IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Certified

April 9, 2009

Complaint Intake: #21599-I

Mark Hudson, Administrator
Mill Pond Assisted Living
1201 SE Mill Pond Ct.
Ankeny, IA 50021-6534

RE: I. Final Incident Investigation Report– #21599-I
II. Civil Penalty
III. Hearings and Appeals
IV. Conclusion

Dear Mr. Hudson:

I. Final Incident Investigation Report– Mill Pond Assisted Living, Ankeny, IA.

Enclosed is the **Final Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2009) 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. DIA has reviewed the Plan of Correction (POC) and the Request for Reconsideration in response to the complaint investigation Report dated January 28 & February 4, 2009 Based on the information provided, DIA accepts the Request for Reconsideration as it relates to Criteria for Exclusion of Tenant. Request for Reconsideration is being denied for Evaluation of Tenant, Service Plans and Staffing.

Evaluation of Tenant: The need for evaluations is required as soon as the health professional is aware of a significant change in health, functional and cognitive status poses a threat to a tenant's health, safety and well-being.

Service Plans: The need for service plan is required as soon as the health professional is aware of a significant change in health, functional and cognitive status poses a threat to a tenant's health, safety and well-being

Staffing: The lack of RN nursing oversite following a doctor's call to determine the need for emergency room visit. Staff not continuing two hour checks and keeping the tenant safe.

The Final Report notes the **Regulatory Insufficiencies,** as defined in the areas of: Evaluation of Tenant, Service Plans and Staffing.

II. 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 ten thousand ($10,000 00) dollars, is required.

III. Hearings and 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 If the program appeals, the civil penalty will be suspended, pending appeal. If the program does not appeal, the fine is due within 30 days of notice.

IV. Conclusion

Mill Pond Assisted Living is being assessed a $10,000 00 civil money penalty

The Plan of Correction that was submitted is accepted. 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 Incident Investigation Report

Assisted Living Program: **Incident Intake #:21599-I**

Mark Hudson, Administrator
Mill Pond Assisted Living
1201 SE Mill Pond Ct.
Ankeny, IA 50021-6534

Date of Incident Investigation:

January 28 & February 4, 2009

Monitor(s):

Hal L. Chase, RN, BSN MPH
Vickie Clingan, RN, MA

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 an Incident 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:

An on-site visit was conducted at Mill Pond Assisted Living on January 28 and February 4, 2009 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 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	35
Total Population:	40

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

Accreditation Status – Not applicable.

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

Incident Investigation – The 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)]

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

- Monitoring Observation: Tenant #1, a 75 year old, was admitted on 12-2-08 and has diagnoses of: Emphysema, Corpulmonale, Chronic Obstructive Pulmonary Disease (COPD), Anxiety and Edema. Two separate incidents occurred, which indicated a significant change in health status. Service plans of 11-11-08 and 12-30-08 indicated the tenant was self medicating. On 12-17-08, the tenant's physician was notified that the tenant stated, he/she was taking the Lasix 80 mg every morning and "most days" at noon, but misses it at noon "some days" but not two days in a row

  Nurse's notes of 1-14-08, indicated the tenant was hallucinating; seeing a bird flying around and a snake in the apartment. The program notified the tenant's physician that the tenant stated he/she was "very unsteady" since starting the Levaquin, had never taken that strong of a dose. The tenant had called the receptionist telling her a bird had been flying around in his/her apartment and he/she could hear loud music, just one song playing over and over during the night for the past two nights of 1-12-09 and 1-13-09 The physician replied later that day for staff to tell the tenant the Levaquin dose was usual for pneumonia. The physician thought the tenant's problem was either hypoxia or hypercarbondioxide, to check the pulse ox and indicated the tenant may need to be seen in the emergency room. Staff registered nurse (RN) #3 stated she initiated two-hour checks due to the tenant's hallucinations with the intent the Program RN would see the tenant the following morning. The program did not complete functional, cognitive and health evaluations with changes in health and cognitive status to determine if any modifications to services were needed.

- Regulatory Insufficiency: The program did not 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. 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 initial service plan was completed on 11-11-08 and updated within 30-days on 12-30-08, however, both service plan updates were not updated when changes in health status actually occurred as evidenced by the following: Nurse's notes of 12-2-08 indicated the tenant had bilateral lower leg 4+ edema and .25cm open wounds on both legs. Nurse's notes of 12-3-08 indicated 4X4 gauze and Kling wrap to bilateral lower legs and also indicated the tenant was on continuous oxygen, four liters per nasal Cannula, but this treatment was never added to either service plan. Nurse's notes of 12-4-08 indicated Bacitracin was to be applied daily Wound care was not added to the service plan until 12-30-08

Nurse's notes of 1-14-08, indicated the tenant was hallucinating; seeing a bird flying around and a snake in the apartment. The program notified the tenant's physician that the tenant stated he/she was "very unsteady" since starting the Levaquin, had never taken that strong of a dose; the tenant had called the receptionist telling her a bird had been flying around in his/her apartment and he/she could hear loud music, just one song playing over and over during the night for the past two nights of 1-12-09 and 1-13-09 The physician replied, to advise the tenant the Levaquin dose was usual for pneumonia. The physician thought the tenant's problem was either hypoxia or hypercarbondioxide, to check the pulse ox and indicated the tenant may need to be seen in the emergency room. Staff RN #3 stated she initiated two-hour checks due to the tenant's hallucinations with the intent the Program RN would see the tenant the following morning. Nurses notes on 1-15-09 indicated Staff #4 called Staff RN #3 at 8 45 a.m. and stated Tenant #1 told her "get this man he's trying to kidnap the little girl under my bed." The tenant had a pair of pliers in his hand and had been throwing multiple items into his bathroom to "try to kill that man." The program did not update the service plan with a change in cognitive status. The program initiated two hour checks overnight but the program did not establish interventions for staff to implement if the tenant continued to hallucinate.

- Regulatory Insufficiency: The program did not update the service plan as needed to meet the needs of the tenant. (25.28(3))

- Regulatory Insufficiency: The program did not individualize the service plan to indicate the tenant's identified needs and the tenant's request for assistance and expected outcomes. (25.28 (4)(a))

C. 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]

Incident: The program reported at 8:51 a.m., the fire alarms sounded and smoke and water were identified in a tenant's apartment.

- Monitoring Observation: Tenant #1's nurse's notes of 1-14-09, indicated Tenant #1 was hallucinating; seeing a bird flying around and a snake in the apartment. The program notified the tenant's physician on 1-14-09 that the tenant stated he/she was "very unsteady" since starting the Levaquin, had never taken that strong of a dose; the tenant had called the receptionist telling her a bird had been flying around in his/her apartment and he/she could hear loud music, just one song playing over and over during the night for the past two nights of 1-12-09 and 1-13-09 The physician replied, to advise the tenant the Levaquin dose was usual for pneumonia. The physician thought the tenant's problem was either hypoxia or hypercarbondioxide, to check the pulse ox and indicated the tenant may need to be seen in the emergency room. Staff RN #3 stated she initiated two-hour checks due to the tenant's hallucinations with the intent the Program RN would see the tenant the following morning. The program initiated two hour checks overnight beginning at 4:00 p.m. on 1-14-09, with the last entry being 4:00a.m.on 1-15-09 Staff #1, who worked the night shift, stated two hour checks were completed until 4:00 a.m. and didn't continue because her shift ended at 6:00 a.m. Staff #1 stated she had checked on Tenant #1 at 4:00 a.m., noted the tenant was confused and showing signs of hallucinations. Staff

#1 stated she reported the tenant's status to Staff RN #2 at the adjacent health center and was told to report the tenant's status to the assisted living RNs when they arrived. Staff RN #2 stated she told Staff #1 to call her or to come to the health center if the tenant needed assistance. No other contact was made between Staff #1 and Staff RN #2.

Staff #4 stated she worked 6:00 a.m. to 2:00 p.m. the morning of 1-15-09 She stated she was running late for work, was assigned the hallway where Tenant #1 resided, but did not get verbal report and did not read the report book. Staff #4 stated she began to administer medications in her assigned hallway and noticed Tenant #1's door was propped open, entered and was asked to call the tenant's daughter She did so and handed the phone to the tenant. Before leaving she told the tenant she would be back to check on him/her because the tenant seemed confused. Staff #4 returned around 8:00 a.m. to 8:15 a.m. and found the tenant sitting in a scooter holding a pair of pliers. Tenant #1 stated, "He's in there. the girl is under the bed and the son of a bitch is in the bathroom."

The tenant stated he/she had thrown an extension plug and the pliers were going to be used to "kill him," referring to a man in the tenant's apartment. The tenant told Staff #4 to call the police "so they could handcuff me because I am dangerous." Staff #4 suggested the tenant watch television, turned on the television and left. Staff #4 assisted another tenant and went to the dining room to finish setting a table. She asked Staff #5 if Tenant #1's behavior was normal which Staff #5 indicated the tenant had been hallucinating the night before and staff were to complete two-hour checks. Staff #5 suggested Staff #4 to call Staff RN #3 According to nurse's notes Staff RN #3 directed Staff #4 "to make the R [resident] safe. make sure. .remains safe" and to check the tenant's pulse ox and she would handle things when she arrived. Staff #4 stated she finished setting up two tables in the dining room, went to get the pulse oximeter and heard the fire alarm. Staff #4 stated she knew she needed to assist another tenant and evacuate the hall she was assigned to. During this evacuation she heard over the radio there was smoke in Tenant #1's apartment, saw Tenant #1 being brought down a service hall by Emergency Medical Technicians (EMTs) and transferred to the emergency room.

The program's Maintenance Supervisor stated Tenant #1's comments immediately after the fire indicated the tenant started the fire. The tenant's family members also indicated the tenant started the fire. Nurse's notes of 1-15-09 indicated the tenant and other tenants were evacuated and Staff RN #3 indicated the tenant had not received any injuries. Tenant #1 denied feeling any burning of the chest, cough or shortness of breath. The tenant recalled having hallucinations last evening but did not know why he/she saw "those things last night." Tenant #1 stated, "The kidnapper was in my room. I had to kill him because it was either him or me." Nurse's notes of 1-15-09 indicated the tenant was admitted to a local hospital on 1-15-09 for possible pneumonia. Nurse's notes of 1-16-09 indicated the program received a report from the hospital the tenant had expired on 1-15-09

- Regulatory Insufficiency: The program did not have sufficient trained staff available at all times to fully meet tenants' identified needs. (25.33 (1))

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

- Monitoring Observation: Maintenance Supervisor stated the program was first aware of the fire when the alarm sounded at 8:51 a.m. on January 15, 2009 Smoke detection had been activated in the dwelling unit. The smoke detection in the dwelling units are stand alone and are not wired to any exterior notification equipment. Smoke detection in all common areas is tied to the fire panel. The fire alarm and smoke detection system does comply with NFPA 72. Program Administrator, Maintenance Worker, and Program RN were the first to respond to Unit 113 Once they entered Unit 113 they found the Tenant #1 sitting on a mobile scooter in the living room watching television. They immediately evacuated Tenant #1 to the Chapel and was given medical attention from the Program RN until the EMT's arrived. Program Administrator stated this took approximately five minutes after the alarm sounded. The Administrator stated the tenant in Unit 113 was the first person to be evacuated.

  The Fire Department reported receiving the alarm at 8:53 a.m. on January 15, 2009 and arrived on site at 8:59 a.m. on January 15, 2009 The fire was contained in the bedroom of Unit 113 Fire report states: "products that were involved in the fire were on the bed, floor and in front of the dresser " Fire report also states the occupant started the fire to remove the people inside the apartment. There were no other people inside of the apartment and staff stated Tenant #1 has been having hallucinations after a change of medications. The fire was located directly under a sprinkler head. One sprinkler head had been activated.

  After review of the programs evacuation plan it was found the plan meets the NFPA 101, Life Safety requirements. The life safety systems worked properly and the program demonstrated the proper evacuation process during this incident.

- Regulatory Insufficiency: None noted.

Dated this 9th day of April, 2009