IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Incident Intake #: 32124-I
32356-I

March 29, 2011

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

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

Dear Ms. McCoy:

I. Final Incident Investigation Report – Jersey Ridge Place, Davenport, IA

Enclosed is the **Final 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: Nurse Review, Structural Requirements and Other (not following program's own policies and procedures). **Jersey Ridge Place** ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

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 **Jim Berkley** and remit the civil penalty assessed by check or money order in the amount of six hundred fifty dollars ($650) 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 $1,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on March 27, 2011, has been reviewed and will constitute the final POC related to the on-site visit of February 7, 2011.

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 Program Coordinator, Jim Berkley, 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:

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

Incident Intake #: 32124-I
32356-I

Date of Incident Investigation:

February 7, 2011

Monitor(s):

Stephanie Cummins, MA
Maribeth Freland, 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 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 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:

An on-site visit was conducted at Jersey Ridge Place on February 7, 2011. 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 and provides specialized care in a dedicated setting 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):	13
Current number of tenants without cognitive disorder:	19
Total Population:	32

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

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

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Nurse Review

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

- Monitoring Observation: Tenant # 1, a 97 year old tenant residing in the program's secured dementia unit, was admitted 11-5-09 and diagnoses include: Vascular Dementia, Spinal Stenosis and Blindness in the Left Eye. 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.

  According to the Incident Report, dated 12-6-10 at 7:00 a.m., the smoke alarm in Tenant #1's apartment set off the building's fire alarm system. Staff #1 responded to the alarm. She found the tenant sitting in his/her wheelchair. The wheelchair back was sitting up against a space heater, which had caught papers in the wheelchair back pouch on fire. The report lacked follow up by the nurse.

  On 2-7-11 at 10:40 a.m. the monitor observed Tenant #1's wheelchair. The pouch on the back of the wheelchair had been removed. The back of the wheelchair had a 50 cent piece sized melted area in the center of the back however had not completely melted through the material. Nurse review was not completed as needed.

- 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 to 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))

B. Structural requirements

Incident Allegation #32124-I: The program reported a tenant had a space heater in his/her room. The tenant backed the wheelchair into the heater, igniting papers that were in a pouch on the back of the wheelchair

- Monitoring Observation: According to the Incident Report, dated 12-6-10 at 7:00 a.m., the smoke alarm in Tenant #1's apartment (in the secured dementia unit) set off the building's fire alarm system. Staff #1 responded to the alarm. She found the tenant sitting in his/her wheelchair. The wheelchair back was sitting up against a space heater, which had caught papers in the wheelchair back pouch on fire. The report lacked follow up by a registered nurse.

  The local fire department's report indicated receiving the alarm at 7:03 a.m. on 12-6-10 and arrived at the program at 7:05 a.m. The report indicated no injury to the tenant and a property loss of $250.00. The report concluded the leather vehicle seat of the tenant's wheelchair first ignited after being in close proximity to a portable

electric heater. The report indicated upon arrival the firemen found "heavy white smoke" in the tenant's apartment with no fire present. Staff had reported papers in the pouch on the back of the wheelchair had been on fire and put out by staff prior to the fire department's arrival.

On 2-7-11 at 10:40 a.m. the monitor observed Tenant #1's wheelchair. The pouch on the back of the wheelchair had been removed. The back of the wheelchair had a 50 cent piece sized melted area in the center of the back; however, had not completely melted through the material.

Staff #1, #2, #3, #4 and #5 all reported having knowledge of the space heater in Tenant #1's apartment prior to the fire. Staff #1 reported the space heater had been in the tenant's apartment since September 2010. Staff #3 reported the heater had been brought to the tenant's apartment "sometime this winter". Staff #4 indicated the tenant's relative brought the space heater to the tenant's apartment in October or November of 2010. Staff #5 reported the space heater had been in the tenant's apartment for a "couple of months". Staff #3, #4 and #5 reported the tenant could not turn the heater on and off independently. Staff #3 reported night shift staff turned the heater on when the tenant went to bed and day shift staff shut the heater off when the tenant got up each morning.

The monitor interviewed the nurse on 2-7-10. The nurse reported she was not in the building when the fire occurred however arrived while the fire department was still on the premises. The nurse reported she had gone to the tenant's apartment to assess him/her; however, the tenant's clinical record lacked documentation of a nurse review following the fire. The nurse reported having knowledge of the space heater in Tenant #1's apartment prior to the fire; however, could not recall how long the heater had been present.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481-69.35(1)(b))

C. Other

Incident Allegation #32356-I: The program reported a dietary staff saw a tenant standing by one of the outside doors in the dining room. A couple of minutes later, the dietary staff member looked out the window and saw the tenant outside the program in the parking lot a few feet from the door. The program reported a direct care staff walked down the hall to respond to the pager alarm. The tenant did not sustain any injuries.

- Monitoring Observation: Tenant #2, an 85 year old, was admitted on 4-16-08 and diagnoses include: Rheumatoid Arthritis, Advanced Dementia and Seasonal Allergies. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. The tenant resided in the dementia unit. The tenant was not moved to the dementia unit until 1-5-11.

  According to an Incident Report dated 1-1-11, the tenant was seen at the door and was looking out. Staff #7 looked out the dining room window and saw the tenant headed for the street. Staff #7 ran out to get the tenant and brought the tenant back in the building. According to a nurse review, dated 1-3-11, staff received notification via

the pager system. Staff met dietary staff as she brought the tenant back into the building. Staff #5 stated she received a page at approximately 4:00 p.m. that indicated the door by the kitchen went off. The incident report did not discuss the pager alert or another staff involved. Staff #5 did not fill out an incident report. The incident report did not indicate how far the tenant was from the building.

According to an Incident Report dated 1-5-11, the tenant was seen outside the building fully clothed; however, was not wearing a coat or hat. The tenant was seen at 12:00 p.m. in the tenant's apartment during 30 minutes checks. The tenant was moved to the secured dementia unit on 1-5-11. The incident report indicated it was witnessed by Staff #8; however, she did not give a statement related to the witnessed incident. The incident report did not indicate which door the tenant exited or how far the tenant was from the building.

The missing information on the incident reports made it difficult to determine the specific details of the elopements on 1-1-11 and 1-5-11. Staff interviews were inconsistent regarding what staff were present and what doors the tenant exited when the tenant eloped. The history of the door alarms was reviewed and was inconsistent with the elopement time provided on the incident report and the exit doors.

The tenant did not sustain any injuries related to the elopement on 1-1-11, according to the nurse review dated 1-3-11. The tenant did not sustain any injuries related to the elopement on 1-5-11, according to the incident report.

The tenant was moved to the secured dementia unit on 1-5-11.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: There were door alarms in the designated dementia specific unit. Those alarms were tested on 2-7-11 and functioned appropriately. The rest of the building was not a designated dementia unit; however, was dementia specific by definition at the time of the investigation. According to a program document, all doors were secured with an alarm system. Upon exiting any of the doors a page was transmitted to the universal worker via the clip on the pager. The pagers alerted staff to the specific exit door that was opened. The front entrance door was programmed not to alarm during the hours of 8:00 a.m. and 4:00 p.m. Monday through Friday. The doors were in the non-secured dementia unit were tested. The exit door by the kitchen and one of the west doors, alarms did not function appropriately. The doors were opened and a page was not sent to staff's pager or to the computer. The test was completed on 2-7-11.

  According to an Incident Report dated 1-1-11, Tenant #2 was seen at the door and was looking out. Staff #7 looked out the dining room window and saw the tenant headed for the street. Staff #7 ran out to get the tenant and brought the tenant back in the building. According to a nurse review dated 1-3-11, staff received notification via the pager system. Staff met the dietary staff as she brought the tenant back into the building. Staff #5 stated she received a page at approximately 4:00 p.m. that indicated the door by the kitchen went off. The monitors reviewed the records of the

system for 1-1-11 and the history did not reflect the exit door by the kitchen was opened around 4:00 p.m. Staff #6, the Manager, stated if a page was received on the pager it would be reflected on the computer.

The incident report indicated the nurse and family were notified. The nurse stated she was not aware of the elopement until 1-3-11. The program's Missing Resident policy indicated once the tenant was found, the tenant should be checked by a nurse and staff were to contact the nurse on call. The nurse was not notified of the elopement until 1-3-11. The program did not follow the procedure for a missing tenant.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2))

Dated this 28th day of March, 2011.