IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Incident Intake #: 33041-I

April 5, 2011

Mr. Bert Vigen, Administrator
Oakwood Place Assisted Living
4126 NW Blvd.
Davenport, IA 52806

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

Dear Mr. Vigen:

I. Final Incident Investigation Report – Oakwood Place Assisted Living, 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: Criteria for Exclusion of Tenants and Tenant Rights. **Oakwood Place Assisted Living** ("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 24, 2011, has been reviewed and will constitute the final POC related to the on-site visit of March 1, 2011.

Based on the information provided in the Request for Reconsideration submitted on March 24, 2011, DIA **denies** your request as it relates to Criteria for Exclusion of Tenant and Tenant Rights due to the fact that data included in this report for the March 1, 2011 on-site did not repeat the same set of circumstances as the report for the February 15, 2011 on-site.

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:

Incident Intake #: 33041-I

Bert Vigen, Administrator
Oakwood Place Assisted Living
4126 NW Blvd.
Davenport, IA 52806

Date of Investigation:

March 1, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH

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 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 incident investigation on-site visit was conducted at Oakwood Place Assisted Living on March 1, 2011. 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:	42
Current number of tenants with cognitive disorder:	3
Total Population of GPP:	45

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:	57

***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 medications and activities.

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

Incident Investigation – The incident investigator(s) made the observations detailed in the following areas.

A. Criteria for Exclusion of Tenants

Incident Allegation: The program reported a tenant with dementia left the program without staff knowledge.

- Monitoring Observation: Tenant #1, an 87 year old, was admitted 5-1-06, and had diagnoses of: Alzheimer's Dementia, Edema, Atrial Fibrillation, Hypertension and Anxiety. The tenant resided in the general population. A cognitive evaluation was completed on 2-15-11 and staged the tenant at five on the Global Deterioration Scale, which revealed moderately severe cognitive decline. Resident notes of 1-21-11 revealed an electronic monitoring system was used to notify staff if the tenant attempted to exit an outside doorway. The tenant's service plan was updated on 1-21-11 and revealed the tenant occasionally walks the halls during the night and becomes angry if staff tried to redirect him/her or made decisions for the tenant. If the tenant attempted to leave the program, staff were directed to give specific reasons why the tenant should stay inside the program. Staff were to call family and the registered nurse (RN) if the tenant attempted to leave the program.

  Resident notes of 1-25-11 revealed the tenant exited the program. Staff were notified of the tenant's leaving by the electronic monitoring system and was escorted back to the program. On 2-15-11 the RN reviewed the electronic monitoring system with the tenant's family member. The electronic monitoring system was working and the tenant had not attempted to leave the program. The RN and the family member agreed to discontinue 30 minute safety checks.

  Resident notes of 2-23-11 at 10:00 p.m. revealed program security found the tenant between the outside set of doors and the inside set of doors of the independent apartment building. A monitor noted the independent apartment building was several buildings away, at least 200 feet away, from the assisted living program. The program RN was notified and instructed staff to initiate 15 minute safety checks, notify the tenant's family until she arrived at the program. The program RN arrived at 10:45 p.m. and completed a nurse review. She noted the tenant was dressed appropriately and was wearing a sweater when found. The tenant was checked for bruises or open areas and the tenant denied pain or discomfort. Staff reported the tenant had been "very restless" during the evening hours. The tenant was wearing his/her identification bracelet and electronic monitoring watch.

  The RN noted the electronic monitoring system did not signal or page staff the tenant had left the program. The program RN reported she initiated one-on-one continuous staff observation of the tenant until the electronic monitoring system and watch was activated and tested. Program documentation revealed an automatic computer software update activated sometime in the evening hours, deactivated the electronic monitoring system during the time the tenant had eloped from the program. Automatic software updates were disabled and future updates would be done during regular business hours.

  Staff communication records of 2-25-11 revealed the tenant was walking the halls from 11:00 p.m. until 3:00 a.m. and was looking for his/her son and was trying to leave. Communication records of 2-27-11, revealed staff had seen the tenant was

wandering in the hall. An incident report of 2-27-11 revealed the electronic monitoring system signaled staff at 10:48 p.m., the tenant had opened and closed an exit door. Staff suspected the tenant stepped out without letting the door close and came back inside the program. Security staff noted there were a couple of foot prints outside the exit door.

On 2-28-11, at 10:45 p.m., the tenant was seen outside of a side entrance stairwell. The incident report of the same date revealed at 12:45 a.m. the tenant went out an exit door. The tenant reported he/she was going to get his/her car to "load ... stuff to go home." At 1:15 a.m. the tenant attempted to go to the main entrance of the program, but staff diverted the tenant from going outside. Staff redirected the tenant back into the program, but the tenant continued to wander the halls until 2:00 a.m., when the tenant returned to his/her apartment.

Staff #1 stated the tenant would often look for his/her car, his/her son and would want to leave the program. The tenant will, at times, resist redirection from staff and would continue to try and leave the program. Staff #2 stated the tenant wandered throughout the building, and the wandering would increase throughout the evening and early morning hours. The tenant would continue elope from the program. The tenant "will get out regardless." The electronic monitoring system would alarm, but the tenant would get out. Staff were directed to watch the tenant and when he/she wanders. The tenant becomes agitated when staff attempted to follow him/her. The tenant was not easily redirected.

On 2-15-11, the Department investigated an incident of an elopement by the tenant on 1-14-11 at 2:30 p.m. The tenant was found outside the program, near the parking lot.

Despite the implementation of interventions in response to the tenant's wandering and elopements, the tenant has chronically eloped from the program.

- Regulatory Insufficiency: Program shall not knowingly admit or retain a tenant who, despite intervention chronically elopes. (IAC r.481-69.23(1)(c)(1))

B. Tenant Rights

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

Monitoring Observation: Tenant #1's resident notes of 2-23-11 at 10:00 p.m. revealed program security found the tenant between the outside set of doors and the inside set of doors of the independent apartment building. A monitor noted the independent apartment building was several buildings away, at least 200 feet away, from the assisted living program. The program RN was notified and instructed staff to initiate 15 minute safety checks, notify the tenant's family until she arrived at the program. The program RN arrived at 10:45 p.m. and completed a nurse review. She noted the tenant was dressed appropriately and was wearing a sweater when found. The tenant was checked for bruises or open areas and the tenant denied pair or discomfort. Staff reported the tenant had been "very restless" during the evening hours. The tenant was wearing his/her identification bracelet and electronic monitoring watch.

The RN noted the electronic monitoring system did not signal or page staff the tenant had left the program. The program RN reported she initiated one-on-one continuous staff observation of the tenant until the electronic monitoring system and watch was activated and tested. Program documentation revealed an automatic computer software update activated sometime in the evening hours, deactivated the electronic monitoring system during the time the tenant had eloped from the program. Automatic software updates were disabled and future updates would be done during regular business hours.

- Regulatory Insufficiency: All tenants have the right to receive care, treatment and services which are adequate and appropriate (IAC r.481-67.3(2))

Dated this 25th day of March, 2011.

Oakwood ALP Incident 33041-I, 3-1-11 Tenant & Staff List

Tenant List:

1. Arlene Hennings

Staff List:
Administrator – Bert Vigen
Program RN – Mary Kay Harris
Staff #

1. Anne Tracy
2. Lisa Carvalho