IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 29947-C
29948-C
29727-I

October 11, 2010

Ms. Kara Ludlum, Regional Systems Manager
Oak Park Place
1381 Oak Park Place
Dubuque, IA 52002

RE: I. Final Complaint and Incident Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Ludlum:

I. Final Complaint and Incident Investigation Report – Oak Park Place, Dubuque, IA

Enclosed is the **Final Complaint and Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69. The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Service Plan, Medications, Nurse Review, Staffing, and Other (lack of notification). **Oak Park Place** ("Program") is being assessed a $2500 civil penalty.

II. Civil Penalty

If, within 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 civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Tamara Halvorson** and remit the civil penalty assessed by check or money order in the amount of sixteen hundred twenty five dollars ($1625) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $2500 civil penalty. The Plan of Correction (POC) submitted on October 7, 2010, has been reviewed and will constitute the final POC related to the on-site visit of August 9, 10, and 11, 2010. The Request for Reconsideration has been denied due to the fact that Tenant #3 is on Hospice, has had frequent falls and is staged at five on the Global Deterioration Scale which indicates moderately severe cognitive decline resulting in impaired decision making ability.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal 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 enclosed Report, please contact your Certification Coordinator, Tamara Halvorson, at 515/281-5721.

Sincerely,

Ann Martin

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:

Ms. Jackie Scott, Housing Director
Oak Park Place
1381 Oak Park Place
Dubuque, IA 52002

Complaint Intake #: 29947-C
29948-C
29727-I

Date of Investigation:

August 9, 10 and 11, 2010

Monitor(s):

Hal Chase, RN BSN MPH
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. 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 and incident investigation on-site visit was conducted at Oak Park Place on August 9, 10 and 11, 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:	36
Current number of tenants with cognitive disorder:	1
Total Population of GPP:	37

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

Total Population of DSP:	18
Total Census of ALP:	55

***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, Nurse Review and Staffing.

Complaint Investigation – The complaint investigators made the observations detailed in the following areas.

A. Evaluation of Tenant

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

Monitoring Observation: Tenant #2, an 89 year old, was admitted 7-9-10 with diagnoses of Coronary Artery Disease, Diabetes, and Advanced Dementia. Tenant #2 was admitted to the hospital on 7-16-10 through 7-20-10 and on 8-2-10 through 8-4-10 for congestive heart failure. The tenant was taken to the emergency room on 8-7-10 for low blood sugar. The nurse narrative on 7-30-10 documented the tenant received services of a home health nurse. The service plan dated 7-20-10 indicated the tenant also received physical therapy services. The clinical record lacked documentation of cognitive, functional or health evaluations to determine any changes to services needed.

Tenant #4, a 92 year old, was admitted 4-29-06 with diagnoses of: Coronary Artery Disease, Aortic Stenosis, Hyperlipidemia, Osteoarthritis, Duodenal Ulcer, Chronic Anxiety and Depression. The clinical record for Tenant #4 contained a nursing narrative dated 8-4-10 which documented the tenant currently had a urinary tract infection and the physician had ordered Lortab for pain, Cipro for antibiotic, Naproxen for pain and Restoril, a hypnotic medication used short term for insomnia. The Service plan dated 8-2-10 did not address interventions for urinary tract infection or pain and the clinical record did not contain cognitive, functional or health evaluations regarding urinary tract infection.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall 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 r. 481-69.22(2))

B. Service Plan

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

- Monitoring Observation: Tenant #1, an 84 year old, was admitted on 2-13-09 with diagnoses of: Alzheimer's Disease, Lumbar Spinal Stenosis, Dysphagia, and Depression. The cognitive evaluation completed on 6-23-10 staged the tenant at six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The tenant resides in the secured dementia unit. The functional assessment of 6-23-10 documented the tenant required full assistance from one person to ambulate. The service plan of 6-23-10 directed staff to place a body alarm if the tenant appeared unsteady and to place a bed alarm so that staff is immediately notified upon tenant wakening and may assist the tenant out of bed. The incident report dated 7-6-10 documented the tenant was found on the floor by the bed wrapped in blanket at 10:30 p.m. Staff #9, who discovered the tenant on the floor on 7-6-10, stated that the alarm

was not sounding and he could not remember if it was attached to the tenant. Observation of the tab alarm revealed it was placed on the upper right side of the head board with Velcro. The cord was approximately two feet long which would allow the tenant to fall out of bed without the alarm sounding if the tab was attached to the tenant's right side. Staff #9 indicated that the tenant had been found previously out of bed carrying the alarm. The service plan did not contain specifics regarding how or when the staff was to place the alarm to effectively monitor the tenant's movements.

Tenant #2 was admitted to the hospital on 7-16-10 through 7-20-10 and on 8-2-10 through 8-4-10 for congestive heart failure. The tenant was taken to the emergency room on 8-7-10 for low blood sugar. The nurse narrative on 7-30-10 documented the tenant received services of a home health nurse. The service plan dated 7-20-10 indicated the tenant also received physical therapy services. The service plan did not include specifics regarding the additional service providers.

Tenant #3, an 86 year old, was admitted 4-24-09 with diagnoses of: Dementia, Alzheimer/presenile, Coronary Artery Disease, Diverticulosis, Gastric Ulcer, Hyperlipidemia, History of Myocardial Infarction and Peripheral Vascular Disease. Tenant #3 had been admitted to Hospice services and received routine visits from a hospice nurse and hospice volunteer. The service plan of 7-28-10 did not indicate interventions for hospice staff nor did the clinical record contain a hospice care plan.

The clinical record for Tenant #4 contained a nursing narrative dated 8-4-10 which documented the tenant currently had a urinary tract infection and the physician had ordered Lortab for pain, Cipro for antibiotic, Naproxen for pain and Restoril, a hypnotic medication used on a short term basis for insomnia. The service plan dated 8-2-10 did not address interventions for urinary tract infection or pain.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum the service providers, if other than the program, including but not limited to providers of hospice care, home health, occupational therapy, and physical therapy. (IAC r. 481-69.26 (4c))

C. Medications

Complaint Allegation 29947-C: It was alleged multiple staff made multiple medication errors and documentation of missed medications and narcotic count was not completed according to policy.

- Monitoring Observation: The following medication errors were identified:

1. Tenant #5's Medication Administration Record (MAR) indicated on 8-9-10, a nebulizer treatment was documented as administered at 10:55 a.m and not 12:00 p.m. as ordered.

2. Tenant #6's MAR indicated on 8-9-10, Zymar eye drops were documented as administered at 10:55 a.m. and not 12:00 p.m. as ordered.

Staff #5 who had administered the medications acknowledged the program policy for medication administration one hour before and up to one hour after ordered to be considered timely. Staff #5 stated she had set up the nebulizer treatment and signed it off and was going to go back and administer it later.

3. Tenant #7's MAR indicated on 8-9-10, Senna were documented as administered on 8-6-10. A tablet of Senna remained in the blister pack for 8:00 administration on 8-6-10.

4. Tenant #8's MAR indicated on 8-9-10, two tablets of Acetaminophen were documented as administered on 8-6-10. two tablets remained in the blister pack for 12:00 p.m. administration on 8-6-10.

5. The program policy for counting narcotics directed staff to count the narcotics together with two staff at the end of each shift and sign on the back of the declining balance sheet for the corresponding time and date.

On 8-10-10 at 8:00 a.m. Staff #5 stated that she had counted narcotics with the staff person leaving at 6:00 a.m. The narcotic count sheets for 8-10-10 for the 7:00 a.m. shift were blank. Staff #5 said she was going to recount the narcotics later and sign them off. This process did not follow the program policy.

- Regulatory Insufficiency: When medications are administered traditionally by the program the administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

D. Nurse Review

Complaint Allegation 29947-C: It was alleged staff did not follow physician's orders.

- Monitoring Observation: Tenant #2 scored 24 out of 31 on a cognitive evaluation completed 7-20-10 which indicated normal cognitive function. The tenant was admitted to the hospital on 7-16-10 through 7-20-10 for Congestive Heart Failure. The discharge orders included an order for home health care and an order to weigh the tenant every day and call the physician if a weight gain of three pounds or more. According to the MAR dated 7-26-10, the tenant had a weight increase of three pounds. The clinical record lacked documentation that the physician was notified of the weight increase. The tenant was subsequently admitted to the hospital again on 8-2-10 with Congestive Heart Failure. The clinical record lacked documentation of completion of a nurse review for changes in health condition.

The cognitive assessment for Tenant #4 was completed 5-28-10 and scored the tenant with 31/31 which indicated normal cognitive functioning. A physician's order dated 8-4-10 directed staff to monitor pain closely and call the physician if not controlled. The clinical record lacked documentation of evaluation or assessment of the tenant's pain level from 8-4-10 to present time.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program. (IAC-69.27(2))

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

- Monitoring Observation: Tenant #2 was admitted to the hospital on 7-16-10 through 7-20-10 and on 8-2-10 through 8-4-10 for congestive heart failure. The tenant was taken to the emergency room on 8-7-10 for low blood sugar. On 8-9-10 the tenant was found on the floor unresponsive while in the lower lobby bathroom, taken to the hospital by emergency personnel and admitted for pleural effusion. The clinical record lacked documentation of a nurse review completed after 8-4-10.

  Tenant #4 was diagnosed with a urinary tract infection on 8-4-10. The clinical record contained a physician's order dated 8-4-10 which directed staff to monitor pain closely and call the physician if not controlled. The medication Naproxen was ordered twice a day for 2 weeks, Lortab as needed for pain and Restoril. On 8-5-10 the program wrote a verbal order to discontinue the Lortab and the Restoril at the family's request. The clinical record lacked documentation of evaluation or assessment of the tenant's pain level.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation, assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

E. Staffing

Complaint Allegation 29947-C and 29948-C: It was alleged the program did not have a registered nurse (RN) on staff to answer questions.

- Monitoring Observation: The Director of Nursing, a RN, had resigned effective 7-27-10. Since that time the corporate RN had been on call for the building. The corporate RN reported she was physically in the building at some time during the days of 7-28 and 29, 8-2, 3, 4 and 9. Staff #6, a licensed practical nurse, reported she worked at

the program from 9:30 a.m. to 6:00 p.m., Monday through Friday, since 8-2-10. Staff #4, #5, and #6, stated the registered nurse was always available to answer phone calls.

- Regulatory Insufficiency: None noted.

Complaint Allegation 29947-C: It was alleged response to tenant call light could take up to 50 minutes.

- Monitoring Observation: Random days 7-1, 7-18, 7-21, and 7-24 were identified and review of the pendant response time indicated that the longest average time for response to pendant calls was 3.2 minutes.

- Regulatory Insufficiency: None noted.

Incident Allegation 29727-I: The program reported Tenant #1 was found on the floor on 7-6-10 at 10:20 p.m. The tenant's personal alarm did not sound. The tenant sustained a fractured hip. The program reported the incident to the Department on 7-7-10.

- Monitoring Observation: The cognitive evaluation for Tenant #1 dated 6-23-10 staged the tenant at 6 indicating severe cognitive decline. The functional assessment of 6-23-10 documented the tenant required full assistance from one person to ambulate. The service plan of 6-23-10 directed staff to place a body alarm if the tenant appeared unsteady and to place a bed alarm so that staff is immediately notified upon tenant wakening and may assist the tenant out of bed. The incident report dated 7-6-10 documented the tenant was found on the floor by the bed wrapped in blanket at 10:30 p.m. Staff #9, who discovered the tenant on the floor on 7-6-10, stated that the alarm was not sounding and he could not remember if it was attached to the tenant. Observation of the tab alarm revealed it was placed on the upper right side of the headboard with Velcro. The cord was approximately two feet long which would allow the tenant to fall out of bed without the alarm sounding if the tab was attached to the tenant's right side. Staff #9 indicated that the tenant had been found previously out of bed carrying the alarm. Staff #4 stated that the tenant's alarm sounded all the time and the service plan did not say how or where to place the alarm. The service plan did not contain specifics regarding how or when the staff was to place the alarm to effectively monitor the tenant's movements.

- Regulatory Insufficiency: In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to emergency needs of the tenants. (IAC r. 481-69.29 (2))

F. Dementia-Specific Education for Program Personnel

Complaint Allegation 29947-C: It was alleged staff did not complete and document dementia or dependent adult abuse training appropriately.

- Monitoring Observation: Review of personnel records of Staff #1, #2, #4, and #5 revealed dementia education had been completed appropriately. The forms were documented and signed by both the nurse and the employee. Staff #4 and #5 stated

that training was either completed at staff meetings or the employee watched a video and then signed off when done.

- Regulatory Insufficiency: None noted.

G. Other

Complaint Allegation 29947-C: It was alleged a tenant with cognitive impairment went outside of the program independently, without program knowledge, fell and sustained an injury.

- Monitoring Observation: The GDS completed 7-19-10 staged Tenant #3 at 5 which indicated moderately severe cognitive decline. The service plan of 5-21-10 documented the tenant was experiencing more confusion at night. The plan also indicated the tenant walked independently with a walker due to frequent falls. The plan documented that the program and family were aware that the tenant would venture outside onto grassy areas so staff were to remind the tenant to walk on paved areas because he/she was a fall risk. Incident report dated 7-10-10 documented the tenant was walking outside on the sidewalk around the building independently and got too close to the edge of the hill and fell down the hill. The Hospice narrative sheet documented the tenant had been down to Mass in the lower level and somehow got out of the building and was found shortly thereafter when the van driver found him laying on the bank outside the building. The tenant's skin was peeled off the left forearm and he/she also sustained a bump on the head. The nurse's narrative documented the tenant had also fallen on 6-14, 6-29, and 7-6-10. The nurse's narrative on 7-12-10 documented discussion with tenant's family regarding placement in the secured memory care unit for the tenant's safety. Nurse's narrative on 7-13-10 indicated the Hospice nurse discussed concerns for the tenant's safety, agitated state and notable decline in cognition indicating that walking outside without assistance was a safety risk. During interview on 8-10-10, the tenant stated the program told him/her to no longer walk outside independently. The service plan of 7-28-10 did not contain interventions to prevent the tenant from exiting the building independently. The Director of Housing stated she did not think the exit from the building on 7-10-10 was elopement so did not report it; however, the tenant was cognitively impaired and exited the building without staff knowledge and fell sustaining injury.

- 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 r. 481-67.4(4))

Dated this 7th day of September 2010.