IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

CERTIFIED

June 19, 2009

Complaint Intake #: 22836-C

Dean Phillips, Administrator
Prairie Hills Assisted Living at Independence
505 Enterprise Drive SW
Independence, IA 50644-9603

RE: I. Final Complaint Investigation Report - #22836-C
II. Civil Penalty
III. Hearings/Appeals
IV. Conclusion

Dear Mr. Phillips:

I. Final Complaint Investigation Report – Prairie Hills Assisted Living at Independence, Independence, 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 (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. The Final Report notes **Regulatory Insufficiencies** in the areas of: Service Plans and Other (not reporting a substantial fire or injury within 24 hours).

DIA is denying the Request for Reconsideration in regard to Other (not reporting a substantial fire or injury within 24 hours) as Iowa Administrative Code chapter 231C.12 indicates: "The department of inspections and appeals shall be notified within twenty-four hours, by the most expeditious means available, of any accident causing substantial injury or death, and any substantial fire or natural or other disaster occurring at or near an assisted living program."

DIA is accepting the program's Plan of Correction (POC).

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 one thousand ($1,000.00) dollars, is required.

III. 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. 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

Prairie Hills – Independence's Plan of Correction is accepted. A civil penalty of $1,000.00 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,

Rose Boswell for

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Complaint Intake #: 22836-C

Dean Phillips, Administrator
Prairie Hills Assisted Living at Independence
505 Enterprise Drive SW
Independence, IA 50644-9603

Date of Investigation:

May 4 & 5, 2009

Monitor(s):

Stephanie Cummins, 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 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 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:

A complaint investigation on-site visit was conducted at Prairie Hills at Independence on May 4 & 5, 2009. 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:	32
Current number of tenants with cognitive disorder:	1
Total Population of GPP:	33

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	13
Total Census of ALP:	46

***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 were substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Service Plans, Medications and Nurse Review.

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

A. 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: Five tenant files were reviewed.

Tenant #2, a 71 year old, was admitted on 1-3-07 and diagnoses include: Chronic Obstructive Pulmonary Disease (COPD), Alzheimer's Disease, Depression, Anxiety and Obsessive Compulsive Disorder (OCD). The tenant was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive impairment. The tenant resided in the dementia unit. The tenant's service plan was updated on 2-27-09 to reflect when the tenant began receiving Hospice services. The service plan was updated, as needed; however, the update did not reflect the type or frequency of services provided by Hospice. According to Staff #2, #3 and #4, the tenant received assistance with a.m. cares and breakfast on weekdays. Staff #2 and #4 stated the tenant had companion care on second shift. These services were not reflected on the tenant's service plan.

- Regulatory Insufficiency: The program did not consistently update service plans that were individualized and indicated at a minimum the tenant's identified needs and the tenant's requests for assistance and expected outcomes. (25.28(4)a)

B. 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 was alleged a tenant, who was court committed to the program, had a fall with an injury and appropriate protocol was not followed post fall.

Monitoring Observation: Five tenant files were reviewed. None of the five tenant files had documents in their files that indicated they were court committed to the program, according to the Wellness Director (RN) and Wellness Assistant (RN). The monitor reviewed the five files and did not find documentation to show any of the five tenants reviewed were court committed to the program.

According to interviews with Staff #2, #3 and #4, Tenant #1 had a fall with an injury. Tenant #1, a 79 year old, was admitted on 12-19-06 and diagnoses include: Senile Dementia with Delusions and Behavioral Disturbances. The tenant was staged at a four on the GDS, which indicated moderate cognitive impairment. The tenant resided in the dementia unit and moved out on 3-27-09. The tenant had a General Power of Attorney document in the file. According to the tenant's service plan, the tenant was independent with mobility, dining and dressing, transfers and toileting. The tenant received program assistance with medication administration and bathing.

According to an incident report dated 3-23-09 at 7:30 p.m., Tenant #1 tripped over a chair leg and fell hitting his/her head on a plant stand. The tenant complained of his/her right side being sore and had a small bump on the right side of his/her head. The tenant refused to let staff check anything besides his/her head or to take vitals and indicated he/she was okay. Staff #1 stated the night the tenant fell, she asked to check the tenant several times and he/she refused. The tenant limped with one step and then did not limp after that. Staff #1 stated the tenant did not complain of pain, did not have any changes with mobility and did not require additional services with cares that night. She wrote the incident report and left it in the box for the Wellness Director.

The tenant fell on 3-23-09 at 7:30 p.m. and nurse reviews were completed on 3-24-09, 3-25-09 and 3-27-09. According to the nurse review dated 3-24-09, the tenant fell last evening and refused to allow staff to evaluate, refused vitals, ambulated without difficulty and did not appear to have an injury. The Wellness Director attempted to evaluate the tenant on 3-24-09. The tenant stated "I am fine, everyone just needs to leave me alone." The Wellness Director asked to look at the tenant's hip and leg as the tenant did complain it was hurting a bit but the tenant did not allow it to be assessed. The tenant ambulated around the room without much difficulty. The Wellness Director stated on 3-24-09, the tenant walked without difficulty, was weight bearing on both legs and did not have facial grimacing. The Wellness Director did not observe any shortening of the legs, the tenant did not have a limp, did not complain of pain and sat without difficulty.

A nurse review completed on 3-25-09 indicated the tenant appeared to be more uncomfortable and had pain in the hip and leg but refused to allow the Wellness Director to assess. Staff #1 was able to get the tenant to stand on the leg and to ambulate in the room. The tenant was able to bear weight but the left leg did appear painful and the tenant did favor the leg. The tenant stated "I don't need anything from any of you-just go away now." The Wellness Director indicated she asked to look at the tenant's hip on 3-25-09 and the tenant did not allow it.

An e-mail was sent to the family from the Wellness Director on 3-25-09, which discussed the fall and the tenant's overall status. The Wellness Director stated she communicated with the tenant's family via e-mail per their preference. (IAC Chapter 25 for assisted living program does not have a regulation that pertains to the timeframe of notifying family or legal representatives.)

According to a program document, on 3-26-09, the Wellness Assistant called and left a message for the family regarding concerns with the tenant. Family returned a call to the program on 3-26-09 and indicated the tenant had an appointment to see the doctor on 3-27-09 and family planned to take the tenant. The tenant allowed the Wellness Assistant to take his/her heart rate and respirations, following this telephone call; however, adamantly refused blood pressure or any other assessment on 3-26-09.

Nurse review was completed again on 3-27-09. The tenant refused to go to the doctor's appointment with the family and the tenant was transferred by ambulance. According to the Wellness Assistant, initially, the tenant was diagnosed with a Urinary Tract Infection (UTI) and then a radiologist found the hip fracture. On 3-27-09 at 1930 the tenant was admitted for a UTI and hip fracture with surgery planned for Saturday morning.

The Wellness Director and Wellness Assistant indicated the tenant did not have any recent hallucinations, did not have increased confusion or signs or symptoms of a UTI prior to the fall.

The tenant moved out on 3-27-09.

- Regulatory Insufficiency: None noted.

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

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

Monitoring Observation: According to Staff #5, the Maintenance Supervisor, Tenant #3 rented a garage and had a workshop in the garage. The tenant was working in the garage on 3-19-09 and came into the program at approximately 3: 00 p.m. The garages are not connected to the building where the tenants reside. Around supper time a visitor was leaving the program and saw flames coming from the garage. The fire department was called. Staff #5 stated there were eight garages total and all had smoke damage. Four of the garages had structural damage to the roof. Staff #5 reported none of the tenants were in the garages at the time of the fire and there were no injuries. Tenant #3's belongings were damaged in the fire; however, no other tenants had belongings damaged. Staff #5 stated the official cause from the insurance companies was undetermined.

According to the fire department report, the type of situation was a garage fire with fire showing and the fire was put out. The report indicated one third of the building had flame damage, smoke damage was throughout and the estimated loss was $40,000. Tenant #3 used the unit for wood working and left around 3:00 p.m. after cutting out wheels on a drill press. The fire appeared to have started in the area where the drill press was located, according to the fire department report. Tenant #3 moved out on 3-31-09. The fire was not reported to DIA.

On 3-23-09 Tenant #1 fell, according to an incident report. The tenant refused to be assessed post fall and was transported by ambulance on 3-27-09 to the hospital. The tenant was admitted with a UTI and hip fracture. The tenant had surgery and went to a higher level of care, post hospitalization. The tenant moved out on 3-27-09. The program did not report the fall with substantial injury to the Department.

- Regulatory Insufficiency: The program did not consistently notify the department of inspections and appeals within twenty-four hours, by the most expeditious means available, of any accident causing substantial injury or death, and any substantial fire or natural or other disaster occurring at or near an assisted living program. (231C.12)

Dated this 19th day of June, 2009.