IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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September 26, 2014

**Complaint/Incident Intake #: 49331-C**

Ms. Laura Ubben, Director
Windhaven Assisted Living Center
5500 South Main Street
Cedar Falls, IA 50613

**RE: Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report – Windhaven Assisted Living Center, Cedar Falls, IA**

Dear Ms. Ubben:

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 a survey by DIA on **September 9 & 10, 2014.** The Report notes a Regulatory Insufficiency in the area(s) of: Policies and Procedures.

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 recertification process has not been completed. In addition, the State Fire Marshal's (SFM) inspection report has not been received for your program. An extension to your certificate is attached effective **September 29, 2014**.

The certificate will be sent when the process has been completed.

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 Investigation & Recertification Monitoring Evaluation Report

**Assisted Living Program:** **Complaint/Incident Intake #:** 49331-C

Laura Ubben, Director
Windhaven Assisted Living Center
5500 South Main Street
Cedar Falls, IA 50613

**Date of Complaint/Incident Investigation & Monitoring Visit:**

September 9 & 10, 2014

**Monitor(s):**

Stephanie Cummins, MA
Stephanie Radabaugh, PhD

**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: | 84 |
| Number of tenants with cognitive disorder: | 8 |
| Total Population of Program at time of on-site | 92 |

| **Dementia-Specific Program by Dedication** | |
|---|---|
| Number of tenants without cognitive disorder: | 6 |
| Number of tenants with cognitive disorder: | 25 |
| Total Population of Program at time of on-site | 31 |
| **TOTAL census of Assisted Living Program** | 123 |

**Tenant/Family Satisfaction Results** – A community meeting with 22 tenants and one tenant interview was held. Tenants stated the building was clean and had no odors. A suggestion was made to address a few stained areas on the hallway carpeting which had already been cleaned with a carpet cleaner. No concerns were noted regarding the timeliness of maintenance or laundry services. Tenants were satisfied with the activity program and complimented the transportation system offered. A wide variety of food was offered and the amount of food was satisfactory using the restaurant-style ordering. Several tenants stated wait times for receiving food was long but it was not all of the time. A consensus agreed wait times varied depending on the day, the foods ordered and how many arrived to eat at the same time. One tenant noted the Program's chef held regular food meetings for tenant suggestions but attendance was very low if any. Staff was described as caring, fantastic, prompt and helpful. Tenants felt staff was well-trained and that if they did not know the answer to something, they would promptly seek someone who did. Tenants all felt safe at the Program and stated they would recommend it to others.

**Complaint/Incident Investigation** – The Complaint/Incident investigator(s) made the observations detailed in the following area.

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

**A. Policies and Procedures**

- Monitoring Observation: Ten tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10).

  Tenant #1, a 94 year old, was admitted on 8-10-11 and diagnoses included: Multiple Sclerosis (MS), Esophageal Reflux, Edema, Neurogenic Bladder, Constipation, Sensorineural Hearing Loss and Cystitis. Tenant #1's service plan indicated no staff assistance was required for mobility. Tenant #1 used a walker and asked for assistance when needed. Tenant #1 had a wheelchair that Tenant #1 either self-propelled or walked behind. Tenant #1 would request an escort to and from meals if Tenant #1 was having a MS flare up. Tenant #1 was independent with transfers and if having a flare up would need assistance.

  According to Nurse's Notes dated 7-6-14 at 12:50 a.m. Tenant #1 reported to staff that Tenant #1 fell in the bathroom and hit Tenant #1's head. Tenant #1 was standing in front of the bathroom sink. Staff escorted Tenant #1 to the reclining chair with assist of one staff and reported Tenant #1 felt dizzy. An assessment was completed by a nurse and Tenant #1 was alert and responsive. Tenant #1's pupils were equal and reactive to light bilaterally. Hand grips were equal bilaterally. There was range of motion to upper and lower extremities. A small hematoma was noted to the back of Tenant #1's head and there was no complaint of pain upon palpitation.

  Nurse's Notes dated 7-6-14 at 1:10 a.m. indicated no change in status. At 1:25 a.m. Tenant #1 remained awake and an ice pack was applied. At 1:40 a.m. Tenant #1 remained awake and the ice pack was repositioned. No additional discomfort was voiced when asked. At 2:10 a.m. Tenant #1 remained awake. At 2:40 a.m. Tenant #1 had no change in status, remained awake and verbalized when spoken to. Nurse's Notes dated 7-6-14 at 3:00 a.m. indicated the Resident Assistant reported Tenant #1 remained awake and verbalized with no complaints of discomfort. The ice pack was renewed. At 4:30 a.m. Tenant #1 was snoring in the chair and was unresponsive to verbal stimuli after several attempts. Nurse's Notes dated 7-6-14 at 4:50 a.m. indicated a doctor was notified and an order was received to attempt to plantar stroke to arouse and if ineffective to call 911. At 5:00 a.m. a call was placed to paramedics and at 5:10 a.m. paramedics arrived to transport Tenant #1 to a hospital. Nurse's Notes dated 7-6-14 at 7:15 a.m. indicated Tenant #1 was admitted to a hospital with a diagnosis of a head bleed. Tenant #1 died on 7-6-14 at 5:20 p.m., according to Nurse's Notes.

  The Senior Director and Director said Tenant #1 ambulated independently at the time of the incident and there was no culpability to the Program.

Neurological checks were completed for Tenant #1 on a Neuro Checks document. Information regarding Tenant #1 from the Neuro Checks document is contained in the following table:

| DATE | TIME | BLOOD PRESSURE | PULSE | PUPILS | GRIPS | MENTAL STATUS | TIME BETWEEN CHECKS |
|---|---|---|---|---|---|---|---|
| 7-6-14 | 12:50 a.m. | 184/82 | 77 | PERL | Equal and strong | Alert and responsive | Incident occurred at 12:50 a.m. |
| 7-6-14 | 1:10 a.m. | 178/79 | 80 | PERL | Equal bilaterally | Alert and responsive | **20 minutes** (12:50 a.m. to 1:10 a.m.) |
| 7-6-14 | 1:25 a.m. | 178/** Number documented for diastolic blood pressure was not legible | 80 | PERL | Equal bilaterally | Alert and responsive | **15 minutes** (1:10 a.m. to 1:25 a.m.) |
| 7-6-14 | 1:40 a.m. | 201/88 | 88 | PERL | Equal bilaterally | Alert and responsive | **15 minutes** (1:25 a.m. to 1:40 a.m.) |
| 7-6-14 | 2:10 a.m. | 188/80 | 80 | PERL | Equal bilaterally | Alert and responsive | **30 minutes** (1:40 a.m. to 2:10 a.m.) |
| 7-6-14 | 2:40 a.m. | 156/70 | 70 | PERL | Equal bilaterally | Awakes and stated felt better | **30 minutes** (2:10 a.m. to 2:40 a.m.) |
| 7-6-14 | 4:30 a.m. | 170/87 | 86 | None reactive | None | Snoring, unresponsive. Calls to the doctor, paramedics and sent to a hospital | **1 hour 50 minutes** (2:40 a.m. to 4:30 a.m.) |

The Program's Suspected Head Injury policy indicated that upon a suspected head injury of a tenant the nurse in charge should obtain vital signs and initiate neurological checks. Neurological checks should be completed every 15 minutes for

1 hour, every 1 hour for 2 hours, and then every shift for a complete 24 hours. If the tenant had vital signs and neurological checks within normal limits for 24 hours the assessment was complete. If the vital signs and/or neurological checks were abnormal at any time throughout the assessment, the physician must be called immediately.

The Neuro Checks document had entries for neurological checks that included time, blood pressure, pulse, pupils, grips and mental status. The time intervals listed on the Neuro Checks document indicated 4 checks at 15 minutes, 2 checks at 30 minutes, 3 checks at 2 hours and 2 checks at 8 hours. The time intervals listed on the Neuro Check document where staff documented the checks did not match the time intervals specified in the Program's Suspected Head Injury policy. Regarding the incident with Tenant #1, staff completed the Neuro Checks document according to the time intervals indicated on the form; however, those intervals were not consistent with the time intervals listed in the policy. Neurological checks were not completed per policy regarding the incident on 7-6-14 with Tenant #1.

Review of a tenant file and policy indicated the Program did not follow their policy regarding a suspected head injury.

- 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 established 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. Structural Requirements**

Complaint/Incident Allegation: It was alleged there was an odor in the building.

- Monitoring Observation: Ten tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10).

  Review of tenant files indicated Tenants #1, #2, #3, #4, #5, #6, #7, #8 and #9 did not exceed the level of care and did not have unmanageable incontinence. The Program had applied for a waiver of administrative rule regarding level of care for Tenant #10.

  Review of the tenant files indicated the service plans reflected toileting assistance and interventions related to incontinence for tenants who requested assistance with toileting needs. Interventions for toileting assistance were individualized and included: staff assistance and reminders for toileting, removal of soiled protective undergarments, laundering of bed linens and personal clothing and garbage removal.

  Staff #1 said odors such as urine or feces were not a problem at the Program. Staff #1 said no tenants had unmanageable incontinence.

  Staff #2 said there have been no problems with urine odors in tenant apartments or hallways. Staff #2 said no current tenants had unmanageable incontinence.

The Senior Director said one tenant reported a concern regarding odor in a hallway. A log was developed to monitor the hallway for odors. There were no complaints from another other tenants regarding odor and the log did not reveal concerns regarding odors. The carpet in the hallway was going to be cleaned.

The Director said one tenant reported a concern regarding odor in a hallway. A log was developed to monitor the hallway for odors. An air freshener was placed and then removed. There were no complaints from other tenants regarding odors. Garbage was removed daily from tenant apartments and staff removed soiled incontinence products.

A community meeting with 22 tenants and one tenant interview was held. Tenants stated the building was clean and had no odors. A suggestion was made to address a few stained areas on the hallway carpeting which had already been cleaned with a carpet cleaner. No concerns were noted regarding the timeliness of maintenance or laundry services. Tenants stated they would recommend the Program to others.

The Program provided an odor log for the North Hallway in the building. The log had entries from 5-9-14 to 5-22-14 with checks completed at least daily, most dates with more than check per day. The checks were completed at various times and shifts. The log resumed on 6-2-14 to 6-5-14 and one entry on 6-11-14. The checks were completed at various times and shifts. The log resumed on 8-28-14 to 9-6-14 with checks completed multiple times each day including on 9-2-14 where the area was checked six times. The documentation of staff initials indicated there was different staff performing the checks. Of the entries documented from 5-9-14 to 9-6-14 no odor was documented with the exception of two entries. One entry said staff smelled an air freshener and the other entry was reflected as an odor, both occurred in May 2014.

Monitor observations were completed in the same hallway in the building as indicated on the odor log (North Hallway). Monitor observation of the Program's North Hallway on 9-9-14 at 10:20 a.m., 1:55 p.m. and 2:55 p.m. revealed no concerns regarding odors. Monitor observation of the Program's North Hallway on 9-10-14 at approximately 9:00 a.m. to 9:15 a.m. revealed no concerns regarding odors.

The Program provided a housekeeping schedule for tenant apartment cleaning, an apartment cleaning checklist staff completed for each apartment cleaned and an apartment cleaning procedure.

Review of tenant files, staff interviews, observations, a community meeting with tenants and review of an odor log did not reveal concerns regarding an odor in the building.

- Regulatory Insufficiency: None noted.