IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 38389-C

May 1, 2012

Mr. Jack Collins, Administrator
Walnut Ridge Assisted Living
1701 Campus Drive
Clive, IA 50325

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

Dear Mr. Collins:

I. Final Complaint/Incident Investigation Report – Walnut Ridge Assisted Living, Clive, 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: Tenant Rights, Tenant Documents and Evaluation. **Walnut Ridge Assisted Living** ("Program") is being assessed a $1,250 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 to the State of Iowa in the amount of seven hundred thirty seven dollars and fifty cents ($737.50) 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 $1,250 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on April 23, 2012, has been reviewed and will constitute the final POC related to the on-site visit of March 26, 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:

Jack Collins, Administrator
Walnut Ridge Assisted Living
1701 Campus Drive
Clive, Iowa 50325

Complaint/Incident Intake #:

38389-C

Date of Complaint/Incident Investigation:

March 26, 2012

Monitor(s):

Maribeth Freland, RN
Joyce Kix, RN

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:	40
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	41
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	16
Total Population of Program at time of on-site	16
TOTAL census of Assisted Living Program	57

Program History – The program received the following regulatory insufficiencies as the result of the January 12, 18 and 19th, 2011 Recertification and Complaint (32548-C) on site: Evaluation, Criteria for Exclusion of Tenants, Service Plan, Medications, Nurse Review, Staffing, Tenant Rights and Other, (non-notification of elopement).

During the Recertificatio0n Revisit and Complaint Investigation (32548-C) of April 14th 2011 on-site, the program received regulatory insufficiencies in the areas of: Tenant Rights and Other (not following plan of correction).

The program received regulatory insufficiencies in the areas of: Evaluation, Service Plan, Medications, Nurse Review, Staffing, Tenant Rights, Program Notification to the Department and Plan of Correction during the April 26 and 27 and May 3, 4, 5, 2011, Second Recertification Revisit and Complaint and Incident Investigation (33811, 33653, 33852). The program was fined $8,000.

The program received regulatory insufficiencies in the areas of Medications and Plan of Correction during the August 1 and 2, 2011, Third Recertification Revisit, Revisit to Complaints (33811-CR, 33653-CR and 33852-M).

The program received regulatory insufficiencies in the areas of Service Plan and Nurse Review during the January 31 through February 1, 2012 Complaint Investigation (37357-C).

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged the program forced tenants to allow provision of services despite tenant refusal.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1 and #2, interviewed staff members and made observations of both Tenant #1 and #2.

  Tenant #1, an 84 year old who resided in the program's general population area, was admitted on 12-2-11 with the diagnosis of impaired vision. Tenant #1 answered all questions correctly on the program's cognitive assessment, completed on 11-21-11, indicating no cognitive impairment.

  Staff #1, registered nurse (RN), completed an evaluation of Tenant #1's health and functional status on 11-21-11. The RN completed a Service Plan, dated 11-21-11, documenting Tenant #1 was independent with all activities of daily living, administered his/her own medications and exhibited no behavioral concerns.

  Tenant #2, an 85 year old who resided in the program's general population area, was admitted on 12-2-11 with diagnoses of: Alzheimer's Disease, Hypertension and Lumbar Disk Disease. Tenant #2 scored a 6 on the Global Deterioration Scale (GDS) completed on 1-5-12, which indicated severe cognitive decline. Tenant #2 currently lived with Tenant #1 and the clinical record documented Tenant #1 as Tenant #2's legal representative.

  Tenant #2's service plan, updated by Staff #1, RN, on 1-5-12, documented Tenant #2 required physical assistance with bathing, set up and cuing for grooming and dressing, was independent with cuing for transfers, required physical assistance to ambulate in hallways and required physical assistance to toilet. The service plan documented Tenant #1 assisted Tenant #2 with ambulation in his/her apartment and with medication administration.

  Tenant #2's clinical record contained documentation of Tenant #1's request to provide toileting assistance and assistance with grooming/dressing for Tenant #2. The Nurse Review Notes and the Service Charting contained multiple entries indicating Tenant #1 voiced his/her request to perform these tasks for Tenant #2 yet staff refused to allow him/her to do so, forcing Tenant #1 to allow staff member assistance. Between January 2012 and March 2012, Tenant #1 did assist Tenant #2 on many occasions with toileting and hygiene needs. Tenant #2's clinical record lacked any documentation of falls while Tenant #1 was assisting and lacked documentation of skin issues or urinary tract infections resulting from improper care.

  During interview, Staff #3, certified nurse aide (CNA), reported when caring for Tenant #2 his/her legal representative may say "no but we insist if she needs it."

  During interview, Staff #4, CNA, reported when caring for Tenant #2 his/her legal representative may refuse assistance and then block use of the bathroom but she reported usually waiting and providing the care despite the representatives refusal.

During Staff #5, resident care assistant (RCA), reported when caring for Tenant #2 his/her legal representative may refuse assistance and get frustrated when staff members assist.

An occupational therapist began working with Tenant #1 and Tenant #2 to determine Tenant #1's ability to provide safe assistance to Tenant #2 on February 21, 2012. The occupational therapist sent a note to the program on February 27, 2012 outlying his/her plan to teach Tenant #1 how to safely provide assistance to Tenant #2 with toileting, transfers, grooming/hygiene and dressing. The occupational therapist provided the training, ceasing teaching on March 20, 2012 and sent a letter to the program on March 20, 2012 stating that Tenant #1 had been trained and showed competency with toileting and transferring during toileting.

According to Nurse Review Notes and Service Charting documentation, after March 20, 2012, staff members continued to force provision of toileting assistance before and after meals.

The clinical records for Tenant #1 and Tenant #2 documented multiple occurrences when the program talked with family members regarding falls, behaviors, and decision making for Tenant #1 and #2. The program could not provide evidence of a signed permission to release medical and personal information to any other person with the exception of third party payers.

Tenant #1 was Tenant #2's legal representative, which allowed him/her to make decisions for Tenant #2. Tenant #1 clearly made his/her request to provide assistance with toileting and hygiene needs well known to the program. The clinical record lacked documentation of any deviation in Tenant #2's health status related to poor care provision provided by Tenant #1. Staff members denied Tenant #1's request to provide care for Tenant #2; thereby, disallowing Tenant #1 and Tenant #2's autonomy. The program released medical and personal information to persons who neither tenant had given permission for release.

- Regulatory Insufficiency: All tenants have the right to be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481- 67.3(1))

- Regulatory Insufficiency: All tenants have the right to receive respect and privacy in the tenant's medical care program. Personal and medical records shall be confidential, and the written consent of the tenant shall be obtained for the records' release to any individual, including family members, except as needed in case of the tenant's transfer to a health care facility or as required by law or a third-party payment contract. (IAC r. 481-67.3(3))

B. Involuntary Discharge

Complaint/Incident Allegation: It was alleged tenants were involuntarily discharged from the program after voicing concerns to program administration.

- Monitoring Observation: During interview, the Administrator reported giving papers initiating involuntary discharge to two tenants in the past year. The monitors reviewed the clinical records of Tenants #1 and #2.

  Tenant #1 signed his/her Occupancy Agreement/Residential Lease on 11-29-11 with update on 12-2-11. Tenant #2's legal representative signed his/her Occupancy Agreement/Residential Lease on 11-29-11 with update on 12-2-11. The Residential Leases included a clause allowing for involuntary discharge when a tenant failed to fulfill all the requirements of residency, including but not limited to, a promise to avoid acting in a boisterous, unruly or thoughtless manner, a promise to avoid actions which may disturb the rights of other tenants, a promise to allow a registered nurse to evaluate each tenants health and functional status and a promise to sign a service plan outlining tasks required to meet each tenants individual needs.

  Tenant #1's clinical record contained documentation citing multiple episodes of his/her aggressive behavior toward multiple staff members, aggressive behavior toward another tenant and aggressive actions in common areas of the program, which were witnessed by other tenants. Tenant #2 was issued a notice of involuntary discharge on March 9, 2012 citing the aggressive behavior as the reason for discharge.

  Tenant #2's clinical record contained a service plan, completed by Staff #1, RN, on 3-1-12, outlining specific identified tasks required to meet his/her needs. The document had been signed by Staff #1 and included documentation indicating Tenant #2's legal representative refused to sign the service plan. Tenant #2's legal representative was issued a notice of involuntary discharge on March 9, 2012 citing the reason for discharge was due to the legal representatives failure to sign Tenant #2's service plan.

  Both tenants, either directly or through a responsible party, signed occupancy agreements which indicated the tenant may be involuntarily discharged from the program for unbecoming behaviors and/or failure to sign a recommended service plan. Tenant #1 exhibited such behaviors; thereby, allowing the program to issue the notice according to the agreements clause. Tenant #2's legal representative refused to sign the recommended service plan; thereby, allowing the program to issue the notice according to the agreements clause.

- Regulatory Insufficiency: None noted.

C. Occupancy Agreement

Complaint/Incident Allegation: It was alleged the program did not follow the responsibilities identified in the occupancy agreement which required 24 hour nursing availability.

- Monitoring Observation: The monitors reviewed the occupancy agreements for Tenants #1 and #2. Tenant #1 signed his/her Occupancy Agreement/Residential Lease on 11-29-11 with update on 12-2-11. Tenant #2's legal representative signed his/her Occupancy Agreement/Residential Lease on 11-29-11 with update on 12-2-11. The Residential Leases included a clause identifying nursing services would be

provided to each tenant on a 24 hour basis seven days weekly, either directly or by phone if a nurse is not onsite.

The monitors reviewed the program incident reports for December 2011 and January through March 2012. The monitors noted Tenant #2 sustained a fall on 12-24-11 at 7:42 AM, while being assisted by a program RCA. The incident report indicated the RCA did not notify a nurse until 12-26-11 at 9:00 AM. The fall occurred over the weekend, a time which had not been routinely staffed by a nurse. The monitors requested the program's on-call schedule for December 2011 to determine which nurse had been on-call. Staff #1, RN, indicated she and Staff #2, RN, shared on-call coverage during December 2011; however, she reported the program had not been keeping written documentation of the on-call schedule until January 2012. Staff #1 and Staff #2 could not recall who had been on-call on 12-24-11. Staff #1 and Staff #2 both agreed that 12-24-11 had been covered by one or the other.

The program was unable to provide documentation showing on-call coverage occurred on 12-24-11. The program is required to follow it's occupancy agreement, which required 24 hour nursing coverage either directly or by phone. Prior to the Department's investigation the program had identified and implemented maintenance of documentation of the on-call coverage.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in the rule 67.10(3) for determining that a regulatory insufficiency exits.

- Regulatory Insufficiency: None noted.

During the course of the investigation, the following information was identified:

D. Tenant Documents

- Monitoring Observation: The program's Incident Report form documented reasons to complete the form as falls, injuries (such as burns, lacerations/skin tears or unresponsive episodes), behaviors (including altercations with other tenants/staff members, striking out and pushing), elopement and theft of items/money. The monitors reviewed the program's December 2011 through March 2012 incident reports. The monitors noted no reports for Tenant #1 and noted one report for Tenant #2, which documented he/she fell with minor physical injury 12-24-11.

  After review of Tenant #1 and #2's clinical records, the monitors identified the following concerns:

Tenant #	Date	Type of Incident	Incident Report
Tenant #1	12-24-11	Grabbed staff arm and pushed; yelled	none
Tenant #1	12-25-11	Grabbed staff arm in anger; pushed another staff who was scared and called for help	none

Tenant #1	12-28-11	Grabbed staff by shoulders in anger	none
Tenant #1	12-29-11	Grabbed hand and squeezed it in anger	none
Tenant #1	1-13-12	Upset, pushed staff and threw walker into wall twice	none
Tenant #1	1-17-12	Pushed the wheelchair into the apartment cupboards in anger and threw the foot pedals into the seat of chair.	none
Tenant #1	1-31-12	Pushed staff in anger	none
Tenant #1	2-2-12	Shoved staff out of way in anger. Later pushed staff and threw wheelchair down onto the floor.	none
Tenant #1	2-24-12	Pushed another tenant which nearly resulted in the tenant's fall.	none
Tenant #1	2-25-12	Hit staff with the wheelchair	none
Tenant #1	3-3-12	Kicking another tenant's walker many times in anger in the main dining area- hit staff with wheelchair in anger	none
Tenant #1	3-5-12	Grabbed staff arm and pushed staff. Beat on bedroom and bathroom doors in anger	none

Tenant #1 exhibited multiple episodes of physical altercations with staff members and another tenant, including grabbing, pushing and throwing items, which placed others at risk. The program did not maintain documentation of completion of incident reports for the exhibition of the above stated behaviors as identified on the incident report form.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record). (IAC r. 481- 69.25(1) o.)

E. Evaluation

Complaint/Incident Allegation: It was alleged the registered nurse did not assess a tenant in a timely manner after the tenant fell and experienced pain.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1 and #2.

Tenant #1's clinical record contained documentation of an evaluation of his/her cognitive, health and functional status, dated as completed by Staff #1, RN, on 11-21-11. The clinical record lacked an evaluation of Tenant #1's cognitive, health or functional status within 30 days of admission. Tenant #1's clinical record also included 12 episodes of aggressive behavior exhibited by Tenant #1 toward staff members and another tenant between December 2011 and March 2012. The behaviors included grabbing staff members in anger, pushing staff members and another tenant in anger and throwing a wheelchair and walker in anger, placing others at a safety risk. The clinical record lacked documentation of an evaluation of Tenant #1's cognitive, health or functional status when the above stated behaviors were identified.

Tenant #2's clinical record contained an evaluation of his/her health and functional status, completed by Staff #1, RN, on 3-1-12, documenting multiple changes in Tenant #2's health and functional status. Staff #1 failed to complete a GDS for Tenant #2 with the noted significant change.

The monitors reviewed incident reports completed by the program for December 2011 through March 2012. The monitors noted a report showing Tenant #2 fell in his/her apartment while being assisted by a RCA on 12-24-11 at 7:42 AM. The incident report documented observance of a "half dime sized" skin tear on Tenant #2's right hand. The RCA assessed Tenant #2's vital signs and notified Tenant #2's family. The report lacked any documentation of reports of pain immediately following the fall. The report indicated the RCA did not notify Staff #2, RN until 12-26-11 at 9:00 AM.

The clinical record also contained a Nurse Review Note, dated 12-26-11 at 9:00 AM. The note documented Staff #2 completed a physical assessment of Tenant #2. Tenant #2 denied pain at this time and had been ambulating normal distances without difficulty. According to a Nurse Review Note, dated 12-26-11 at 1:00 PM, Staff #2 had been called to Tenant #2's room by his/her legal representative, who reported Tenant #2 began reporting onset of back pain that day. At that time, Tenant #2 denied pain when asked again by Staff #2 and exhibited no difficulty with movement. Staff #2 offered to make an appointment with Tenant #2's physician; however, the legal representative stated he/she felt Tenant #2 did not require medical evaluation. The representative indicated a plan to give Tenant #2 Tylenol as needed.

According to a Nurse Review Note, dated 12-27-11 at 10:00 AM, Tenant #2's legal representative reported he/she had been experiencing an increase in back pain. Staff #2 contacted a family member to report the legal representative's concerns; documenting the family members report that back pain had been a chronic problem for Tenant #2 and did not feel medical evaluation was required.

According to a Nurse Review Note, dated 12-27-11 at 2:00 PM, Tenant #2's family member contacted the program giving permission to call an ambulance for transfer to evaluate his/her reports of pain. Tenant #2 was transferred for medical evaluation and returned to the program at 5:30 PM with instructions to alternate Tylenol and Ibuprofen for the back pain.

The RN failed to complete an evaluation of Tenant #1's cognitive, health and functional status within 30 days of admission to the program and with identification of a significant change in his/her behaviors between December 2011 and March 2012. The RCA did not contact the RN at the time of Tenant #2's fall. The nurse completed a physical assessment of Tenant #2 immediately upon becoming aware of his/her previous fall over the weekend. Reports documented no reports of pain immediately following the fall. The nurse assessed Tenant #2 on the afternoon of 12-26-11 following the first report of pain. The legal representative and a family member chose not to seek medical evaluation until 12-27-11 at approximately 2:00 PM.

- 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 as needed. (IAC r. 481-69.22(2))

F. Service Plans

Complaint/Incident Allegation: It was alleged the program prepared service plans identifying inaccurate needs.

Monitoring Observation: The monitors reviewed the clinical records of Tenant #1 and Tenant #2. Tenant #1's service plan had not been updated since 11-30-11. Tenant #1's clinical record included 12 episodes of aggressive behavior exhibited by Tenant #1 toward staff members and another tenant between December 2011 and March 2012. The behaviors included grabbing staff members in anger, pushing staff members and another tenant in anger and throwing a wheelchair and walker in anger, placing others at a safety risk. Tenant #1's service plan lacked any interventions addressing Tenant #1's exhibited behavior.

Tenant #2's service plans, dated as updated on 1-5-12 and 3-2-12, documented accurate interventions reflecting Tenant #2's individualized needs related to bathing, toileting, grooming, dressing, mobility and transfers. The service plan indicated Tenant #2 required the assistance of program staff members to toilet, groom, dress, transfer and ambulate. Tenant #2's legal representative, who is physically and cognitively capable to perform his/her own tasks independently, had requested to provide the services for Tenant #2 and denied need for staff member assistance on multiple occasions. The registered nurse did not adjust the service plan to address the legal representative's request. Tenant #2's legal representative refused to sign the 3-2-12 updated service plan as he/she believed the accounting of who would provide each task for Tenant #2 to be inaccurate.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in the rule 67.10(3) for determining that a regulatory insufficiency exits.

- Regulatory Insufficiency: None noted.

G. Medications

Complaint/Incident Allegation: It was alleged the program did not administer medications as ordered by a physician.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1 and #2. Tenant #1's clinical record indicated he/she dispensed his/her own medications. Tenant #2's clinical record indicated his/her family member dispensed his/her medications. Program staff members did not handle any of either tenant's medications since admission to the program.

- Regulatory Insufficiency: None noted.