chair. They encouraged Tenant #1 to allow them to assist Tenant #1 to a standing position and pivoted Tenant #1 into the wheelchair. The Manager stood behind the chair and guided Tenant #1's buttocks into the chair. They wheeled Tenant #1 into the dining room and gave Tenant #1 the cup of coffee Tenant #1 had from the private dining room. Tenant #1 was approached by the Life Enrichment Coordinator and threw the coffee at the Life Enrichment Coordinator. Tenant #1 sat in the main dining room where the HCC could see Tenant #1 throughout the meeting and there were no further problems.

According to the Manager's statement, on 4-10-14 at 2:00 p.m. the employees were getting ready to have a meeting in the private dining room. Tenant #1 noticed everyone was going into the room so Tenant #1 went into the private dining room, got out of the wheelchair and sat down on one of the dining room chairs. Prior to the meeting several staff tried to get Tenant #1 to move back into the wheelchair so they could move Tenant #1 but Tenant #1 refused. The HCC directed Staff #1 to help transfer Tenant #1 into the wheelchair. The Manager made sure the wheelchair was supported and helped guide Tenant #1 into the wheelchair. The HCC and Staff #1 moved Tenant #1 in the wheelchair into the public dining room. Staff gave Tenant #1 a cup of coffee. The Life Enrichment Coordinator tried to calm Tenant #1 down and Tenant #1 threw the cup of coffee at the Life Enrichment Coordinator.

According to the Program's incident investigation summary, Staff #1 expressed a concern about the care of a tenant to management company staff on 4-11-14. Management company staff completed interviews with Staff #1, the HCC and the Manager on 4-11-14.

In the phone call with management company staff and the Manager on 4-11-14 at 5:30 p.m., the Manager said Tenant #1 refused to move from the table for approximately 10 minutes despite approaches from different staff. She said Tenant #1 was assisted to stand pivot into the wheelchair and "was gently and professionally moved" by the Manager, the HCC and Staff #1. Tenant #1 supported Tenant #1's own weight during the transfer as Tenant #1 stood on Tenant #1's own.

According to an In-Service/Training Program document, there was an in-service on 4-10-14 and 17 staff signed as participants. The facilitators were identified as the Manager and the HCC.

According to the Resident Rights policy located in the Occupancy Agreement, all the tenants having the following rights including the right to refuse services.

Review of Tenant #1's file and incident reports identified Tenant #1 refused cares and services. The service plan provided interventions related to refusals of whirlpools. The service plan reflected Tenant #1 ambulated with a walker when Tenant #1 was outside the apartment. Tenant #1 transferred independently and used a walker in the halls without the need for assistance. Per statements regarding the alleged incident and the Program's incident investigation summary, Tenant #1 did not want to move from the private dining room and had refused to move.

Tenant #1 was physically moved by staff from the private dining room to the main dining room. The policy regarding the right to refuse services was not followed related to Tenant #1.

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

- Monitoring Observation: Review of incident reports indicated there was not an incident report completed related to alleged incident with Tenant #1 on 4-10-14.

  According to the Incident Report policy, each employee would immediately notify the Nurse/Manager if a tenant became ill, had fallen, their behavior was abnormal, or any unusual event occurred. An incident form would be completed by the HCC or Manager for documentation purposes. The Manager or HCC would indicate a person in charge on the schedule to fill out the report in their absence. The HCC was responsible to follow up with a nurse review within 24 hours of the incident.

  An incident report was not completed per policy as it related to the alleged incident with Tenant #1.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures establishment by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)

B. Program Reporting to the Department

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

- Monitoring Observation: Review of a Program incident investigation summary identified Tenant #1 was involved in an alleged incident with staff.

  According to Staff #1's statement, Tenant #1 was sitting in the dementia unit and Tenant #1 decided Tenant #1 did not want to stay in the dementia unit. Staff #1 attempted to redirect Tenant #1 but Tenant #1 was insistent on leaving. Staff #1 followed Tenant #1 for safety as Tenant #1 was using a walker and was unsteady on Tenant #1's feet. Tenant #1 stopped by the private dining room, walked into the room and sat down in a chair at the table. Other staff was arriving for an employee meeting so Staff #1 asked other staff to keep an eye on Tenant #1 while she returned to the dementia unit. At 2:00 p.m. when the employee meeting was about to begin Staff #1 came to the meeting and saw other staff trying to redirect and the Healthcare Coordinator (HCC) asking Tenant #1 to move into the wheelchair. Tenant #1 was "noncompliant and over stimulated by all of the encouragements." Tenant #1 refused to move and was not responding to staff encouragements. Tenant #1 said no and Tenant #1 did not want to move and became very angry and agitated. The HCC and Manager instructed Staff #1 to assist in transferring Tenant #1 from the chair into the wheelchair. Staff #1 was on the left side and followed the direction of the HCC to grab under Tenant #1's arm. The Manager grabbed the back of the pants pulling Tenant #1 up from the chair.

Tenant #1 dug Tenant #1's feet into the ground and screamed, "Help! Call the cops!" The HCC pushed the wheelchair backwards due to the fact Tenant #1 would not lift Tenant #1's feet (dragging). Tenant #1 grabbed the door frame on the way out and said, "Help!" again. The HCC brought Tenant #1 a cup of coffee and Tenant #1 threw the cup of coffee at her. Tenant #1 was breathing heavy, Tenant #1's head was bobbing and was swearing under Tenant #1's breath. Tenant #1 was also throwing punches at any staff member that came near.

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According to the Program's incident investigation summary, Staff #1 expressed a concern about the care of a tenant to management company staff on 4-11-14. Management company staff completed interviews with Staff #1, the HCC and the Manager on 4-11-14.

Management company staff was notified by the Department that a complaint was made regarding an allegation of dependent adult abuse and separation between the alleged victim and alleged perpetrators was required. The Program did not report an allegation of suspected dependent adult abuse to the Department.

- Regulatory Insufficiency: If a staff member or employee is required to make a report pursuant to this section, the staff or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours. (235E.2 (3)(a))

C. Evaluation

Complaint/Incident Allegation: It was a tenant's cognitive evaluation score was changed to hide an alleged incident involving the tenant.

- Monitoring Observation: Two tenant files (Tenant #1 and Tenant #2) were reviewed. No concerns were identified regarding Tenant #1's evaluations.

  Tenant #2, a 94 year old, was admitted on 12-10-13, and diagnoses include: History of Falls, History of Fractured Wrist, Removal of Bilateral Cataracts, History of Upper Respiratory Infection and Urinary Tract Infection (UTI), Osteoporosis, and Dementia. Tenant #2 was staged at a three on the GDS, which indicated mild cognitive decline. Tenant #2 had resided in the dementia unit and at the time of the investigation Tenant #2 resided in the general population.

  According to the service plan dated 5-9-14, Tenant #2 was independent with mobility, dressing, and hygiene and grooming activities. Tenant #2 had a vehicle at the Program used to drive to and from the Program to Tenant #2's residence and for shopping independently.

  According to evaluations dated 12-2-13 and 1-6-14, Tenant #2 was staged at a two on the GDS, which indicated very mild cognitive decline.

  According to an evaluation dated 3-3-14, Tenant #2 was staged at a four on the GDS, which indicated moderate cognitive decline. According to the Nurse's Notes dated 3-3-14, Tenant #2 returned to the Program following a hospitalization for back pain.

  The HCC said Tenant #2 had a UTI and was admitted to the hospital and it was resolved (regarding the change in Tenant #2's cognitive status).

  On 3-4-14 a letter was sent inform the physician Tenant #2 had a change in the GDS, scoring a four, which indicated moderate cognitive decline. The physician responded and indicated Tenant #2's durable power of attorney should be activated due to change of condition.

  According to evaluations dated 4-22-14 and 4-24-14, Tenant #2 was staged at a two on the GDS, which indicated very mild cognitive decline.

  According to the Nurse's Notes dated 4-22-14 the GDS was completed due to Tenant #2 driving Tenant #2's car independently and shopping without difficulty.

The GDS evaluation completed on 4-24-14 was completed due to Tenant #2 requesting to be independent in medication management, according to Nurse's Notes dated 4-24-14.

According to the Nurse's Notes dated 5-12-14, Tenant # 2 moved from the dementia unit to an apartment in the general population.

According to a fax to the physician dated 4-10-14, Tenant #2's dementia scale had been assessed to be a GDS of two. Tenant #2 "now comes and goes" from the Program.

The Manager said one time Tenant #2 called a taxi to go to the bank and sign papers. The Manager told Tenant #2 she would take Tenant #2. The Manager called the bank and asked if they could bring the papers to the Program. The Manager was on the phone when the taxi was there and the Manager followed the taxi to the bank.

According to a fax from the Manager and the HCC, Tenant #2 signed the papers at the bank on 4-8-14. The fax also indicated the HCC checked the service plan dated 3-3-14 and Tenant #2's GDS was two.

The service plan dated 3-3-14 reflected Tenant #2 was staged at two on the GDS. The GDS (cognitive evaluation tool) completed on 3-3-14 reflected Tenant #2 was staged at a four. The fax to the physician to inform the physician Tenant #2's dementia scale had been assessed to be a GDS of two was on 4-10-14.

The GDS was completed on 3-3-14 and not again until 4-22-14. A fax was sent to the physician on 4-10-14, which indicated Tenant #2's GDS had changed. An evaluation was not completed to reflect the change in cognition that was indicated to the physician.

While a deviation from 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.