IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 37363-I

February 9, 2012

Ms. Jenny Knust, Director
John's Harbor
3520 Grand Avenue
Des Moines, IA 50312

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

Dear Ms. Knust:

I. Final Complaint/Incident Investigation Report – John's Harbor, Des Moines, 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 Insufficiencies in the area(s) of: Evaluation, Service Plans, Structural Requirements and Other (following Program's Plan of Correction). **John's Harbor** ("Program") is being assessed a $2,000 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 **Rose Boccella** and remit the civil penalty assessed by check or money order in the amount of one thousand three hundred dollars ($1,300) 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 $2,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on February 8, 2012, has been reviewed and will constitute the final POC related to the on-site visit of January 17, 2012.

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, Rose Boccella, at 515/281-7039.

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:

Jenny Knust, Director
John's Harbor
3520 Grand Avenue
Des Moines, IA 50312

Complaint/Incident Intake #: 37363-I

Date of Complaint/Incident Investigation:

January 17, 2012

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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	4
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	15
TOTAL census of Assisted Living Program	15

Program History – The program received a regulatory insufficiency in the area of Structural Requirements during this certification period.

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

A. Evaluation

Complaint/Incident Allegation: The Program reported Tenant #1was found on the floor on 1-3-12, bleeding from a wound on the head. Tenant #1 was unresponsive for two minutes. Tenant #1 was transported to the hospital. Tenant #1 was later diagnosed with a subarachnoid bleed (internal bleeding of the head).

- Monitoring Observation: Tenant #1, an 81 year-old, was admitted on 10-30-09 and had diagnoses of: Rheumatoid Arthritis, Parkinson's Disease, and Hypertension (HTN). Tenant #1 was staged at five to six on the Global Deterioration Scale (GDS) which indicated moderately severe to severe cognitive decline. The Program appropriately reported the injury of 1-3-12 within 24 hours. An incident report was completed at the time of injury.

  Functional, cognitive, and health evaluations were completed on 5-13-11 and the service plan was updated following frequent falls in April 2011. Tenant #1 was seen by a physician in May 2011. Medications were adjusted and Physical Therapy (PT) was ordered. Tenant #1 was to see a neurologist in August 2011 because of the Parkinson's Disease. The neurologist ordered medication and PT to help with a freezing gait and evaluation for a new walker. Nurse's notes dated 9-26-11 indicated there had been no recent falls. PT was completed 9-29-11. Nurse's notes documented two falls in October 2011. A nurse review dated 11-11-11 indicated Tenant #1 had an unsteady gait, was unable to retain information provided by PT, needed assist and redirection daily, and had a scissors-like gait which contributed to falls. Nurse's notes documented four more falls between 11-12-11 and 12-27-11. The incident reports which documented the falls of 12-9-11 and 12-27-11 indicated Tenant #1 hit his/her head with those falls. On 12-7-11 a fax was sent to the physician which indicated Tenant #1 was more difficult to care for in the evenings. The fax documented Tenant #1 was wandering "endlessly" and making others upset.

Tenant #1 was agitated when staff tried to redirect. The physician responded with an increase in Seroquel, an antipsychotic medication. The physician was to be informed if Tenant #1 was not better in a week. Nurse's notes dated 12-28-11 indicated family would start looking for placement for a higher level of care. Tenant #1 was found on the floor on 1-3-12 bleeding from a head wound. A large bruise was also noted over the right shoulder. Tenant #1 was unresponsive for two minutes. A neurological check was completed and was found to be normal except for a left grip stronger than the right. The difference was attributed to right shoulder pain. Tenant #1 was transported to the hospital via ambulance. Tenant #1 was diagnosed with bleeding in the brain. Tenant #1 died 1-10-12.

The most recent functional, cognitive, and health evaluations were completed 5-13-11. Tenant #1 was evaluated by PT twice; in May and September 2011. There was no evaluation of Tenant #1's condition after completion of either PT evaluation. Tenant #1 had six falls between October and December 2011. Evaluations were not completed after a series of falls, two of which resulted in bumps to the head. Tenant #1 was noted to be wandering endlessly, upsetting others, and agitated. Medication was changed and there was no evaluation to determine the effectiveness of the medication on Tenant#1's behavior. It was discussed with the family Tenant #1 required a higher level of care. Evaluations were not completed with changes of condition.

During the course of the investigation, the following was noted:

Tenant #2, an 85 year-old, was admitted on 3-22-08 and had diagnoses of: HTN, Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux Disease, Dementia, Hypothyroidism, and Osteoarthritis. Tenant #2 was hospitalized in May 2011 due to a fall and a pelvic fracture. Tenant #2 scored 11 of 11 points on the cognitive assessment which indicated no or mild impairment.

Functional, cognitive, and health evaluations were completed on 8-23-11 and the service plan was updated. Nurse's notes dated 8-29-11, 9-16-11, and 9-18-11 documented falls. It was documented on 9-18-11 Tenant #2 felt dizzy and hit his/her head during the fall. A fax dated 9-20-11 sent to the physician requested Meclizine be scheduled three times a day rather than "as needed" due to the dizziness during the falls. An order was requested for PT evaluation. The physician ordered the change to the medication on 9-30-11. PT visited three times and recommended Tenant #2 have stand-by assist with all ambulation. Nurse's notes dated 10-17-11 indicated Tenant #2 tripped and had a small bump on the head. Nurse's notes dated 1-10-12 indicated Tenant #2 was ambulating in the apartment, fell and hit his/her head on the edge of the wall. A laceration on the left side of the head was noted to be bleeding profusely. Tenant #2 was transported to the emergency room via ambulance. A scan of the head was completed and was negative. Three staples were placed into the left scalp laceration. Skin tears were also noted on the arm. Tenant #2 returned to the Program on the same day with discharge instructions which included wound care and "fall precautions." Nurse's notes dated 1-12-12 indicated Tenant #2 needed increased assistance when using the walker. Tenant #2 was noted to be unsteady at times. Reminders were given to use a call pendant to request assistance when getting up.

Evaluations were not completed after a series of falls, two of which resulted in a bump to the head. Evaluations were not completed with significant change.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also 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 when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Service Plans

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1 was evaluated by PT following two series of falls. The goal was to decrease unsafe behavior. On 9-29-11 PT identified staff members were inconsistent with verbal cueing to Tenant #1 to reduce the scissor gait. PT noted staff members did not remind Tenant #1 to use the walker when Tenant #1 ambulated without it. PT gave instruction to work through the freezing gait. A front wheeled walker was recommended. PT documented the reason Tenant #1 was discharged from treatment was secondary to non-compliance of staff members and Tenant #1.

  Staff #1 stated Tenant#1 was noted to wander into other tenant's rooms, which had been occurring for about the last six months. On 12-7-11 a fax sent to the physician documented Tenant #1 was more difficult to care for in the evenings. The fax documented Tenant #1 was wandering "endlessly" and making others upset. Tenant #1 was agitated when staff tried to redirect.

  The current service plan dated 5-13-11 did not indicate specific strategies for the scissor gait, the freezing gait, or the type of walker needed, which were fall prevention strategies identified by PT. The service plan did not indicate Tenant #1 was receiving PT services. The service plan did not indicate interventions for wandering into other tenant's rooms or interventions for increased agitation.

  Tenant #2 was treated for a head laceration on 1-10-12. Discharge instructions included wound care and "fall precautions." An interview with the Program Nurse indicated the only wound care was to keep the staples dry and only nurses were caring for the skin tears. The current service plan dated 8-23-11 was not updated to include keeping the staples dry or wound care provided by the nurse. The service plan for Tenant #2 did not indicate stand-by assistance was required as suggested by PT, nor that PT was ordered. Nurse's notes dated 1-12-12 indicated Tenant #2 needed increased assistance when using the walker. Tenant #2 was noted to be unsteady at times. Reminders were given to use a call pendant to request assistance when getting up.

Staff #2 was interviewed and stated, since the fall, staff members had been providing stand-by assist with Tenant #2 when ambulating. The service plan did not indicate interventions for falls.

The service plans did not indicate the tenants identified needs or services provided by PT.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (a) the tenant's identified needs and preferences for assistance; and (c) the service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy. (IAC r. 481-69.26(4)(a)(c))

C. Structural Requirements

During the course of the investigation, the following was noted:

- Monitoring Observation: The Program was dementia-specific. At approximately 9:30 a.m. the kitchen door was found open with no staff members present. Tenants were observed in the dining room and in the lounge. In the kitchen, food warmers were seen on the counter, and the food warmers were hot to the touch.
  At 12:08 p.m., the kitchen door was again found open with no staff members present. Tenants were observed in the dining room. In the kitchen, food warmers were seen on the counter, and the food warmers were hot to the touch.

  Hot food warmers were readily accessible to tenants in the dementia unit. The hot food warmers were a potential burn hazard. The kitchen was not safe.

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

D. Other

During the course of the investigation, the following was noted:

- Monitoring Observation: The Program received a regulatory insufficiency during the June 27, 2011, Recertification on-site related to food warmers which had been placed on a dining room table. The Program had submitted a Plan of Correction on July 21, 2011, which stated all electrical items identified in the inspection report have been moved to the kitchen, which will be locked when a staff member is not present. The Program failed to follow the Plan of Correction.

- Regulatory Insufficiency: Monitoring revisit. The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. (IAC r. 481-67.10(8))