IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

October 6, 2008

Karen J. Mc Coy, Administrator
Jersey Ridge Place Assisted Living
5605 Jersey Ridge Rd
Davenport, IA 52807-3132

RE: I. Final Complaint Investigation Report
II. Hearings and Appeals
III. Civil Penalty
IV. Conclusion

Dear Ms. McCoy:

I. Final Complaint Investigation Report – Jersey Ridge Place Assisted Living, Davenport, IA

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2007) and Iowa Administrative Code, chapters 321—25, pertaining to assisted living programs and 321—26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. The Final Report notes the **Regulatory Insufficiencies,** as defined in the areas of: Evaluation of Tenant, Service Plan, Nurse Review and Other.

DIA is accepting the Plan of Correction (POC).

II. Hearings/Appeals

The Program may appeal the DIA decision in accordance to 321 IAC 26.4, within 30 days of notice, by submitting a request for appeal to the DIA. Hearings will be held pursuant to 481 IAC Chapter 10.

III. Civil Penalty

If no appeal is requested within 30 days of receipt of this Final Complaint Investigation Report the civil penalty obligation, in the amount of two thousand five hundred ($2,500.00) dollars, is required.

IV. Conclusion

Jersey Ridge Place Assisted Living's Plan of Correction is accepted. A civil penalty of $2,500.00 is assessed.

DIA may revisit the program to confirm compliance in fulfilling the POC's corrective measures. If the program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

If you have any questions in regard to these matters, please contact me at (515) 281-5077.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Complaint Intake #: 17461

Ms. Karen J. McCoy, Administrator
Jersey Ridge Place Assisted Living
5605 Jersey Ridge Rd
Davenport, IA 52807-3132

Date of Monitoring Visit:

August 13, 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 25.8(3)]. 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 an Initial Certification 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 this chapter 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 specialized care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

Recertification revisit and complaint investigations were conducted at Jersey Ridge Place Assisted Living on August 13, 2008. 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:	22
Current number of tenants with cognitive disorder:	6
Total Population:	28

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 holds itself out as providing specialized care in a dedicated setting:	5
Current number of tenants without cognitive disorder:	5
Total Population:	10

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

Program History – There were substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Criteria for Exclusion of Tenants, Service Plans, Nurse Review and Other.

The April 15, 2008 recertification monitoring evaluation resulted in a fine of $500.00.

On-Site Monitoring Evaluation – The monitor(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)]

During the course of the recertification, the program received a regulatory insufficiency related to not consistently evaluating Tenant #1, #2, #3 and #4's functional, cognitive and health status within 30-days and as needed to determine the tenant's continued eligibility for the program and to determine any modifications to services needed.

Monitoring Observation: Tenant #1 was discharged from the program on 5-2-08.

Tenant #2, an 87 year old, was admitted on 6-15-06 and had diagnoses of: Parkinson's Disease and Schizoaffective Disorder. Nurse's notes of 5-19-08 through 6-6-08 indicated behavior changes, a strong urine odor, increased confusion and changes in ambulation. The program requested an order from the tenant's physician, on 5-27-08, for a urinalysis and culture and sensitivity as they suspected the tenant had a urinary tract infection (UTI). The program did not complete functional, cognitive and health evaluations with a change in health status.

Tenant #3, an 85 year old, was admitted on 2-4-02 and had diagnoses of: Diabetes Mellitus Type II, Coronary Artery Disease (CAD), Coronary Artery Bypass Graft (CABG), Neuropathy, Gastroesophageal Reflux Disease (GERD), Phlebitis, Arthritis and Left Hip Surgery and Chronic Obstructive Pulmonary Disease (COPD). A service plan of 4-9-08 indicated the tenant was independent with medications. Nurse's notes of 6-11-08 indicated the tenant returned to the program from eye surgery. Functional and health evaluations were completed on 6-11-08 as the tenant needed staff assistance with medications. The program did not complete a cognitive evaluation with a change in health status.

Tenant #4, a 96 year old, was admitted on 3-4-08 and had diagnoses of: Hypertension (HTN) and Dementia. Nurse's notes of 4-14-08 indicated Physical Therapy (PT) was to start on 4-15-08. Nurse's notes of 5-23-08 indicated the tenant had increased confusion and a strong urine odor. The program did not complete functional, cognitive and health evaluations with a change in health status.

During the course of the complaint investigation, the following information was obtained.

Monitoring Observation: Tenant #6, an 86 year old, was admitted on 2-27-04 and has diagnoses of: Parkinson's Disease and Polycythemia Nervosa. Nurse's notes of 5-21-08 indicated the tenant had increased confusion and a strong urine odor. On 5-23-08 the tenant's physician ordered antibiotic therapy twice daily for five days. Nurse's notes of 6-9-08 indicated the tenant's urine was darker in color and the tenant had increased confusion and an inability to assist with cares. Nurse's notes of 7-7-08 indicated the tenant's physician had concerns related to reddened area on bilateral buttocks where skin was dry and peeling. The program did not complete functional, cognitive and health evaluations with a change in health status.

Nurse's notes dated 7-18-08 indicated the tenant was sent to the emergency room complaining of chest pain. The tenant returned the same day. Nurse's notes of 7-18-08

indicated the tenant returned to the program with a diagnosis of a bladder infection and was put on antibiotic therapy, one tablet every 24 hours for three days. The tenant also had the addition of an antihypertensive medication. The program completed functional and health evaluations but did not complete a cognitive evaluation with a change in health status.

- Regulatory Insufficiency: The program did not consistently evaluate each tenant's functional, cognitive and health status, as needed, to determine the tenant's continued eligibility for the program and to determine any modifications to services needed. (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]

During the course of the recertification, the program received a regulatory insufficiency related to not excluding Tenant #1 from the program, who required routine two-person assistance with standing, transfer or evacuation.

Complaint Allegation: It is alleged Tenant #1 is a routine two person transfer with ambulation, transfer and evacuation.

Monitoring Observation: Tenant #1 was discharged from the program on 5-2-08.

Complaint Allegation: It is alleged Tenant #5 is totally incontinent and resists cares and fractured his/her arm.

Monitoring Observation: Tenant #5, an 87 year old, was admitted on 6-15-06 and has diagnoses of: Macular Degeneration, Seborrheic Keratosis, Alzheimer's Disease, Skin Cancer, Atherosclerosis, Raynaud's Disease, Hyperlipidemia, Pseudolefolations Syndrome, Osteoarthritis, Osteoporosis, HTN, Bursitis-Shoulder, and Peripheral Vascular Disease (PVD). A cognitive evaluation was completed on 6-4-08 staging the tenant at a five on the Global Deterioration Scale (GDS), indicating moderately severe cognitive decline. The tenant was discharged from the program on 8-8-08.

Complaint Allegation: It is alleged Tenant #7 goes to the bathroom all over his/her room.

Monitoring Observation: Tenant #7, an 82 year old, was admitted on 11-14-05 and has diagnoses of: Dementia and HTN. A service plan of 5-15-08 indicated the tenant was incontinent of bowel and bladder and needed staff assistance with changing undergarments. Nurse's notes of 5-15-08 through 8-6-08 did not indicate episodic periods of urinating in inappropriate places. Staff #4 and #5 did not identify the tenant as someone who had unmanageable incontinence.

Complaint Allegation: It is alleged Tenant #8 uses a walker and doesn't walk well, has pulled his/her catheter out twice and is frequently constipated.

Monitoring Observation: Tenant #8, an 83 year old, was admitted on 2-9-08 and has diagnoses of: History of Hip Fracture, Coronary Atherosclerosis, HTN, Chronic Kidney Disease, Benign Prostate Hypertrophy, Anemia, Insomnia, Gastroesophageal Reflux

Disease (GERD), Iron Deficiency Anemia and Hyperlipidemia. The tenant received a 30-day written notice, on 8-8-08, to transfer from the program.

Complaint Allegation: It is alleged that all tenants, except Tenants #9, #10 and #11, are kept in the Dementia Unit for financial reasons, rather than being moved to a nursing home level of care.

Monitoring Observation: The RN, Staff #4 and Staff #5 did not identify any tenants who exceeded occupancy and transfer criteria.

Complaint Allegation: It is alleged Tenant #12 is a routine two person transfer as the tenant no longer walks.

Monitoring Observation: Tenant #12, a 93 year old, was admitted on 10-20-02 and had diagnoses of: HTN and Osteoporosis. The tenant passed away on 5-6-08.

- 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 recertification, the program received regulatory insufficiencies related to: not consistently developing service plans based upon evaluations to meet specific service needs, individualizing service plans for tenants who are unable to plan their own activities, including planned and spontaneous activities, identifing service provider(s) other than the program and for not updating service plans, as needed, but not less than annually for Tenants #1, #2, #3 and #4.

Monitoring Observation: Tenant #1 was discharged from the program on 5-2-08.

Tenant #2's service plan was not updated to reflect changes in health status related to behavior changes, a strong urine odor, increased confusion and changes in ambulation as indicated in nurse's notes of 5-19-08 through 6-6-08.

Tenant #3's service plan was updated on 6-11-08 to include a change from the tenant being independent with medications to having the program administer medications; however, the service plan was not based upon a cognitive evaluation.

Tenant #4's service plan was updated on 4-7-08 and 5-19-08, but was not updated when a change in condition existed. Nurse's notes of 4-14-08 indicated PT was to start 4-15-08. Nurse's notes of 5-23-08 indicated the tenant had increased confusion and a strong urine odor. The program requested a urinalysis and culture and sensitivity.

Complaint Allegation: It is alleged Tenant #6 is incontinent, wears two Depends undergarments at a time and needs staff assistance with dressing and bathing.

Monitoring Observation: Tenant #6's service plan of 2-25-08, appropriately indicated staff were to assist with Activities of Daily Living (ADLs), including assistance with dressing, bathing and toileting, as the tenant was incontinent of bowel and bladder.

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

Monitoring Observation: Tenant #6's nurse's notes of 5-21-08 indicated the tenant exhibited increased confusion and a strong urine odor. On 5-23-08 the tenant's physician ordered antibiotic therapy twice daily for five days. Nurse's notes of 6-9-08 indicated the tenant's urine was darker in color and the tenant had increased confusion and an inability to assist with cares. Nurse's notes of 7-7-08 indicated the tenant's physician had concerns related to a reddened area on the tenant's bilateral buttocks where the skin was dry and peeling. The program did not update the service plan to include interventions related to the tenant's increased confusion, antibiotic therapy and treatment to the buttocks.

Nurse's notes of 7-18-08 indicated the tenant was sent to the emergency room complaining of chest pain. The tenant returned the same day. Nurse's notes of 7-18-08 indicated the tenant returned to the program with a diagnosis of a bladder infection and was put on antibiotic therapy, one tablet every 24 hours for three days and they also added an antihypertensive medication. The program updated the service plan on 7-18-08 but indicated there was no change in services. The program did not update the service plan to include interventions related to the bladder infection.

- Regulatory Insufficiency: The program did not consistently develop service plans based on evaluations conducted in accordance with 25.23(1) and 25.23(2) and designed to meet the specific needs of the individual tenant. (25.28(1)

- Regulatory Insufficiency: The program did not consistently individualize the service plan and indicate, at a minimum, the service provider(s) if other than the program. (25.28(4)(c))

- Regulatory Insufficiency: The program did not consistently update the service plan as needed, but not less than annually. (25.28(3))

D. Nurse Review - Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. [321 IAC 25.30]

During the course of the recertification, the program received a regulatory insufficiency related to not consistently assessing and documenting the health status of each tenant, making recommendations and referrals as appropriate and monitoring the progress of previous recommendations when there are changes in health status for Tenants #1 and #4.

Monitoring Observation: Tenant #1 was discharged from the program 5-2-08.

Tenant #4's nurse's notes of 4-14-08 through 5-23-08 indicated a change in health status as the tenant began PT on 4-15-08, experienced increased confusion and a strong urine odor and the program requested a urinalysis and culture and sensitivity, as it was suspected the tenant had a urinary tract infection. The program did not complete a nurse review to determine if evaluations were needed and if the service plan needed to be updated due to a change in health status.

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

Tenant #6's nurse's notes of 5-21-08 indicated the tenant had increased confusion and a strong urine odor. On 5-23-08 the tenant's physician ordered antibiotic therapy twice daily for five days. Nurse's notes of 6-9-08 indicated the tenant's urine was darker in color and the tenant had increased confusion and an inability to assist with cares. Nurse's notes of 7-7-08 indicated the tenant's physician had concerns related to a reddened area on bilateral buttocks where skin was dry and peeling. Nurse's notes of 7-18-08 indicated the tenant was sent to the emergency room complaining of chest pain. The tenant returned the same day with a diagnosis of a bladder infection and was put on antibiotic therapy, one tablet every 24 hours, for three days and had an addition of an antihypertensive medication. The program did not complete a nurse review to determine if evaluations were needed and if the service plan needed to be updated due to a change in health status.

Tenant #7's nurse's notes of 5-21-08 indicated the tenant received an order for a urinalysis and culture and sensitivity due to increased frequency of urination and increased confusion. The program did not complete a nurse review to determine if evaluations were needed and if the service plan needed to be updated due to a change in health status.

- Regulatory Insufficiency: The program did not consistently assess and document the health status of each tenant, make recommendations and referrals as appropriate and monitor the progress of previous recommendations when there are changes in health status (25.30(4))

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 there is only one staff working each shift on the Dementia unit.

Monitoring Observation: Review of June 2008 and August 2008 staff schedules indicated there was a minimum of two direct care staff available at the program twenty-fours a day. Staff #4 and Staff #5 stated there was sufficient trained staff to meet the needs of tenants in both the general population and dementia unit.

- Regulatory Insufficiency: None noted

F. Other – The provisions of this section address the program's noncompliance with other applicable statutory and administrative rule requirements.

During the course of the recertification, the program received a regulatory insufficiency related to not consistently assuring the buildings and grounds were well-maintained, clean, safe and sanitary.

Monitoring Observation: A monitor inspected the dementia unit kitchen and storage closets and did not find any chemicals or devices that would be dangerous to tenants.

- Regulatory Insufficiency: None noted

Monitoring Observation: The program's Plan Of Correction, submitted on 7-25-08 relating to the report of 4-15-08 indicated the program planned to make corrections in the following areas: Evaluation of Tenant, Service Plans and Nurse Review. These corrections were not fully implemented.

- Regulatory Insufficiency: The program did not fully implement the Plan of correction submitted. (26.2((6)a))

Dated this 6th day of October, 2008.