IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED

February 16, 2010

Incident Intake: #26558-I

Mary Jo Pipkin, Executive Director
Keystone Cedars
6325 Rockwell Dr NE
Cedar Rapids, IA 52402-7203

RE: I. Final Incident Investigation Report – #26558-I
II. Appeals/Hearings
III. Civil Penalty
IV. Conclusion

Dear Ms. Pipkin:

I. Final Incident Investigation Report

Enclosed is the **Final 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 area of Service Plans. Keystone Cedars (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 February 9, 2010, following the on-site visit of December 8 and 10, 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,

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 #: 26558-I**

Mary Jo Pipkin, Executive Director
Keystone Cedars
6325 Rockwell Dr NE
Cedar Rapids, IA 52402-7203

Date of Incident Investigation:

December 8 & 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 Keystone Cedars on December 8 & 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:	67
Current number of tenants with cognitive disorder:	0
Total Population of GPP:	67

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:	80

***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, Nurse Review, Food Service, Staffing, Dementia Specific Education and Structural Requirements.

The on-site recertification visit dated May 28, 2008 resulted in the above Regulatory Insufficiencies.

Incident Investigation – The 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.

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

Monitoring Observation: Three tenant files were reviewed.

Tenant #1, 92 years old, was admitted on 10-29-05 and diagnoses include: Alzheimer's Dementia, Status Post Right Knee Surgery, Osteoarthritis, Hypertension (HTN) and Neuropathy. The tenant was staged at a five - six on the Global Deterioration Scale (GDS), which indicated moderately severe to severe cognitive decline. The tenant resided in the dementia unit. The tenant's most current service plan dated 11-19-09 did not reflect the use of a bed rail, or the fact that the tenant slept low in the bed. The service plan did not reflect the identified needs of the tenant.

Tenant #2, 88 years old, was admitted on 9-10-09 and diagnoses include: Dementia, HTN, Coronary Artery Disease (CAD), Syncope, Benign Prostate Hypertrophy (BPH), Pain, Constipation, Anxiety, Neuropathy and Incontinence. The tenant's most current service plan dated 10-2-09 did not reflect the use of a bed rail. According to Nurse's Notes the tenant had four falls or was found on the ground between 9-11-09 and 11-4-09. The service plan did not reflect these incidents or address the identified needs of the tenant.

Tenant #3, 95 years old, was admitted on 4-14-05 and diagnoses include: Myocardial Infarction (MI) (1999), Arthritis, HTN, Dementia and Transurethral Resection of the Prostate (TURP). The tenant was staged at a five on the GDS, which indicated moderately severe cognitive impairment. The tenant resided in the dementia unit. The tenant's most current service plan dated 5-12-09 did not reflect the use of a bed rail. The service plan did not reflect the identified needs of the tenant.

- 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. (IAC r. 25.28(4)(a)).

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

Incident Allegation: The program reported a tenant apparently rolled out of bed and had his/her head and neck wedged between the mattress and an assistive bed rail. Staff found the tenant when completing two hour rounds. It was reported no vitals were obtainable and an ambulance and the Medical Examiner were called. It was reported the tenant died of asphyxiation due to being tangled in bed sheets and rolling out of bed.

Monitoring Observation: According to an Incident/Accident Report dated 12-5-09, Tenant #1 was found by Staff #2 while staff was completing two hour rounds and room checks. The tenant had apparently rolled out of bed. Upon entering the room to assist the tenant, staff found the tenant wedged between the bed and the quarter assistive bed rail. According to the report, staff lowered the tenant to the floor on his/her stomach and vitals were not obtainable. Staff called 911 and the ambulance arrived and emergency

personnel assessed the situation and called the Medical Examiner (ME). Staff notified the Executive Director (ED), the nurse and family at approximately 4:00 a.m. The report indicated the ME made the statement that the tenant died from asphyxiation due to being tangled up in bed sheets and rolling off the side of the bed.

Staff #1 was interviewed. He stated that at approximately 3:10 a.m. Staff #3 told him the tenant had rolled out of bed and was not moving. Staff #1 responded and found the tenant's head was wedged between the bar and the mattress. The tenant's fingers on the left hand were turning purple and the bed sheet was wrapped around the tenant's body. He laid the tenant on the floor and listened for heart sounds. Staff #2 called 911 and they asked to speak to Staff #1. They told Staff #1 to roll the tenant over and listen for respirations. The paramedics arrived and did not attempt resuscitation. The tenant had a Do Not Resuscitate (DNR) order. The Paramedics certified the time of death. The ME arrived and took pictures and asked questions, according to the staff. Staff #1 filled out the incident report, called the Executive Director (ED), the nurse and family. Staff #1 stated there had been no issues with the bed rail previously and the tenant usually slept pretty far down in the bed and his/her feet would hang over the bottom of the bed. The tenant stayed in bed throughout the night and was not one to get up and walk around. Staff #1 stated the bed had not been moved and visual checks were completed every two hours. He indicated there were sufficient staff to meet the needs of the tenants and there were no tenants that were exceeding the appropriate level of care.

Staff #2 was interviewed. She stated she checked on the tenant at approximately 3:50 a.m. to 3:55 a.m. and the tenant did not answer. She saw the tenant was wrapped up in the sheet with his/her head on the bed and body on the floor. She observed the tenant's skin had turned blue. She called Staff #3 who responded in approximately three minutes followed by Staff #1. Staff #1 attended to the tenant and Staff #2 called 911. Staff #2 stated she had previously checked on the tenant between 2:30 a.m. and 2:45 a.m. and she assisted with changing the tenant's protective undergarment. Staff #2 stated tenants in the dementia unit received two hour visual checks and staff documented those checks. Staff did not assist with the bed rail and it was always on the bed. She stated there had not been any issues previously with the bed rail and the tenant. Staff #2 stated neither the tenant's bed nor bed rail were recently moved and it was not a new bed. She stated there were sufficient staff to meet the needs of the tenants and there were no tenants that were exceeding the appropriate level of care.

Staff #3 was interviewed and stated Staff #2 called her at approximately 3:30 a.m. and said to come over right away because the tenant was not moving. Staff #3 responded in one minute and Staff #1 responded approximately 30 seconds after. The tenant was on the floor twisted in the covers which were wrapped around the tenant. The tenant's head and neck were caught in the bar (rail). Staff #1 removed the covers and the tenant had turned blue. Staff #2 called 911 and relayed questions to Staff #1. Staff #1 checked for pulse and breathing. Staff called the ED, the nurse and family. The ME arrived at the program and talked with the tenant's family. Staff #3 stated staff completed the required two hour checks consistently and staff documented the checks. She stated the bed rail had been in place for a while and was not new, the rail was always on the tenant's bed and the bed and rail had not been moved. Staff #3 stated there were sufficient staff to meet the needs of the tenants and there were no tenants that were exceeding the appropriate level of care.

The nurse was interviewed and stated Staff #1 called her at 3:58 a.m. and told her that the tenant had apparently rolled out of bed and his/her head was stuck between the rail and the mattress. She said Staff #1 attempted to obtain vitals; however, vitals could not be obtained. Staff called 911 and the paramedics arrived. The ME was also called to the program. The nurse stated there had been no issues with the bed rails and once the rails were set they were set. She stated the rails were sturdy and did not have a lot of play. The nurse stated the required two hour checks were completed consistently.

Program staff completed two hour rounds on tenants in the dementia unit. These checks were documented consistently for Tenant #1. The checklist showed the tenant was taken to the bathroom at 12:00 a.m. and 2:00 a.m. on 12-5-09. The checks showed the tenant was sleeping when checked at 10:00 p.m. on 12-4-09.

The tenant's service plan and Monthly Assignment/Sign Off Sheet consistently documented two hour checks for Tenant #1.

A review of tenant #1's file and an interview with the tenant's physician indicated the bed rail was not physician ordered. An invoice for a bed rail was dated 1-8-08. The cost of the bed rail was billed to the tenant's family. The Physical Therapist provided services for the tenant in July of 2008 and the bed rail was in place at that time. She stated there had been no other issues with bed rails in the building. An interview with the Physical Therapist indicated the bed rails in this level of care were not covered by Medicare they were assistive devices and they typically never have a physicians order. She stated it was an adaptive device to increase independence and it would be billed out of pocket.

The monitor observed the tenant's bed and bed rail. Photographs were taken while on-site. The tenant's bed appeared to be a full size bed. The tenant had a personal bed and not a hospital or program supplied bed.

According to the Preliminary Report of Investigation by the Medical Examiner, the manner of death was an accident and the probable cause of death was positional asphyxiation due to the tenant having his/her neck caught between the handrail and bed. The report listed Dementia as a contributing factor. The Certificate of Death indicated the immediate cause of death was positional asphyxiation and indicated the approximate interval between onset and death was minutes.

- Regulatory Insufficiency: None noted.

Dated this 15th day of February, 2010.