IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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**Complaint/Incident Intake #: 45769-IRV**
**46645-C**

March 11, 2014

Mr. Nick Lensch, Manager
Courtyard Estates at Cedar Pointe
6182 NE 12th Avenue
Pleasant Hill, IA 50327

**RE: Final Complaint/Incident Investigation Report – Courtyard Estates at Cedar Pointe, Pleasant Hill, IA**

Dear Mr. Lensch:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of March 3 and 4, 2014, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding 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

# IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
## Assisted Living Program
## Final Complaint/Incident Investigation Report

**Assisted Living Program:**

Nick Lensch, Manager
Courtyard Estates at Cedar Pointe
6182 NE 12th Avenue
Pleasant Hill, IA 50327

**Complaint/Incident Intake #:** 45769-I-RV
# 46645-C

**Date of Complaint/Incident Investigation:**

March 3 and 4, 2014

**Monitor(s):**

Lori Miner, RN BSN
Wendy Kuhse, RN BS

**Definitions:** ***The following definitions are relevant:***

**Assisted Living Program** – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

**Dementia-Specific Assisted Living Program** - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

**Regulatory Insufficiency** - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

**Overview**: ***In preparing this report, the following information was considered:***

**Current Program Census**

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

| **Dementia-Specific Program by Dedication** | |
|---|---|
| Number of tenants without cognitive disorder: | 3 |
| Number of tenants with cognitive disorder: | 16 |
| Total Population of Program at time of on-site | 19 |
| **TOTAL census of Assisted Living Program** | 19 |

**Program History** – The program did not receive any regulatory insufficiencies during the August 7, 2013 Recertification on-site. During the Complaint and Incident Investigation (45769-I, 45771-C) of November 4 and 5, 2013, the program received regulatory insufficiencies in the areas of structural and criteria for admission and retention.

**Complaint/Incident Investigation** – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

**A. Tenant Rights**

Complaint/Incident Allegation: It was alleged a tenant had a call light taken away and laid on the floor following a fall. (46645-C)

- Monitoring Observation: The program identified itself as a dedicated dementia program. Iowa Administrative Code 69.29(2) states in lieu of providing a call light system, program serving persons with dementia shall follow written staff procedures that address how the program will respond to tenants' emergency needs.

  Tenant #1, an 81 year-old, was admitted on 8-24-13 and had diagnoses of: Alzheimer's Type Dementia, Peripheral Neuropathy, Hypertension, Dermatitis, Alopecia, and Irritable Bowel Syndrome. Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitively decline.

  The service plan was reviewed for Tenant #1. Tenant #1 had a history of exit-seeking. The service plan indicated Tenant #1 had a call pendant but also had a plan to receive visual checks 32 times a shift, approximately every 15 minutes. A review of the nurse's notes from 11-1-13 through 2-11-14, the date of discharge from the program, did not indicate Tenant #1 had any falls.

  Tenant #2, a 90 year-old, was admitted on 1-31-13 and had diagnoses of: Hypothyroidism, Confusion and Memory Loss, Macular Degeneration, Incontinence,

Right Below the Knee Amputation, History of Urinary Tract Infection, and Depression. Tenant #2 also had a history of skin redness and breakdown in skin folds. Tenant #2 was staged at four on the GDS which indicated moderate cognitive decline.

Incident reports documented Tenant #2 was found by the bed lying on the right side at 5:15 a.m. on 11-15-13. Documentation indicated Tenant #2 did not think to page for assistance in getting up. Tenant #2 had a skin tear to the right leg stump. An incident report dated 11-27-13 at midnight indicated Tenant #2 paged for assistance. Tenant #2 was found on the floor next to the bed with a bump on the left cheek bone. On 12-19-13, Tenant #2 fell on the way out of the bathroom while using a walker. Tenant #2's fall was slowed by a staff member. No injury was observed. On 1-24-14 at 8:15 p.m. Tenant #2 was found on the bathroom floor with no injury. Documentation included a comment by Tenant #2 which indicated Tenant #2 had not been on the floor for a long period of time. Documentation indicated a family member had been notified of each incident.

The service plan for Tenant #2 indicated Tenant #2 had a call pendant. Tenant #2 had correctly demonstrated the use of the call pendant. The service plan also indicated Tenant #2 was on hourly checks.

Task sheets for November and December 2013 and January and February 2014 were reviewed. Documentation indicated Tenant #2 was checked hourly.

Tenant #3, a 73 year-old, was admitted on 10-27-2013 and had diagnoses of: Parkinson's Disease, Anxiety, Insomnia, Hallucinations/delusions, Paranoia, and a History of Falls. On 10-02-2013, Tenant #3 was staged at three which indicated mild cognitive decline.

Documentation in the nurse's notes indicated Tenant #3 sustained approximately 13 falls during the time frame 10-27-2013 through 12-22-2013. Notes documented Tenant #3 incurred some skin tears but no major injuries during the falls. During that time, Tenant #3's physician was notified and orders were received for numerous medication changes, orders for Physical Therapy (PT) and Occupational Therapy (OT), which included implementation of assistive devices, and a hospice evaluation.

On 12-2-13, Tenant #3 agreed to a managed risk agreement which was put into place due to multiple, frequent falls and Tenant #3 continued to desire to stay independent with ambulation in the apartment.

Ongoing documentation in the program nurse's notes indicated Tenant #3 remained independent in ambulation but sustained approximately 3 falls during the time frame 12-22-2013 through 03-03-14.

According to the service plan dated 12-02-13 Tenant #3 was able to use the emergency pendant for assistance, and staff provided reminders on the use of the emergency pendant. Notes of 12-28-13 documented a staff member found Tenant #3's call pendant in the dining room and went to return the pendant to Tenant #3. Upon returning the pendant, Tenant #3 was found on the floor. There was no other documentation in the nurse's notes to suggest Tenant #3 did not have a call pendant.

In addition staff provided 16 visual checks per shift for Tenant #3. Task sheets for November and December 2013 and January and February 2014 were reviewed. Documentation indicated Tenant #3 was checked according to the service plan schedule.

Tenant #4, an 81 year-old, was admitted on 5-04-14 and had diagnoses of: Dementia, Hypothyroidism, Abdominal Pain, Constipation, Urinary Frequency, and Urinary Tract Infections. On 01-09-14 Tenant #4 was staged at five on the GDS which indicated moderately severe cognitive decline.

The service plan dated 02-28-14 indicated Tenant #4 was able to demonstrate appropriate use of the emergency call pendant. In addition staff provided visual checks eight times a shift. Task sheets for November and December 2013 and January and February 2014 were reviewed. Documentation indicated Tenant #4 was checked according to the service plan schedule. There was no documentation Tenant #4 sustained any falls.

Tenant #5, an 88 year-old, was admitted on 5-4-13 and had diagnoses of: Dementia, Hypothyroidism, Arthritis, Depression, Anxiety, Headaches, and History of Respiratory Infection. Tenant #5 was staged at five on the GDS which indicated moderately severe cognitive decline.

Nurse's notes were reviewed. On 11-7-13, the notes documented Tenant #5 had a change of condition and was independent with ambulation without any assistive device. Nurse's notes documented falls on 11-18 and 11-25-13. One of the falls was observed. There was no documentation Tenant #5 was left on the floor following the falls. Nurse's notes dated 2-19-14 documented Tenant #5 was found on the floor when staff was checking on Tenant #5. Tenant #5 sustained a laceration to the head and was transferred to the emergency room for evaluation. Sutures were used on the laceration. Tenant #5 returned to the program.

The service plan dated 12-23-13 documented Tenant #5 had a call pendant but in addition staff provided visual checks 16 times a shift. Task sheets for November and December 2013 and January and February 2014 were reviewed. Documentation indicated Tenant #5 was checked according to the service plan schedule.

The program identified itself as dementia-specific by dedication. The program provided call pendants and had a system in place in lieu of a call pendant for the monitoring of tenants' emergency needs. The program provided documentation the monitoring system was followed as ordered to meet tenants' individual needs. Tenant #5 was identified as needing more care due to a laceration obtained during a fall. There were no injuries identified as related to a tenant left unattended on the floor.

- Regulatory Insufficiency: None noted.

**B. Staffing**

Complaint/Incident Allegation: It was alleged staff members did not use proper technique to transfer a tenant. (46645-C)

- Monitoring Observation: Staff #1 and #2 were observed with Tenants #2 and #4 assisting with toileting cares. Tenant #2 was observed with a gait belt and walker. Tenant #2 required minimal assistance from Staff #2 to transfer off the toilet. Staff #1 used the gait belt and transfer techniques appropriately.

  Tenant #4 required assistance to the bathroom. Monitors observed Staff #1 guide Tenant #4 appropriately.

  Interviews were conducted with Staff #1 and #2. No tenants were identified as routinely requiring maximal assistance with transfers.

  Staff #1 stated Tenant #2 was sick earlier and required more assistance when getting up. Staff #1 reported Tenant #2 was no longer sick. Tenant #2 required assistance with clothing when toileting.

  Staff #2 reported Tenant #2 had some skin breakdown on the stump of the leg and had trouble getting used to a new artificial leg. Tenant #2 required more transfer assistance during that time period. The skin on the stump has now healed and Tenant #2 is walking with the use of the artificial leg. Tenant #2 required assistance with clothing when toileting.

  Staff #1 reported Tenant #4 disliked sitting on the toilet, and did not know how to use the bathroom independently.

  Tenants # 3 and #5 were identified as being independent with ambulation and transfer.

  Training records for Staff #1, #2, and #3 were reviewed. Staff #1, #2, and #3 all had documented nurse-delegated training on transferring a tenant and the use of gait belts.

  Staff members were observed assisting tenants appropriately. The program had documentation of staff training on transfers and gait belts.

- Regulatory Insufficiency: None noted.

**C. Criteria for Admission and Retention**

Complaint/Incident Allegation: During the onsite monitoring investigation of November 4 and 5, 2013, Tenant #1 was identified as exceeding criteria to be retained in assisted living because of an elopement and exit-seeking behavior. The program submitted a request for reconsideration which the department accepted. Tenant #1 was allowed to stay at the program. (45769-I-RV)

- Monitoring Observation: Tenant #1, an 81 year-old, was admitted on 8-24-13 and had diagnoses of: Alzheimer's Type Dementia, Peripheral Neuropathy, Hypertension, Dermatitis, Alopecia, and Irritable Bowel Syndrome. Tenant #1 was staged at five on

the Global Deterioration Scale (GDS) which indicated moderately severe cognitively decline.

The program submitted a request for reconsideration to the Department dated 12-2-13 which indicated Tenant #2 did not exceed criteria for retention in the program. The Department accepted the request.

Nurse's notes for the month of December 2013 did not contain documentation of any exit-seeking behavior exhibited by Tenant #1. At the end of December 2013, Tenant #1 began to experience increased anxiety, and exit-seeking behaviors resumed in January of 2014. The physician was consulted and medications were changed. On 2-3-14 a nurse review and evaluations were completed. The physician had indicated there were no further options and Tenant #1 would benefit from a higher level of care. Tenant #1 was voluntarily discharged from the program on 2-11-14.

Clinical records were reviewed for Tenants #2, #3, #4, and #5. None of the records indicated any tenant exceeded criteria for retention in an assisted living program.

- Regulatory Insufficiency: None noted.

**D. Service Plans**

Complaint/Incident Allegation: It was alleged a tenant did not receive incontinence care as needed resulting in skin breakdown. It was alleged a tenant was not ambulated as directed. It was alleged a tenant had body odor.(46645-C)

- Monitoring Observation: The service plan for Tenant #2 was reviewed. The service plan dated 2-4-14 documented Tenant #2 required assistance with bathing and dressing and required the assistance of one person for ambulation. The service plan indicated Tenant #2 was alert enough to tell staff when he/she was feeling up to walking. Tenant #2 walked short distances in the apartment. The service plan also indicated Tenant #2 was incontinent at times and used incontinence products. Staff members assisted with toileting and perineal care. The service plan identified Tenant #2 had a history of urinary infections and symptoms of infection were listed on the service plan. Staff members were to report when Tenant #2 exhibited signs of infection.

  The service plan also indicated Tenant #2 had a history of Depression, was on an antidepressant and listed interventions for staff to use if Tenant #2 was depressed or tearful.

  Staff #1 stated Tenant #2 was sick earlier and required more assistance when getting up. Staff #1 reported Tenant #2 was no longer sick. Tenant #2 required assistance with clothing when toileting.

  Staff #2 reported Tenant #2 had some skin breakdown on the stump of the leg and had trouble getting used to a new artificial leg. Tenant #2 required more transfer assistance during that time period. The skin on the stump has now healed and Tenant

#2 is walking with the use of the artificial leg. Tenant #2 required assistance with clothing when toileting.

Tenant #2 was observed during the toileting process. Tenant #2 was observed to have a dry incontinence product. Tenant #2 had no body odor and there was no foul urine odor noted. Tenant #2 was observed. There was no skin breakdown on the buttocks.

Tenant #2 did most of the transferring from the toilet to the walker. Task sheets for December 2013 and January and February 2014 were reviewed. Documentation indicated Tenant #2 was toileted four times a shift. Task sheets indicated Tenant #2 was ambulated in the apartment with a walker, gait belt, and one-person assist three times daily. The task sheets also documented Tenant #2's refusal to ambulate on four occasions.

The service plan dated 12-2-13 was reviewed for Tenant #3. The service plan indicated Tenant #3 required stand-by assistance with bathing, assistance with dressing. Tenant #3 was identified as independent with toileting, but required stand-by assistance when ambulating outside the apartment. Task sheets were reviewed and cares were provided as indicated in the service plan. The service plan did not identify a history of urinary infection and did not indicate a predisposition to skin breakdown.

The service plan dated 1-9-14 was reviewed for Tenant #4. The service plan indicated Tenant #4 required prompting for bathing, hygiene, and dressing. Tenant #4 required assistance with toileting and was independent with ambulation. Task sheets were reviewed and cares were provided as indicated in the service plan. The service plan identified a history of urinary infections

Nurse's notes dated 12-27-13 documented Tenant #4 had skin irritation in the buttocks area. The physician was notified and skin cream was ordered. Evaluations were completed due to the change in skin condition. Notes of 1-6-14 documented Tenant #4 had diarrhea. A medication was ordered for the diarrhea, but the buttocks skin was red and irritated due to the diarrhea. A nurse review dated 1-14-14 documented the diarrhea had stopped but treatment to the buttocks skin continues for redness to the area. Documentation of 1-23-14 documented the buttocks area was healing well.

Tenant #4 was observed during the toileting process. Tenant #4 was observed to have a dry incontinence product. Tenant #4 had no body odor and there was no foul urine odor noted. Monitors observed Staff #1 guide Tenant #4 appropriately to the toilet. Tenant #4 got mad during the toileting process. The monitors were unable to observe skin on the buttocks, but did not observe any skin redness in the front area underneath the incontinence product.

Staff #1 reported Tenant #4 dislikes sitting on the toilet, and does not know how to use the bathroom independently. Staff #1 reported Tenant #4 had a bout of diarrhea a couple months prior which resulted in problems with the skin, but the skin has now healed.

Staff #2 reported Tenant #4 does not like to go to the bathroom, but will go with assistance. Tenant #4 will get mad when trying to toilet. Staff #2 reported Tenant #4 had diarrhea a couple months ago and had skin breakdown, but the skin is now healed

Staff #1 reported none of the tenants at the program had skin issues currently. The service plan dated 12-23-13 was reviewed for Tenant #5. The service plan indicated Tenant #5 required stand-by assistance with bathing, hygiene, and dressing. The service plan indicated Tenant #5 was independent with toileting. Nurse's notes were reviewed with no documentation of skin breakdown. . Task sheets were reviewed and cares were provided as indicated in the service plan.

Tenant #5 was observed sitting in the dining room. Tenant #5 was observed to be neat, clean, and without odor.

The monitors toured the assisted living program. There were no odors in the hallways. Tenants were observed sitting in the common area. As the monitors walked the common areas there were no tenants with body odor. Furniture was observed to be dry. There were no tenants who were observed to have incontinence products which were no longer working.

- Regulatory Insufficiency: None noted.