IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake: 29591-C

September 9, 2010

Ms. Karen McCoy, Director
Jersey Ridge
5605 Jersey Ridge Road
Davenport, IA 52807

RE: I. Final Complaint Investigation & Recertification Monitoring Evaluation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Standard Certification
V. Conclusion

Dear Ms. McCoy:

I. Final Complaint Investigation & Recertification Monitoring Evaluation Report – Jersey Ridge, Davenport, IA

Enclosed is the **Final Complaint Investigation & Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapter 481—67 and 481—69. The Report notes the Regulatory Insufficiencies in the area(s) of: Service Plan, Medications, Nurse Review, Food Service, Dementia Specific Education for Program Personnel, Record Checks and Other (mandatory dependent adult abuse training). Jersey Ridge("Program") is being assessed a $500 civil penalty.

DIA is accepting the Plan of Correction (POC) following the Program's submission of 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 in accordance with IAC 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 cover letter to the attention of **Tamara Halvorson** and remit the penalty assessed by check or money order in the amount of three hundred twenty five ($325) 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 30 days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to IAC chapter 481—10. If the Program appeals, the civil penalty will be suspended, pending the appeal process. If the Program does not appeal, the fine is due within 30 days of notice.

IV. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0079** with effective dates of **May 4, 2010** through **May 3, 2012.**

V. Conclusion

The Program is being assessed a $500 civil penalty. The POC submitted on September 4, 2010, has been reviewed and will constitute the final POC related to the on-site visit of July 20 & 21, 2010.

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, 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 Investigation & Recertification Monitoring Evaluation Report

Assisted Living Program: **Complaint Intake #: 29591-C**

Karen McCoy, Director
Jersey Ridge
5605 Jersey Ridge Road
Davenport, IA 52807

Date of Investigation:

July 20 & 21, 2010

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. 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 Jersey Ridge on July 20 & 21, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

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 fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS):	12
Current number of tenants without cognitive disorder:	20
Total Population:	32

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

Tenant/Family Satisfaction Results – A community meeting with eight tenants was held. The tenants did not have any issues with housekeeping, laundry or maintenance. One tenant stated it was a nice place. Their needs were met and they received medications on time. Staff answered requests for assistance between 5-15 minutes. The variety and temperature of the food was appropriate. The meat was tough, especially the roast. There were sufficient activities offered and they received a calendar of activities. The tenants made their own decisions and the nurse was available. The tenants were satisfied with the program and would recommend it to others.

Program History – There were no substantiated Regulatory Insufficiencies found during this certification period.

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

A. Service Plan

- Monitoring Observation: Six tenant files were reviewed.

  Tenant #2, a 78 year old, was admitted on 7-10-08 and diagnoses include: Alzheimer's Disease, Dementia with Behavior Disorder and Osteoarthritis. The tenant was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The tenant resided in the dementia unit. The tenant had an order for physical therapy (PT) with a start date of 3-30-10 and discontinue date of 6-29-10. PT services were not indicated on the service plan. Staff assisted the tenant with toileting. The tenant's service plan indicated staff were to provide reminders, as needed, to use the toilet and were to assist with peri care. The service plan indicated staff were to give privacy and check on the tenant. The tenant was observed and it took staff encouragement for the tenant to stand and go into the bathroom. The tenant refused to sit on the toilet. The service plan did not accurately reflect the needs of the tenant.

  Tenant #4, an 84 year old, was admitted on 5-15-05 and diagnoses include: Congestive Heart Failure (CHF), Arthritis, Hypertension (HTN), Peripheral Vascular Disease (PVD), Osteoporosis, Glaucoma and Diverticulitis. Physical therapy and occupational therapy (OT) were ordered. The service plan did not reflect PT and OT.

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

B. Medications

Complaint Allegation: It was alleged staff transcribed medication orders.

- Monitoring Observation: Six tenant files were reviewed. Physician orders were noted by licensed nursing staff. Orders transcribed to the medication administration records (MARs) were not consistently initialed or signed which made it difficult to determine who had transcribed orders to the MAR. Staff #4 indicated nurses were supposed to be the only staff to transcribe orders; however, in the past month other staff transcribed orders. She was not sure who was transcribing the orders; however, stated it happened. Staff #6 stated in the past, staff transcribed orders; however, currently only nurses transcribed orders.

Complaint Allegation: It was alleged staff wrote on tenant prescription bottles and there were medication errors.

- Monitoring Observation: A medication bottle was found and the prescription label had writing on it. Tenant #1 had an order for Coumadin 3 mg by mouth daily.

Tenant #1's prescription label for Coumadin on the bottle was altered with writing on the bottle (see pictures). Tenant #2 had an order for Ensure four times daily beginning 5-28-10. According to MARs for the month of June 2010, the tenant received the supplement three times a day and not four times daily as ordered. Medication error reports for the past three months were requested. Three medication error reports were provided. The dates of the reports were 6-15-10, 6-16-10 and 7-12-10.

- Regulatory Insufficiency: 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))

C. Nurse Review

- Monitoring Observation: Tenant #3, a 90 year old, was admitted on 7-1-08 and diagnoses include: History of Stroke, Diabetes, HTN, Hyperlipidemia, Vascular Dementia, Hypothyroidism and Chronic Diarrhea. The tenant was staged at five on the GDS, which indicated moderately severe cognitive decline. The tenant resided in the dementia unit. The tenant had a physician's order for pureed diet. The tenant's current health assessment reflected the pureed diet and difficulty swallowing food and pills. Staff #15, kitchen staff, indicated the tenant received chopped meats and did not have pureed diets. The tenant did not receive the pureed diet per physician's order.

- 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 licensed practical nurse via nurse delegation: To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program. (IAC r. 481-69.27(2))

D. Food Service

- Monitoring Observation: Staff files were reviewed. Staff #7 did not have an annual in-service training on food protection. Staff #13 had a copy of food safety training; however, it was not dated. Current food safety training was not documented for Staff #13. Staff #10, #11 and #12 did not have documented food safety training.

- Regulatory Insufficiency: Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (IAC r. 481-69.28(5))

E. Staffing

Complaint Allegation: It was alleged the program did not have a Director of Nursing (DON) from December 2009 to May 2010.

- Monitoring Observation: Staff #1 registered nurse (RN) worked from 7-28-09 to 12-25-09. Staff #2, (RN) worked at the program from 1-3-05. Staff #2 worked part time from 12-29-09 to 5-13-10 and then went PRN. Staff #3, (RN) worked from 5-13-10 to 6-29-10. Staff #4, licensed practical nurse (LPN) worked from 3-1-10 to the present time. Time records were pulled for Staff #2, who worked part time from 12-29-09 to 5-13-10. The records showed Staff #2 worked between one and four days a week during that time period. Staff #2 was interviewed and indicated she worked three to five times per week during that time period. Staff #2 indicated currently she assisted with on-call responsibilities, assisted with any RN issues and delegated tasks to staff. Staff #5, #6, #7 and #8 indicated there were no concerns regarding nursing coverage in the building. The tenants indicated the nurse was available (LPN). Staff #9, an agency RN, worked at the program 12 days between 6-29-10 and 7-20-10.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged there was not appropriate nurse delegation training.

- Monitoring Observation: Five staff files were reviewed. Staff #7, #8, #13 and #14 had nurse delegation training completed by Staff #2 (RN). The nurse delegation training was completed on 6-30-10. According to time records, Staff #7 and Staff #14 did not work on 6-30-10. Staff #8 worked on 6-30-10; however, indicated she was not trained by Staff #2. Staff #2 indicated in an interview she had not observed staff performing delegated tasks on 6-30-10. Staff administered medications, provided medical cares and assisted with Activities of Daily Living (ADLs). Staff did not have appropriate nurse delegation.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

F. Dementia-Specific Education for Program Personnel

- Monitoring Observation: Four staff files were reviewed. Staff #4 was hired on 3-1-10 and had four hours of dementia training and case studies. Staff #4 did not have eight hours of dementia training within 30 days of hire. The program employed three activity assistants, Staff #10, #11 and #12. Staff #10 was hired on 11-16-09. A hire date was not provided for Staff #11 and #12. Staff #10, #11 and #12 did not have appropriate dementia-specific education.

- Regulatory Insufficiency: All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia training within 30 days of either employment or the beginning date of the contract, as applicable. (IAC r. 481-69.30(1)

- Regulatory Insufficiency: All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. (IAC r. 481-69.30(3))

G. Record Checks

- Monitoring Observation: A hire date was not provided for Staff #11 and #12. Criminal history checks and abuse checks were not found for Staff #11 and Staff #12. Appropriate background checks were not completed.

- Regulatory Insufficiency: Pursuant to Iowa Code section 135C.33, a prospective employee of a program shall have a criminal history check, dependent adult abuse check, and child abuse check performed before the prospective employee begins work. If a prospective employee has a criminal history or an abuse history, the prospective employee shall not be employed by the program unless the department of human services has performed an evaluation and determined that the record does not warrant the employment prohibition. Proof of preemployment background check shall be maintained in the program's employee file. The program must meet all requirements of Iowa Code section 135C.33 and administrative rules adopted pursuant to Iowa Code section 135C.33. (IAC r. 481-67.9(3))

H. Other

Complaint Allegation: It was alleged there was back charting in the tenant files.

- Monitoring Observation: Staff #2 worked part time from 12-29-09 to 5-13-10 and then went PRN. Time records were pulled for Staff #2, who worked part time from 12-29-09 to 5-13-10. The records showed Staff #2 worked between one and four days a week during that time period. Staff #2 was interviewed and indicated she worked three to five times per week during that time period. Staff #2 stated there were no concerns regarding falsification of records. Staff #9, an agency RN, worked at the program 12 days between 6-29-10 and 7-20-10. Staff #9 indicated her job responsibilities included completing scheduled assessments. She did not have any concerns with back charting or falsification of records. Staff #5, #6, #7 and #8 indicated they did not have concerns regarding back charting or falsification of records. Six tenant files were reviewed and no back charting or falsification of records was found.

- Regulatory Insufficiency: None noted.

- Monitoring Observation: Staff #10, #11 and #12 were paid activity assistants and did not have mandatory dependent adult abuse training. Staff #10 was hired on 11-16-09. A hire date was not provided for Staff #11 and #12.

- Regulatory Insufficiency: A person required to report cases of dependent adult abuse pursuant to section 235B.3, other than a physician whose professional practice does not regularly involve providing primary health care to adults, shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment or self-employment which involves the examination, attending, counseling, or treatment of adults on a regular basis. Within one month of initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person's employer or, if self-employed, from the department. The person shall complete at least two hours of additional dependent adult abuse identification and reporting training every five years. (235B.16(5)(b))

Dated this 4th day of August 2010.