IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 35646-I

October 14, 2011

Ms. Nikki Gillies, Administrator
Jersey Ridge Assisted Living
5605 Jersey Ridge Road
Davenport, IA 52807

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

Dear Ms. Gillies:

I. Final Incident Investigation Report – Jersey Ridge 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 Insufficiency in the area(s) of: Structural Requirements. **Jersey Ridge Assisted Living** ("Program") is being assessed a $1500 civil penalty reduced from $2,000 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 September 28, 2011, has been reviewed and will constitute the final POC related to the on-site visit of August 30, 2011.

Elements #1 & #2 of the Request for Reconsideration regarding Staffing has been accepted based on the fact that the alarm malfunctioned and staff appeared to follow the program's policy. The Department did not agree with Element #3 as the Missing Tenant Policy was not accessible to staff based on staff interviews.

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 #:** 35646-I

Nikki Gillies, Administrator
Jersey Ridge Assisted Living
5605 Jersey Ridge Road
Davenport, IA 52807

Date of Incident Investigation:

August 30, 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 Jersey Ridge Assisted Living on August 30, 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:	27
Current number of tenants with cognitive disorder:	2
Total Population of GPP:	29

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

Total Population of DSP:	10
Total Census of ALP:	39

***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 found during this certification period in the areas of Nurse Review, Structural, Service Plan, Medications, Food Service, Staffing, Dementia Specific Education, Record Checks and Dependent Adult Abuse Training.

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

A. Structural

Incident Allegation: On 8-29-11 the program reported Tenant #1 (the Tenant) had eloped from the Program on 8-27-11. The Tenant had attempted to leave the dementia unit, alarming the exit door at approximately 3:00 p.m. Staff redirected the Tenant away from the exit door and reset the door alarm and secured the exit door. At approximately 3:25 p.m. staff went to check on the Tenant and noticed the exit door was partially open. Staff searched inside and the perimeter of the Program. The Tenant was found at a restaurant, approximately 300 yards from the Program.

- Monitoring Observation: Tenant #1 (the Tenant), an 86 year old, was admitted on 4-16-08 and had diagnoses of: Dementia, Rheumatoid Arthritis and a history of a Left Knee Replacement. A Global Deterioration Scale was completed on 4-4-11 and 8-27-11 and staged the Tenant at six, which indicated severe cognitive decline. The Tenant resided in the dementia unit. Nurse's notes of 1-24-11 through 8-26-11 revealed the Tenant made one attempt to leave the dementia unit. The service plan of 4-5-11 indicated the staff was to monitor the Tenant for exit seeking behaviors and redirect and reassure the Tenant everything was okay. Staff reassuring the Tenant helped the Tenant feel better and reduce his/her anxiety. On 5-4-11, the Tenant went out of the dementia unit and down the hallway of the general population. Staff was able to redirect the Tenant back to the dementia unit.

No other attempts were made to elope from the Program. Staff #1 reported on 8-27-11, at approximately 3:00 p.m. she arrived at the program for the beginning of her shift. She was checking the medication administration records (MARs) and received an end of shift report from day staff when the exit door alarm activated. The Tenant had attempted to leave the Program. The Tenant was redirected and staff continued their end of shift report. Staff #1 reported she was going through the MARs to determine what tenants received 4:00 p.m. medications. She then noticed she hadn't seen the Tenant recently. On the way to the Tenant's room, she noticed the exit door was "cracked" open. She opened the door to see if the Tenant had gone down the hall. The dementia unit and tenant's rooms and the outside courtyard were checked, without the Tenant being found. Program staff searched the entire program without success. The Administrator was called and staff was directed to "do a second sweep of the building."

The Administrator reported she called local police and reported the Tenant was missing. Staff found the Tenant at a local restaurant. Restaurant staff reported the Tenant had been there for about 45 minutes. Staff brought the Tenant back to the program. The program initiated hourly door checks until the security system company inspected the security system. The Tenant was evaluated and the service plan was updated on 8-27-11 to include specific interventions related to the tenant's wandering and exit seeking behavior. Staff was to complete hourly safety checks on the Tenant and was to engage the tenant in one-on-one activities. The Administrator reported the program completed door alarm checks on all doors leading into and from the dementia unit at the beginning of each shift.

On 8-30-11, a security system company inspected and tested all doors for proper alarming and paging. The Administrator indicated when the Tenant attempted to leave the dementia unit, staff closed the door and activated the door alarm system, but the door did not reset in the security system.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481-69.35(1)(b))

Dated this 13th day of October, 2011.