IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

July 13, 2009

DEMAND LETTER

CERTIFIED

Amy Pagel, Executive Director
Traditions of Iowa
609 Highway 150 N
West Union, IA 52175-1057

RE: I. Final Incident Investigation Report, Traditions of Iowa, West Union, IA
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Pagel:

I. Final Incident Investigation Report #22790-I, Traditions of Iowa, West Union, IA

Enclosed is the **Final Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with the Code of Iowa, Chapter 231C, Iowa Administrative Code, chapter 25, pertaining to assisted living programs and, chapter 26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. The report notes the Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Service Plan, and Other (notification within 24 hours). A copy of the Final Report is enclosed.

DIA is denying your request for reconsideration in regard to Other (notification within 24 hours). The program is required to report "substantial injuries" within 24 hours of occurring. The program cannot request reconsideration of a fine; however, the program may request an appeal after the final report is received.

DIA is accepting the Plan of Correction (POC) following the program's submission of additional information.

II. Civil Penalty

If, within thirty (30) days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 231C.14. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send written notice to the Certification Coordinator and remit the penalty assessed by check or money order in the amount of $500.00 within 30 business days after the receipt of this

demand letter to: Iowa Department of Inspections and Appeals, Lucas State Office Bldg., 3rd Floor, Chris Nothaft, Adult Services Bureau, 321 E. 12th St., Des Moines, IA 50319-0083.

III. Appeals/Hearings

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

Traditions of Iowa is being assessed a $500.00 civil money penalty. The Plan of Correction is accepted. The Request for Reconsideration has been denied per above. 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 regarding this certification, please contact me at 515-281-5077.

Sincerely,

Ann Martin

Ann Martin, RN, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #: 22790-I**

Amy Pagel, Executive Director
Traditions of Iowa
609 Highway 150 N
West Union, IA 52175-1057

Date of Incident Investigation:

June 10, 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 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 Traditions of Iowa on June 10, 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:	28
Current number of tenants with cognitive disorder:	2
Total Population of GPP:	30

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

Total Population of DSP:	11
Total Census of ALP:	41

***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 was a substantiated Regulatory Insufficiency in the past certification period in the area of Service Plans.

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 95 year old, was admitted on 12-3-08 and diagnoses include: Moderate Dementia - Alzheimer's Type, Hypertension (HTN), Rheumatoid Arthritis, Osteoporosis, Osteopenia, Severe Coronary Artery Disease (CAD) and Recurrent Transient Ischemic Attacks (TIA's). The tenant was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive impairment. The tenant resided in the dementia unit and was discharged on 3-31-09. According to Progress Notes dated 2-13-09 to 3-26-09, the tenant had increased combative behaviors, especially during cares, increased drowsiness, increased weakness and refusals of meals. Evaluations were not completed, as needed.

- Regulatory Insufficiency: The program did not consistently evaluate each tenant's functional, cognitive and health status, as 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 Progress Notes dated 2-13-09 to 3-26-09, indicated the tenant had increased combative behaviors, especially during cares, increased drowsiness, increased weakness, and refusals of meals. The nurse developed a new service plan tool and updated the tenant's service plan on 3-3-09 using the new tool. She felt this tool was better and less confusing than the previous tool and she had not obtained signatures. The service plan was not updated, as needed. The tenant's 30 day service plan was signed only by the nurse. The service plan was not signed by two staff and the tenant or the tenant's legal representative.

- Regulatory Insufficiency: The program did not consistently update each tenant's service plan within 30 days and as needed, by a multidisciplinary team that consists of no fewer than three individuals, including a health care professional and other staff appropriate to meet the needs of the tenant, in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. (25.28(3))

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 Allegation: It was reported Tenant #1 was found lying on the floor covered with his/her blankets from the bed when staff completed rounds at 2200. The tenant stated his/her right hip hurt. Staff called the Director of Nursing and they were instructed to call the ambulance. The tenant's family was notified. The tenant was evaluated and had a

hip fracture, had surgery and would be transferring to a nursing home or skilled care for rehabilitation.

Monitoring Observation: According to an Incident Call and Communication Log sheet, on 3-27-09 at 10:00 p.m., Tenant #1 was found lying on the floor covered with blankets. The report stated the tenant was checked at 9:00 p.m. and was awake in bed. Staff checked on the tenant at 10:00 p.m. and found the tenant on the floor. Vitals were taken, the nurse was called, 911 was called, per the nurses instruction, and the family was called. The tenant's service plan indicated one hour checks were completed every hour. According to the Memory Care Rounds document, checks were completed and documented every hour (until the tenant left for the hospital) on 3-27-09. According to a program policy, visual hourly checks were completed and documented on tenants with confusion at a four or greater on the GDS and in accordance with the service plans.

Staff #1 was working on 3-27-09 and found the tenant on the floor. Staff #1 stated the tenant used a walker prior to the incident and was compliant with using the walker most of the time. She was not aware of any falls prior to the incident. Staff #1 stated staff completed one hour checks and those checks were documented. She checked the tenant at 8:30 p.m., after a family member left, checked the tenant again at 9:00 p.m. and both times the tenant was awake and in bed. At 10:00 p.m. she checked the tenant and found the tenant on the floor, covered up. The tenant was awake and the staff noticed his/her leg was "out", she put a pillow behind the tenant's head and tried to get the tenant comfortable. The tenant complained of pain to the right leg. Staff #1 went to get Staff #2. Staff #1 took the tenant's vitals and Staff #2 called the nurse. The nurse told staff to call 911 and the family and Staff #2 did so. Staff #1 stayed with the tenant and the ambulance arrived 10-15 minutes after the tenant was found on the floor. The tenant left in the ambulance, was diagnosed with a hip fracture and did not return to the program.

The nurse stated she was called at home by staff and informed that Tenant #1 was found on the floor with blankets. Staff told the nurse the tenant complained of pain and they did not move the tenant. The nurse told staff to call 911 and the family. The nurse stated the ambulance arrived within five minutes and it was leaving when she arrived. The nurse met with staff after the incident and got the details of the incident. The tenant had a hip fracture, had surgery and transferred to a nursing home. The nurse felt staff handled the situation appropriately.

The Executive Director was notified of the incident on 3-28-09 and called DIA and left a message on 3-30-09. She received a call back on the day the web submission occurred and was told to report the incident. The incident was submitted via the web on 4-1-09. The Executive Director felt staff handled the situation appropriately.

- Regulatory Insufficiency: None noted.

D. 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 the Incident Call and Communication Log and Progress Notes, Tenant #1 was found lying on the floor on 3-27-09 at 10:00 p.m. The

tenant was taken by ambulance to the hospital and was diagnosed with a hip fracture. The tenant had surgery was transferred to a higher level of care and did not return to the program. The Executive Director was notified of the incident on 3-28-09 and called the Department on 3-30-09. She stated she left a message with the Department on 3-30-09 and received a call back on the day the web submission occurred and was told to report the incident. The incident was submitted via the web on 4-1-09. The substantial injury was not reported to the Department within 24 hours.

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

Dated this 13th day of July, 2009.