Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 15433**

Pat Hanson, Administrator
Courtyard Estates Assisted Living
6132 NE 12th
Pleasant Hill IA 50327

Date of Monitoring Visit:

January 31, 2008

Monitor(s):

Hal L Chase, RN BSN MPH

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Courtyard Estates Assisted Living on January 31, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* **–** A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves 5 or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale (GDS):	5
Current number of tenants without cognitive disorder:	27
Total Population:	32

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Complaint History – There were no substantiated complaints during this certification period.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

- Complaint Allegation: It is alleged the program did not evaluate the following tenants with a change in condition: Tenant #1 had 4+ Edema and altered mental status changes, Tenant #2 had fallen and sustained skin tear on 12-28-07 and a large lump was noted on 12-30-08 on the right side under the last two ribs, Tenant #4 had a small lump on his/her head and when touched the tenant's eyes would roll back in his/her head and the tenant would be light headed.

- Monitoring Observation: Tenant #1, a 90 year old, was admitted on 1-31-06 and has diagnoses of: Bilateral total knee replacement, Cognitive Decline, Atrial Fibrillation, Hypertension (HTN), Aortic Valve Replacement and History of Coronary Artery Bypass Graft. A cognitive evaluation was completed on 1-2-08 staging the tenant at four on the Global Deterioration Scale (GDS), indicating moderate cognitive decline. Nurse's care notes of 12-12-07 through 12-27-07 indicated a change in condition related to needing assistance with Activities of Daily Living (ADLs), having three plus pitting edema bilaterally below the knees, finding the tenant on the floor when showering independently and noting mental status changes requiring the tenant to be sent to a local hospital emergency room for evaluation. The registered nurse (RN) completed a health assessment on 12-26-07 and left a message with the tenant's physician. The program did not complete functional and cognitive evaluations at the onset of a change in condition to determine if any modifications to needed services were needed.

  Tenant #2, a 90 year old, was admitted on 1-27-06 and has diagnoses of: HTN, Progressive Dementia, Urge Incontinence, Cardiomegaly, Arteriosclerotic Heart Disease and a History of Cerebral Vascular Accident (CVA) with Expressive Dysphasia. A cognitive evaluation was completed on 9-11-07 staging the tenant at four on the GDS, indicating moderate cognitive decline. Program records indicated the tenant had fallen on 12-28-07 and sustained a skin tear. The tenant's file indicated no other incidents of falls. The tenant's incident report of 12-28-07 indicated the tenant sustained a skin tear, but did not indicate a large lump on the right side of the tenant's chest. The RN stated she was not aware of any lump located by the tenant's ribs.

  Nurse's care notes of 11-29-07 indicated the tenant should be pushed/escorted by staff to all activities and meals and to encourage fluids. The program did not complete functional, cognitive and health evaluation with a change in condition to determine if modifications to needed services were needed.

  Tenant #4, a 64 year old, was admitted on 11-12-05 and has diagnoses of: CVA with Expressive Dysphasia, Insulin Dependent Diabetes Mellitus, Coronary Artery Disease with History of Myocardial Infarction, Atrial Fibrillation, Pacemaker, Cardiomegaly, Constipation, Multi-infarct Dementia Gastro Esophageal Reflux Disease (GERD), History of Seizure Disorder, Anemia, Depression, History of Cholecystectomy, Appendectomy, Bunionectomy, Cervical Fusion and Partial Hysterectomy. Nurse's care notes of 12-20-07 indicated the tenant had a lump "on part" of the tenant's head. The program contacted the tenant's physician noting a "large hematoma noted" on the

right posterior occipital and asked for any new orders. On 12-28-07 the tenant was seen by the tenant's physician and returned to the program. Nurse's care notes did not indicate any further incidents.

- Regulatory Insufficiency: The program did not complete functional, cognitive and health evaluations as needed, to determine tenants' continued eligibility for the program and to determine any modifications to needed services. (25.23 (2))

B. Criteria for exclusion of tenants - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

Complaint Allegation: It is alleged Tenant #1 was a two person assist, had altered mental status and was aggressive.

- Monitoring Observation: Tenant #1's nurse's care notes of 12-12-07 through 1-3-08 indicated the tenant did not exceed occupancy and transfer criteria. Staff #1, #2 and #3 did not identify this tenant as someone who required routine two-person assistance with standing, transfer or evacuation.

- Regulatory Insufficiency: None noted.

C. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #1's service plan of 10-24-07 indicated the tenant was independent with bathing and dressing. Nurse's care notes of 12-12-07 through 12-27-07 indicated a change in condition related to needing assistance with Activities of Daily Living (ADLs), having three plus pitting edema bilaterally below the knees, finding the tenant on the floor when showering independently and noting mental status changes requiring the tenant to be sent to the emergency room for evaluation. The tenant was hospitalized on 12-27-07, returning to the program on 1-2-08. The program updated the service plan on 1-4-08, but did not update the tenant's service plan to meet the needs of the tenant when a change in condition was identified on 12-12-07.

  Tenant #2's service plan of 9-11-07 indicated the tenant uses a walker, but is independent with mobility. Nurse's care notes of 11-29-07 indicated the tenant should be pushed/escorted by staff to all activities and meals and to encourage fluids. The program did not update the tenant's service plan to meet the needs of the tenant when a change in condition was identified on 11-29-07.

  Tenant #3's service plan of 12-21-07 was not updated to include services from an outside provider. Nurse's care notes of 12-24-07 indicated the tenant would be receiving physical therapy, occupational therapy related to increased weakness, gait training and difficulty with swallowing. The program did not update the tenant's service plan to meet the needs of the tenant when a change in condition was identified on 12-24-07.

- Regulatory Insufficiency: The program did not consistently update tenants' service plans, when tenants' need personal care or health-related care as needed. (25.28 (3))

- Regulatory Insufficiency: The program did not individualize the service plan and indicate the service provider(s) if other than the program. (25.28(4)d)

D. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

Complaint Allegation: It is alleged staff are administering medications to tenants but are not watching the tenants take the medications resulting in tenants not taking their medications.

- Monitoring Observation: Tenant #5, an 87 year old, was admitted on 11-30-05 and has diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Atrial Fibrillation, Posterior Vitreous Detachment (PVD), CAD, Angina, Osteopenia, Vertigo and Pacemaker. The tenant stated staff will occasionally leave medications for him/her to take.

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Medication and treatment documentation indicated medications and treatments were not charted as given or documented as refused. The RN stated staff were to document tenant refusal on the back side of the Medication Administration Record (MAR). A review of the MAR, treatment record and nurse's notes indicated staff did not document why medications or treatments were not given.

Tenant #3	Senna S 2 tabs twice daily	1-31-08 – Recorded as refused with no explanation.
Tenant #3	Metoclopromide 5mg	1-10-08 – Not given or recorded
Tenant #3	Polyethylene Glycol	1-2-08, 1-10-08, 1-22-08, 1-23-08, 1-29-08 – 1-30-08 – Either not recorded as given or refused with no explanation.
Tenant #3	Orothostatic Blood Pressures and Pulse Daily	1-8-08 – Not recorded as completed.
Tenant #3	Weight Daily	1-8-08, 1-10-08, 1-30-08 – Not recorded as completed.
Tenant #7	Weight every Saturday	1-12-08, 1-19-08, 1-26-08 – Not recorded as completed.

- Regulatory Insufficiency: The program did not consistently follow an acceptable medication protocol (25.29(2)a) ((IAC 655-Chapter 6).

E. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation: It is alleged Tenant #3 sustained an injury and called for assistance; however, the call system malfunctioned and the tenant laid on the floor for two hours before being found.

- Monitoring Observation: Tenant #3, a 91 year old, was admitted on 10-24-07 and has diagnoses of: Congestive Heart Failure (CHF), Orthostatic Hypotension, GERD, Disease with Dysphasia, Deconditioning, Weight Loss and Hearing Loss. Nurse's care notes of 12-16-07 at 3:30 p.m. indicated the tenant had fallen two hours earlier and sustained a head laceration and possibly other injuries. Nurse's care notes of the same entry indicated the tenant's pendant "(code alert) did not go off." Nurse's care notes of 12-16-07 indicated the tenant was admitted to the hospital with five broken ribs, a punctured lung and a head laceration. An incident report of 12-16-07 indicated the tenant "hit" the pendant around 1:30 p.m. with no response of staff. Program records indicated the events history report of the "Quick Response" system of 12-16-07 beginning at 12:09 p.m. through 3:50 p.m. did not record the tenant's pendant being activated. The RN stated the Quick Response system has been problematic, but the program has fixed the problems they were having with the system. The program did not provide tenant's with access to a 24-hour personal emergency response system.

Complaint Allegation: It is alleged night staff told tenants they would have to stay in soiled undergarments because staff couldn't lift tenants to change them.

- Monitoring Observation: Tenant #2 stated night staff helps him/her change his/her undergarments. Tenant #3 stated night staff offers toileting assistance if needed. Tenant #5 stated he/she has seen night staff help tenants with toileting and changing of undergarments. Staff #1 stated tenants have told her night staff will help them to the restroom. Staff #2 stated night staff changes and helps tenants at night. Staff #3 stated she will help tenants' at night to the toilet if needed.

Complaint Allegation: It is alleged night staff sleeps at night.

- Monitoring Observation: The RN stated she was not aware of night staff sleeping at night. Staff #1, #2 and #3 had no knowledge of night staff sleeping at night.

Complaint Allegation: It is alleged staff are not being trained in Cardio Pulmonary Resuscitation (CPR) Certified and the program did not have an Automatic Electronic Defibrillator (AED).

- Monitoring Observation: 321 Iowa Administrative Code (IAC) Chapter 25 does not have regulations requiring staff to be trained in CPR or for the program to have an AED.

Complaint Allegation: It is alleged the nurse who is on call during the weekends, will not come to the program when needed.

- Monitoring Observation: Tenant's #1, #2 and #3 stated the RN has been available when they needed her, even on weekends and holidays. Staff #1, a Licensed Practical Nurse (LPN), stated if a tenant sustains an injury staff are to call the RN, then 911 and family, if necessary. Within 24-hours the nurse will assess. Staff #1 stated she has been at the program at night and weekends when needed to assess tenants. Staff #2 stated she is not aware of the RN or on call nurse not coming to the program when asked by staff.

  Complaint Allegation: It is alleged the nurse did not assess a tenant within 24-hours of an injury.

  Monitoring Observation: IAC Chapter 25 does not have regulations requiring assisted living programs to assess a tenant within 24-hours of an injury.

- Regulatory Insufficiency: The program did not provide each tenant access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch. (25.33(3))

F. Life safety – The program shall follow written emergency policies and procedures and structural safety requirements. [321 IAC 25.37]

Complaint Allegation: It is alleged the program lost power and did not have a backup generator available to run oxygen equipment needed by tenants.

- Monitoring Observation: IAC Chapter 25 does not have regulations requiring assisted living programs to have backup generators available to tenants.

- Regulatory Insufficiency: None noted.

G. Structural requirements – The structure of the program shall be designed and operated to meet the needs of the tenants. The buildings and grounds shall be well-maintained, clean, safe and sanitary.

Complaint Allegation: It is alleged Tenant #3 sustained an injury and called for assistance; however, the call system malfunctioned and the tenant laid on the floor for two hours before being found.

- Monitoring Observation: Tenant #3, a 91 year old, was admitted on 10-24-07 and has diagnoses of: Congestive Heart Failure (CHF), Orthostatic Hypotension, GERD, Disease with Dysphasia, Deconditioning, Weight Loss and Hearing Loss. Nurse's care notes of 12-16-07 at 3:30 p.m. indicated the tenant had fallen two hours earlier and sustained a head laceration and possibly other injuries. Nurse's care notes of the same entry indicated the tenant's pendant "(code alert) did not go off." Nurse's care notes of 12-16-07 indicated the tenant was admitted to the hospital with five broken ribs, a punctured lung and a head laceration. An incident report of 12-16-07 indicated the tenant "hit" the pendant around 1:30 p.m. with no response of staff. Program records indicated the events history report of the "Quick Response" system of 12-16-07 beginning at 12:09 p.m. through 3:50 p.m. did not record the tenant's pendant being activated. The RN stated the Quick Response system has been problematic, but the program has fixed the problems they were having with the system. The program

did not provide tenant's with access to a 24-hour personal emergency response system.

- Regulatory Insufficiency: The program did not comply with Life Safety Code, 1994 edition, published by the National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02169-7471, or as required in administrative rules promulgated by the state fire marshal. (25.40(1)e), (231C.4)

Dated this 20th day of February, 2008.