IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Complaint: #26340-C

February 16, 2010

Angie O'Brien, Administrator
Courtyard Estates Assisted Living
6132 NE 12th Avenue
Pleasant Hill, IA 50327-8911

RE: Final Recertification and Complaint Investigation Report, Courtyard Estates Assisted Living, Pleasant Hill, IA

Dear Ms. O'Brien :

Enclosed is the **Final Recertification and Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C (2010) and Iowa Administrative Code, chapters 481—69, pertaining to assisted living programs and 481—67, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. **No Regulatory Insufficiencies were identified.**

The review of the recertification documents you submitted has been completed and are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **#S0220** with effective dates of **November 10, 2009** through **November 9, 2011.** This certificate must be posted in the building for public viewing.

If you have any questions regarding this Report, please contact me at 515-281-5003.

Sincerely,

Connie Schaffer

Connie Schaffer
Certification Coordinator – Central Iowa
Health Facilities Division
Adult Services Bureau

Enclosures

Iowa Department of Inspections and Appeals
Assisted Living Program Final Recertification Monitoring Evaluation & Complaint Investigation Report

Assisted Living Program: **Complaint Intake: #26340-C**

Angie O'Brien, Administrator
Courtyard Estates Assisted Living
6132 NE 12th Avenue
Pleasant Hill, IA 50327-8911

Date of Monitoring Visit:

January 14, 2010

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. IAC r. 481-67.10(5). 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 Recertification Monitoring Evaluation 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 481 IAC chapter 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 or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site monitoring evaluation was conducted at Courtyard Estates Assisted Living on January 14, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	25
Current number of tenants with cognitive disorder:	4
Total Population:	29

Dementia Specific Program (DSP)* – Not applicable.

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

Tenant/Family Satisfaction Results – A community meeting was held with 12 tenants. Tenants stated the program was clean, warm, inviting and they liked living at the program. Tenants stated staff were polite, courteous and trained to provide the services they needed. Tenants stated when they have called for assistance staff had responded within five minutes of being called. The nurse was available when needed and was direct but not impolite. Tenants stated they liked the food offered and temperatures were appropriate. They would like the plates to be warmer, the cold plates cool the hot food quickly. Tenants stated there were enough activities. Tenants felt safe and were receiving the services they needed. Tenants stated they were generally satisfied with the program and would recommend it to a friend.

Program History – There have been no substantiated Regulatory Insufficiencies during this recertification period.

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

A. Evaluation of Tenant

Complaint Investigation: It is alleged on 11-12-09 staff told the registered nurse (RN) Tenant #1 had a rash on his/her lower back and right leg. The RN indicated the tenant had a heat rash. On 11-13-09 it was reported the tenant's rash had spread, blisters were present and some of the blisters were open and draining. The RN was notified of the tenant's status, looked at the tenant's rash but did not take any action. On 11-15-09 the tenant was complaining of back pain and the RN notified the tenant's physician and on 11-17-09 the tenant was seen by his/her physician and was diagnosed with Shingles. It is alleged the RN did not take quicker action to care for the tenant despite the spread of the rash over the tenant's lower body. It is alleged the RN was negligent for not calling the tenant's physician sooner about the tenant's health status.

- Monitoring Observation: Tenant #1, a 99 year old, was admitted to the program on 10-31-2006. Diagnoses included Hypertension (HTN), Osteoarthritis, Constipation, Diverticulitis, Stress Incontinence, Restless Leg Syndrome (RLS), Mitral Stenosis, Peripheral Neuropathy, Pseudo Gout, Degenerative Joint Disease (DJD), Depression and a History of a Cholecystectomy. Nurse's notes of 11-13-09 indicated staff notified the RN the evening of 11-11-09 of a rash on the tenant's back. On 11-12-09 the RN evaluated the tenant's ability to transfer and ambulate with the assist of one staff and noted a change in the tenant's skin color of the tenant's left lower back and three blisters that had opened. The tenant denied pain to his/her back. The physician was contacted and an order was obtained to cleanse the right lower back, pat dry and apply a triple antibiotic ointment and cover with gauze without tape twice daily until healed. Functional, cognitive and health evaluations were completed on 11-13-09 and the service plan was updated to reflect treatment of the tenant's rash. Nurse's notes of 11-17-09 indicated staff told the RN on 11-16-09 the tenant's rash appeared to have spread to the lumbar back area. The RN called the tenant's daughter and requested the tenant be seen by his/her physician or physician assistant (PA). The tenant was seen on 11-17-09, diagnosed with Herpes Zoster to the right lumbar area without infection and an order was given to treat the tenant with Bacitracin and to apply a four by four gauze twice daily until healed, with a follow-up in three to four months. Medication Administration Record (MARs) indicated the tenant was treated for this rash beginning 11-13-09 until 11-23-09. Nurse's notes of 11-23-09 indicated the tenant had labored breathing, was sent to a local emergency room and later admitted for Anemia and infection – etiology unknown. Nurse's notes of 11-30-09 indicated the tenant was transferred to a skilled nursing facility for therapy. The tenant has not returned to the program.

Complaint Investigation: It is alleged staff helped Tenant #2 remove one of his/her socks and a sore was present on one of the tenant's toes. Staff had checked the tenant's toe four hours later and the top of the tenant's foot was red and the redness was spreading. Staff notified the RN and it is alleged the RN told staff the tenant was independent with medication administration and the program did not have to do anything for the tenant. It is alleged the program told staff to contact the tenant's family. The tenant was later hospitalized for an infection and was treated with antibiotics.

- Monitoring Observation: Tenant #2, a 95 year old, was admitted on 1-24-09. Diagnoses included Osteoporosis, Arthritis, History of Poor Balance and Falls, Atrial

Fibrillation, Hypothyroidism, HTN, Pacemaker, Overactive Bladder and History of Constipation. Nurse's notes of 8-17-09 indicated the RN was notified by staff the tenant's left toe was purple with puss present. Family was notified and the tenant was taken the same day by family to a local emergency room. The tenant was admitted to the hospital with an admitting diagnosis of Cellulitis of the toe. Nurse's notes of 9-23-09 indicated the tenant would be returning to the program on 9-24-09. Functional, cognitive and health evaluations were completed on 9-23-09. A physician's order of 9-24-09 indicated the tenant's left toe was to be cleansed with water and soap, pat dry and apply Betadine and cover with a bandaid twice daily until healed. The tenant's service plan was updated on 9-23-09 to reflect treatment of the tenant's left toe. Nurse's notes of 10-1-09 indicated the tenant's left toe was healing without complication with "very slight pink erythema surrounding well formed scab." MAR's beginning 9-24-09 through 10-16-09 indicated the tenant received treatment for his/her toe until it was discontinued as the toe had healed. Nurse's notes of 10-27-09 indicated the RN was notified on 10-24-09 the tenant's left toe was red and warm. The tenant's physician was contacted and an order was written for antibiotic therapy. Nurse's notes of 10-30-09 indicated the tenant needed moderate assist of two staff for transfers and was transferred to a local skilled nursing facility. The tenant returned to the program on 11-5-09. Functional, cognitive and health evaluations were completed on 11-4-09, prior to the tenant's return to the program and the tenant's service plan was updated on 11-5-09 when the tenant returned to the program. Nurse's notes of 11-12-09 indicated the tenant was seen by his/her podiatrist and was referred to a specialist and possible surgery consult. Nurse's notes of 11-13-09 indicated the tenant's left toe was warm, purple with a scab with a small pocket of fluid. Nurse's notes of the same entry indicated the RN was waiting for results from the tenant's specialist. Nurse's notes of 11-17-09 indicated the tenant's left toe had a scab and was slightly purple and warm. Nurse's notes of 12-4-09 indicated the tenant's left toe was scaling without signs or symptoms of infection and would continue to monitor. Nurse's notes of 12-16-09 indicated the tenant had fallen on 12-11-09 and sustained a small laceration to the left eyebrow and would continue to monitor the tenant frequently. No further falls occurred. Nurse's notes of 12-22-09 indicated the RN was notified by staff the tenant's right ankle and toe was swollen and purple early a.m. on 12-21-09. The tenant's daughter was notified and the tenant was taken to his/her physician. The tenant returned from the physician's office with no new orders with the tenant's foot noted as stable.

- Regulatory Insufficiency: None noted.

B. Other

Complaint Investigation: It is alleged staff fear retaliation from the RN if they filed a complaint with the Department. It is alleged there were tenants who feared retaliation from the RN.

- Monitoring Observation: The Administrator and Staff #2 were interviewed and each stated they did not feel intimidated or threatened with retaliation from the RN. The Administrator stated staff had not complained of retaliation from the RN. The Administrator stated tenants had not told her they were fearful of the nurse, feared retaliation from her or were not receiving cares from her. Staff #2 stated she was recently hired in November, 09 and had heard there had been retaliation and turmoil

with staff and the RN but she never witnessed any of it. Staff #2 stated she had never received any complaints from tenants concerning the RN. Tenants never complained of their cares not being met or the nurse was not responsive to their needs. Staff #3 stated she was not threatened with retaliation from the RN. Staff #3 stated she had told a tenant about the death of a person at her church and the rumor there had been blood coming out of the person's mouth and there had been blood on the floor. The RN stated she should be fired because the tenant could have nightmares," but the Administrator had saved her job. Staff #3 stated tenants did not tell her they had been mistreated by the RN.

A community meeting was held with 12 tenants in attendance. Tenants stated staff were polite, courteous and were trained to provide the services needed. Tenants stated the nurse was available when needed. Tenant's stated the nurse was direct but she wasn't impolite and never thought she was rude or inappropriate. Tenant #3 and #4 were interviewed privately and each stated the nurse was responsive to their needs, professional, approachable and never felt she didn't have time to see them.

- Regulatory Insufficiency: None noted.

Dated this 16th day of February, 2009.