IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Complaint Intake #: 30152-C
30794-C
31057-I

January 6, 2011

Ms. Melissa Sherod, Interim Administrator
Courtyard Estates at Cedar Pointe
6132 NE 12th Avenue
Pleasant Hill, IA 50327

RE: Final Incident & Complaint Investigation Report, Courtyard Estates at Cedar Pointe, Pleasant Hill, Iowa

Dear Ms. Sherod:

Enclosed is the **Final Incident & Complaint 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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Incident & Complaint Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Ms. Melissa Sherod, Interim Administrator
Courtyard Estates at Cedar Pointe
6132 N.E. 12th Ave.
Pleasant Hill, IA 50327

Incident Intake #: 31057-I
Complaint Intake #: 30152-C
30794-C

Date of Investigation:

October 26 & 27, 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 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 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:

A complaint investigation on-site visit was conducted at Courtyard Estates at Cedar Pointe on October 26 & 27, 2010. 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 but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS):	12
Current number of tenants without cognitive disorder:	11
Total Population:	23

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

Tenant/Family Satisfaction Results –

Program History – The program received no regulatory insufficiencies during this certification period.

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

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

A. Criteria for Exclusion of Tenants

Complaint Allegation #30152-C: It is alleged a tenant who has had difficulty with his/her knees, has had several falls in the last month and three out of four days is a two person assist.

Complaint Allegation #30794-C: It is alleged a tenant has fallen without injury, but is too high a level of care.

- Monitoring Observation: Six tenant files were reviewed. Tenant #5, a 95 year old was admitted on 1-24-09 and had diagnoses of: Osteoporosis, Arthritis, History of poor balance and falls, Atrial Fibrillation, Hypothyroidism, Hypertension (HTN), History of Pacemaker Placement, History of Overactive Bladder and a History of Constipation. Nurse's notes of 8-30-10, revealed the tenant had been weaker over the past week, was unable to do as much for himself/herself, had decreased mobility and at times required two staff to assist with transfers. Notes of the same entry revealed the tenant was able to transfer with a maximum assist of one staff with the use of a gait belt on day and evening shifts and assistance of two staff was becoming more frequent, especially on the night shift when the tenant needed to use the toilet. Incident reports of 7-14-10 through 10-5-10 revealed one incident of 8-22-10 where the tenant, with the assistance of staff, was unable to stand, sat at the end of the bed and slid to the floor. No injury was reported.

  The tenant's physician was notified on 8-30-10 of the tenant's health status and an order was given for physical therapy and a hospital bed to assist in transfers. The program completed functional, cognitive and health evaluations on 8-30-10 and updated the tenant's service plan to reflect the tenant's need for assistance with transfers, the use of a gait belt and a hospital bed. Nurse's notes of 9-16-10 revealed physical therapy reported the tenant was stronger and the tenant was able to move with light assist of one. The tenant reported "feeling stronger" and continued to work with physical therapy.

  Nurse's notes of 9-30-10 revealed the tenant received physical therapy weekly and was gauging his/her progress by how long he/she could stand using a walker. The tenant was an assist of one and used a wheelchair for transport and mobility. Nurse's notes of 10-12-10 revealed the tenant's physician admitted the tenant to the hospital for a possible clot in the hand. The program was notified by the hospital the tenant had a surgical procedure to excise a thrombus. The tenant was stable and would be hospitalized for a couple of days. The tenant returned to the program on 10-14-10. Functional, cognitive and health evaluations were completed on 10-14-10, the service plan was updated on 10-15-10 and revealed the tenant received wound care, the assist of one with transfers, was independent with ambulation with a seated wheeled walker and was to take frequent rest breaks when ambulating. The tenant continued to receive physical therapy to improve strength, gait and transfers.

  Staff #1 stated the tenant had two falls in the last month, had a wound on the left leg and used a gait belt with a one person transfer most of the time. Staff #2 stated staff was worried because the tenant didn't want to do anything. The tenant received physical therapy and had improved and stated one staff was needed assistance with transfer and ambulation, but the tenant had improved. Staff #3 stated the tenant

complained of knee pain, had a history of falls, received physical therapy, but some staff thought the tenant needed two staff with transfers. Transferring the tenant had improved, but the tenant had Arthritis and had good and bad days. A monitor observed staff transfer the tenant from a chair to his/her wheelchair safely on two separate occasions, observed the tenant ambulate a short distance independently and used a wheelchair to get from his/her apartment to the dining room.

Tenant #6, an 87 year old, was admitted on 7-26-10 and had diagnoses of: HTN, Chronic Obstructive Pulmonary Disease (COPD), Osteoporosis, History of Gallstones and History of Cancer of the Left Kidney. Nurse's notes of 7-30-10 revealed an annual assessment was completed. A service plan of 7-27-10 revealed the tenant needed assistance with activities of daily living (ADLs), but was not dependent for ADLs and was independent with ambulation and transfer. Nurse's notes of 9-15-10 revealed the tenant had slid out of a chair due to chronic left knee pain. Nurse's notes of 9-28-10 through 10-4-10 revealed the tenant complained of left ankle pain, was found on the floor sitting by the bed and reported he/she had slid off the bed. On 10-14-10 the registered nurse (RN) spoke to the tenant about needing more assistance with transfer and was now an assist of one for all transfers. Functional, cognitive and health evaluations were completed on 10-14-10 and the service plan was updated on the same date included staff assistance of one with all transfers. Staff #1 stated the tenant needed staff assist of one with transfers because of pain of the left ankle. The tenant has pain medications administered as needed. Staff #2 stated the tenant had a change in ambulatory status and now needed the assist of one staff for all transfers because of pain in the left leg and ankle. No other care needs exceeded level of care. Staff #3 stated the tenant needed the assist of one staff with transfers and had good days and bad days.

- Regulatory Insufficiency: None noted.

B. Tenant Documents

Complaint Allegation #30152-C & 30794-C: It is alleged the program's RN was shredding papers.

- Monitoring Observation: In a prepared written statement, the program indicated the program complied with regulations requiring the program to retain tenant's medical records for five years and employee files for seven years. No documentation was shredded unless the documents were duplicates.

  The investigation conducted by the department was not impeded by the lack of program documentation, including information related to tenant documentation. All documentation requested by the monitor was provided.

  Staff #1 stated she hadn't seen anyone shred documentation that shouldn't be shredded. Staff did shred old copies of tenant's service plans. Staff #2 stated she hadn't seen documents shredded that shouldn't have been shredded. She didn't know what had been shredded but stated tenant documents had been available when needed. Staff #3 stated she had seen anyone shred documents but staff will shred envelopes and copies of old service plans when a new service plan is made.

- Regulatory Insufficiency: None noted.

C. Service Plan

Complaint Allegation #30152 # & 30794-C: It is alleged a staff person was pushing a tenant while using a wheeled walker, had fallen backwards and hit his/her head. After the fall the tenant was able to walk, but the tenant was sent to the hospital and returned later that day. The next day the tenant had another fall. The tenant's pendent went off and instead of answering it staff did a narcotic count first. This was the second fall for the tenant in the last 24-hours. The tenant had been on hospice for two years due to COPD and other respiratory issues. The tenant went to a hospice house and died three days later.

- Monitoring Observation: Six tenant files were reviewed. Tenant #2's nurse's notes of 7-28-10 revealed the tenant passed away. The tenant, a 90 year old, was admitted on 11-30-05 and had diagnoses of: COPD, Congestive Heart Failure (CHF), Hypothyroidism, Rheumatoid Arthritis, Hyperlipidemia and History of Pacemaker Placement. The tenant had previously been admitted to hospice. Date of initial hospice admission was unknown. Nurse's notes of 6-11-10 revealed a 90-day nurse review was completed and indicated no change in functional, cognitive and health status. Notes of 6-14-10 revealed the tenant completed the last dose of antibiotic therapy for an upper respiratory infection and reported no shortness of breath. The tenant continued to have a chronic cough due to the tenant's COPD but this was considered normal.

  Nurse's notes of 7-12-10 revealed the tenant needed increased assistance with ADLs and had increased confusion. Nurse's notes of 7-15-10 revealed a nurse review was completed. Functional, cognitive and health evaluations were completed on 7-15-10 and the tenant's service plan was updated on the same day and reflected coordinated care between hospice and the program, increased need for ADLs, staff assistance to and from the dining room for meals and was independent with a wheeled walker in his/her apartment. An incident report of 7-24-10 revealed the tenant wanted to see the garden in the courtyard. On the way down the sidewalk the walker hit a bump and the wheeled walker started to tip backwards. Staff tried to pull it back but staff was unsuccessful in stopping it from tipping. The tenant hit the concrete and sustained a "goose egg" on the back of the head, the tenant's right arm was bleeding and there was a small skin tear on the right leg. Additional staff assisted with the injury, 911 was called; the RN and the tenant's family were notified. The tenant was transported to a hospital emergency room for care.

  Nurse's notes of 7-24-10 revealed hospital staff called and advised the program RN the tenant would be returning to the program. Hospital staff gave report and discharge instructions to monitor for nausea and vomiting, changes in vision, numbness or tingling to the head, and return the tenant to the emergency room if signs and symptoms worsened. Notes of the same date, but separate entry revealed the RN notified staff the tenant was returning to the program and to call when the tenant returned. Notes indicated the RN received a call from staff the tenant had returned. The RN instructed staff to monitor vital signs every hour for four hours and again at 7:00 a.m. The RN instructed staff to monitor for increased severe pain, blurred vision, nausea and vomiting, and increased confusion, anxiety and, difficulty waking

the tenant, unresponsiveness or lethargy to notify the RN or call 91 and call the hospice RN and inform him/her of the incident. Nurse's notes of 7-25-10 revealed staff called the RN at 1:35 a.m. and asked if the tenant could have Tylenol for pain. Staff reported the tenant complained of increased discomfort to the back of the head, rib cage area and back. The RN instructed staff to give ice packs as ordered previously. Nurse's notes of 7-25-10 revealed at 6:35 a.m. staff called the RN and reported the tenant was in severe pain all over, especially the rib cage area. The RN instructed staff to notify family the tenant would be returning to the hospital emergency room. Staff reported the tenant was unable to get out of bed due to pain but the tenant needed to use the restroom but staff reported the tenant cried out in pain. The RN instructed staff to see if the tenant would use the bed side commode and to call back. Staff called the RN at 7:00 a.m. and told the RN the tenant was in too much pain to use the commode. Staff reported when attempting to call family the tenant had fallen out of bed. Nurse's notes of the same date but separate entry revealed the RN received a phone call at 7:30 a.m. the tenant was transported by ambulance to the hospital emergency room. Nurse's notes of the same date but separate entry revealed the tenant was admitted to the hospital. Nurse's notes of 7-26-10 revealed hospital staff reported the tenant was admitted to a hospice house, because the tenant's pain was not under control. Nurse's notes of 7-28-10 revealed the program was notified the tenant had passed away.

The interim Administrator stated records of pendant calls could not be recalled after 30 days and when the tenant had been removed from the system. The tenant had been discharged from the program on 7-28-10. Staff #1 stated the tenant had previously used his/her pendant and staff responded quickly and within the first five minutes. The tenant was independent with ambulation until the accident and after the fall the tenant needed assistance with ambulation. Staff #2 stated the tenant did not have a history of falls and was on vacation when the tenant fell and was gone when she returned. Staff #3 stated the tenant received coordinated care between hospice and the program. After the fall of 7-24-10 the tenant needed assistance with ambulation and the tenant could use his/her pendant. Staff responded within five minutes when paged and the tenant's needs were met. Staff #4 stated in a phone interview the tenant did not have a history of falls prior to the tenant's hospital emergency visit of 7-24-10. The tenant wore his/her pendant but did not use it as the tenant thought he/she was able to get up by himself/herself. Staff would answer the tenant's pendant calls quickly and were told to stop what they were doing if not with another tenant.

- Regulatory Insufficiency: None noted.

D. Nurse Review

Complaint Allegation 30152-C & 30794-C: It is alleged two tenants had urinary issues that weren't taken care of for 36 hours. Notes for first shift staff are not always passed on and no one told the nurse. A tenant was catheterized because the urinary tract infections (UTIs) were so bad. Another tenant was sent to the hospital for severe vaginal bleeding with clots due to a severe urinary tract infection that went untreated. Staff had been told to monitor for blood in the urine as the tenant had hemorrhoids

- Monitoring Observation: Six tenant files were reviewed. Tenant #3, an 80 year old, was admitted on 12-2-05 and had diagnoses of: History of Cerebral Vascular

Accident (CVA) with residual weakness of the left side, Atrial Fibrillation, Gastro Esophageal Reflux Disease, Hiatial Hernia, History of Cataract Surgery and a History of Urinary Tract Infections (UTIs). Nurse's notes of 5-27-09 revealed the tenant complained of burning with urination. The tenant's physician was notified and the tenant went to an Urologist on 6-1-10 and returned with a permanent Foley catheter.

Physician order of 6-2-09 revealed the tenant had a permanent in-dwelling urinary catheter placed along with instructions for care. Nurse's notes of 7-19-10 revealed the tenant requested the removal of the indwelling catheter due to continuous UTIs. A physician's order of 7-19-10 revealed an order to remove the indwelling catheter and to notify the physician with any updates. The program's RN completed a nurse review on 7-20-10, determined a change in condition existed and updated evaluations and service plan on 7-20-10 to reflect the tenant's current status. Nurse's notes of 8-3-10 revealed the tenant complained of left hip pain and staff reported foul smelling urine and increased confusion. Nurse's notes of 8-4-10 revealed the tenant's physician was concerned about the possible UTI and retention and possible re-catheterization. Nurse's notes of the same date but separate entry revealed the tenant was re-catheterized due to urinary retention.

The tenant's current service plan was updated on 8-6-10 and revealed the tenant was provided daily catheter care every shift and to change the leg bag as often as the tenant requested. Staff was to notify the program RN and the home health RN when the tenant complained of burning, change in urine color or characteristic of urine. The home health RN would provide catheter maintenance/changing per physician's order and the program RN and home health RN would consult with each other and the tenant's physician as needed to provide continuity of care to the tenant.

Nurse's notes of 8-18-10 through 10-13-10 revealed the tenant had at least four incidents of burning with urination and treatment with antibiotics, with the program RN completing at least six nurse reviews related to the tenant's urinary status and treatment.

Tenant #4, a 93 year old, was admitted on 1-27-06 and had diagnoses of: HTN, Dementia, Urge Incontinence, History of UTIs, History of Hemorrhoids, Cardiomegaly, History of CVA and Expressive Aphasia. The tenant was staged at four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. A service plan of 4-7-10 revealed the tenant had a long history of UTIs and Hemorrhoids. Staff were to encourage the tenant to drink fluids, to assist the tenant with toileting, to give reminders to wipe gently after voiding and to notify the RN if the tenant had blood on his/her incontinent undergarments or when the tenant voided.

Nurse's notes of 8-3-10 through 8-6-10 revealed staff reported the tenant's urine was dark in color, was foul smelling, voiding more frequently with little content and denied burning or pain with urination. Staff had reported the tenant showed increased confusion and requested a physician's order for a urinalysis. Notes of 8-10-10 revealed the RN completed a nurse review related to a hospital emergency room visit of 8-7-10, returning the same day for a possible UTI and was prescribed an antibiotic. Nurse's notes of the 8-12-10, written as a late entry, clarified a report made by staff on 8-7-10, that the tenant had bright red blood in the toilet when urinating and had

passed "clots." The RN instructed staff to call the tenant's daughter and to have the tenant taken to the hospital emergency room.

Notes of 8-24-10 revealed a nurse review was completed and reported the tenant had completed a full dose of antibiotic therapy and had fully recovered from the UTI diagnosed on 8-7-10. Nurse's notes of 10-4-10 revealed the RN was notified on 10-3-10 the tenant was found on the floor in living room of the apartment. The tenant had complained of having pain of the right arm. Emergency medical services transported the tenant to a hospital emergency room and the tenant was later admitted. Nurse's not 10-7-10 revealed the tenant's physician reported hospice care would be appropriate as the tenant organs were starting to shut down. The tenant has not returned to the program.

Staff #1 stated oral report is given to staff and didn't work all of the time. She stated she provided catheter care for Tenant #3 and staff was trained to provide catheter care. She stated she advised the RN when Tenant #4 was confused or not feeling well. Staff #2 stated a communications book was used for staff and it worked okay. She stated Tenant #3 had a catheter but she didn't do catheter care as she wasn't trained. She stated Tenant #4 received cranberry juice because of a history of UTIs and reported no other issues. Staff #3 stated she gave oral report and it worked well. She stated she received instruction on catheter care for Tenant #3 and care instructions are on the medication administration record and staff who administered medication to tenants took care of the catheter. She stated there were RN interventions for staff to look for blood in the urine, color and odor of the urine and if the tenant was irritable or fatigued and to notify the RN if the tenant worsened. Program records revealed staff attended an in-service on communication on 10-14-10 and included objectives to ensure communication with tenants, family and staff for quality care and well being.

- Regulatory Insufficiency: None noted.

E. Staffing

Complaint Allegation #30152-C & 30794-C: It is alleged tenant pendant calls are not being answered in a proper amount of time due to lack of staff and management assistance. It takes up to 20 minutes to answer call lights.

- Monitoring Observation: A review of at least 150 pendant calls made from 10-17-10 through 10-26-10 revealed staff responded within 15 minutes of being called, with the exception of at least six pendant calls that exceeded, on average 18.50 minutes. A community meeting was held with 20 tenants. Tenants reported staff responded quickly, within ten to 15 minutes of being called. One tenant reported it took 20 minutes a couple of times for staff to respond. Staff #1 stated she believed pendant calls were answered within five minutes. Staff #2 stated she hadn't seen staff not respond to pendant calls and staff usually responded within three to four minutes of being called. Staff #3 stated she was not aware of any staff that ignored pendant calls. It is difficult to answer pendant calls when alone and getting to everyone. She stated response time to pendant calls were three to four minutes. Staff #1, Staff #2 and Staff #3 stated tenants have not complained for lack of help due not having sufficient staff available to meet their needs.

- Regulatory Insufficiency: None noted.

Complaint Allegation #30152-C: It is alleged tenants did not want program on-call RN anywhere near them and were refusing to have the program RN come in when there has been a problem.

- Monitoring Observation: A community meeting was held with 20 tenants. Tenants reported staff responded quickly, within ten to 15 minutes of being called. One tenant reported it took 20 minutes a couple of times for staff to respond when called. Tenants stated they needed a regular RN as they have lost too many RNs. Tenants stated the on-call RN was available when needed and didn't have any problem with her.

- Regulatory Insufficiency: None noted.

F. Structural requirements

Complaint Allegation #30794-C: It is alleged the cement sidewalk behind the building slopes off to one side and is not a safe area.

- Monitoring Observation: Photos were taken of the sidewalk outside the program's courtyard and were forwarded, along with the complaint, to the department's structural engineer for review. The program indicated the strategy for repairing the sidewalk included redirecting the flow of water and slowing down the flow of water. An environmental work order of 4-23-10 revealed the sidewalk tripping hazards were painted. A local concrete company was contacted for an estimate to inspect and find a solution to repair the sidewalks.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481 (69.35 (1))

G. Other

Incident Allegation31057-I & Complaint #30794-C: The program reported on 7-21-10 Tenant #1 had told staff on 7-20-10, he/she was missing $2,000.00 for his/her wallet. The tenant showed staff a carbon copy of the check used to withdraw $1000.00 from the tenant's bank. The program registered nurse (RN) called the tenant's bank and confirmed $1000.00 was withdrawn from the tenant's account.

- Monitoring Observation: Tenant #1, a 92 year old, was admitted on 1-31-06 and had diagnoses of: Hypertension, Chronic Obstructive Pulmonary Disease, Osteoporosis, History of Gall Stones and a History of Cancer of the Left Kidney. A service plan of 3-12-10 indicated the tenant needed assistance with activities of daily living (ADLs).

  The program's RN documented that on 7-20-10 Tenant #1 reported $2000.00 was missing from his/her wallet. Staff called the Administrator who instructed staff to help the tenant look for the missing money. The last time the tenant remembers having the money was Wednesday, 7-14-10 when the tenant went to the beauty shop. The tenant reportedly put the money in an envelope and put the envelope in his/her purse and then put the purse in a dresser drawer. The Administrator arrived and

spoke to the tenant, asking where the money was kept and helped look for a second time. The program RN confirmed the tenant had withdrawn $1000.00 from the bank. Both the Administrator and program RN could not be interviewed as they no longer worked at the program.

Staff #1 and Staff #2 were interviewed and each stated they helped the tenant look for the money but the $1000.00 wasn't found. Staff #2 stated the tenant showed her a carbon copy of the check the tenant wrote to the bank which indicated the check was written on 7-13-10 for $1000.00. A review of staff's schedule for 7-4-10 – 7-20-20 indicated at least 10 staff had access to the tenant's apartment.

Tenant #1 was interviewed and stated he/she didn't remember the specific dates of when he/she had written a check for $1000.00. The tenant remembered he/she had earlier thought $2000.00 was missing, but a review of carbon copy of the check and confirmation from the bank confirmed the amount was $1000.00. The tenant stated the money was placed in a wallet in the tenant's purse that had been placed in a dresser in the tenant's bedroom. The tenant went to get the money and the money was missing. The tenant hadn't opened the purse for a couple of weeks after he/she received the $1000.00. The tenant stated he/she hadn't seen staff come into his/her apartment without his/her consent, but stated the apartment door was not locked and anyone could have come into the apartment when he/she was gone.

The program notified the department within twenty-fours as required.

- Regulatory Insufficiency: None noted.

Dated this 6th day of December, 2011.