IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
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(515) 281-4115 Phone
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
52005-C
52006-M

May 4, 2015

Ms. Cheri Orcutt, Director
Clover Ridge
205 Ehlers Lane
Maquoketa, IA 52060

RE: Final Complaint/Incident Investigation Report, Clover Ridge, Maquoketa, Iowa

Dear Ms. Orcutt:

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 **April 7 - 20, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Notification of Dependent Adult Abuse, Tenant Documents, Service Plans and Dementia Specific Education for Program Personnel.

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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0078	A. BUILDING: _____ B. WING _____	C 04/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER RIDGE	205 EHLERS LANE MAQUOKETA, IA 52060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 22 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 22 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 8 Number of tenants with cognitive disorder: 7 Total Population of Program at time of on-site: 15 TOTAL census of Assisted Living Program: 37 An investigation of Complaint #52005-C and Incident #52006-M was completed. There were regulatory insufficiencies related to the investigation of Complaint #52005-C and Incident #52006-M. Iowa Code 235E.2(3)(a) If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person ' s designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours. This requirement is not met as evidenced by:	A 000		

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A 000	Continued From page 1 Based on review of Program documents, staff failed to report allegations of dependent adult abuse regarding Tenant #1. (Incident #52006-M) 1. Tenant #1, a 73 year old was admitted on 6-20-13 and diagnoses included: dementia with behavioral disturbances, hypertension with lower extremity edema, chronic anxiety with paranoia, hypokalemia, constipation and pedal edema. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit. 2. The Program completed a self-report to the Department related to allegations of dependent adult abuse regarding Tenant #1 and Staff A and Staff B. Seven staff (Staff C, D, E, F, G, H and I) provided statements regarding various allegations including verbal comments made to Tenant #1. Staff A, B, C, D, E, F, G, H and I were identified on the staff list as universal workers. According to the information submitted to the Department in the self-report, the allegations were initially brought up by a non-caregiving staff at a meeting with administrative staff in February 2015. That prompted the Manager to conduct staff interviews. Staff C, D, E, F, G, H and I did not report the allegations until staff was interviewed by the Manager regarding possible concerns. 3. Review of Program documents indicated Staff C, D, E, F, G, H and I had documented dependent adult abuse training.	A 000		

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A 000	Continued From page 2 4. According to an In-Service/Training Program document, an in-service was held on 2-26-15 and 2-27-15 and the objective was dependent adult abuse. There was also a training on 3-7-15 and it was indicated as a dependent adult abuse refresher. Staff C, D, E, F, G and H attended one of the training sessions. 5. According to the Program's Adult Abuse Reporting policy, all staff was trained as mandatory reporters of dependent adult abuse within 90 days of employment and every 5 years. If it was suspected that a dependent adult had been abused it must be reported to the Manager or nurse immediately. The Manager was responsible to notify the Department within 24 hours of their notification.	A 000		
A 079	481-69.25(1)q Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant ' s own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs) This REQUIREMENT is not met as evidenced by: Based on review of tenant files, Program documents and a staff interview the Program	A 079		

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A 079	Continued From page 3 failed to document personal or health-related care on task sheets for one of five tenant files reviewed (Tenant #2). One tenant, who could not self-advocate, received safety or visual checks every 10 minutes as indicated on the service plan. The checks were not consistently documented as completed. (During the course of the investigation of Complaint #52005-C) 1. Tenant #2, an 84 year old, was admitted on 7-25-11 and diagnoses included: hyperlipidemia, dementia, history of falls, chronic renal insufficiency, depression, hypertension, back pain, arthritis and osteoporosis. Tenant #2 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit. 2. Tenant #2's service plan dated 3-4-15 indicated Tenant #2 resided in a 24-hour supervised dementia area. The service plan also reflected Tenant #2 had 10 minute safety checks due to increased exit-seeking behaviors. 3. According to Nurses/Care Notes dated 3-4-15, a change of condition evaluation was completed due to exit seeking and difficulty with meals. Tenant #2 had some exit seeking behaviors in the past week. Medications had been adjusted per doctor recommendations. A urinalysis and lab work were ordered to rule out a medical cause. There had been no exit seeking behaviors since 2-28-15. 4. Incident reports for February 2015 were reviewed. There were incident reports related to Tenant #2 exit seeking and leaving the building (with staff knowledge) including those dated	A 079		

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A 079	Continued From page 4 2-22-15, 2-25-15 (three reports) and 2-26-15 (two reports). According to an incident report dated 2-25-15 at 5:00 p.m., staff observed Tenant #2 attempt to go out the doors 15 plus times. 5. According to an interview with the Health Care Coordinator on 4-14-15 at 12:08 p.m. and at the exit meeting, checks were in place for Tenant #2 and the frequency of the checks was every 10 minutes. Staff was to visually check Tenant #2's location. Tenant #2 was unable to advocate for Tenant #2's self. 6. Documentation of the 10 minute checks for Tenant #2 were requested and checks were provided dated 3-10-15 to 3-23-15. There was no documentation of checks provided after 3-23-15.	A 079		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant ' s identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents the Program failed to develop service plans that reflected the identified needs and preferences for assistance regarding four of five tenant files (Tenants #1, #2, #3 and #4). Service plans did not reflect the identified needs of the tenants and preferences for assistance. (Complaint #52005-C)	A 089		

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A 089	Continued From page 5 1. Tenant #1, a 73 year old was admitted on 6-20-13 and diagnoses included: dementia with behavioral disturbances, hypertension (HTN) with lower extremity edema, chronic anxiety with paranoia, hypokalemia, constipation and pedal edema. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit. Tenant #1 had a doctor's order dated 3-12-15 for an elastic bandage, wrap both arms, night and day for two weeks then Tenant #1 could go without. The wraps were not added to the service plan and were not on the March 2015 medication administration records (MARs). Nurses/Care Notes from 12-15-14 to 2-23-15 indicated Tenant #1 displayed behaviors including: going into other tenant apartments, consumed beverages from the dementia unit refrigerator, removed Tenant #1's clothing in the common areas, yelled and growled, slammed doors, put mulch in Tenant #1's nose, urinated in the common areas and outside in the courtyard, set off door alarms and did not sleep much at night. The service plan reflected Tenant #1 had behaviors with urinating in common areas and in the courtyard. The service plan provided interventions related to the toileting behavior. There were no cleanliness issues related to incontinence observed in the common areas. The service plan reflected Tenant #1 had a history of dementia with paranoia, agitation with confusion and chronic anxiety. The service plan reflected activities Tenant #1 enjoyed and staff was to provide one on one emotional support if they noted any tearfulness or verbalization of	A 089		

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A 089	Continued From page 6	A 089		

depression, anxiety or paranoia. The service plan did not address Tenant #1's behaviors including: going to other tenant apartments or consuming beverages from the dementia unit refrigerator including thickened beverages. The service plan also did not reflect behaviors including: Tenant #1 removed clothing in the common areas, yelled and growled, slammed doors, put mulch in Tenant #1's nose, set off door alarms and did not sleep much at night. The service plan did not reflect interventions related to the behaviors. The service plan did not reflect the identified needs of Tenant #1.

2. Tenant #2, an 84 year old, was admitted on 7-25-11 and diagnoses included: hyperlipidemia, dementia, history of falls, chronic renal insufficiency, depression, HTN, back pain, arthritis and osteoporosis. Tenant #2 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit.

According to a Condition Report document dated 1-20-15, Tenant #2 had a hard time taking a medication cup out of staff hands and Tenant #2 attempted to eat part of a napkin at supper time. The doctor indicated to provide closer supervision at medication pass and meal times. The service plan dated 3-4-15 reflected Tenant #2 preferred staff provided only cloth napkins during meal times. The service plan did not reflect staff was to provide closer supervision at medication pass and meal times. The service plan did not reflect the identified needs of Tenant #2.

3. Tenant #3, an 80 year old, was admitted on 8-26-14 and diagnoses included: hypothyroidism, depression, anxiety, hepatitis C, hyperlipidemia, history of urinary tract infection, history of falls,

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A 089	Continued From page 7 osteoporosis and urge incontinence. Tenant #3 was staged at a three on the GDS, which indicated mild cognitive decline. Tenant #3 resided in the dementia unit. According to a Program document, Tenant #3 had a diagnosis of hepatitis C. The service plan reflected Tenant #3 had a history of falls. Nurses/Care Notes from 2-14-15 to 3-26-15 indicated Tenant #3 had falls and some falls with injuries. The service plan dated 3-25-15 did not reflect Tenant #3's diagnosis of hepatitis C and precautions related to the diagnosis for staff and tenant safety. The service plan did not reflect the identified needs of Tenant #3. 4. Tenant #4, an 88 year old, was admitted on 6-16-11 and diagnoses included: insulin dependent diabetes, HTN, renal insufficiency, congestive heart failure and increased confusion with short term memory loss. Tenant #4 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit. Nurses/Care Notes dated 2-23-15 indicated Tenant #4 was acting slow and confused. Tenant #4's blood sugar was 59. Nurses/Care Notes dated 4-1-15 indicated a new order was received to change the glucose gel order to the following: if Tenant #4's blood sugar was less than 60 call the nurse, squeeze the entire contents of the tube in Tenant #4's mouth, if no response in the 15 minutes then repeat the dose and for Program staff to offer a bedtime snack. The MAR would be updated and the snack would added to the service plan.	A 089		

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A 089	Continued From page 8 The service plan dated 3-9-15 reflected Tenant #4's insulin was in pre-filled dose pens. Staff monitored Tenant #4's blood sugars as ordered by the doctor. On 4-1-15 an update was made to the service plan to reflect a snack was to be offered at bedtime due to low blood sugar in the morning. The service plan did not reflect Tenant #4's low blood sugar parameters and instructions related to the low blood sugars. The service plan did not reflect signs and symptoms of low blood sugars. The service plan did not reflect the identified needs of Tenant #4. 5. The Program's Service Plan policy indicated the service plan would identify all services needed and/or requested by the tenant.	A 089		
A 123	481-69.30(3) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(3) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on review of staff files the Program failed to complete eight hours of dementia training annually for two of two staff files (Staff A and B). Two direct-contact staff did not have eight hours of dementia training annually.	A 123		

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A 123	Continued From page 9 (Incident #52006-M) 1. Staff A, a universal worker, did not have eight hours of dementia training annually. Review of the February 2015 schedule indicated Staff A had worked in the dementia unit. 2. Staff B, a universal worker, did not have eight hours of dementia training annually. Review of the February 2015 schedule indicated Staff B primarily was scheduled in the general population; however, had worked in the dementia unit. 3. According to the Program's Dementia Specific Assisted Living Program policy, eight hours of dementia-specific education training would be provided for all staff within 30 days of employment, and eight hours annually for direct care staff.	A 123		

Clover Ridge Place
504 Ehlers Lane
Maquoketa, Iowa 52060
Ph: 563-562-2125
Fx: 563-652-0145

Date: May 14, 2015

Complaint/Investigation Intake #'s: 52005-C and 52006-M

Plan of Correction (POC) Submitted For:

- Investigation Date: April 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 and April 20, 2015
- Monitors: Stephanie Cummins MA

POC:

A. Reporting Dependent Adult Abuse in a Facility or Program:

a. Regulatory Insufficiency:. If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours. 235E2 (3)(a).

Program POC:

1. **Elements detailing how the program will correct the insufficiency as it relates to the tenant:**

   A. With respect to tenant #1 in the program, when allegations were made, Staff A and Staff B were suspended at the time of investigation and will be terminated.
   B. With respect to tenant #1 in the program, all allegations of abuse will be reported directly to the Program Manager and/or Healthcare Coordinator immediately who shall notify the department within twenty-four hours.
   C. With respect to tenant #1 in the program, all current staff as of March 7, 2015 received additional Dependent Adult Abuse training on February 26, 27 and March 7, 2015.

2. **Actions program taking to protect tenants in similar situations:**

   A. All allegations of abuse will be reported directly to the Program Manager and/or Healthcare Coordinator immediately who shall notify the department within twenty-four hours.
   B. If the Program Manager and/or Healthcare Coordinator is the alleged abuser, staff will report the abuse directly to the department within twenty-four hours.

C. The manager and the Healthcare Coordinator will review the policy and procedure manual regarding Dependent Adult Abuse and communicate it with our staff.
D. All program staff will receive Dependent Adult Abuse training annually.

3. Measures taken to ensure problem does not recur:

A. The Program Manager and/or Healthcare Coordinator will report all allegations of abuse according to Iowa Code 235E.2(3)a, within twenty-four hours of notification of any allegation of abuse.
B. If the Program Manager and/or Healthcare Coordinator is the alleged abuser, staff will report the abuse directly to the department within twenty-four hours.
C. All program staff will attend annual training for Dependent Adult Abuse.

4. Date by which the regulatory insufficiency will be corrected:

A. Substantial compliance with the regulatory insufficiency shall be in place by May 15, 2015.

B. Tenant Documents

a. Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs) 481-69.25(1)q, (231C)

Program POC:

1. Elements detailing how the program will correct the insufficiency as it relates to the tenant:

A. With respect to Tenant #2 the task sheets will be revised to make an individual sheet for each resident detailing their individualized tasks including visual checks for memory care, which will be complete by May 22, 2015.

2. Actions program is taking to protect tenants in similar situations:

A. The Healthcare Coordinator will provide an in-service regarding the revised task sheets and inform staff the importance of documentation.
B. Staff retraining in proper procedures of resident elopement, reporting, documentation, and visual checks, will occur during the in-service on May 21 and May 22, 2015.

3. Measures taken to ensure problem does not recur:

A. Staff will be instructed to review the task sheets during shift change to confirm all tasks are completed and signed off prior to leaving.
B. The Healthcare Coordinator will check for completion of task sheets on a weekly basis.

4. Date by which the regulatory insufficiency will be corrected:

A. Substantial compliance with the regulatory insufficiency shall be in place by May 22, 2015.

C. Service plan

a. Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. 481-69.26(4), (231C).

Program POC:

1. Elements detailing how the program will correct the insufficiency as it relates to the tenants:

A. With respect to Tenant #1, #2, #3, AND Tenant #4, the Healthcare Coordinator was provided training regarding completion of developing service plans that reflect the identified needs and preferences of the residents on May 6, 2015.

2. Actions program is taking to protect tenants in similar situations:

A. All doctor orders will be added to the service plan and also added on the Medication Administration Record (MAR).
B. All service plans will address resident behaviors including interventions to reflect the needs of the resident.
C. All service plans will be individualized to the resident's needs including interventions related to their diagnoses.
D. All service plans will include diagnoses that require precautionary measures for staff and resident safety.
E. Any service plans regarding residents with specific diagnoses, the service plan will include details and interventions to meet the needs of the resident.
F. All service plans will identify services needed and/or requested by the resident and will be individualized to meet the needs of the resident.

3. Measures taken to ensure problem does not recur:

A. The Healthcare Coordinator will ensure documentation has been recorded in the resident's chart, to include changes from nurse reviews and any scheduled assessments to correlate with the service plan, which includes reviewing each service plan to ensure it is up-to-date meeting the resident's needs and/or requests.

4. Date by which the regulatory insufficiency will be corrected:

A. Substantial compliance with the regulatory insufficiency shall be in place by June 3, 2015.

D. Dementia-Specific Education for Program Personnel:

a. **Regulatory Insufficiency:** All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia specific continuing education annually. Direct contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. 481-69.30(3), (231C).

Program POC:

1. **Elements detailing how insufficiency was corrected for residents:**

   A. All staff will receive the annual dementia specific training according to the program's policy, which requires eight hours of dementia-specific education training to be provided for all staff within 30 days of employment, and eight hours annually for direct care staff.

2. **Actions program taking to protect tenants in similar situations:**

   A. The program will provide dementia-specific training on May 20, 21, 26, & May 27, , 2015, any staff who need renewal.
   B. All staff will be trained in a dementia-specific training annually.

3. **Measures taken to ensure problem does not recur:**

   A. Annual training will be conducted according to 481-69.30(3), (231C).

4. **Date by which the regulatory insufficiency will be corrected:**

   A. Substantial compliance with the regulatory insufficiency shall be in place by June 3, 2015.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Clover Ridge Place
205 Ehlers Lane
Maquoketa, Iowa 52060
(563) 652-2125 ph. (563) 652-0145 fax

May 20, 2015

Rose Boccella
Dept. of Inspections & Appeals
Lucas State Office Building
Des Moines, Iowa

Dear Rose,

Per your request, I am providing additional information for our Plan of Correction.

Health Care Coordinators training was provided by:
Jacquie Spier RN, MSN
Senior Housing Nurse Clinician

Updates to service plans were completed for three of the four residents as identified below. Resident #1 had an order for bandages that was for a two week period of time. That time had passed prior to the State visit, therefore an update was unnecessary.

Resident #2	4/18/2015
Resident #3	4/22/2015
Resident #4	4/18/2015

Thank you for your time and consideration. If you have additional questions, please feel free to call. 563-652-2125 or 563-212-5228.

Sincerely,

Cheri Orcutt,
Manager