IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 33376-C

May 24, 2011

Ms. Pamela Wells, Director
Glenwood Place
2907 South 6th Street
Marshalltown, IA 50158

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

Dear Ms. Wells:

I. Final Complaint Investigation Report – Glenwood Place, Marshalltown, IA

Enclosed is the **Glenwood Place** 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: Evaluation of Tenant, Criteria for Exclusion of Tenant, Service Plan, Nurse Review, and Staffing. **Glenwood Place** ("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 May 12, 2011, has been reviewed and will constitute the final POC related to the on-site visit of April 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 Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 33376-C**

Pamela Wells, Director
Glenwood Place
2907 South 6th St.
Marshalltown, IA 50158

Date of Investigation:

April 7, 2011

Monitor(s):

Joyce Kix, RN
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 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 Glenwood Place on April 7, 2011. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific unit, but may include tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	37
Current number of tenants with cognitive disorder:	3
Total Population of GPP:	40

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

Total Population of DSP:	8
Total Census of ALP:	48

***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. –

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

The following information was identified during the course of the investigation.

A. Evaluation of Tenant

- Monitoring Observation: Tenant #1, a 95 year old, was admitted 10-20-07 with diagnoses of: Alzheimer's Disease, Hypertension (HTN), Lumbago, Arthritis, and Depression. The Short Portable Mental Status Questionaire scored the tenant with mild cognitive impairment. The service plan dated 1-21-11 documented the tenant was very weak and debilitated, required sponge baths by staff, staff assistance with dressing, grooming, toileting, and eating and required staff assistance of one to two persons to transfer. During interview, Staff #1 reported the tenant required two persons for transfer. Staff #2 stated that Tenant #1 was bedbound in late December. Staff #3 reported the tenant was totally dependent with toileting and dressing. The tenant's family member stated it took two staff to transfer the tenant after a hospitalization last winter. The family made the decision to transfer the tenant to a nursing home because he/she had lost weight and sustained pressure sores and the family felt the tenant needed a higher level of care. Incident reports document the tenant had fallen and/or been found on the floor six times since 1-26-11. The clinical record documented the tenant lost 25.2 pounds from 5-10 to 11-10 and had not been weighed since. The clinical record lacked documentation of completion of comprehensive health, cognitive or functional evaluations since 1-21-11 for falls and potential continued weight loss and declining functional abilities.

  Tenant #2, an 84 year old, was admitted 5-31-09 with diagnoses of: Diabetes, HTN, Dementia, Degenerative Arthritis, and Hearing Loss. The tenant scored 4 on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. According to the program Vital Sign Flow sheet, the tenant lost 29.7 pounds from 11-2010 to 12-2010. During the month of January 2011 the tenant lost another 1.3 pounds. The clinical record contained documentation of comprehensive assessments completed 12-29-10 and 2-7-11 which lacked any reference to the tenant's weight loss. The service plans of 12-29-10 and 2-7-11 directed staff to offer the tenant limited selections of food and prompt and cue the tenant to eat with an additional intervention under "Other Resident Needs" that staff offer snacks. The evaluations were completed but lacked inclusion of evaluation of the tenant's weight loss to determine any changes to services needed.

  Tenant #6, a 76 year old, was admitted 9-16-08 with diagnoses of Alzheimer's Disease and Diabetes. The tenant scored 6 on the GDS which indicated severe cognitive decline. According to the program Vital Sign Flow sheet, the tenant lost 1.2 pounds in September 2010, 4.6 pounds in October 2010, 9 pounds in November 2010, 4.9 pounds in December 2010, and 4.1 pounds in January 2011 for a total weight loss of 23.8 pounds. The evaluations completed 12-7-10 for a change of condition due to a new diagnosis of pyria, (gum disease), included no new interventions or mention of weight loss. The service plan of 12-7-10 documented the tenant's appetite was good and directed staff to encourage the tenant to eat when he/she appeared to have stopped. According to Staff #2, the tenant was unable to follow commands and had sustained an open wound on his/her coccyx. Staff #2 advised the registered nurse (RN) regarding the tenant's weight loss and indicated the tenant struggled to eat independently. Staff #2 said she suggested to family that they

bring a supplement drink. The clinical record lacked documentation of completion of health, cognitive and functional evaluations for changes in health condition observed by staff of weight loss and open wounds.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Criteria for Exclusion of Tenants

Complaint Allegation: It was alleged that a tenant was totally incontinent but the program stated the tenant could stay as long as they could sort of function.

- Monitoring Observation: Tenant #1's service plan dated 1-21-11 documented the tenant was very weak and debilitated, required sponge baths by staff, staff assistance with dressing and grooming, toileting, and eating and staff assistance of one to two persons to transfer. During interview, Staff #1 reported the tenant routinely required two persons for transfer. Staff #2 stated that Tenant #1 was bedbound in late December. Staff #3 reported the tenant was totally dependent with toileting and dressing. The tenant's family member stated it took two staff to transfer the tenant after a hospitalization last winter. The family made the decision to transfer the tenant to a nursing home because he/she had lost weight and sustained pressure sores and the family felt the tenant needed a higher level of care. Incident reports document the tenant had fallen and/or been found on the floor six times since 1-26-11. The clinical record documented the tenant lost 25.2 pounds from 5-10 to 11-10 and had not been weighed since. The family member stated that the program did not suggest the tenant be discharged and instead was encouraging him/her to stay. The clinical record did not contain documentation that the program had applied to the department for a waiver in order to retain a tenant who exceeded the level of care criteria restrictions. According to record review, staff and family interview, the tenant exceeded the level of care criteria for assisted living. The tenant transferred to a nursing home level of care 4-2-11 at the family's request.

- According to the program Vital Sign Flow sheet, Tenant #6 lost 1.2 pounds in September 2010, 4.6 pounds in October 2010, 9 pounds in November 2010, 4.9 pounds on December 2010, and 4.1 pounds in January 2011 for a total weight loss of 23.8 pounds. The evaluations completed 12-7-10 for a change of condition due to a new diagnosis of pyria included no new interventions or mention of weight loss. The service plan of 12-7-10 documented the tenant's appetite was good and directed staff to encourage the tenant to eat when he/she appeared to have stopped. The service plan also indicated the tenant was incontinent. According to Staff #2, the tenant was unable to follow commands prior to discharge and had become totally incontinent and sustained an open wound on his/her coccyx. Staff #2 advised the registered nurse (RN) regarding the tenant's weight loss and indicated the tenant struggled to eat independently. Staff #2 said she suggested to family that they bring a supplement

drink. The family reported the tenant could no longer eat independently and was totally incontinent, however the program director advised the family the tenant could stay as long as he/she could "sort of" function. The program had advised the family that staff could not feed tenants. The documentation from admission papers dated 2-18-11 from the nursing home indicated the tenant had a pressure ulcer on the coccyx which measured 1 by 1 centimeter (cm) with 0.2 cm depth. The admission assessment from the nursing home also documented the tenant required assistance with all activities of daily living. The clinical record lacked documentation of a request for a waiver from the department for a tenant who exceeded level of care. According to the clinical record, family and staff, the tenant was incontinent, could not follow simple commands, could not eat independently and exceeded the level of care criteria for assisted living. The tenant was discharged to a nursing home at the family's request on 2-18-11.

- 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))

The following information was identified during the course of the investigation.

C. Service Plan

- Monitoring Observation: Tenant #1's service plan dated 1-21-11 documented the tenant was very weak and debilitated, required sponge baths by staff, staff assistance with dressing, grooming, toileting, and eating and required staff assistance of one to two persons to transfer. During interview, Staff #1 reported the tenant required two persons for transfer. Staff #2 stated that Tenant #1 was bedbound in late December. Staff #3 reported the tenant was totally dependent with toileting and dressing. The tenant's family member stated it took two staff to transfer the tenant after a hospitalization last winter. The family made the decision to transfer the tenant to a nursing home because he/she had lost weight and sustained pressure sores and the family felt the tenant needed a higher level of care. Incident reports document the tenant had fallen and/or been found on the floor six times since 1-26-11. The clinical record documented the tenant lost 25.2 pounds from 5-10 to 11-10 and had not been weighed since. The clinical record lacked evidence of inclusion in the service plan of interventions to meet the specific needs for Tenant #1.

  According to the program Vital Sign Flow sheet, Tenant #2 lost 29.7 pounds from 11-2010 to 12-2010. During the month of January 2011 the tenant lost another 1.3 pounds. The clinical record contained documentation of comprehensive assessments completed 12-29-10 and 2-7-11 which lacked any reference to the tenant's weight loss. The service plans of 12-29-10 and 2-7-11 directed staff to offer the tenant

limited selections of food and prompt and cue the tenant to eat with an additional intervention under "Other Resident Needs" that staff offer snacks. The evaluations were completed but lacked inclusion of evaluation of the tenant's weight loss to determine any if changes to the service plan were needed.

According to the program Vital Sign Flow sheet, Tenant #6 lost 1.2 pounds in September 2010, 4.6 pounds in October 2010, 9 pounds in November 2010, 4.9 pounds on December 2010, and 4.1 pounds in January 2011 for a total weight loss of 23.8 pounds. The evaluations completed 12-7-10 for a change of condition due to a new diagnosis of pyria included no new interventions or mention of weight loss. The service plan of 12-7-10 documented the tenant's appetite was good and directed staff to encourage the tenant to eat when he/she appeared to have stopped. According to Staff #2, the tenant was unable to follow commands and had sustained an open wound on his/her coccyx. Staff #2 advised the registered nurse (RN) regarding the tenant's weight loss and indicated the tenant struggled to eat independently. Staff #2 said she suggested to family that they bring a supplement drink. The clinical record lacked evidence of inclusion in the service plan of interventions to meet the specific needs Tenant #6.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))

D. Nurse Review

Complaint Allegation: It was alleged a tenant lost 40 pounds and the family was not notified. It was also alleged a tenant had a pressure ulcer which was not identified by the program.

- Monitoring Observation: Tenant #1 required staff assistance of one to two persons to transfer. During interview, Staff #1 reported the tenant required two persons for transfer. Staff #2 stated that Tenant #1 was bedbound in late December. Staff #3 reported the tenant was totally dependent with toileting and dressing. The tenant's family member stated it took two staff to transfer the tenant after a hospitalization last winter. The family made the decision to transfer the tenant to a nursing home because he/she had lost weight and sustained pressure sores and the family felt the tenant needed a higher level of care. Incident reports document the tenant had fallen and/or been found on the floor six times since 1-26-11. The clinical record documented the tenant lost 25.2 pounds from 5-10 to 11-10 and had not been weighed since. The tenant transferred to a nursing home level of care 4-2-11 at the family's request. The clinical record lacked evidence of nurse review of changes in health and functional status.

  According to the program Vital Sign Flow sheet, Tenant #2 lost 29.7 pounds from 11-10 to 12-10. During the month of January 2011 the tenant lost another 1.3 pounds. The clinical record contained documentation of comprehensive assessments completed 12-29-10 and 2-7-11 which lacked any reference to the tenant's weight loss.

The RN stated she forgot to review the tenants' vital signs flow sheet to evaluate for weight loss. The service plans of 12-29-10 and 2-7-11 directed staff to offer the tenant limited selections of food and prompt and cue the tenant to eat with an additional intervention under "Other Resident Needs" that staff offer snacks. The evaluations were completed but lacked inclusion of evaluation of the tenant's significant weight loss.

Tenant #5, an 88 year old, was admitted 11-25-09 with diagnoses of: Dementia, HTN, Asthma, and Hypercholesterolemia. According to the Vital Sign Flow Sheet, the tenant had lost 21 pounds from May 2010 to September 2010. The clinical record lacked documentation of a nurse review upon identification of significant weight loss.

According to the program Vital Sign Flow sheet, Tenant #6 lost 1.2 pounds in September 2010, 4.6 pounds in October 2010, 9 pounds in November 2010, 4.9 pounds on December 2010, and 4.1 pounds in January 2011 for a total weight loss of 23.8 pounds. The evaluations completed 12-7-10 for a change of condition due to a new diagnosis of pyria included no new interventions or mention of weight loss. According to Staff #2, the tenant was unable to follow commands and had sustained an open wound on his/her coccyx. Staff #2 advised the registered nurse (RN) regarding the tenant's weight loss and indicated the tenant struggled to eat independently. The clinical record lacked evidence of nurse review for changes in health status of weight loss and open wounds. Upon discharge and admission to a nursing home 2-18-11, a 1 by 1 cm by .2 cm pressure ulcer was identified on the tenant's coccyx. The RN stated she was not aware of a wound on the tenant's coccyx. The Nurse's Notes lacked evidence of notification to the family of skin condition or weight loss.

- Regulatory Insufficiency: 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))

E. Staffing

Complaint Allegation: It was alleged a tenant needed feeding assistance which was not provided by the program.

- Monitoring Observation: According to the program Vital Sign Flow sheet, Tenant #6 lost 1.2 pounds in September 2010, 4.6 pounds in October 2010, 9 pounds in November 2010, 4.9 pounds on December 2010, and 4.1 pounds in January 2011 for a total weight loss of 23.8 pounds. The evaluations completed 12-7-10 for a change of condition due to a new diagnosis of pyria included no new interventions or mention of weight loss. The service plan of 12-7-10 documented the tenant's appetite was good and directed staff to encourage the tenant to eat when he/she appeared to have stopped. According to Staff #2, the tenant was unable to follow commands and Staff #2 had observed the tenant at 1:45 pm to still be sitting at the dining room table with cold food on the plate. Staff #2 advised the registered nurse (RN) regarding the tenant's weight loss and indicated the tenant struggled to eat independently. Staff #2 said she suggested to family that they bring a supplement drink. The family reported the tenant could no longer eat independently.

The program had advised the family that staff could not feed tenants. The program practice as described by the RN was to prompt and cue tenants to eat. Staff were advised they could load the spoon but not actually sit by the tenant and feed them. According to staff and family interview, Tenant #6 could not feed himself/herself. The program failed to fully meet the tenant's identified needs when they did not provide assistance with eating.

- 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 20th day of May 2011.