IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
48318-C
49321-I
49882-I

September 25, 2014

Ms. Amanda Buchholz, Director of Memory Care
Senior Star at Elmore Place ALPD
4504 Elmore Avenue
Davenport, IA 52807

RE: Final Complaint/Incident Investigation Report, Senior Star at Elmore Place ALPD, Davenport, Iowa

Dear Ms. Buchholz:

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 **September 16 & 18, 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.

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:

Amanda Buchholz, Director of Memory Care
Senior Star at Elmore Place ALPD
4504 Elmore Avenue
Davenport, IA 52807

Complaint/Incident Intake #: 48318-C
49321-I
49882-I

Date of Complaint/Incident Investigation:

September 16 & 18, 2014

Monitor(s):

Margaret Kaltefleiter, RN MS

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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	37
Total Population of Program at time of on-site	37
TOTAL census of Assisted Living Program	37

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

A. Staffing

Complaint/Incident Allegation #49882-I: The Program reported Tenant #1 had fallen and suffered a left hip fracture.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #1, an 86 year old, was admitted on 9-2-14 and diagnoses included: Rheumatoid Arthritis, Asthma, Hypertension (HTN) and Hypercholesterolemia. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. According to Tenant #1's service plan dated 9-2-14, Tenant #1's risk for falls was high. Staff would assist with mobility and transfers, would encourage Tenant #1 to use call device before getting up and staff would encourage Tenant #1 to use the personal help button for staff assistance. The service plan indicated staff would assist with mobility, including escorts and stand-by assistance. Tenant #1 was able to ambulate short distances using walker with one staff assist using a gait belt. Tenant #1 required one assist using gait belt with transfers to ensure safety. Tenant #1 would begin therapy for PT/OT to continue improving strength and endurance. Tenant #1 required a wheelchair at times when tired or weak. Staff was to utilize the wheelchair throughout the day when Tenant #1 was unable to ambulate.

  According to an Incident Report Form dated 9-4-14 at 11:45 p.m., Staff #1 came out of the medication room and heard someone yelling for help. She found Tenant #1 sitting on the floor on buttocks with back against the wall just inside the apartment door. Tenant #1 stated Tenant #1 needed to go to the bathroom. Tenant #1 was assisted up and into a wheelchair due to staff unable to assess in Tenant #1's position against the wall. Tenant #1 was assisted into bed and complained of pain in left hip and left foot rotated out. Emergency personnel and Tenant #1's family were notified and Tenant #1 was transferred to a hospital. The Director of Nursing and Assistant

Director of Nursing (ADON) were notified and Tenant #1's physician was notified via fax.

According to the Nurse's Notes dated 9-5-14 at 8:30 a.m., spoke with hospital who indicated Tenant #1 had left hip fracture and would have surgery scheduled. An entry dated 9-8-14 at 1:30 p.m., Tenant #1's Power of Attorney stated Tenant #1 would be moving to a nursing home that afternoon and would not return to the Program.

Staff #2 was interviewed and stated she cared for Tenant #1 for two days on the second shift (2:00 p.m. to 10:00 p.m.). Tenant #1 never got up to walk alone and would only get up with the assistance of staff or Tenant #1's family. Tenant #1 did not have any falls on the second shift.

The ADON was interviewed and stated Tenant #1 needed the assist of one staff for ambulation with a gait belt and assist of one staff with a walker for short distances or when using a wheelchair.

The Director of Memory Care (Director) was interviewed and stated Tenant #1 had only resided at the Program for two days, was an appropriate admission for the Program and was still in the adjustment phase to Tenant #1's new surroundings.

Staff #2, the ADON and Director stated there was enough staff to meet the needs of the tenants.

An incident report was completed and the Program notified the Department.

Review of Tenant #1's file, incident report and interviews with Staff #2, the ADON and Director indicated interventions were in place to assist Tenant #1 with ambulation needs.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #49321-I: The Program reported Tenant #2 had eloped.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #2, a 94 year old, was admitted on 10-8-13 and diagnoses included Anxiety, Cellulitis, Cervical Disc Disorder with Myelopathy, Chronic Constipation, Denied History of Current Smoker, Dementia, Depression, Diabetes Mellitus, Edema, Essential HTN, Fatigue, Gastritis and Hyperlipidemia. Tenant #2 was staged at a five on the GDS which indicated moderately severe cognitive decline.

  According to Tenant #2's service plan dated 5-20-14, Tenant #2 often wanted to go home, would become fixated on the idea that Tenant #2 was supposed to be home and parents were going to be worried. At times would try to leave out the door, would push the door and became verbally aggressive towards staff when they redirected.

According to an Incident Report Form dated 7-18-14 at 4:30 p.m., Tenant #2 got out of the building without staff supervision, walked to the front of the building and came in through the front door. There were no apparent injuries. Tenant #2's vital signs were taken and temperature was 98.2 degrees, pulse 83, respirations 18 and blood pressure was 150/73. Oxygen saturation was at 93%.

Staff #3 was interviewed and stated she was bringing tenants to the dining room and heard the alarm go off. She stepped into the hall and looked to the north door and the south door and didn't see anything. Someone else checked the doors but she couldn't remember who. She went back into the dining room and heard the alarm again within one minute and looked into the hall again and didn't see anything. Another staff checked the doors. She then went to apartment 106 and assisted a tenant into the bathroom when the pager went off and indicated it was the north exit door.

Staff #2 was interviewed and stated she was assisting a tenant and heard the alarms go off, she radioed for staff and someone said they were at the north exit door. She stated it was about 4:30 p.m. and she couldn't remember who responded to her call. She looked out the window and saw Staff #6 outside. She only heard the alarms go off one time. She stated the alarms were working okay. She stated Tenant #2 had not had any more exit seeking behaviors or elopement attempts. According to a statement written by Staff #2 on 7-18-14, Staff #2 was helping a tenant when the alarm went off. From the window saw Staff #6 but did not notice or hear anything else. Had previously shut alarm off and checked doors but not a tenant was in sight.

A written statement from Staff #6 indicated he was in the dining room area when he heard the wander light go off and he looked at the light box and saw a white light. He then ran up front to check the door and the ADON was there and said she already checked the front. He walkied staff and a woman responded saying she put in the code and swiped her key at both doors. That's when the ADON and Staff #6 saw Tenant #2 walking up to the front door outside of the building.

The ADON was interviewed and stated she heard the alarms and then they were off. She was busy in the front area of the building going between the desk and meeting room and saw Tenant #2 walk by the meeting room window so she went outside and brought Tenant #2 in. She couldn't remember what Tenant #2 was wearing but was dressed appropriately; it was nice weather, sunny and around 80 degrees. She directed staff to do a head count and walk around the building. She assessed Tenant #2 with no apparent injuries, vital signs were fine. She met with the staff who said the alarms went off and one staff went out and didn't see anyone but couldn't remember which staff went out. That day the alarm would go off for no reason. Maintenance had been there and thought they had the alarm fixed but it kept going off after that. The alarm was fixed the next week and in the interim staff was assigned to sit in the hallway to watch both doors until the alarm company could come to the Program. The extra staffing was started the night Tenant #2 eloped. She stated she thought the whole system was replaced.

The Director was interviewed and stated the ADON had called her and said Tenant #2 had eloped. She directed the ADON to interview staff. The ADON saw Tenant #2 coming from the north and assisted Tenant #2 in through the front door. The doors alarmed and maintenance checked and the doors functioned properly. She stated staff

followed the elopement policy and said staff looked outside and didn't see anyone. She stated Tenant #2 had exit seeking behaviors prior to the elopement but did not have any previous elopements.

A written statement from the Environmental Services Director indicated on the morning of 7-18-14 the Director notified him that the door alarms were not working correctly. Maintenance checked the alarms and after some testing and diagnoses believed the alarms worked properly. At 4:56 p.m. he was called and told he needed to come in and check the alarms because a tenant had eloped. He arrived on campus at 5:15 p.m. and found the north and south doors were not operating correctly. At 5:19 p.m. he called the alarm service company for help. He followed their directions for rebooting and the company thought the reboot worked. At 6:29 p.m. he was called again that the alarms were going off but the doors were staying locked. Secondary alarms were installed on both doors. The alarms were then going off again so he called the company back at 8:37 p.m. and requested an after hour repair visit. The parts needed were not in stock and would not be available for several days. He notified the Director who scheduled extra staff to watch the doors. On 7-19-14 he purchased one more alarm and installed it on the front door. The alarm company was there on 7-22-14 to install the new parts.

A floor plan of the Program and grounds was provided. The monitor walked the potential route Tenant #2 may have taken from the north exit door, on the grass along the side of the building or possibly through the parking lot to a sidewalk that went along the east side of the building leading to the front door of the building.

According to the Elopement of Tenants policy, all staff needed to respond immediately to door alarms and locate the tenant that had wandered outside and direct the tenant back inside. Staff was to immediately alert other team members including the AL Director and/or Executive Director if a tenant could not be located.

According to the State Climatologist, on 7-18-14 at 3:52 p.m. at the Davenport Airport, the temperature was 75 degrees; winds were from the south at nine miles per hour, few clouds, mostly sunny and no heat index.

Staffs #2, #3, the ADON and the Director stated there was enough staff to meet the needs of the tenants.

The Program provided documentation of staff re-training regarding the policy on elopement of tenants and the routine monitoring of exterior door alarms held from 7-18-14 through 7-21-14.

An incident report was completed and the Program notified the Department.

Per review of Tenant #2's file, an incident report, Elopement of Tenants policy and interviews with Staffs #2, #3, the ADON and Director, written statements from Staff #6 and the Environmental Services Director, Tenant #2 exited the building without staff supervision. Tenant #2 was observed outside, assisted into the building and had no apparent injuries.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

B. Medications

Complaint/Incident Allegation 48318-C: It was alleged a tenant was given medications to control behaviors and staff didn't monitor the effects. The tenant was sedated, could barely walk and staff thought it was funny.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #3, a 94 year old, was admitted on 4-23-13 and diagnoses included: Dementia, Cough, HTN and Carotid Artery Disease. Tenant #3 was staged at a seven on the GDS which indicated very severe cognitive decline. Tenant #3 received hospice services. According to a fax dated 10-25-13 and sent to Tenant #3's physician, a hospice nurse asked to discontinue Lorazepam 0.5 mg twice a day and to start Haldol 0.5 mg twice a day instead as Tenant #3 was still having agitation and aggression with the Lorazepam. The physician signed the order.

  Medication Administration Records (MARs) were reviewed for Tenant #3 from 8-1-13 through 12-26-13. Administration and effectiveness of medications were documented appropriately.

  Staffs #4, #5, the ADON and Director were interviewed and stated they were not aware of any staff who ever made fun of a tenant who was sedated.

  Review of tenant files and review of MARs indicated medications were administered and effectiveness of the medications was documented. Interviews with Staffs #4, #5, the ADON and Director indicated staff had not made fun of a tenant who was sedated.

- Regulatory Insufficiency: None noted.

C. Other

Complaint/Incident Allegation 48318-C: It was alleged a tenant had a significant weight loss in a short time.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #3's weight was 121.6 pounds at the time of admission on 4-23-13. On 5-14-13, Tenant #3 weighed 135 pounds and had three to four plus pitting edema, bilaterally on ankles and feet. On 6-10-13 Tenant #3 weighed 141 pounds with three to four plus edema on bilateral lower extremities (BLE) and feet. On 7-5-13 Tenant #3 weighed 137 pounds with plus three edema of the right foot and plus one edema of the left foot. According to the Monthly Record of Vital Signs and Weight/Height, Tenant #3 refused to be weighed in August 2013. In September Tenant #3 weighed

136.6 pounds and in November 122 pounds. On 10-25-13 Tenant #3 weighed 121 pounds. On 12-23-14 Tenant #3 weighed 122 pounds and had three plus edema of BLE of feet. An order for Lasix one tablet orally once per day was ordered on 6-10-13 and discontinued on 11-22-13 for edema.

Tenant #5, a 92 year old, was admitted on 3-13-14 and diagnoses included: Atrial Fibrillation, Pacemaker Placement, Congestive Heart, Peripheral Vascular Disease, HTN, Glaucoma, Gastric Esophageal Reflux Disease (GERD), Rheumatoid Arthritis, Depression and Osteoarthritis. Tenant #5 was staged at a five on the GDS which indicated moderately severe cognitive decline. According to a Monthly Record of Vital Signs and Weight/Height, Tenant #3's weights were as follows: October 2013 169.8 pounds; November 2013 168 pounds; December 2013 167 pounds; January 2014 163 pounds; February 2014 159.4 pounds. According to the Nurse's Notes dated 1-16-14 a signed order was received for nutritional drink daily. A physician document dated 2-19-14 indicated Tenant #5's family called with concerns that Tenant #5 was not eating well and was losing weight. The physician indicated there was not much he could do about the appetite.

Review of Tenant #3 and Tenant #5's files indicated weight loss with actions taken by the Program per physician order.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation 48318-C: It was alleged staff seemed to antagonize a tenant.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed. None of the files reviewed included any documentation regarding tenants feeling antagonized by staff.

  Staffs #4 and #5, the ADON and the Director were interviewed and stated they were not aware of any staff that seemed to antagonize tenants. The Director stated no staff had received disciplinary action regarding antagonizing tenants.

  Staffs #4 and #5 stated they were not aware of any staff being requested to not care for a tenant due to antagonistic behaviors. The ADON stated Tenant #3 and Staff #7 didn't seem to get along but she was not sure. The Director stated Tenant #3's family requested Staff #7 not care for Tenant #3. She stated Staff #7 was tall and bigger, thus towered over Tenant #3 who was small. Tenant #3 didn't respond well to Staff #7. Some days Tenant #3 didn't like other staff or hospice staff.

  On 9-16-14 at 11:20 a.m., the monitor observed three staff interacting with tenants during a painting activity. Staff was cordial, helpful and assisted tenants with their needs. On 9-18-14 at 12:00 p.m., the monitor observed tenants eating lunch. Staff assisted with serving, food needs and complimented tenants and asked tenants how they were doing. Five staff was present during this time. No staff displayed any antagonistic behaviors.

Review of tenant files, interviews with Staffs #4, #5, the ADON and the Director and monitor observations did not indicate any staff antagonized a tenant.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation 48318-C: It was alleged a tenant had a couple areas on arm that looked like needle marks.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed. No documentation of needle marks was indicated in the files.

  The ADON was interviewed and stated Tenant #3 had a mark that looked like a needle mark but she was not sure what it was. It was just one red pin point itty bitty mark on the back of upper arm.

  The Director was interviewed and stated Tenant #3 had a pencil in Tenant #3's apartment. She asked hospice if the mark was self-inflicted and they didn't know. Once the pencils were removed from the apartment there were no more marks. Tenant #3 would try to stab staff with a pencil.

  Review of tenant files and interviews with the ADON and Director indicated Tenant #3 had a mark that looked like a needle mark but they were not sure what it was. Once pencils were removed from Tenant #3's apartment no more marks were found.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation 48318-C: It was alleged a hospice nurse had not seen a tenant for two months.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed. Tenants #3 and #4 received hospice services.

  Tenant #3 was admitted to hospice services on 5-12-13. Documentation of skilled nursing visits by the hospice program was provided from 5-12-13 through 12-25-13 for a total of 45 visits with visits occurring each month.

  Tenant #4, an 86 year old was admitted on 12-19-13 and diagnoses included: Arthritis, Pulmonary Hypertension, HTN, Deconditioning, Coronary Artery Bypass Graft, Aortic Valve Replacement, Anemia, Profound Weakness, Falls, Hyperactive Bladder, Depression, GERD and Gastritis. Tenant #4 was staged at a seven on the GDS which indicated very severe cognitive decline. Tenant #4 was admitted to hospice on 1-3-14. Documentation of skilled nursing visits by the hospice program was provided from 1-5-14 through 2-27-14 for a total of 19 visits.

  Per review of Tenant #3 and #4's files, tenants received hospice services on an ongoing schedule.

- Regulatory Insufficiency: None noted.