IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
48424-C

October 3, 2014

Ms. Shelley Wicks, Administrator
Leland Smith Assisted Living
309 Ovesen Drive
Wilton, IA 52778

RE: Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report, Leland Smith Assisted Living, Wilton, Iowa

Dear Ms. Wicks:

Enclosed is the **Final Complaint/Incident Investigation & 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 an investigation by DIA on **September 18 and 22, 2014.** The Report notes a Regulatory Insufficiency in the area(s) of: Food Service.

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.

Enclosed you will find the Assisted Living Program Certificate **S0187** with effective dates of **March 19, 2014** through **March 18, 2016**.

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 & Recertification Monitoring Evaluation Report

Assisted Living Program:

Shelley Wicks, Administrator
Leland Smith Assisted Living
309 Ovesen Drive
Wilton, IA 52778

Complaint/Incident Intake #: 48424-C

Date of Complaint/Incident Investigation & Monitoring Visit:

September 18 and 22, 2014

Monitor(s):

Stephanie Cummins, MA

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:	27
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	27
TOTAL census of Assisted Living Program	27

Tenant/Family Satisfaction Results – A community meeting with 13 tenants and one tenant interview were held. The tenants said housekeeping services were completed to their satisfaction. The building and grounds were safe, clean and sanitary. A request was made by the tenants to have the public restroom unlocked. Nursing services were available and staff responded in less than five minutes. The tenants received the services expected when the occupancy agreement was signed. They described staff as helpful and wonderful. Staff was trained to provide the services needed. The tenants liked the food and said the temperature of the food was appropriate. The tenants said staff served them appropriately. Suggestions were made to increase the variety of foods and serve less pasta and starches. One tenant said there were too many desserts offered. There were no improvements requested regarding activities. The tenants received an activity calendar. They enjoyed Bingo, music and cards. A suggestion was made to have an exercise room. The tenants felt safe and made their own decisions. A comment was made regarding the availability of the television room for all tenants and to ensure the selection for television programming was respected by others. They were generally satisfied with the Program and would recommend it to others.

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

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

A. Staffing

Complaint/Incident Allegation: It was alleged a tenant fell and laid on the floor for hours because checks were not completed and the tenant was unable to call for help.

- Monitoring Observation: Five tenant files were reviewed.
  Tenant #1, an 86 year old, was admitted on 9-6-12 and diagnoses included: Hypertension (HTN), Gout and Anxiety. Tenant #1 was staged a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. The service plan reflected Tenant #1 received hourly checks. The documentation of the hourly checks

was consistently documented from May 2014 to the time of the investigation in September 2014. Incident reports from May 2014 to September 2014 were reviewed and there were no falls documented for Tenant #1. Tenant #1 had hourly checks, the checks were documented as completed and there were no falls documented.

Tenant #2, a 93 year old, was admitted on 11-20-09 and diagnoses included: HTN, Osteoporosis, Esophageal Reflux, Depressive Disorder and Anxiety. Tenant #2 was staged a two on the GDS, which indicated very mild cognitive decline. Tenant #2 had checks completed every two hours. The documentation of checks every two hours was consistently documented for June, July and August 2014. Incident reports from May 2014 to September 2014 were reviewed and indicated Tenant #2 had an incident report dated 5-1-14. Tenant #2 fell getting up to get juice and Tenant #2 did not have any pain or injuries. The incident report indicated (under additional comments and/or steps taken to prevent recurrence) Tenant #2 was told to press the pendant if Tenant #2 wanted juice. Tenant #2 had checks every two hours, the checks were documented as completed and Tenant #2 had one fall with no injuries.

Tenant #3, a 96 year old, was admitted on 7-1-09 and diagnoses included: Diabetes Mellitus, HTN and Hypothyroidism. Tenant #3 scored a four on the scored objective tool, which indicated cognitive impairment should be assessed further. Tenant #3 was staged at a one on the GDS, which indicated no cognitive decline. Tenant #3 was discharged on 8-1-14. Tenant #3 had checks completed every two hours. The documentation of checks every two hours was consistently documented for April, May, June and July 2014. Incident reports from May 2014 to September 2014 were reviewed and indicated Tenant #3 had an incident report dated 5-16-14. According to the incident report, Tenant #3 was in the bathroom and lost Tenant #3's balance. Tenant #3 had fallen and cut open the skin on the right outside of the hand. Tenant #3 denied further injury and had no other complaints. The incident report (under additional comments and/or steps taken to prevent recurrence) indicated staff was to ensure Tenant #3 put the pendant on after showers. Nurse's Notes dated 5-16-14 indicated Tenant #3 was found on the apartment floor at 6:30 a.m. Tenant #3 had fallen by losing Tenant #3's balance walking out of the bathroom. Tenant #3 had a laceration to the outside of the right hand. Nurse's Notes dated 5-16-14 indicated Tenant #3 received five sutures and new orders were received to check blood pressure every day, monitor right arm laceration for signs and symptoms of infection, to push fluids on 5-16-14 and 5-17-14 and remove sutures on 5-26-14. The service plan was updated on 5-16-14 and reflected staff was to ensure Tenant #3's pendant was on after showers. The service plan also reflected to assist with dressing and mobility, to monitor the laceration site for signs and symptoms of infection and to push fluids on 5-16-14 and 5-17-14. Tenant #3 had checks every two hours, the checks were documented as completed and Tenant #3 had one fall that resulted in a laceration and sutures.

Tenant #4, an 82 year old, was admitted on 3-16-07 and diagnoses included: Diabetes Type 1, B12 Deficiency and Depression. Tenant #4 was staged at a three on the GDS, which indicated mild cognitive decline. Tenant #4 was discharged on 8-2-14. The service plan reflected Tenant #4 received hourly visual checks. The documentation of checks every hour was consistently documented for May, June and July 2014. Incident reports from May 2014 to September 2014 were reviewed and

there were no falls documented for Tenant #4. Tenant #4 had hourly checks, the checks were documented as completed and there were no falls documented.

Staff #1, #2, #4 and the Registered Nurse (RN) said tenants received the cares requested and tenant checks were completed appropriately. Staff #1, #2, #4 and the RN said pendants or pull cords were available to all tenants and staff responded within five minutes. Staff #2, #4 and the RN was not aware of any instances where a tenant did not have a pendant to call for help and needed staff to respond.

Staff #1 said she worked the night shift on the night of Tenant #3's incident. Staff #1 said Tenant #3 was checked at 4:00 a.m. and was in bed. The incident with Tenant #3 was unwitnessed and Tenant #3 did not have a pendant. Staff #1 said she was in the hallway near Tenant #3's apartment after the 4:00 a.m. check and did not hear anyone calling for help.

Staff #5, said she had just come on shift and staff went into Tenant #3's apartment and found Tenant #3 laying on the floor outside the bathroom. Tenant #3 reported Tenant #3 had gotten up sometime during the night. Tenant #3 did not have a pendant and Staff #5 believed it was because of the shower.

Staff #2 worked second shift the day before Tenant #3's incident and assisted Tenant #3 with a shower. Staff #2 said she was not aware of a time when Tenant #3 did not a pendant after a shower.

According to the Staffing for Personal and Health-related Services policy, each tenant would have access to a 24-hour personal emergency response system that automatically identified the tenant in distress and could be activated with one touch. When one or more tenants had a cognitive disorder or dementia, staff would physically check on the tenant every hour for needs.

A community meeting with 13 tenants and one tenant interview were held. The tenants said there was enough staff to meet their needs and they received all the cares requested. The tenants had a pendant to call for assistance and the pendants were made available to them. It took staff less than five minutes to respond if the pendant was used and nursing services were available.

Review of tenant files, interviews, a community meeting and review of incident reports and a policy did not reveal concerns regarding tenant checks or staff response to pendants. Tenant #3 had an incident on 5-16-14 and Tenant #3 was not wearing a pendant; however, it could not be determined what circumstances lead to Tenant #3 not wearing the pendant. The service plan was updated after the incident and reflected staff was to ensure Tenant #3 had the pendant after a shower.

- Regulatory Insufficiency: None noted.

B. Food Service

- Monitoring Observation: Six staff files were reviewed.

  Staff #1, a certified nursing assistant (CNA), did not have an annual in-service training on food protection. Staff #1 said she served food.

  Staff #2, a CNA, did not have an annual in-service training on food protection. Staff #2 said she served food.

  Staff #3, a personal care attendant, did not have an annual in-service training on food protection.

  The RN said Staff #1, #2 and #3 served food.

  A community meeting with 13 tenants and one tenant interview were held. The tenants liked the food and the said staff served them appropriately. An observation of the noon meal on 9-22-14 did not reveal concerns regarding food safety and sanitation.

  Review of staff files and interviews revealed an annual in-service training on food protection was not completed for staff that served food.

- Regulatory Insufficiency: Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (IAC r. 481-69.28(5))