IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

April 2, 2010

Complaint Intake: #27347-C

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

RE: I. Final Complaint Investigation Report – #27347-C
II. Civil Penalty
III. Hearings and Appeals
IV. Conclusion

Dear Ms. Pipkin:

I. Final Complaint Investigation Report –Keystone Cedars Assisted Living, Cedar Rapids, 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 481 – 67 and 69. The Final Report notes **Regulatory Insufficiencies,** as defined in the areas of: Evaluation of Tenant, Service Plan and Other. Keystone Cedars (Program) is being assessed a $2,000.00 civil penalty.

DIA is accepting the Plan of Correction (POC). DIA is denying the program's Request for Reconsideration in relation to Evaluation of Tenants, Service Plans and Other. In regard to Evaluation of Tenants, the program did not complete evaluations with a change in condition and did not ensure the Nurse completed an assessment with such a change. In regard to Service Plans, the program did not include all information regarding tenant cares on the Service Plan that was obtained, from the program, by the monitor during the on-site. In regard to Other, the program did not report to the DIA a serious injury or elopement, within the required timeframe.

You are unable to ask for a request of reconsideration for a fine; however, you can request an appeal of the fine and that is explained in section III. Hearings and Appeals.

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 one thousand three hundred dollars ($1,300.00) within 30 business days after the receipt of this demand letter. Please be sure to identify the program and its location on the check or money order.

III. Hearings/Appeals

The Program may appeal the DIA decision in accordance to 481 IAC 67.13, 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

The Program is being assessed a $2,000.00 civil penalty. The final Plan of Correction (POC) submitted on April 1, 2010, has been reviewed and is accepted. The Request for Reconsideration has been denied as explained 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. Your previous request for an appeal was premature; if you still wish to appeal please inform DIA of that within 30 days.

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 Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 27347-C**

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

Date of Investigation:

February 3 and 4, 2010

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. IAC r. 481-67.10(5). 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 481 IAC chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Keystone Cedars on February 3 and 4, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that does is not include a Dementia Specific unit, but may include have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	62
Current number of tenants with cognitive disorder:	0
Total Population of GPP:	62

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

Total Population of DSP:	12
Total Census of ALP:	74

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

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.

An Incident Investigation dated December 8 and 10, 2009, resulted in a Regulatory Insufficiency in the area of Service Plans and a civil money penalty of $500.00.

The Recertification Monitoring Evaluation dated May 28, 2008, resulted in Regulatory Insufficiencies in the areas of: Evaluation of Tenants, Service Plans, Medications, Nurse Review, Food Service, Staffing, Dementia Specific Education and Structural Requirements.

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

A. Evaluation of Tenant

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

Monitoring Observation: Three tenant files were reviewed.

Tenant #1, 91 years old, was admitted on 6-10-05 and diagnoses include: Rheumatoid Arthritis, Parkinson's Disease, Osteoporosis and History of Transient Ischemic Attacks (TIAs). The tenant had a managed risk for falls and received Hospice services. According to an Incident/Accident Report dated 1-25-10 at 2:45 p.m., the tenant was using a toilet and the tenant's family member instructed the tenant to push his/her pendant for assistance when he/she finished. The tenant did not call for assistance, lost his/her balance and fell. The tenant's family member notified the nurse to request assistance. The tenant was found lying on his/her right side by the toilet and had a head laceration. An ambulance was called and transported the tenant to the hospital. The tenant returned to the program on 1-28-10, Status Post (S/P) fall with a head injury and no further measures could be taken at the hospital. The Nurse's Notes indicated comfort measures only, the tenant was non-responsive, all oral medications were discontinued, repositioning was to be completed every two hours and staff were to check and empty the catheter bag every shift. The Hospice nurse was interviewed and she reported the tenant received excellent care and she did not have any concerns with the care. Evaluations were completed on 2-1-10; however, were not completed, as needed, with the return to the program following significant changes.

Tenant #2, 85 years old, was admitted on 4-20-09 and diagnoses include: Hypertension (HTN), Depression, Dementia, Anxiety, Insomnia, Osteoporosis, Chronic Diarrhea, Colon Cancer and Lung Cancer. The tenant received Hospice services. According to an Incident/Accident Report dated 2-1-10 at 12:50 a.m., staff responded to a pendant alarm and could not find the tenant in his/her apartment. The tenant was found outside the building lying on his/her back. The tenant could not walk and staff carried the tenant into the building. According to Nurse's Notes dated 2-1-10 at 12:50 a.m., vitals were taken and the tenant's blood pressure was 191/136, pulse was 79 and respirations were 18. Vitals were taken one hour later and the tenant's blood pressure was 162/107, pulse 77 and respirations 14. The tenant stated his/her right hand was a little sore. According to notes dated 2-1-10 at 6:00 a.m. the tenant was complaining of pain from the fall. It was noted the tenant was unable to ambulate or bear weight and was screaming out in pain. The nurse instructed staff to send the tenant to the hospital for evaluation of current signs and symptoms. According to Hospital Records, the tenant sustained a right inferior pubic ramus fracture and superior pubic ramus fracture. Evaluations were not completed as needed with a significant change in status.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC 481 r.69.22(2))

B. Service Plan

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

Monitoring Observation: Three tenant files were reviewed.

Tenant #1's file was reviewed. According to an Incident/Accident Report dated 1-25-10 at 2:45 p.m., the tenant was using a toilet and the tenant's family member instructed the tenant to push his/her pendant for assistance when finished. The tenant did not call for assistance, lost his/her balance and fell. The tenant's family member notified the nurse for assistance. The tenant was found lying on the right side by the toilet and had a head laceration. An ambulance was called and the tenant was transported to the hospital. The tenant returned to the program on 1-28-10, S/P fall with a head injury as no further measures could be taken at the hospital. The tenant was receiving comfort measures only, was non-responsive, all oral medications were discontinued, the tenant required repositioning every two hours, and staff were to check and empty the catheter bag every shift. The Hospice nurse was interviewed and reported the tenant received excellent care and she did not have any concerns. The tenant's service plan was updated on 2-1-10; however, the service plan was not completed, as needed, with a return to the program following significant changes.

Tenant #2's file was reviewed. According to an Incident/Accident Report, dated 2-1-10 at 12:50 a.m., staff responded to a pendant alarm and could not find the tenant in his/her apartment. The tenant was found outside the building lying on his/her back. The tenant could not walk and staff carried the tenant into the building. According to Nurse's Notes dated 2-1-10 at 12:50 a.m., vitals were taken and the tenant's blood pressure was 191/136, pulse was 79 and respirations were 18. Vitals were taken one hour later and the tenant's blood pressure was 162/107, pulse 77 and respirations 14. The tenant stated his/her right hand was a little sore. According to notes dated 2-1-10 at 6:00 a.m., the tenant was complaining of pain from the fall. It was noted the tenant was unable to ambulate or bear weight and was screaming out in pain. The nurse instructed staff to send the tenant to the hospital for evaluation of current signs and symptoms. According to Hospital Records, the tenant sustained a right inferior pubic ramus fracture and a superior pubic ramus fracture. The tenant's service plan indicated staff were to check the tenant every two hours for toileting; however, the rounds sheet indicated staff were to assist the tenant with toileting every two hours and assist with toileting every four hours on third shift. This was not reflected on the service plan. The service plan was not updated, as needed, with a significant change.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC 481 r. 69.26 (3))

C. Staffing

Complaint Allegation: It was alleged a tenant was found outside the program, without appropriate winter clothing, and the tenant fell on the ice and sustained two pubic fractures.

Monitoring Observation: According to an Incident/Accident Report dated 2-1-10 at 12:50 a.m., staff responded to Tenant #2's pendant alarm and could not find the tenant in his/her apartment. Staff checked the first floor and had additional staff assist in searching for the tenant. The tenant was found outside the building lying on his/her back. The tenant could not walk and staff carried the tenant into the building. According to Nurse's Notes dated 2-1-10 at 12:50 a.m., vitals were taken and the tenant's blood pressure was 191/136, pulse was 79 and respirations were 18. Vitals were taken one hour later and the tenant's blood pressure was 162/107, pulse 77 and respirations 14. The tenant stated his/her right hand was a little sore. According to notes dated 2-1-10 at 6:00 a.m., the tenant was complaining of pain from the fall. It was noted the tenant was unable to ambulate or bear weight and was screaming out in pain. The nurse instructed staff to send the tenant to the hospital for evaluation of current signs and symptoms. According to Hospital Records, the tenant sustained a right inferior pubic ramus fracture and a superior pubic ramus fracture.

According to a review of the tenant's file, interviews with Staff #1, #2, #3 and the program and Hospice nurses, the tenant had not eloped or wandered previously. A Mini Mental Status Examination (MMSE) was completed on 10-20-09 and resulted in a score of 26 out of 30, indicating the tenant was cognitively intact. The Hospice nurse indicated the tenant was diagnosed with a Urinary Tract Infection (UTI) in the hospital. Staff #1 and #2 stated the tenant was outside wearing pajamas and was barefoot.

Staff #1 was interviewed and indicated Staff #2 found the tenant outside and stated the tenant could not bear weight. Staff #1 picked up the tenant and carried him/her inside. Staff #2 got a wheelchair and the tenant was put into the wheelchair and taken to his/her apartment. Staff #2 changed the tenant's protective undergarment and pajamas and Staff #1 took his/her vitals. Staff #1 stated he called the nurse after taking the tenant's vitals and the nurse stated to monitor closely. He stated the tenant was not in a lot of pain and did not express any complaints of pain while he carried the tenant into the building. Staff #1 stated when Staff #2 changed the tenant's clothes, the tenant was a little sore but did not express any specific pain or soreness. Staff #1 stated the tenant's temperature was not taken after the tenant was found outside and he did not observe any misalignment of the tenant's hips or deformity. Staff #1 stated when Staff #2 later went in to check on the tenant, the tenant grabbed staff's arms with both hands. Checks were completed on the tenant at least every hour. Staff #1 stated at the beginning of the incident the tenant hardly verbalized pain and towards the end of the shift the pain increased. He stated he administered an as needed Tylenol, which dulled the pain, and he reported to the staff at shift change that the tenant had an elopement and a fall. Staff #1 stated neither the tenant nor the tenant's spouse requested to go to the hospital. Staff #1 stated there were no skin changes with tenant and he/she did not appear to have frostbite. Staff #1 did not call the nurse after the initial report.

Staff #2 was interviewed. She stated Staff #1 told her the tenant had paged for assistance and was not in his/her room. Staff #2 went outside and Staff #1 checked the second

floor. Staff #2 found the tenant outside, lying on the wet ground. She asked the tenant if he/she could walk and the tenant wrapped his/her arms around her neck. Staff #2 stated the tenant could not walk, was barely bearing weight and said he/she hurt but did not say where. Staff #1 responded and carried the tenant inside and the tenant was put into a wheelchair. The tenant did not verbalize any pain when put into the wheel chair by staff. Staff #2 stated the tenant did not know how he/she got outside and he/she was grateful staff located her. She stated the tenant was aware he/she had pushed the pendant. Staff #2 stated the tenant did not complain of any pain during transfers. Staff #1 called the nurse and Staff #2 changed the tenant out of his/her clothes. Staff #2 stated the tenant was able to stand at that time and got into bed with the assistance of one person. Staff observed a slight scratch on the tenant's right ankle when changing the tenant into pajamas. Staff #2 stated the tenant complained of soreness; however, not pain. Staff #2 stated as the night progressed the tenant had more complaints of being sore and staff checked on the tenant every hour. Staff #2 stated staff observed a bulging area around the tenant's lower abdomen and the tenant stated it was sore. Staff #2 stated there was no deformity noted but it hurt when the tenant moved their leg, the tenant was given Tylenol and information about the incident was passed along to first shift staff. Staff #2 stated she would have sent the tenant to the hospital if it was up to her, just to be on the safe side.

Staff #3 was interviewed and stated that when she arrived Staff #1 told her what had happened with the tenant. Staff #3 visited the tenant and observed the tenant's foot was turned out and hurt when touched. Staff #3 did not move the tenant but called the nurse and the nurse told her to send the tenant to the hospital. Staff #3 called the tenant's family and the ambulance. The ambulance arrived within five minutes and the tenant was transported to the hospital. Staff #3 had asked the tenant if he/she wanted to go to the hospital and the tenant told her it could wait until tomorrow. Staff #3 stated she did not have concerns about the tenant not being sent out until first shift because, initially, the tenant complained of soreness and did not verbalize hip pain.

The Hospice nurse indicated the bulged area of the abdomen that was observed by staff was not new.

The Medication Administration Record (MARs) were reviewed and on documentation on 2-1-10 indicates that an as needed (PRN) Tylenol, 500 mg, was administered at 3:35 a.m., due to a complaint of pain. At 4:00 a.m. staff charted the medication was effective.

The Hospice nurse was interviewed and stated she was made aware of the fall and elopement by the Hospice Home Health Aide (HHA) on the morning of the incident.

The program nurse was interviewed and stated she was called by Staff #1 at approximately 1:00 a.m. Staff#1 told the nurse the tenant had used the pendant and staff could not find the tenant initially. Staff #1 stated Staff #2 had found the tenant outside and they brought the tenant back inside. Staff #1 told the nurse Staff #2 changed the tenant's clothes and put the tenant into bed with extra blankets. Staff #1 told the nurse the tenant was comfortable in bed and did not report the tenant was in any pain. The nurse told staff to monitor the tenant throughout the night. Staff did not report any deformity or rotation and did not call with any additional changes on third shift. The nurse stated at approximately 6:00/6:15 a.m. Staff #3 called her and stated she had checked on the tenant and stated there was more going on with the tenant and he/she was crying out in pain. The nurse instructed Staff #3 to send the tenant to the hospital. The

nurse stated she did not have any issues with how third shift staff handled the situation and it was reported at that time the tenant was clean, dry and resting comfortably in bed. The nurse stated the tenant was not sent earlier based on the information communicated to the nurse from staff. The nurse stated Staff #3 sent the tenant to the hospital and she learned of the fracture in the early afternoon on that day.

- Regulatory Insufficiency: None noted.

D. Structural requirements

Complaint Allegation: It was alleged a tenant fell on the ice and sustained two pubic fractures.

Monitoring Observation: The monitor observed the sidewalks on 2-3-10 and on 2-4-10 and they appeared clear. Three staff were interviewed. Staff #1, #2 and #3 indicated the sidewalks were cleared promptly and there were no complaints regarding the sidewalks. Staff #1 and #2 responded to Tenant #2 who was found outside on 2-1-10. Staff #1 and #2 indicated the sidewalk was clear and was wet. Staff #1 stated there was sand on the sidewalk. The nurse was interviewed and stated there were no issues with the sidewalks. Staff #1 and #2 stated there was no precipitation on 2-1-10 when the tenant was found outside. Tenant council/meeting minutes for the past three months were reviewed and there were no concerns regarding the sidewalks and snow/ice removal.

- Regulatory Insufficiency: None noted.

E. Other

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

Monitoring Observation: Three tenant files were reviewed.

Tenant #1's file was reviewed. According to Incident/Accident Report dated 1-25-10 at 2:45 p.m., the tenant was using a toilet and the tenant's family member instructed the tenant to push his/her pendant for assistance when finished. The tenant did not call for assistance, lost his/her balance and fell. The tenant's family member notified the nurse for assistance. The tenant was found lying on his/her right side by the toilet and had a head laceration. An ambulance was called and the tenant was transported to the hospital. The tenant returned to the program on 1-28-10, S/P fall with a head injury as no further measures could be taken at the hospital. The Nurse's Notes indicated comfort measures only, the tenant was non-responsive, all oral medications were discontinued, repositioning was to be completed every two hours and staff were to check and empty the catheter bag every shift. The program did not report the fall with major injury to the Department.

Tenant #2's file was reviewed. According to an Incident/Accident Report, dated 2-1-10 at 12:50 a.m., staff responded to Tenant #2's pendant alarm and could not find the tenant in his/her apartment. The tenant called for assistance, was found outside by staff at 12:50 a.m., on the sidewalk without winter clothing, sustained a fracture and was admitted to the hospital. The nurse indicated family stated at the tenant's prior residence he/she would go outside to get a breath of fresh air when he/she had trouble sleeping and the

nurse indicated the tenant pressed the pendant to call for assistance. The program did not report the elopement to the Department.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available of any accident causing major injury. "Major injury" shall also mean a substantial injury. "Major injury" shall be defined as any injury which requires admission to a higher level of care for treatment, other than for observation. (IAC 481 r. 67.4(1)a(2))

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available when a tenant elopes from a program. (IAC 481 r. 67.4(4))

Dated this 1st day of April, 2010.