IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 33087-C
Incident Intake #: 33130-I

April 21, 2011

Bert Vigen, Director
Oakwood Place
4126 NW Blvd.
Davenport, IA 52806

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

Dear Mr. Vigen:

I. Final Complaint and Incident Investigation Report – Oakwood Place, Davenport, 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: Criteria for Exclusion of Tenant and Staffing. **Oakwood Place** ("Program") is being assessed a $1500 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 nine hundred seventy five dollars ($975) 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 $1500 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on April 15, 2011, has been reviewed and will constitute the final POC related to the on-site visit of March 15, 2011. The Request for Reconsideration has been denied in relation to Criteria for Exclusion of Tenant due to this investigation covered a different set of circumstances and facts regarding the same tenant as a previous investigation. The Request for Reconsideration has been denied in relation to Staffing as the program did not meet the tenants' needs.

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 and Incident Investigation Report

Assisted Living Program:

Complaint Intake #: 33087-C
33130-I

Bert Vigen, Director
Oakwood Place
4126 NW Blvd.
Davenport, IA 52806

Date of Investigation:

March 15, 2011

Monitor(s):

Joyce Kix, RN
Maribeth Freland, RN
Margaret Kaltefleiter, 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 Oakwood Place on March 15, 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:	35
Current number of tenants with cognitive disorder:	1
Total Population of GPP:	36

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

Total Population of DSP:	15
Total Census of ALP:	51

***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.

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

A. **Criteria for Exclusion of Tenants**

Complaint Allegation #33087-C: It was alleged that four tenants exceeded the criteria for level of care provided in assisted living.

Incident Allegation #33130-I: The program reported a tenant left the program without an escort on 3-1-11 at 11:45 p.m.

- Monitoring Observation: Five tenant files were reviewed. The monitors found that tenant #2 and #3 did not exceed the criteria for retention in an assisted living program. Tenant #4 and #5 had been discharged from the program due to increased care needs.

  Tenant #1, an 87 year old, was admitted 5-1-06 with diagnoses of: Alzheimer's Dementia, Atrial Fibrillation, Edema, Hypertension and Anxiety. A cognitive evaluation completed 2-15-11 staged the tenant at five on the Global Deterioration Scale which indicated moderately severe cognitive decline. The tenant's weight on 2-11 was 137 pounds. Resident notes documented an electronic monitoring system, (bracelet worn by the tenant), was in place to notify staff if the tenant attempted to exit an outside doorway. The service plan dated 2-15-11 documented the tenant received assistance with medication administration and bathing. The plan documented the tenant was at risk of leaving the facility without an escort but family did not want the tenant moved to a secure area. The clinical record documented a history of the tenant leaving the program without an escort on 10-15 and 16-10 and 1-25-11. On 2-15-11 the program discontinued 30 minute safety checks because they felt the tenant was still able to leave the program between the checks. On 2-23-11 the tenant left the program unescorted. The Resident Notes indicated the tenant also attempted to leave the program on 2-27-11 at 10:54 and on 2-28-11 at 12:45 a.m. On 3-1-11 at 5:00 p.m. the nurse documented the tenant's family was advised the tenant was at risk for falls, wandering too far, being hit by a car, or getting into a vehicle with an unknown person and that serious injury and/or death was a real possibility. The nurse documented that she explained to the family that the tenant would need to find placement that would keep the tenant safe because the program could not provide that in the assisted living. They agreed to think about the situation overnight. The program did not issue the tenant notice of intent to discharge or immediately notify the tenant advocate by certified mail of an involuntary discharge.

  The Resident note of 3-1-11 also indicated that hourly checks were re-initiated at 2:30 p.m. Review of the hourly check documentation revealed the safety checks on 3-1-11 at 7:30 p.m. and 9:30 p.m. were omitted. According to the documentation, the tenant was last seen in his/her apartment at 11:30 p.m. At 11:42 p.m. the electronic monitoring system indicated the tenant left the program through the stairwell #2 door. According to the note, at 11:51 p.m. the tenant was returned to the program by a security guard who found the tenant outside the building walking on the sidewalk. The nurse documented on a final investigation sheet that the third shift staff person failed to call the nurse at the time of the incident per program policy. The first shift called the nurse when she received report at 6:30 a.m. on 3-2-11. Staff #5 stated that

the pager sounded but she was with another tenant that and could not leave to check. The tenant returned to the program without resistance and sustained no injury.

The director reported that he was not able to retrieve the computer print out of the pages and responses for Tenant #3 on 3-1-11 because the tenant had been discharged from the program and deleted from the system.

Three staff were interviewed. One staff member stated that the program is sometimes understaffed and second shift says they can't get all things done but first shift completes the showers as ordered.

Another staff person indicated that in the past she had "fudged" on the signatures of safety checks because she did not have time to complete them. She stated she did not feel she had appropriate training on the electronic monitoring system and the bracelet had to be taken off the tenant when he/she left the building. She reported that the program director had been informed that the pager system malfunctioned and indicated the tenant was in an unauthorized area but when checked, the tenant was in his/her room.

Another staff member stated that the pager system did not work half the time. The pager would indicate the tenant was out the door but the tenant was still in his/her room.

The state climatologist reported the weather on 3-1-11 was clear with an outside temperature at 12:52 a.m. of 29 degrees with 15 miles per hour wind and a wind chill of 18 degrees.

According to the nurse, the incident occurred on 3-1-11 at 11:42 p.m. and was not reported to her until 6:30 a.m. on 3-2-11. She did not complete notification to the department until 3-3-11 at 2:51 p.m. which is beyond the requirement of notice within 24 hours of knowledge by eight hours. The nurse said she got busy and forgot.

The program continued to retain a tenant who exceeded level of care criteria and despite intervention chronically eloped. The tenant was transferred to a locked unit on 3-3-11.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: a. Is bed-bound; or b. Requires routine, two-person assistance with standing, transfer or evacuation; or c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk; or d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or e. Is under the age of 18; or f. Requires more than part-time intermittent health related care; or g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or h. Is medically unstable; or i. Requires maximal assistance with activities of daily living. (IAC r. 481-69.23(1))

B. Staffing

Complaint Allegation #33087-C: It was alleged the program was short staffed and were not able to shower or toilet tenants appropriately and/or as assigned.

- Monitoring Observation: Review of the staff schedule for three months revealed at least four staff were scheduled for day and evening shifts with two staff scheduled for night shift.

  The task sheets for four tenants were reviewed. According to the task sheets, showers were provided as ordered on service plans. Two of the tenants were on scheduled toileting plans. No tenants were found to have skin breakdown from lack of cares.

  Four staff were interviewed. During interview, staff stated that the program is sometimes understaffed and second shift says they can't get all things done but first shift completes the showers as ordered.

  Another employee stated that at least 17 of 28 days in February, she was not able to administer medications within the two hour time requirement. She stated that sometimes medications would be one half hour late because there was not time between assisting with bathing, serving meals and providing cares.

  During interview, a third staff member indicated that in the past she had "fudged" on the signatures of safety checks because she did not have time to complete them. She stated she did not feel she had appropriate training on the electronic monitoring system and the bracelet had to be taken off the tenant when he/she left the building. She reported that at times staff didn't take lunch breaks when they were working two sections because they didn't have time.

  A fourth employee stated that second shift was short handed, especially when one staff person had to leave Oakwood to go to the independent living housing to pass medications or follow up on falls.

  According to the Resident Notes, Staff #5 stated that the pager sounded on 3-1-11 at 11:42 p.m., but she was with another tenant that and could not leave to check. A tenant had eloped and was found outside by a security guard.

  The program failed to assure a sufficient number of trained staff were available at all times to meet the needs and maintain the safety of the tenant who was at risk for elopement.

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

Dated this 21st day of April 2011.