IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 49781-C

October 7, 2014

Ms. Carrie Young, Manager
River Bend Retirement Community
813 Tyler Street NE
Cascade, IA 52033

RE: Final Complaint/Incident Investigation Report – River Bend Retirement Community, Cascade, IA

Dear Ms. Young:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of September 29 & 30, 2014, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding 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:

River Bend Retirement Community
Carrie Young, Manager
813 Tyler Street, NE
Cascade, IA 52033

Complaint/Incident Intake #: 49781-C

Date of Complaint/Incident Investigation:

September 29 & 30, 2014

Monitor(s):

Wendy E. Kuhse 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 below were provided by the Program at the time of the on-site visit.

	General Population Program
Number of tenants without cognitive disorder:	36
Number of tenants with cognitive disorder:	1
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. Service Plans

Complaint/Incident Allegation: It was alleged that the program considered placing a Foley catheter and waking a tenant hourly as an intervention for urinary incontinence.

- Monitoring Observation:

  Tenant #2, a 101 year old, was admitted on 1-9-12 and diagnoses include: Macular Degeneration, Malignant Neoplasm, and Facial Nerve Palsy. Tenant #2 scored four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline.

  According to documentation in the medical record, Tenant #2 experienced a change of condition and staff completed a full evaluation (health, functional and cognitive) and updated Tenant #2's individual service plan. Documentation in the nurse's care notes dated 7-16-14 indicated Tenant #2 returned from a physician's visit with orders for a new medication. Staff documented that the additional medication was not a change to Tenant #2's daily routine and indicated Tenant #2's service plan remained unchanged.

  Documentation in the nurse's care notes dated 7-31-14 indicated another medication change and again added that this did not constitute a significant change for Tenant #2 and the service plan remained unchanged.

  Documentation in the nurse's care notes dated 8-5-14 at 3:30 p.m. indicated a change in condition for Tenant #2 due to the admit to hospice services. Staff completed a full evaluation (health, functional and cognitive) and updated Tenant #2's individual service plan.

  Documentation in the nurse's care notes dated 8-8-14 indicated new physicians orders for medications. Staff identified that Tenant # 2's service plan remained unchanged.

Documentation in a nurse review on 8-19-14 at 2:10 p.m. indicated staff noted Tenant #1 on the floor at 9:45 p.m. on 8-18-14. Staff completed a physical assessment and notified Tenant #2's physician. Staff evaluated Tenant #2's service plan and noted this incident did not represent a change of condition and Tenant #2's individual service plan remained unchanged.

A nurse review completed on 8-30-14 indicated Tenant #2 was being treated for an urinary tract infection. Documentation in the nurse's care notes also indicated this was not a significant changed as the treatment was to be short term, and would resolve with no change in the daily routine for Tenant #2. Staff did make minor changes on Tenant #2's service plan related to the antibiotic treatment.

Tenant #4, a 101 year old, was admitted on 1-9-12 and diagnoses include: Atrial Fibrillation, Coronary Artery Disease, Hypertension, Congestive Heart Failure, Benign Prostate Hypertrophy, Hyperlipidemia, Complete Heart Block with Syncope and Pacemaker. Tenant #4 was staged at a six on the GDS which indicated severe cognitive decline.

According to documentation in the medical record, Staff notified Tenant #4's physician via facsimile on 10-8-13 of an increase in incontinence by Tenant #4. Staff received physician's orders to complete a urinalysis and culture and sensitivity test if indicated. Results of the urinalysis were received and noted by the nurse manager on 10-11-13. There were no new physician's orders.

Documentation in a facsimile to Tenant #4's physician dated 10-15-13 indicated Tenant #4 had been placed on a toileting program and continued to have unmanageable bladder and occasional bowel incontinence. The nurse manager requested the physician review Tenant #4's medications and advise her of changes. The nurse manager also questioned the possibility of a urology consult and/or insertion of a Foley catheter. Tenant #4's physician gave orders for the urology consult but not the Foley catheter.

Staff completed an evaluation (health, functional and cognitive) of Tenant #4 on 11-25-13. The individual service plan was also updated to include staff to assist Tenant #4 with toileting in the am and pm, after meals, and around 1:00 a.m. and 4:00 a.m. Staff also placed signs in Tenant #4's apartment to help Tenant #4 locate the bathroom.

Documentation in a facsimile dated 11-26-13 informed the physician of Tenant #4's continued urinary incontinence and questioned additional medications. Tenant #4's physician responded that staff should wait until after Tenant #4's urology consult.

Documentation in a 90 day nurse review indicated Tenant #4 continued on a toileting schedule and had signs in the apartment to help him/her locate the bathroom. The review also indicated staff continued to assist Tenant #4 with toileting approximately every 3 hours during waking hours and at approximately 1:00 a.m. and 4:00 a.m. Staff also provided peri-cares when Tenant #4 was incontinent and assisted Tenant #4 with placing protective undergarments.

Staff also completed task sheets documenting hourly checks and toileting schedules on Tenant #4.

- Regulatory Insufficiency: None noted.

B. Nurse Review

Complaint/Incident Allegation: It was alleged that the program refused to perform/acquire physician's orders for a urine sample on a tenant who was exhibiting confusion and an increase in falls.

- Monitoring Observation:
  Tenant #1, a 88 year old, was admitted on 8-5-11, and diagnoses include: History of Colorectal Cancer, Macular Degeneration, Hearing Loss, Hypercholesterolemia, Cellulitis, and Dementia. Tenant #1 was staged at a four on the GDS which indicated moderate cognitive decline.

  According to documentation in a nurse review dated 8-19-14, staff found Tenant #1 sitting on the floor leaning against the wall at approximately 9:00 am. The notation indicated staff completed an assessment on Tenant #1 and found no injuries. Documentation also indicated Tenant #1 was receiving antibiotics for a toe infection. Staff placed a call to Tenant #1's physician and received orders to transfer Tenant #1 to the emergency room for treatment and evaluation.

  Documentation in the nurse's care notes dated 8-19-14 at 4:40 p.m. indicated Tenant #1 had been admitted to the hospital for confusion. The notation also indicated that a urinalysis had been completed and was negative for a urinary infection.

  Tenant #2's medical record was reviewed. According to documentation staff completed a "subsequent health/functional assessment" dated 8-25-14 at 3:30 p.m. due to a change in condition for Tenant #2.
  Comments on the evaluation indicated Tenant #2 had sustained multiple falls (8-5-14, 8-7-14, 8-18-14, and 8-24-14) and an increase in services related to overall all health and dementia .

  According to documentation in the nurse's care notes dated 8-30-14 at 2:00 p.m. staff received a call from the hospice nurse indicating a new physician's order for Bactrim DS, for five days to treat a urinary tract infection.
  During an interview on 9-30-14 at 1:40 p.m. the nurse manager stated she did not recall Tenant #1 showing signs of a urinary tract infection at that time. The nurse manager stated all physicians' orders go through the hospice nurse when a Tenant has hospice services. The nurse manager stated she recalled talking to the hospice nurse about obtaining a urine sample and the hospice nurse indicated a urine sample on the Tenant #2 would likely always show an infection due to Tenant #2's poor oral intake and increased incontinence. The nurse manager stated the hospice nurse did not initially collect a urine sample but did so after a day or so elapsed

During an interview on 9-3014 at 5:26 p.m. the hospice nurse stated according to the hospice notes, assisted living staff reported Tenant #2 had an ongoing strong urine odor related to dehydration and that Tenant #2 was non symptomatic.

Documentation in the hospice notes on 8-25-14 revealed no mention of signs and symptoms of any urinary issues.

The hospice nurse indicated hospice staff received a phone call on 8-27-14 updating Tenant #2's condition following several falls, and indicating Tenant #2 had sustained no further falls.
The hospice nurse indicated the hospice records showed a urine sample was obtained on 8-28-14. The hospice nurse also stated that Tenant #2's physician did not give orders for an antibiotic until results of the culture and sensitivity were received. The hospice nurse also indicated that it is usual protocol for the Assisted Living nurse manager to contact the hospice nurse for any orders such as those for urine samples to test for urinary tract infections.

- Regulatory Insufficiency: None noted.