IOWA DEPARTMENT OF
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September 9, 2014

Complaint/Incident Intake #: 47867-C
47948-C
49544-C

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

RE: Final Complaint/Incident/Recertification Monitoring Evaluation Report – Arlington Place of Red Oak, Red Oak, IA

Dear Ms. Smith:

Enclosed is the **Final Complaint/Incident/Recertification Monitoring Evaluation 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 a survey by DIA on **August 25 & 26, 2014.** The Report notes a Regulatory Insufficiency in the area(s) of: Staffing.

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.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Also enclosed you will find the Assisted Living Program Certificate **S0137** with effective dates of **February 28, 2014** through **February 27, 2016**.

If you have any questions in regard to this 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/Recertification Monitoring Evaluation Report

Assisted Living Program:

Complaint/Incident Intake #: 47867-C
47948-C
49544-C

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

Date of Recertification/Complaint/Incident Investigation:

August 25 & 26, 2014

Monitor(s):

Margaret Kaltefleiter, RN MS
Michael Rohner, OTR-L

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:	15
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	16
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	25

Tenant/Family Satisfaction Results – A community meeting with 10 tenants was held. They stated the best thing about living there was the caring services they received. Housekeeping services were completed to their satisfaction and the buildings and grounds were safe, clean and sanitary. One tenant mentioned sometimes laundry items were missed but were usually found later. Nursing services were available when needed and staff responded within five minutes or less when called. One tenant said it took a little bit longer at night to receive a response. Services were provided as expected when the occupancy agreement was signed. The care received was described as very caring and cheerful. Staff treated the tenants with respect; knew what services to provide and were trained appropriately for the most part. Tenants stated they liked the food, a good variety of meats, vegetables and desserts were offered and the food was served at the appropriate temperature. One tenant suggested a better evening meal be served but other tenants stated the menu offered multiple alternative options. Some tenants would like to be asked what entrée they'd prefer while they are standing at the salad bar and others stated they would prefer to be asked after they sat down at the table. The tenants stated the cooks were very good. Plenty of activities were offered with playing cards, Bingo, Scrabble, church services and exercise being their favorites. They felt safe, made their own decisions, were generally satisfied with the Program and had recommended it to their friends.

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

A. Tenant Rights

Complaint/Incident Allegation #47948-C: It was alleged staff were rough with tenants when cares were provided.

- Monitoring Observation: During the community meeting with 10 tenants, they were asked if staff were rough when providing cares and they responded "no way." The tenants were in agreement cares were provided in a very caring manner. Private tenant interviews were conducted with two tenants who stated they were treated very well, staff was wonderful, the nurse was nice and no staff was rough with them or with others.

  Staffs #1, #3, the Nurse and the Housing Manager (Manager) were interviewed and stated they were not aware of any staff that were rough with tenants. Staffs #1, #2, #3, the Nurse and the Manager stated no tenants had bruises or complained of pain due to staff being rough with them during cares. The Manager stated no staff had been disciplined in regards to providing rough cares.

  Tenant files were reviewed for Tenants #1, #2, #3 and #4 and documentation did not indicate any staff had been rough with tenants during cares.

  Interviews with tenants, staff, the Nurse and Manager and review of tenant files did not indicate staff was rough with tenants during cares.

- Regulatory Insufficiency: None noted.

B. Criteria for Admission and Retention

Complaint/Incident Allegation #49544-C: It was alleged a tenant might not be at an appropriate level of care.

- Monitoring Observation: Review of Tenant #1, #2, #3 and #4's files indicated tenants were at the appropriate level of care for assisted living.

  A Program document was provided that indicated Tenant #5 was discharged on 7-29-14 due to needing a higher level of care. Tenant #6 was discharged on 8-26-14 due to needing a higher level of care.

  Staffs #1, #2, the Nurse and the Manager were interviewed and stated there were no tenants that exceeded the level of care for assisted living.

  Per review of tenant files, Program documents and interviews with staff, the Nurse and the Manager there were no tenants who exceeded the level of care for assisted living.

- Regulatory Insufficiency: None noted.

C. Other

Complaint/Incident Allegation #47867-C: It was alleged tenants who were cognitively impaired and resided in the dementia unit were given the alarmed door code, left the unit, came and went as they pleased and administration expected staff to catch the tenants who eloped.

- Monitoring Observation: A floor plan of the Program was provided that indicated the location of the dementia unit and the alarmed door. The Manager stated due to a need for a dementia unit in the fall of 2013, either at the end of October or beginning of November, a fire door was removed, a window was placed in the top half of an alarmed door and the hall that housed nine tenants was locked for the safety of cognitively impaired tenants. At that time the alert and oriented tenants that resided in some of those apartments did not want to move and continued to live within the dementia unit. Currently there were two tenants who were cognitively impaired and seven who were not that resided in the unit. After the alarm was installed she suspected a staff member gave the alarm code to the alert and oriented tenants as some tenants knew the code and would come and go as they desired. Each time she discovered tenants had the code, the code would be changed. The Manager had to change the code three times and each time informed staff not to provide the code to anyone, tenants or visitors. She stated no tenants or visitors currently had the code to the alarmed door, only staff had the code.

  The Manager stated the Program was adding on with construction starting later this fall and hoped to open next spring. The new addition will be a dedicated dementia unit and once it is open the current dementia unit area will be reverted back to a general population hall.

  At the community meeting held with 10 tenants, the tenants stated when the dementia unit was first locked, for about a week or two, they were given the code but that changed and now no alarm door codes were given to tenants or visitors.

  Staff #1 was interviewed and stated no tenants were given the code to the alarmed door, not even family, and if anyone saw the code it was changed immediately. The Nurse was interviewed and stated only the staff had the code to the alarmed door. She stated no code was needed to enter the dementia unit and staff would enter the code when tenants or visitors wanted to leave the unit. Staffs #2, #3 and the Manager were interviewed and stated none of the tenants in the dementia unit or anyone else was given the alarmed door codes.

  The monitors entered and exited the dementia unit multiple times during the onsite visit and were not given the code to the alarmed door. Each time the monitors exited a staff member inserted the code and the code was not able to be seen during this process.

  Interviews with Staffs #1, #2, #3, the Nurse and the Manager indicated there had not been any elopements at the Program. During the community meeting the tenants stated it had been more than a year since a tenant left the building without supervision.

  Per interviews with tenants, staff, the Nurse and the Manager and observations by the monitors indicated only staff had the code to the alarmed dementia unit door and the code was not given to anyone. Per interviews with tenants, staff, the Nurse and the Manager there had not been any elopements.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47867-C: It was alleged management instructed staff to not document incidents of elopement and disciplined staff who did.

- Monitoring Observation: Incident reports were reviewed for all incidents that occurred from 6-19-14 through 8-24-14 and there were no incidents of elopement.

  Per 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 Nurse or Manager for documentation purposes. The Manager or Health Care Coordinator would indicate a person in charge on the schedule to fill out the report in their absence. When an incident report was written, it should be factual and to the point and it must be signed, showing time and date by the writer.

  A Program document indicated an In-service/Training Program was held on 6-19-14 and staff was trained on the proper completion of incident reports.

  Staffs #1, #2, #3 and the Nurse were interviewed and stated staff had not been told to not document elopements and had not been disciplined for documenting elopements. The Manager was interviewed and stated staff had to document elopements and no staff had been disciplined for documenting elopements.

  Per review of incident reports, incident report policy and interviews with staff, the Nurse and the Manager indicated incident reports were maintained and staff was expected to document incidents, including elopements, and no staff had been disciplined regarding documentation of elopements.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #49544-C: It was alleged administrative policies related to employment were not followed.

- Monitoring Observation: Files for 10 staff (Staffs #1, #2, #4, #5, #6, #7, #8, #9 #10 and #11) were reviewed; seven current staff and three staff who were no longer employed by the Program. No issues were identified with background checks, mandatory dependent adult abuse training, dementia training or food safety training.

  A review of the Team Member Handbook indicated the Program was an "At Will" employer. Per the handbook, what "at will" meant was that employment was of no specific length. In addition, it meant the employee could discontinue employment at any time for any reason or for no reason, and the Program retained the same right.

  The Program provided a list of terminated staff from the previous three months. Employee Status/Wage Forms for Staffs #7, #10 and #11 were provided and reflected Staffs #7, #10 and #11 were no longer employed at the Program. Staffs #7, #10 and #11 had signed a Team Member Handbook Acknowledgement that indicated the Team Member Handbook was not an employment agreement or guarantee of employment. The Team Member was an "at will" Team Member of the Program

which meant either the Team Member or the Program could terminate the employment relationship for any reason or no reason.

According to the Team Member Handbook section on Corrective Action, Corrective action was taken in response to a team member not acting in the best interest of the tenants and fellow team members or the Program. Corrective action may include verbal warnings, written warnings, suspension or termination, depending upon the severity of the problem. The Program reserved the right to choose the appropriate level of discipline for any violations, up to and including termination.

The Manager was interviewed and stated all Program policies and procedures as outlined in the Team Member Handbook were followed, including those related to employment and corrective action. The Manager stated no staff had been disciplined or terminated for talking to the Department.

Per review of staff files, review of policies regarding "At Will" employment and Corrective Action and an interview with the Manager, administrative policies regarding employment were followed.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #49544-C: It was alleged a tenant did not receive appropriate wound care.

- Monitoring Observation: Tenant files (Tenants #1, #2, #3 and #4) were reviewed and did not indicate any wounds or need for wound care.

  According to a Program document provided by the Nurse there were no current tenants with wounds or any tenants receiving wound care. The Nurse stated Tenant #5 had received care for a wound on the leg but was discharged from the Program on 7-29-14.

  Per tenant file reviews, review of a Program document and an interview with the Nurse, no current tenants required wound care.

- Regulatory Insufficiency: None noted.

D. Staffing

- Monitoring Observation: Files for 10 staff (Staffs #1, #2, #4, #5, #6, #7, #8, #9, #10 and #11) were reviewed.

  Delegations for medication administration completed by the previous nurse were found for Staffs #1, #2 and #4. Delegations for medication administration completed by the new Nurse were not available.

  The Nurse was hired on 5-27-14 and stated she had not yet completed medication administration training for staff who were employed at the time she was hired. She stated she started medication administration training the previous week for all new

staff hired after 5-27-14. All other staff not yet delegated was scheduled for training on 8-29-14.

The Nurse provided a document dated 8-26-14 that indicated on 8-25-14 she had posted a mandatory training scheduled for 8-29-14 for Staffs #1, #2 and #4.

Per staff file reviews and an interview with the Nurse, medication administration training had not been completed within 60 days of employment to ensure staff was sufficiently trained and competent in all tasks assigned or delegated.

- Regulatory Insufficiency: The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. (IAC r. 481-67.9(4)(a))