IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

June 27, 2011

Daniel March, Administrator
Heritage House Assisted Living
1200 Brookridge
Atlantic, IA 50022

CORRECTED

RE: Heritage House Assisted Living v. Iowa Department of Inspections and Appeals, Health Facilities Division, Docket No. 10DIAHFL005

Dear Mr. March:

Pursuant to the Consent Order entered into by the parties in the above-captioned matter and approved by the Administrative Law Judge, the Department has rescinded the Civil Penalty of $500.00 previously assessed under Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Final Report, dated April 28, 2011, retains the Regulatory Insufficiency in the area(s) of: Criteria for Exclusion of Tenant.

If you have any questions, please contact your Program Coordinator, Jim Berkley, at 515/281-4116.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

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IOWA DEPARTMENT OF
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TERRY E. BRANSTAD
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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 33239-I

April 29, 2011

Daniel March, Administrator
Heritage House Assisted Living
1200 Brookridge
Atlantic, IA 50022

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

Dear Mr. March:

I. Final Incident Investigation Report – Heritage House Assisted Living, Atlantic, 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 Insufficiency in the area(s) of: Criteria for Exclusion of Tenant. **Heritage House** ("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 April 13, 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 due to additional documentation submitted by the program does not support the program was in compliance at the time of the onsite.

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 #: 33239-I**

Daniel March, Administrator
Heritage House Assisted Living
1200 Brookridge
Atlantic, IA 50022

Date of Incident Investigation:

March 15, 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 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 Heritage House Assisted Living on March 15, 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 program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	65
Current number of tenants with cognitive disorder:	0
Total Population:	65

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 – 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. Criteria for exclusion of tenant

Incident Allegation: The program reported Tenant #1 called staff via his/her personal emergency response system (PERS). Staff found the tenant sitting on his/her bed, bleeding from the left wrist. The tenant stated he/she tried to kill himself/herself.

- Monitoring Observation: Tenant #1, an 82 year old, was admitted on 12-2-08 and had diagnoses of: Bipolar Disorder, History of Stroke, Hypertension, Coronary Artery Disease, Chronic Arthritis and Hypothyroidism. A cognitive evaluation was completed on 7-2-10 and indicated the tenant had normal cognition. A 90-day nurse review, which included a functional evaluation, was completed on 1-13-11 and indicated the tenant was alert and oriented to name, place and time. The tenant had trouble sleeping and awoke with dreams that left him/her unsettled at times. The tenant had no behavior problems, was eating well and attended activities and exercise programs regularly. The tenant was seen every six months for psychiatric oversight and had regular visit scheduled visits with the local mental health center.

A service plan of 7-15-11 revealed the tenant had a history of suicidal thoughts and suicidal attempts. Interventions were established, including frequent night checks and a managed risk agreement related to previous suicidal attempts. A managed risk agreement of 7-15-10 revealed the tenant agreed to tell staff when he/she had feelings of self harm. Staff were to notify the registered nurse (RN) and immediately transfer the tenant to the hospital.

An investigation by the department was completed on 7-29-10 related to an incident of self harm by Tenant #1 on 7-12-10. Nurse's notes of 7-12-10 indicated the tenant was found sitting on the floor next to the bed. The tenant was alert but would not speak to staff. When asked what was wrong the tenant pointed to both shoulders. Staff attempted to help the tenant up from the floor but the tenant refused. The tenant's blood pressure was taken and the tenant's family was called. An ambulance transported the tenant to a local hospital emergency room. Hospital staff indicated the tenant reported he/she had taken several Tylenol PM through the night in an attempt to sleep. A hospital history and physical exam was completed on 7-14-10. During the exam the tenant stated he/she did not truly want to kill himself/herself. The tenant reported he/she was getting one to two hours of sleep. The tenant indicated he/she had an ongoing struggle with suicidal thinking because "I was tired of living." On 7-15-10, the tenant was discharged from the hospital and returned to the program.

Nurse's notes of 7-21-10 through 3-10-11 revealed no incident of self harm or suicidal ideation. An incident report of 3-11-11 revealed the tenant paged staff for assistance. Upon entering the tenant's apartment, staff found the tenant sitting on the edge of the bed and the tenant's left wrist was bleeding. The tenant was questioned by staff and the tenant said he/she tried to kill himself/herself. The tenant was transported to a local hospital emergency room and was later admitted. A review of medication administration records (MARs) for 11-1-10 through 3-11-11 revealed the tenant was compliant with medications administered by the program. A hospital psychiatrist stated the tenant had been frustrated with his/her inability to sleep. The tenant reported his/her spouse had died two years earlier and was embarrassed over the suicide attempt. The tenant was "acutely saddened – possibly acutely lonely." The tenant was to be discharged from the

hospital, admitted to a local nursing facility for observation for five days and then return to the program. Family was to have all sharp objects removed from the tenant's apartment.

A physician assistant who sees the tenant every six months for outpatient psychiatric clinic stated there was no planning or warning to the tenant's suicidal attempts. The tenant was impulsive and it was difficult to predict when he/she may attempt suicide.

The program RN stated the tenant's sleep patterns were inconsistent and would have nightmares. The tenant complained of not sleeping well and would get up in the middle of the night, would come out of his/her apartment and staff would prepare something for the tenant to eat and would go back to bed. There was nothing out of the ordinary leading up the suicidal attempt of 3-11-11. The tenant's suicide attempt was spontaneous. When the tenant made suicidal attempts he/she would have regrets of attempting self harm. It was this time two years ago when the tenant's spouse had died. Staff #1 stated the tenant would have dreams and nightmares and would usually come out of his/her apartment to find staff and would realize where he/she was and was easily redirected back to his/her apartment. Staff stated the tenant used a paring knife to cut his/her wrist.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who is dangerous to self. (IAC r.481-69.23(1))

Dated this 28th day of April, 2011.