IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 37125-C

February 8, 2012

Ms. Pamela Wells, Administrator
Glenwood Place Assisted Living
2907 South 6th Street
Marshalltown, IA 50158

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

Dear Ms. Wells:

I. Final Complaint/Incident Investigation Report – Glenwood Place Assisted Living, Marshalltown, IA

Enclosed is the **Final Complaint/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: Service Plans. **Glenwood Place 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 ($325) within 30 business days after the receipt of this demand letter. The civil penalty has been received.

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 January 23, 2012, has been reviewed and will constitute the final POC related to the on-site visit of December 28 & 29, 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/Incident Investigation Report

Assisted Living Program:

Complaint/Incident Intake #: 37125-C

Pamela Wells, Administrator
Glenwood Place Assisted Living
2907 South 6th Street
Marshalltown, IA 50158

Date of Complaint/Incident Investigation:

December 28 and 29, 2011

Monitor(s):

Lori Miner, RN BSN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	38
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	41
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	8
TOTAL census of Assisted Living Program	49

Program History – The program received regulatory insufficiencies in the areas of Evaluation of Tenant, Criteria for Exclusion of Tenant, Service Plan, Nurse Review, Staffing and Record Checks.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Service Plans

Complaint/Incident Allegation: It was alleged a tenant had a change of condition, and needs were not being met.

- Monitoring Observation: Four tenant files were reviewed. Files for Tenant #1, #2, and #3 documented change of condition reviews followed by service plan updates.

  Tenant #4, an 89 year-old, was admitted on 2-12-11 and had diagnoses of Dementia, Angina, Balance Issues, and Shortness of Breath. Tenant #4 was staged at four on the Global Deterioration Scale which indicated moderate cognitive decline. Tenant #4 resided in the dementia unit. Nurse's noted dated 10-5-11 indicated the physician was contacted regarding Tenant #4's pain, difficulty taking steps, and inability to lift a leg. Pain medication was started and Tenant #4 was reported to be comfortable, but had pain when bearing weight. Tenant #4 was seen by the physician on 10-18-11; a scan was requested to rule out a fracture, but physical therapy was ordered instead. Documentation by The Program Nurse, completed 10-19-11, indicated Tenant #4 had back pain. Nurse's notes of 11-10-11 documented the results of a scan of the back as showing Arthritis and Degenerative Disease. Notes dated 12-8-11 indicated Tenant #4 was seen by another physician, and it was reported the results of magnetic resonance imaging revealed a previously undiagnosed hip fracture.

Tenant #4 was to be non-weight bearing and was to see an orthopedic physician the following week. The service plan dated 10-19-11 was not updated to indicate Tenant #4 was non-weight bearing.

Nurse's notes dated 11-5-11 revealed Tenant #4 complained the buttocks was feeling sore, and Tenant #4 was repositioned in the wheelchair. One-half hour later, Tenant #4 was found to have a reddened coccyx. Nurse's notes dated 11-5-11 stated staff was instructed to apply protective cream, and noted Tenant #4 had a history of skin breakdown. Staff was also instructed to have Tenant #4 sleep in the bed rather than the recliner. A Physician's Report dated 12-1-11 indicated Tenant #4 was getting blisters between the thighs and the Program Nurse requested the physician look at Tenant #4's skin during a visit of that day. Nurse's notes dated 12-2-11 documented an order was received for an evaluation by occupational therapy (OT) and the 12-9-11 notes indicated OT was to evaluate the tenant for wheelchair positioning and pressure-relief cushions.

The service plan dated 10-19-11 did not establish interventions related to skin breakdown and repositioning.

Unless noted otherwise, nurse's notes documented the following:

12-13-11	Abraded area on left shoulder, 4 centimeters (cm) x 2 cm, no drainage A large fluid-filled blister was noted on right heel
12-13-11	Fax to physician regarding blisters (on fax form)
12-15-11	Blister on left shoulder and right heel Clear fluid filled sac covered to protect from friction
12-16-11	(From the health assessment form) left shoulder blister-quarter size, no drainage, color clear. Right heel blister 10cm x 4cm, no drainage, color clear. Intermittent blisters on thighs.
12-16-11	Nurse's notes indicated Tenant #4 had a change of condition—deterioration. The decline in health was evidenced by skin breakdown. Functional, cognitive, and health evaluations were completed at that time.
12-17-11	Special dressing applied to intact blister
12-18-11	Blister intact to right heel, oozing noted
12-19-11	Blister on right heel has broken. Special dressing applied after skin removed from area
12-20-11	Special dressing did not adhere. Right heel area pink in color. Covered with gauze and antibiotic ointment. Coccyx area open 0.2 cm x 0.2 cm-zinc oxide applied. Left shoulder abraded with granulation on edges. Fax form documented communication with physician regarding the broken blister
12-22-11	Tenant #4 has appointment with physician. Wound care orders received. Antibiotic started for infection in area. Order received for "good high protein diet"
12-27-11	Right heel area improving. Left shoulder area remains pink and size of a quarter. Buttocks area showing signs of improvement. Tenant #4 transferred to higher level of care.

Staff #1 was interviewed and stated Tenant #4 was in a wheelchair and wheeled himself/herself with his/her feet. Staff #1 stated Tenant #4 wore shoes until the blister popped, and then dressings were applied twice a day.

Staff #2 was interviewed and stated Tenant #4 had a blister on the right heel from the wheelchair. Tenant #4 used the heel to push himself/herself around. Tenant #4 had a sore on the back. Tenant #4 leaned in the wheelchair and the chair rubbed the back. Staff #2 stated dressings on the heel had to be changed because of the drainage.

Staff #3 was interviewed and stated Tenant #4 had a blister on the foot because Tenant #4 was walking with the heels of his/her feet when using the wheelchair. Staff #3 also stated sores on the coccyx were from sitting in the wheelchair and the sore underneath the armpit was from leaning in the wheelchair. Staff #3 stated the coccyx sore would heal then re-develop. It was reported Tenant #4 had "given up" and wouldn't walk. Tenant #4 stayed in the wheelchair. Tenant #4 leaned to the side. Staff #3 also indicated Tenant #4 had sores on upper thighs from clothes rubbing, but those healed quickly.

Staff #4 was interviewed and stated Tenant #4 ambulated in a wheelchair and would go "around the block" in the dementia unit "constantly." Staff #4 stated the open area on the shoulder was from rubbing against the wheelchair.

The service plan was updated on 12-16-11 after the completion of functional, cognitive, and health evaluations for the change of condition—deterioration, evidenced by skin breakdown. The service plan noted Tenant #4 had a blister on the heel and staff should ensure proper fit of shoes or put on slipper socks. The service plan noted Tenant #4 had been working with OT for a positioning device. The service plan noted Tenant #4 had a history of skin breakdown and wanted "that treated according to physician recommendations," and to have boots on while in bed or recliner. The service plan did not identify the specific recommendations of the physician. The service plan did not include specific interventions for skin breakdown and wound care, skin care to the coccyx, or repositioning/positioning in the wheelchair or bed.

On 12-22-11, the physician ordered a "good high protein diet." The service plan was not updated to include dietary interventions.

Tenant #4 was discharged to a higher level of care on 12-27-11 and no longer resides at the program.

The service plan did not meet the identified needs of Tenant #4 relating to interventions for wound care, skin care, positioning/repositioning in the bed and wheelchair, or dietary interventions to provide for a high protein diet.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (*a*) the tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))