IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
44976-AR1
46468-C

January 13, 2014

Ms. Kim Stodgel, Administrator
Lakeside Village Assisted Living
2067 Highway 4
Panora, IA 50716

RE: Final Revisit to Recertification Monitoring Evaluation and Complaint/Incident Investigation Report, Lakeside Village Assisted Living, Panora, Iowa

Dear Ms. Stodgel:

Enclosed is the **Final Revisit to Recertification Monitoring Evaluation and 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 **December 30 and 31, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Structural Requirements 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 Revisit to Recertification Monitoring Evaluation & Complaint Investigation

Assisted Living Program:

Kim Stodgel, Administrator
Lakeside Village Assisted Living
2067 Highway 4
Panora, IA 50716

Complaint/Incident Intake #: 44976-AR-1
46468-C

Date of Monitoring Visit:

December 30 and 31, 2013

Monitor(s):

Lori Miner, RN BSN
Jim Berkley, 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 were provided by the Program at the time of the on-site.

General Population Program	
Number of tenants without cognitive disorder:	31
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	31
TOTAL census of Assisted Living Program	31

Program History – The program received regulatory insufficiencies in the areas of Evaluation, Service Plans, Tenant Rights, Structural, Policy and Procedures, Tenant Documents, and Life Safety during the August 2013 recertification and complaint investigation.

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

A. Evaluation of Tenant

The program received a regulatory insufficiency during the August 2013 visit related to Complaint/Incident Allegation #44976-A for not evaluating Tenant #1's eligibility to reside at the program, for not evaluating the program's ability to provide needed cares to Tenant#1 and not evaluating the need for outside services. During the course of the investigation, the program was cited for not evaluating Tenants #3 and #4 for exit-seeking behavior and inappropriate sexual behavior.

It was alleged (#46468-C) a tenant sustained an injury and needed follow-up care.

Monitoring Observation: The program reported via the Plan of Correction (POC) from the previous visit that Tenants #1, #2, #3, and #4 were discharged from the program.

Tenant #5, a 68 year-old, was admitted on 12-1-12 and had diagnoses of: Parkinson's Disease, Fibromyalgia, and Anxiety. Tenant #5 had no errors on a cognitive screening tool dated 12-22-13. On 11-6-13 a nurse review was completed in the progress notes which indicated Tenant #5's Healthcare Provider ordered Physical Therapy (PT) and Occupational Therapy (OT) for strengthening and evaluation for an electric scooter. On 11-8-13, OT saw Tenant #5 on one occasion and did not find further visits were indicated. On 11-29-13, PT noted short term goals were met, but long term goals were not fully met. Tenant #5 was encouraged to walk to and from meals. Transfers were noted to be difficult at times.

Evaluations of function, cognition, and health were completed on 12-1-13, after completion of PT. Evaluations indicated Tenant #5 sometimes needed assistance with transfer and ambulation, and used a walker.

An incident report dated 12-11-13 documented Tenant #5 was found sitting on a foot stool half-on and half-off. The right shoulder was into the wheelchair. Tenant #5 reported sitting on the footstool, losing balance and going sideways.

Tenant #5 denied hitting the head, and denied pain or discomfort. No injuries were noted and Tenant #5 was able to complete range-of-motion with all extremities without difficulty. A fax was sent to the Healthcare Provider notifying her of the incident. Evaluations of function, cognition, and health were completed.

Service notes dated 12-12-13 documented Tenant #5's right shoulder was swollen and painful. Tenant #5 was taken to the healthcare provider by a family member. Tenant #5 returned to the program with a diagnosis of a Dislocated Right Shoulder following a history of shoulder problems. Tenant #5 was scheduled for a reduction of the dislocation on 12-13-13.

Tenant #7, an 83 year-old, was admitted on 2-10-12 and had diagnoses of: Diabetes Mellitus Type II, Depression, Degenerative Joint Disease, Anxiety, Status Post Prostate Cancer and Alcohol-Induced Dementia. On 10-7-13, Tenant #7 had two errors on the cognitive screening tool which indicated low risk for cognitive impairment. Evaluations of function, cognition, and health were completed on 10-7-13. There were no changes in condition that warranted further evaluation. There was no documentation to indicate any injuries had occurred.

Tenant #8, a 90 year-old, was admitted on 12-19-13 and had diagnoses of: Hypertension, and Post-Operative Skin Graft wound. Tenant #8 reported the skin graft was completed following the removal of skin cancer. Evaluations of function, cognition, and health were completed on the day of admission. The evaluation included measurements of the wound. The Braden Scale used to determine risk for pressure sores was also completed. There was no documentation to indicate any injuries had occurred.

Tenant #9, an 80 year-old, was admitted on 9-20-13 and had diagnoses of: Hypertension, Thyroid Disorder, and History of Fracture of the Spine. On 10-26-13, Tenant #9 had four errors on the cognitive screening tool which indicated low risk for cognitive impairment. Evaluations of function, cognition, and health were completed on the day of admission and within 30 days of admission. Tenant #9 was legally blind and required assistance outside of the apartment for navigational purposes. Tenant #9 used a walker in the apartment and for short distances. Tenant #9 ambulated independently in the apartment.

An incident report dated 10-9-13 documented Tenant #9 was weak, and disoriented. Tenant #9 was sent to the emergency room by way of ambulance. Tenant #9 left the hospital later in the evening of 10-9-13 and spent the night at the home of a family member. Service notes dated 10-10-13 documented an evaluation of Tenant #9 upon return to the program. No new orders were received.

An incident report dated 10-25-13 and timed at 12:09 a.m. documented staff members heard a loud noise and found Tenant #9 beside the bed with a scrape on the back. The RN/Director was notified and ice was applied to the back. A nurse review was completed as documented in the service notes.

Service notes dated 10-26-13 documented Tenant #9 was found to have a left lower leg that was "weepy" and swollen. The previous RN notified the family, who took Tenant #9 to see the health care provider. Tenant #9 returned to the program with orders to keep the feet elevated when not ambulating, keep shoes off when not ambulating, and an order for an antibiotic. Evaluations of function, cognition, and health were completed upon Tenant #9's return. The functional evaluation indicated Tenant #9 walked independently.

An incident report dated 10-26-13 and timed at 11:29 p.m. documented staff had been in Tenant #9's apartment only to return a few minutes later to find Tenant #9 on the floor in front of the recliner with the walker nearby. Tenant #9 reported getting up to go to the bathroom. Tenant #9 complained of right thigh pain and was sent to the hospital via ambulance. Tenant #9 did not return to the program.

Evaluations were completed at admission, within 30 days of admission, and with significant changes of condition.

Regulatory Insufficiency: None noted.

B. Service Plan

During the course of the investigation of August 2013, the program received a regulatory insufficiency in the area of service plans because service plans did not meet the identified needs of Tenant #1, #2, #3, and #4, and service plans were not signed by the tenant or legal representative.

Monitoring Observation: Tenant #5 received an order for PT on 11-5-13. The service plan of 10-10-13 was updated to include PT services. PT was discontinued on 11-29-13 with a notation that Tenant #5 was to be encouraged to walk to and from meals as tolerated. Following evaluations, the service plan was updated on 12-1-13 which indicated Tenant #5 used a walker for ambulation and would request assistance with activities of daily living (ADL's) as needed.

Tenant #5 sustained a dislocated shoulder. Evaluations were completed on 12-11-13 and the service plan was updated on 12-13-13. The service plan identified the use of the shoulder immobilizer and staff assistance with ADL's. The service plan was signed by the tenant and RN/Director.

Tenant #7 resided in the secured dementia unit. The unit was closed and Tenant #7's wander guard equipment was replaced with hourly checks. The service plan of 11-20-13 identified the change in services provided. The service plan was signed by the tenant and RN/Director.

Tenant #8 had a wound on the leg related to a skin graft after removal of a skin cancer. The service plan of 12-19-13 identified the wound care needed. The service plan was signed by the tenant and RN/Director.

Tenant #9 was admitted to the program on 9-20-13. Service plans were completed at admission and within 30 days of admission. The service plan was signed by Tenant #9 and the previous RN.

On 10-25-13, Tenant #9 was found on the floor. On 10-26-13, Tenant #9 was diagnosed with cellulitis to the lower leg. Evaluations were completed on 10-26-13. The service plan was updated to include interventions for the cellulitis and was based on the evaluations of 10-26-13.

Service plans were completed at admission, within 30 days of admission, and updated with changes in condition. Service plans were based on evaluations and signed by the tenant and an RN.

Regulatory Insufficiency: None noted.

C. Tenant Rights

During the course of the investigation of August 2013, the program received a regulatory insufficiency related to Tenants #1, #3, and #4 and the right to receive care and services which are appropriate and the right to be treated with respect and be free of mental and physical abuse.

It was alleged (#46468-C) staff "made fun" of tenants.

Monitoring Observation: Tenants #1, #3, and #4 were discharged from the program. The RN/Director had documentation of the completion of an assisted living regulatory nurse class. Staff #2 and the LPN reported they had received mandatory reporter training since the last onsite visit in August 2013. The program provided documentation of staff training on Dependent Adult Abuse and Tenant Rights in October 2013.

Clinical records were reviewed for Tenants #5, #7, #8, and #9. Evaluations and service plans were completed including with changes of condition

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Tenant #5 was interviewed and reported feeling safe at the program except after watching bad movies. Some staff members were reported to be more abrupt than other. Tenant #5 reported that generally, the program was a good place to live.

Tenant #7 was interviewed and reported staff members treated Tenant #7 well. Call lights were reported to be answered when needed. Tenant #7 was the only tenant to continue to reside in the dementia unit portion of the building after the dementia unit was closed. Tenant #7 indicated it was "ok" and did not have any complaints about the room.

Tenant #8 was interviewed and stated the staff members treated the tenants very well. Tenant #8 also reported receiving cares that were needed.

Staff #2 was interviewed and was unaware of any staff member making fun of any tenants.

A meeting was held with 19 tenants. Staff members were described as friendly and treated the tenants well. The care was described as good. The tenants reported they felt safe with two staff members present on all shifts.

Regulatory Insufficiency: None noted.

D. Structural requirements

During the course of the investigation of August 2013, the program received a regulatory insufficiency related to clean, safe, and sanitary surroundings. Cleaning chemicals were accessible to tenants with dementia.

Monitoring Observation: The plan of correction identified the program stopped accepting cognitively impaired tenants on 9-15-13. The program had no persons with cognitive impairment at the time of the onsite visit. The program remedied the problem by eliminating a functioning dementia unit. As of 12-31-13, there were no tenants residing in any of the apartments in what had been the dementia unit. A tour of what had been the dementia unit revealed no unsecured chemicals.

Regulatory Insufficiency: None noted.

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

Monitoring Observation: Tenant #7 resided in Apartment (Apt) #256, which had been part of the secured dementia unit. Tenant #7 was continuing to reside in the apartment on 12-30-31. According to information provided by the RN/Director, she thought Apt. 256 had 245 square feet of space. The RN/Director had contacted the Department about the use of the apartments in the former dementia unit as general population apartments and believed the Department had authorized such use.

The program's Maintenance Director was contacted and measured Apt. #257, the same layout as Apt. #256. The apartment was measured at 170 square feet and appropriately did not include the measurement of the bathroom. The Maintenance Director did not deduct the door swing in the measurement.

The Facility Engineer with the Iowa Department of Public Safety in the State Fire Marshal Division was contacted. He stated he had never given permission to the program to use the apartments in the dementia unit as general population apartments. The Facility Engineer stated the blueprints submitted indicated the dementia unit apartments did not meet the 240 square foot single occupancy requirement identified in Iowa Administrative Code 69.35(3)(b).

The program moved Tenant #7 from the former dementia unit to an apartment in the general population area. On 12-31-13, Tenant #7 was interviewed and reported satisfaction with the new apartment.

The program continued to use the apartments in the dementia unit after the dementia unit was closed. The size of the apartment did not meet specifications for a general population apartment.

Regulatory Insufficiency: Programs operated in new construction built on or after July 4, 2001, shall meet the following requirements: (b) Each dwelling unit used for single occupancy shall have a total square footage of not less than 240 square feet of floor area, excluding bathrooms and door swing. (IAC r. 481-69.35(3)(b))

E. Policies and Procedures

During the course of the investigation of August 2013, the program received a regulatory insufficiency related to failure to have a policy or procedure related to keeping the medication room in the dementia unit secured.

Monitoring Observation: The plan of correction identified the program stopped accepting cognitively impaired tenants on 9-15-13. The program had no persons with cognitive impairment at the time of the onsite visit. The program remedied the problem by eliminating a functioning dementia unit. As of 12-31-13, there were no tenants residing in any of the apartments in what had been the dementia unit. The medication room located in what had been the dementia unit was not in use at the time of the onsite visit.

Regulatory Insufficiency: None noted.

F. Tenant Documents

During the course of the investigation of August 2013, the program received a regulatory insufficiency related to incomplete documentation, the use of incident reports, and the use of task sheets. Tenants #1, #3, and #4 were identified.

Monitoring Observation: Tenants #1, #3, and #4 were discharged from the program.

Clinical records were reviewed for Tenants #5, #7, #8, and #9. Incident reports were completed appropriately. The program was able to provide incident reports for the three months prior to the onsite investigation.

Tenant #5 had ice to the shoulder ordered every two hours. The clinical record contained documentation of the placement of ice every two hours

The program did not identify any tenant who was cognitively impaired who would require the use of task sheets for routine cares.

Regulatory Insufficiency: None noted.

G. Life Safety

During the course of the investigation of August 2013, the program received a regulatory insufficiency related to door alarms in the dementia unit.

Monitoring Observation: The plan of correction identified the program stopped accepting cognitively impaired tenants on 9-15-13. The program had no persons with cognitive impairment at the time of the onsite visit. The program remedied the problem by eliminating a functioning dementia unit. As of 12-31-13, there were no tenants residing in any of the apartments in what had been the dementia unit.

Regulatory Insufficiency: None noted.

H. Nurse Review

During the December 2013 onsite visit, the following was noted:

Monitoring Observation: The clinical record for Tenant #5 was reviewed. On 8-29-13 the program received an order to hold the Aleve for scheduled hand surgery on 9-3-13. On 8-30-13, for former program registered nurse (RN) sent a list of Tenant #5's medications to the physician for review. The physician returned the list signed and dated 10-16-13 which indicated Aleve was to be given twice a day. The previous RN was no longer employed by the program. The orders were not noted by the receiving nurse, the RN/Director, with time, date, or signature.

On 9-30-13, the RN/Director sent a list of Tenant #5's medications to the physician for review. The physician returned the list signed and dated 10-16-13, the same date as the 8-30-13 list, which indicated the Aleve had been discontinued. The orders were not noted with time, date, or signature.

The medication administration record for Tenant #5 for the month of December 2013 documented that Aleve was given twice a day for the entire month.

Conflicting orders for Aleve were dated 10-16-13. The order was not clarified with the physician.

On 12-12-13, Tenant #5 received orders from a Healthcare Provider for a shoulder immobilizer and ice following a shoulder dislocation. The orders were not noted by the RN/Director with time, date, and signature.

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. (IAC r. 481-69.27(1))

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))

I. Staffing

It was alleged (#46468-C) call lights were not answered for over an hour.

Monitoring Observation: Staff #2 and the LPN were interviewed. Each indicated call lights were answered in a short period of time, less than 10 minutes. Staff #2 reported Tenant #5 always had the call light on and Staff #2 tried to check on Tenant #5 even when the call light was not on. The LPN reported Tenant #5 put on the call light frequently but the LPN answered the call light in five to seven minutes.

A meeting was held with 19 tenants. The tenants reported call lights were answered in five to ten minutes. Concern was expressed by the tenants that it would change when staffing levels changed after the first of the year. It was reported by the program that one staff member would be present on the overnight shift beginning January 2014.

Call light response times were reviewed for the first 11 days of December 2013. The program averaged 11 calls a day for the first five days of December. There were 11 instances where the response time was longer than 20 minutes with only one response time of 50 minutes.

The call light system was not activated on 12-11-13 when Tenant #5 called for help and was later determined to have a dislocated shoulder.

According to the incident report dated 10-26-13, the call light was not used by Tenant #9 following a fall resulting in transport to the hospital.

The call light data was shared with the RN/Director. The RN/Director stated an in-service would be held on expectations of response times, and response times would be compared to staff schedules to determine if a pattern existed.

Iowa Administrative Code 481-69.29(1) indicates each tenant shall have access to an emergency response system, but does not indicate a minimum standard for response times. The program no longer had a dementia unit and did not identify any tenants with cognitive impairment. Staff interviews and a review of incident reports revealed no negative outcomes related to lack of response to call lights.

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.

J. Criteria for Admission and Discharge

It was alleged (#46468-C) a tenant exceeded criteria to remain at an assisted living program.

Monitoring Observation: Iowa Administrative Code 481-69.23(1) outlines the criteria for assisted living programs to use to determine whether or not a tenant can be retained in the program. Clinical records were reviewed for Tenants #5, #7, #8, and #9. Service notes dated 12-24-13 indicated the family of Tenant #5 was looking into placement for a higher level of care. Tenant #9 did not return to the program after a fall. None of the clinical records reviewed indicated criteria established by Iowa Code had been met for discharge from the program.

Staff #2, Universal Worker, and the Licensed Practical Nurse (LPN) were interviewed. Interviews did not reveal information to suggest further record review was needed.

Regulatory Insufficiency: None noted.