IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

June 29, 2015

Complaint Intake #: 53491-C

Mr. Doug Techel, Executive Director
Prairie Hills at Ottumwa
173 East Rochester Street
Ottumwa, IA 52501

RE: Final Complaint Investigation & Recertification Monitoring Evaluation Report – Prairie Hills at Ottumwa, Ottumwa, IA

Dear Mr. Techel:

Enclosed is the **Final Complaint 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 **June 11 & 15, 2015.** A recertification visit and investigation of Complaint #53491-C was completed. There was a regulatory insufficiency cited related to the recertification visit. The complaint allegation of staffing was not substantiated; however, a regulatory insufficiency was identified during the course of investigation of Complaint #53491-C. The regulatory insufficiencies are indicated on the enclosed report.

The following allegation was investigated in regards to Complaint #53491-C:

1. Allegation: Staffing
   Findings: Unsubstantiated
   Comments: A tenant community meeting, tenant interviews, staff interviews, review of tenant files and review of Program documents did not reveal concerns related to staffing.

The Report notes Regulatory Insufficiencies in the area(s) of: Program policies and procedures and Service Plans.

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. 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

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
	S0259	A. BUILDING _____ B. WING _____	C 06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT OTTUMWA	173 EAST ROCHESTER STREET OTTUMWA, IA 52501

(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: 37 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 41 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 7 Total Population of Program at time of on-site: 8 TOTAL census of Assisted Living Program: 49 A recertification visit was conducted to determine compliance with certification for an Assisted Living Program. In addition to the recertification visit, the investigation of Complaint #53491 was also completed.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. 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.	A 003		

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews, review of Program documents and observation, the Program failed to follow their policy and procedure regarding the completion of incident reports for one of five tenant files reviewed (Tenant #2). Tenant #2 walked away from the building, left Program property and was found by staff walking on a city street. After the incident, safety checks were initiated and Tenant #2 moved to the dementia unit. An incident report was not completed regarding the incident with Tenant #2. (During the course of the investigation of Complaint #53491-C) 1. Tenant #2, an 84 year old, was admitted on 8-5-13 and diagnoses included: anxiety, coronary artery disease, memory lapse/memory loss, hypothyroidism, iron deficiency anemia, left-sided pleural effusion and muscle weakness (right). Tenant #2 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit. Tenant #2 previously resided in the general population and moved to the dementia unit on 6-1-15. According to a Nurse Review document dated 5-21-15, Tenant #2 was sitting outside with another tenant and was noted to walk approximately one and a half blocks (distance) in the middle of the street. Tenant #2 was not able to answer exactly where Tenant #2 was going and why. The document indicated Tenant #2 was unable to demonstrate proper safety due to the incident. Tenant #2 had a cognitive decline in the past month, had become more forgetful and	A 003		

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A 003	Continued From page 2 required more reminders and prompting. Staff would perform 30 minute safety checks while the exit doors were unlocked. Cognitive, health and functional evaluations were completed and the service plan was updated. On 5-21-15 and 6-1-15 (after the incident) Tenant #2 was staged at a five on the GDS, which indicated moderately severe cognitive decline. At the time of the incident Tenant #2 was staged at a four on the GDS, which indicated moderate cognitive decline. 2. According to an interview with Staff A on 6-15-15 at 11:43 a.m., Staff A saw Tenant #2 outside the break room window at approximately 10:15 a.m. Tenant #2 was sitting outside and there were two to three other tenants also sitting outside. Approximately 30 minutes later, another tenant reported Tenant #2 was by the fountain. Staff A and Staff B responded and took a wheelchair. As they were responding to the area, Staff A could see Tenant #2 was on the street and Staff A ran through the grass area to the street. Tenant #2 was on the right side of the street and Staff A estimated the distance Tenant #2 traveled on the city street to be approximately one to two car lengths. As Staff A reached Tenant #2 there was also a police officer who responded to a call received. The officer left as staff responded and was assisting Tenant #2. Tenant #2 told staff Tenant #2 was going home. There were no cars on the street at the time Tenant #2 was found except the police car. Tenant #2 was transported back to the building in a wheelchair by the Executive Director. Tenant #2 did not sustain any injuries and Tenant #2 was dressed appropriately for the weather. Staff A said Tenant #2 would sit outside quite often but did not have a history of wandering. She said prior to the incident there	A 003		

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A 003	Continued From page 3 were no safety concerns with Tenant #2 sitting outside. Staff A said after the incident with Tenant #2, safety checks every 30 minutes were initiated. 3. According to an interview with Staff B on 6-15-15 at 11:31 a.m., at approximately 9:30 a.m. to 10:00 a.m. another tenant reported Tenant #2 was at the end of the Program's driveway. Staff A and Staff B responded and Tenant #2 was observed in front of the fountain on the right side of street. Tenant #2 had Tenant #2's walker. When staff asked Tenant #2 where Tenant #2 was going Tenant #2 did not know. Tenant #2 was transported back to the building in a wheelchair. Tenant #2 did not sustain any injuries; however, Tenant #2 was really tired that afternoon. Tenant #2 was dressed appropriately for the weather at the time of the incident. 4. According to an interview with the Director of Health Services on 6-15-15 at 10:54 a.m., Tenant #2 had previously sat outside in front of the building and prior to the incident there were no concerns with elopement or wandering. Tenant #2 did not sustain any injuries related to the incident. After the incident there were concerns Tenant #2 did not use good judgement and Tenant #2 needed placement in an area with door alarms and supervision. Tenant #2's family was agreeable with a decision to move Tenant #2 to the dementia unit. After the incident with Tenant #2 safety checks were initiated every 30 minutes from 8:00 a.m. to 10:30 p.m. (while the exit doors were unlocked). The safety checks every 30 minutes continued until Tenant #2 moved to the dementia unit. 5. According to an interview with the Executive Director on 6-15-15 at 11:14 a.m., Tenant #2 was	A 003		

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A 003	Continued From page 4	A 003		

sitting outside with other tenants. Another tenant came into the building and reported Tenant #2 was walking down the driveway and had not come back. Staff responded and found Tenant #2 near the fountain on the right side of the street. Tenant #2 was traveling west on the street when staff found Tenant #2. The Executive Director transported Tenant #2 back to the building in a wheelchair. Tenant #2 did not sustain any injuries related to the incident. The Executive Director said it was normal for Tenant #2 to sit outside with other tenants and there were no concerns with Tenant #2's safety prior to the incident. After the incident Tenant #2's family was contacted and safety checks were initiated.

6. According to the State Climatologist, the weather conditions on 5-21-15 at 9:53 a.m. in Ottumwa were as follows: the temperature was 56 degrees, there were clear skies and the winds were from the west-southwest at 14 miles per hour (mph). The weather conditions on 5-21-15 at 10:53 a.m. in Ottumwa were as follows: the temperature was 60 degrees, there were clear skies and the winds were from the west-southwest at 12 mph. Two weather condition readings were obtained as the exact time of the incident with Tenant #2 could not be determined.

7. According to observation on 6-15-15, the Program's parking lot and driveway were perpendicular to the city street. There was a fountain at the edge of the Program's property before reaching the city street. The distance from the Program's front door to the area where Tenant #2 was found walking on the city street was approximately slightly greater than 0 1 of a mile. The city street was a paved two lane road with a posted speed limit of 25 mph at the

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A 003	Continued From page 5 approximate location where Tenant #2 was found. 8. Review of incident reports for the last three months indicated an incident report was not completed related to the incident with Tenant #2 on 5-21-15. 9. According to the Program's Event Reporting policy, an event of concern could be: injury, potential for injury, elopement and abnormal behaviors. Incident reports would be completed by staff first made aware or staff present at the time of the event. Incident reports must be completed by staff before leaving the building at the end of their shift. Completed incident reports would be left in the nursing office.	A 003		
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 review of Program documents, the Program failed to develop service plans that reflected at a minimum: the tenants' identified needs and preferences for assistance for three of five tenant files reviewed (Tenants #1, #2 and #4). Service plans did not reflect the identified needs and preferences for assistance for three tenants including for falls, interventions related to falls, weight loss and decreased appetite.	A 089		

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A 089	Continued From page 6 (Recertification) 1. Tenant #1, a 70 year old, was admitted on 4-25-15 and diagnoses included: Parkinsonism and hypertension. According to incident reports, Tenant #1 had falls on 4-25-15, 5-16-15 and 6-4-15. The fall on 6-4-15 resulted in a scratch. The service plan dated 5-22-15 reflected Tenant #1 used a walker in the apartment and for short distances. Tenant #1 used a wheelchair for longer distances. Staff would provide stand by assistance when Tenant #1 used the walker to meals and activities when Tenant #1 felt weak. Tenant #1 would ask for staff assistance if needed to push Tenant #1 in the wheelchair to meals and activities or for longer distances. The service plan did not reflect Tenant #1 had falls or interventions related to the falls. The service plan did not reflect the identified needs of Tenant #1. 2. Tenant #2, an 84 year old, was admitted on 8-5-13 and diagnoses included: anxiety, coronary artery disease, memory lapse/memory loss, hypothyroidism, iron deficiency anemia, left-sided pleural effusion and muscle weakness (right). Tenant #2 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit. According to incident reports, Tenant #2 had falls on 4-19-15, 5-2-15 and 6-2-15. The fall on 6-2-15 resulted in knee pain. The service plan dated 6-1-15 reflected Tenant #2 used a walker or cane occasionally for longer distances. Staff was to remind Tenant #2 to use the walker or cane when Tenant #2 was noticeably unsteady on Tenant #2's feet. The service plan did not reflect Tenant	A 089		

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A 089	Continued From page 7 #2 had falls or interventions related to the falls. The service plan did not reflect the identified needs of Tenant #2. 3. Tenant #4 an 85 year old, was admitted on 12-3-08 and diagnoses included: abnormal gait, depression, transient ischemic attack and blepharitis right eye with legal blindness. Tenant #4 was staged at a six on the GDS, which indicated severe cognitive decline. Tenant #4 resided in the dementia unit. According to a Nurse Review document dated 4-21-15, Tenant #4 was seen by the doctor on 4-20-15 and the doctor was notified of Tenant #4's continued weight loss and poor appetite. According to a Program document, Tenant #4's weight (in pounds) was as follows: 147 (2-3-15), 143 (3-6-15), 141.5 (4-7-15) and 141 (5-30-15). The service plan dated 4-21-15 reflected Tenant #4 received a supplement, staff was to remind Tenant #4 for meals and staff was to encourage Tenant #4 to eat. The service plan did not reflect Tenant #4 had weight loss or a decreased appetite. The service plan did not reflect the identified needs of Tenant #4. 4. According to the Program's policy regarding service plans, the service plans would include: all services needed or requested by the tenant.	A 089		

Iowa Dept. Inspections and Appeals

ATTN: ROSE BOCCELLA

321 E. 12th Street

Des Moines, IA 50319

7/7/15 Plan of Correction

1. **Program policies and procedures – incident reports**

Prairie Hills at Ottumwa will correct this insufficiency promptly by educating staff at mandatory staff meeting on 7/10/15. Staff will be provided a copy of the policy on incident reporting, ensuring they understand Incident reports are to be filled out for abnormal behaviors as well as injuries IF they are staff member in charge at that time. When incident is reported Administration will review incident log/binder to ensure incident report is filled out for each occurrence.

2. **Service Plans - identifying needs and preferences for assistance**

Prairie Hills at Ottumwa will correct this insufficiency. RN will update Tenant #1, #2, and #4 service plan to reflect the history of falls and history of weight loss. RN educated in regards to having documentation on service plans from this date, 7/6/15, moving forward and will perform periodic chart checks/reviews as reminders, ensuring service plans are in compliance.

Tenant #1. The RN had noted under "mobility" his needs and preferences for assistance of using walker, and staff's assistance pushing in wheelchair for longer distances however she did not note on the service plan his history of falls. RN had only documented this statement on nurses reviews and physical assessments. RN updated service plan adding tenant is to push emergency pendant for assistance especially when feeling weak, and staff to call RN for direction when observing after a fall.

Tenant #2. The RN had noted under "mobility" her needs and preferences for assistance of using walker or cane and staff to provide reminders when noticeably unsteady however she did not note on service plan her history of falls. RN had only documented this statement on nurses reviews and physical assessments. RN updated service plan adding intervention and direction when staff observes resident after a fall to call RN for direction.

Tenant #4. The RN had noted under "dining" his needs and preferences for assistance of staff encouraging tenant to eat, providing meal reminders, and providing nutritional supplement as indicated on MAR, however she did not note on service plan his history of weight loss. RN had only documented this statement on nurses reviews and physical assessments. RN updated service plan.

Thank you,

Doug Techel, Executive Director

Prairie Hills at Ottumwa

173 E. Rochester Street

Ottumwa, IA 52501