IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

**DEMAND LETTER**
**CERTIFIED**
**Complaint Intake #: 32984-C**
**Incident Intake#: 32962-I**

April 14, 2011

Ms. Melissa Thomsen, Administrator
Park Place Independent & Assisted Living
551 Park Avenue
Sac City, IA 50583

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

Dear Ms. Thomsen:

**I. Final Complaint Investigation Report – Park Place Independent & Assisted Living, Sac City, IA**

Enclosed is the **Final Complaint 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: Staffing and Program's Policies and Procedures. **Park Place Independent and Assisted Living** ("Program") is being assessed a $500 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 three hundred twenty five dollars ($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 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 $500 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on March 30, 2011, has been reviewed and will constitute the final POC related to the on-site visit of February 22, 2011. The Request for Reconsideration is denied due to the program failing to meet staffing requirements on a tenant who was staged at a five on the Global Deterioration Scale and the anticipated exit seeking behavior inherent with advancing dementia.

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 Complaint Investigation Report

**Assisted Living Program:**

**Complaint Intake #: 32984-C**
**Incident Intake#: 32962-I**

Melissa Thomsen, Administrator
Park Place Independent & Assisted Living Program
551 Park Avenue
Sac City, IA 50583

**Date of Investigation:**

February 22, 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 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 Park Place Independent & Assisted Living Program on February 22, 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: | 9 |
| Current number of tenants with cognitive disorder: | 0 |
| Total Population: | 9 |

***Dementia Specific Program (DSP)**** – Not applicable.

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

**Program History** – The program did not receive any regulatory insufficiencies during this certification period.

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

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

**A. Staffing**

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

- Monitoring Observation: Tenant #1, an 87 year old, was admitted on 5-16-09 and had diagnoses of: History of Urinary Tract Infections, History of Viral Pneumonia, Chronic Obstructive Pulmonary Disease, Hypertension, Dementia, Chronic Renal Failure and Carotid Artery Stenosis. A cognitive evaluation was completed on 2-8-11 and staged the tenant at five on the Global Deterioration Scale, which indicated moderately severe cognitive impairment.

  Progress notes of 1-14-11 revealed the tenant was hospitalized for Viral Pneumonia and returned to the program on 1-21-11. Functional, cognitive and health evaluations were completed on 1-19-11 and the tenant's service plan was reviewed without changes. On 2-8-11 the program nurse completed a nurse review and indicated the tenant recovered from pneumonia. The tenant had completed antibiotic therapy without adverse reaction. Functional, cognitive and health evaluations were completed on 2-8-11 and the tenant's service plan of 1-19-11was reviewed without changes. The service plan revealed the tenant ambulated independently, needed reminders for bathing and dressing and was independent with all remaining activities of daily living (ADLs). The program administered medications. Medication Administration Records (MARs) of January, 2011 revealed the tenant was prescribed steroidal and antibiotic therapy along with aerosol nebulizer inhalation treatments.

  Progress notes of 2-18-11 at 5:15 a.m. revealed Staff #1 LPN from the adjacent nursing facility, had looked out a window in the south hallway that adjoins the nursing facility and the assisted living program and saw a body lying on the sidewalk with the shoulders and head off the sidewalk and under a car. The nurse called additional staff and went outside to assist the person. The nurse indicated it was a tenant and heard the tenant moan but would not verbalize anything. At 5:17 a.m. the director of nursing and emergency medical services were called. Staff placed several blankets on top of the tenant until an ambulance arrived. The tenant was transported to the hospital. Staff went to the tenant's apartment and found the personal emergency response pendent on the night stand and the GPS tracker was plugged in on the kitchen counter.

  Program documentation revealed assisted living staff work from 7:00 a.m. until 5:30 p.m. Tenants can call 911 for emergencies; otherwise tenants may call the nursing facility or call for assistance using a call light system – using a personal emergency response system (PERS). Nursing facility staff were responsible for answering tenant calls for assistance from 5:30 p.m. until 7:00 a.m. Doors at the main entrance and entrance doors on the southeast corner and north were equipped with alarming systems. An override switch located in the business office would silence the main entrance door and was accessible only to the program manager or her designee.

  Staff #1 LPN stated nursing facility staff did not walk through the assisted living program during the overnight hours. The program nurse would give report to nursing facility staff if a tenant was not feeling well or if a tenant needed to checked on during the overnight hours. She stated she worked on 2-17-11, from 6:00 p.m. until

6:00 a.m. and the program RN did not report on tenants needing to be checked. The door alarms to the assisted living did not alarm, as someone had turned off the main door alarm at the assisted living program and she was not told the alarm system had been turned off.

Staff #2 stated the tenant thought he/she was in a hospital and could eventually go home. The tenant had not made previous attempts to leave the program. The tenant did not have a history of wandering and did not exit seek. The tenant had a pendent he/she could press to call for assistance and he/she knew how to use it.

The program's exit door security alarms policy revealed secured entrance and exit doors are equipped with automatic locking mechanisms and/or alarm systems to minimize the likelihood that persons can enter or leave the premises undetected. The doors at the main entrance facing southwest, the entrance on the southeast corner, and the entrance on the north are all equipped with alarming systems. The alarm can be silenced at the door by entering a set of numbers in the key punch pad prior to opening the exit door. The code is posted by the key punch pad and persons able to read the posting and enter the code are presumed capable of entering and exiting without assistance or supervision. The alarm system on the main entrance door can be silenced with an over ride switch located in the business office, accessible only to the program manager or her designee. The manager or designee may use the over ride switch and silence the alarm during normal business hours or community events when the alerting would be intrusive or disruptive to daily operations and activities occurring n the general vicinity.

According to State Climatologist, the temperature at Sac City for the afternoon of 2-17-11 was 60 degrees Fahrenheit. On 2-18-11 at 7:00 a.m. the temperature was 29 degrees Fahrenheit.

The program manager stated she worked on 2-17-11 and approximately 10:00 a.m. she turned off the main entrance door alarm because several family members were visiting a tenant throughout the day and were coming in and out. She left at 5:30 p.m. and forgot to re-activate the front door alarm.

Staff responsible for the care needs and safety of tenant in the assisted living program were not available when the tenant exited the building.

- 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))

**B. Program policies and procedures.**

Complaint Allegation #32984-C: It was alleged a tenant was found outside the program, lying half way under a car in the parking lot at 5:00 a.m. A staff person who was leaving looked down and found the tenant under her car. The tenant was immediately taken to the hospital.

Incident Allegation #32962-I: At 5:15 a.m. on 2-17-11, a staff nurse noticed a body was lying on the sidewalk outside the program. Staff investigated and determined it was a tenant who lived at the program. The tenant was wearing his/her night clothes and a

hooded sweatshirt. The tenant was wearing shoes but was not wearing socks. Two staff nurses placed a blanket over the tenant and laid beside the tenant until an ambulance arrived. The tenant was transferred to the hospital.

Monitoring Observation: Progress notes of 2-18-11 at 5:15 a.m. revealed Staff #1 LPN from the adjacent nursing facility, had looked out a window in the south hallway that adjoins the nursing facility and the assisted living program and saw a body lying on the sidewalk with the shoulders and head off the sidewalk and under a car. The nurse called additional staff and went outside to assist the person. The nurse indicated it was a tenant and heard the tenant moan but would not verbalize anything. At 5:17 a.m. the director of nursing and emergency medical services were called. Staff placed several blankets on top of the tenant until an ambulance arrived. The tenant was transported to the hospital. Staff went to the tenant's apartment and found the personal emergency response pendent on the night stand and the GPS tracker was plugged in on the kitchen counter.

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- 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(231B,231C,231D))

Dated this 14th of April, 2011.