IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED

November 6, 2009

Complaint Intake: #24485-I
#24576-I
#25077-C
#25166-I
#25468-C

Christina Bricker, Housing Manager
Summit Pointe Senior Living Community
3505 English Glen Blvd
Marion, IA 52302-4711

RE: I. Final Complaint & Incident Investigation Report – #24485-I, #24576-I, #25077-C, #25166-I & #25468-C
II. Appeals/Hearings
III. Civil Penalty
IV. Conclusion

Dear Ms. Bricker:

I. Final Complaint & Incident Investigation Report

Enclosed is the **Final Complaint & Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C, 321 Iowa Administrative Code (IAC) chapter 25 (pertaining to assisted living programs), and 321 IAC chapter 26 (pertaining to monitoring, civil penalties, and complaints). The report notes Regulatory Insufficiencies in the areas of: Evaluation of Tenants, Service Plans, Nurse Review, Staffing, Record Checks and Other. Summit Pointe Senior Living Community ("Program") is being assessed a $500.00 civil penalty.

II. Appeals/Hearings

The Program may appeal the DIA decision in accordance with 321 IAC rule 26.4, within 30 days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to 481 Iowa Administrative Code chapter 10. If the Program appeals, the civil penalty will be suspended, pending the appeal process.

III. 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 three hundred twenty-five dollars ($325.00) within 30 business days after the receipt of this demand letter.

IV. Conclusion

The Program is being assessed a $500.00 civil penalty. The Plan of Correction (POC) submitted on November 2, 2009, following the on-site visit of September 22, 23 & 28, 2009, has been reviewed and 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 this letter and report, please contact your Certification Coordinator, Chris Nothaft, at 515-281-4116.

Sincerely,

Vicki A Chapin for

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Christina Bricker, Housing Manager
Summit Pointe Senior Living Community
3505 English Glen Blvd
Marion, IA 52302-4711

Complaint Intake #: 24485-I
24576-I
25077-C
25166-I
25468-C

Date of Investigation:

September 22, 23 & 28, 2009

Monitor(s):

Stephanie Cummins, MA
Joyce Kix, RN

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 & 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:

A complaint and incident investigation on-site visit was conducted at Summit Pointe Senior Living Community on September 22, 23 & 28, 2009. In preparing this report, the following information was considered:

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):	15
Current number of tenants without cognitive disorder:	99
Total Population:	114

***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 Tenant Documents, Medications, Structure and Other (not fully implementing the Plan of Correction).

The January 7, 2009 Complaint Investigation resulted in a civil penalty of $2,000.00 with Regulatory Insufficiencies in the areas of Tenant Documents, Medications, Structural Requirements and Other. The Program was issued a conditional Certificate, effective April 11, 2008. There were no other sanctions in place at the time of this visit.

The March 3, 2009 Complaint Investigation Revisit resulted in no Regulatory Insufficiencies. A Standard Certificate was issued effective March 10, 1009. All Program sanctions were discontinued.

The June 15 & 16, 2009 Incident Investigation resulted in no Regulatory Insufficiencies.

Complaint Investigation – The complaint 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.

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

Monitoring Observation: Tenant #2, 87 years old, was admitted on 1-9-09 and diagnoses include: Chronic Obstructive Pulmonary Disease (COPD), Irritable Bowel Syndrome (IBS) and Congestive Heart Failure (CHF). The tenant was staged at a five on the Global Deterioration Scale (GDS), which indicated a moderately severe cognitive decline. The tenant resided in the dementia unit. The tenant was found on the floor on 8-30-09 and was sent to the emergency room (ER). Service notes dated 9-1-09 indicated the tenant returned to the program and had a one inch laceration to the right side of the back of the head that was closed with six staples. According to the notes, the tenant moved from the general population to the dementia unit. Evaluations were not completed as needed.

Tenant #3, 70 years old, was admitted on 7-24-09 and diagnoses include: Osteoporosis, Compression Fracture, Atrial Fibrillation, Chronic Lower Back Pain, Dementia, Chronic Urinary Tract Infections (UTIs), Lewy Body Disease - Parkinson's Syndrome. The tenant had falls or was found on the floor eight times from 7-24-09 through 8-28-09. A 30 day evaluation was completed; however, it was completed by a licensed practical nurse (LPN), rather than the registered nurse (RN), when the tenant was not stable.

Tenant #4, 85 years old, was admitted on 8-15-08 and diagnoses include: Acute Renal Failure, Diabetes, Parathyroid Tumor, Memory Loss and Dementia. No GDS was completed as required. The tenant resided in the dementia unit. On 8-02-09, Tenant # 4 was diagnosed and treated for a UTI. The tenant was hospitalized for a UTI on 8-14-09. According to Service Notes, an assessment was prompted by the recent hospitalization and return to the program and the corresponding changes in health and functional status. The tenant was admitted to Hospice on 8-18-09 and new evaluations were completed; however, they were completed by the LPN, rather than the RN, and then co-signed by the RN.

- Regulatory Insufficiency: The program did not evaluate each tenant'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 needed services. The evaluation shall be conducted by a health care professional or a human service professional. (IAC r. 321-25.23(2)).

B. Service Plan – The Program shall develop and update an individualized service plan for each tenant as required.

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

Monitoring Observation: Tenant #1, 99 years old, was admitted on 4-16-09 and diagnoses include: Acute Cerebrovascular Accident (CVA) - Post Fall, Weakness, Hypertension (HTN) and Arthritis. The tenant was staged at a four on the GDS, which indicated moderate cognitive impairment. According to Services Notes, the tenant died on 9-6-09. According to Service Notes, the tenant was admitted to Hospice on 7-31-09 due to

increased memory loss, confusion and weakness. Evaluations completed on 8-1-09 indicated the tenant required stand by assistance (SBA) for mobility. The service plan was updated on 8-1-09 and indicated Hospice would be the primary care giving agency. The service plan did not address the frequency or type of services that Hospice would provide for the tenant.

Tenant #2 was found on the floor on 8-30-09 and was sent to the ER. Service notes dated 9-1-09 indicated the tenant returned to the program and had a one inch laceration to the right side of the back of head which was closed with six staples. According to the notes, the tenant moved from the general population to the dementia unit and a service plan was developed; however, evaluations were not completed. The service plan was not based on evaluations.

- Regulatory Insufficiency: The program did not develop a service plan for each tenant based on the evaluations conducted in accordance with 25.23(1) and 25.23(2), and designed to meet the specific service needs of the individual tenant. (IAC r. 321-25.28(1)).

- Regulatory Insufficiency: The program did not develop 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 and who the service providers are, if other than the program. (IAC r. 321-25.28(4) a,c).

C. Nurse Review - The Program shall provide 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.

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

Monitoring Observation: Tenant #3 had falls or was found on the floor eight times from 7-24-09 through 8-28-09. A nurse review was completed on 8-31-09; however, it was completed by the LPN, rather than the RN, and then co-signed by the RN.

Tenant #4, was hospitalized on 8-14-09 and had been diagnosed and treated for a UTI on 8-2-09. The tenant was admitted to Hospice on 8-18-09 and a Nurse Review was completed; however, it was completed by the LPN, rather than the RN, and then co-signed by the RN.

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- Regulatory Insufficiency: The program did not consistently provide a registered nurse to assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress on previous recommendations at least every 90-days or if there were changes in health status. (IAC r. 321-25.30(3)).

D. 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.

Incident Allegation #24576-I: It was reported Tenant #3 called for help and when staff responded they found the tenant on the floor. The tenant had blood coming from the

back of the head. Staff called the ambulance and the tenant was taken to the hospital and had staples placed in the back of the head. The tenant had previous falls without injury.

Monitoring Observation: According to an incident report dated 7-27-09, Tenant #3 was given medication at 8:00 p.m. and was checked again at 9:00 p.m. At 9:15 p.m. the tenant called for help, staff responded and found the tenant on the floor in front of the couch. Staff #2, had previously instructed the tenant to call when he/she was ready for bed and the tenant had not been ready when checked at 9:00 p.m. According to the incident report, 911 was called. The tenant returned to the program with eight staples in the back of the head.

Staff #2 was interviewed and stated the tenant's light was on and she went to the apartment and found the tenant laying in front of the couch on his/her back with a gash on the back of his/her head. Staff #2 stated the tenant had fallen several times the first week he/she was admitted and the tenant remembered and knew to call for assistance.

Evaluations were completed appropriately prior to admission and the service plan identified the tenant as a fall risk and stated the tenant had decreased balance and weakness. The tenant was instructed to call for ambulation assistance with toileting and cares. The service plan provided instructions for safe ambulation for the tenant.

- Regulatory Insufficiency: None noted.

Incident Allegation #25166-I: It was reported Tenant #1 had fallen and had a subdural bleed.

Monitoring Observation: According to an incident report dated 9-1-09 at 8:10 a.m., the RN had just entered the memory care area when Tenant #1, who was standing behind the dining room chair, fell straight over to the left. The tenant landed on the left side. The RN responded immediately and requested staff to call 911. The tenant had a moderate amount of blood from a laceration to the left side of the head. Immediately pressure was applied to the wound and ice was applied. Emergency Medical Services (EMS) arrived at approximately 8:20 a.m. No vitals were taken because staff was attempting to control the bleeding. A Hospice aide was present and notified the Hospice nurse who then called the family. EMS transported the tenant to the hospital.

The RN was interviewed and stated the tenant needed SBA with ambulation. The tenant had two previous incidents where he/she had slid out of bed. During waking hours, the tenant needed more supervision while the tenant's spouse was at a skilled nursing facility. The tenant ate meals and participated in activities in the memory care unit and returned to the general population apartment after the evening meal. This was agreed to in the service plan. The RN had just come into the memory care unit and saw the tenant starting to get up from the breakfast table. The tenant stood up, took two steps to the left and had a direct fall. She responded and gave instructions to staff to call 911, get the first aid kit and an ice pack. She stayed with the tenant and said the tenant had profuse bleeding from the head; however, did not lose consciousness. EMS arrived four to five minutes later and they were not able to get the bleeding under control. EMS put the tenant in a cervical collar and the tenant was transported to the hospital. The RN did not have issues with staff response to the situation.

According to Service Notes the tenant died on 9-6-09.

- Regulatory Insufficiency: None noted.

Complaint Allegation #25468-C: It was alleged staff did not toilet Tenant #9, who required toileting assistance.

Monitoring Observation: Tenant #9, 90 years old, was admitted on 7-3-09 and diagnoses include: Alzheimer's Disease, Hypothyroidism, Depression, Glaucoma, Gastroesophageal Reflux Disease (GERD), Osteoporsis and HTN. Staff #3 stated she had never refused to take a tenant to the toilet and she had never left a tenant in wet or soiled clothing. She stated Tenant #9 was taken to the toilet when asked. She indicated she may have told the tenant to wait a minute if her hands were full or if she was with another tenant.

- Regulatory Insufficiency: None noted.

Complaint Allegation #25468-C: It was alleged staff did not test the water temperature prior to giving a shower to Tenant #4 and the hot water burned the tenant. It was also alleged that staff were rough with the tenant during a shower.

Monitoring Observation: Staff #3 stated when giving a shower or bath she turns on the water and after letting it run for several minutes she checks it to see if it is too hot and then she turns it to a cooler temperature if needed. She stated she then has the tenant test the water and if it is too hot she turns it to a cooler temperature and has the tenant check it again. She stated she had not been rough or aggressive with any tenants during a shower or after. A monitor checked the water temperature and it was 110 degrees. According to family, Tenant #4 did not sustain an injury related to the incident; however, the tenant requested the staff member not give the tenant another shower.

- Regulatory Insufficiency: None noted.

Complaint Allegation #25077-C & #25468-C: It was alleged it takes over 20 minutes for staff to answer call lights between the hours of 10:00 p.m. and 8:00 a.m. It was also alleged the call light board was buzzing and a staff walked into the dining room three times without looking at the board and did not telephone any rooms that needed assistance. Another staff then came into the room and went to the board to find out who needed help.

Monitoring Observation: Tenant #10 stated about one month ago the tenant called for assistance because he/she felt sick, shaky and perspiring. The tenant is diabetic and waited approximately 20 minutes for assistance. The tenant stated this occurred in the early morning hours. Tenants #11, #12, #13 & #14 indicated staff responded within 3 to 15 minutes but none of them had called for assistance in the overnight hours or early morning hours. Staff #2 and Staff #5 stated there were not enough staff to meet tenant needs and Staff #4 stated there were not enough staff after 7:00 p.m. on Friday, Saturday and Sunday to meet tenant needs.

According to minutes from an Informal Communication Meeting on 8-24-09, the direct care staff brought concerns to the Housing Manager regarding lack of staff to meet

tenant's needs. The Housing Manager stated they added a full time float position in August and she had a follow up meeting the RN regarding issues raised at the meeting.

Staff #3 stated she had never disregarded call lights. Staff #4 stated one time when she worked upstairs call lights were going off and Staff #3 did not call to tell her the lights were going off.

Tenants #10, #12 and #13 indicated their apartments had not been cleaned weekly but had been cleaned bi-weekly. According to a program record, one of the two housekeepers had been out on a medical emergency for the past 10 days. The program contacted four temporary agencies and they refused to provide services at the program. Staff were in communication with tenants on a daily basis and were approximately one week behind.

Complaint Allegation 25468-C: It was alleged a staff took Tenant #8's plate of food away after the tenant ate only three to four bites and did not give the tenant dessert.

Monitoring Observation: Tenant #8, 81 years old, was admitted on 5-29-08 and diagnoses include: Alzheimer's Disease, HTN, Hypothyroidism and CHF. The tenant was staged at a six on the GDS, which indicated severe cognitive impairment. The tenant resided in the dementia unit. The tenant's service plan stated staff were to provide set-up at meals, open small packages, cut up food as needed, remove meat from bones, provide a straw with all drinks and were to place rubber grip eating utensils in the tenant's hand if the tenant was not eating. Staff were also to provide verbal and hand under hand assistance with eating. Staff #3 stated she did take the tenant's food from him/her because she thought the tenant was done eating because the tenant was not making an attempt to eat. Staff #3 stated all tenants get a dessert. Staff #3 received disciplinary action.

- Regulatory Insufficiency: The program did not consistently provide sufficient trained staff available at all times to fully meet tenant's identified needs. (IAC r. 321-25.33(1)).

E. Record Checks – The Program conducts applicable employee record checks.

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

Monitoring Observation: Staff #1 was hired on 7-20-09 and had a termination date of 8-17-09. Preliminary criminal history and dependent adult and child abuse checks were completed on 7-13-09. The criminal history check indicated further research was required and the Iowa Record Check Request form indicated, as of 7-15-09, a record was found. An evaluation was not completed by the Department of Human Services.

- Regulatory Insufficiency: The program did not appropriately complete a Department of Public Safety criminal history check in that, if the Department of Public Safety determines that a person has committed a crime a person shall not be employed in a facility unless an evaluation has been performed by the Department of Human Services. (IAC 135C.33)

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

Incident Allegation #24485-I: It was reported a tenant had money missing from his/her apartment.

Monitoring Observation: Tenant #5, 82 years old, was admitted on 3-31-07 and diagnoses include: Diabetes and CHF. The tenant stated he/she was on vacation with his/her spouse and returned on 7-18-09. The tenant had $600.00, in cash, in his/her wallet/purse which was beside the recliner with two packages covering it up. On 7-21-09 he/she went to an evening activity and decided to check the money. The tenant returned to the apartment on 7-21-09 and all of the money was gone. The money was last seen on 7-18-09 and was found missing on 7-21-09. One week after the incident the tenant returned to the apartment and realized the lights were off in the apartment when they had been left on. The tenant and spouse did not receive any nursing services and received housekeeping on Wednesdays at that time. Housekeeping services were not scheduled during the time period of 7-18-09 to 7-21-09. The tenant called the police and also reported the theft to their insurance company. Usually the tenant's wallet/purse was kept put away and did not have money in it. The tenant always locked the apartment door when gone and staff had no reason to be in the apartment. The tenant stated it had to be someone who had a key.

According to a statement written by the Housing Director, the tenant was given a $500.00 rent concession.

According to Timecard Records, 15 staff had a master key and worked in the time period in question.

Staff interviews were conducted with first, second and third shift staff and an alleged perpetrator could not be identified.

- Regulatory Insufficiency: None noted.

Complaint Allegation #25468-C: It was alleged a staff moved Tenant #7's walker so that the tenant could not ambulate and called the tenant a name other than the tenant's primary name, which was upsetting to the tenant.

Monitoring Observation: Tenant #7, 85 years old, was admitted on 1-16-08 and diagnoses include: CHF, Short Term Memory Loss, Hyperlipidemia, Atrial Fibrillation, Degenerative Joint Disease (DJD) and Osteoporosis.

Staff #3 stated she took Tenant #7's walker away from the tenant at a meal time and did call the tenant a name other than the tenant's primary name. She stated since it was meal time she could not leave the dining room unattended and the tenant needed a neck brace when walking. Staff #3 stated she apologized to the tenant later and promised it would not happen again. Staff #3 received disciplinary action.

Complaint Allegation 25468-C: It was alleged a staff took a tenant's pet to show another tenant without getting the tenant's permission. It was alleged the tenant was upset.

Monitoring Observation: Tenant #6, 83 years old, was admitted on 6-30-08 and diagnoses include: Mild Cognitive Disorder, Hyperlipidemia and Weakness. The tenant resided in the dementia unit. Staff #3 stated she took the tenant's pet out of the tenant's apartment, without permission, to show another tenant. She stated she assured the tenant she was not going to keep the pet. Staff #3 stated she returned the pet to the tenant. Staff #3 received disciplinary action.

- Regulatory Insufficiency: The program did not establish standards for assisted living programs that allow flexibility in design which promotes a social model of service delivery by focusing on independence, individual needs and desires, and consumer-driven quality of service. (IAC r. 231C.1(2)b).

Dated this 6th day of November, 2009.