IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 39886-I

August 14, 2012

Ms. Pamela Wells, Manager
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 Insufficiencies in the area(s) of: Evaluation and Service Plans.

Glenwood Place Assisted Living ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program's continued failure (or refusal) to comply with regulatory requirements within the prescribed time frame established has a direct relationship in the health, safety, or security of tenants. Program failed to perform proper evaluations and update service plans as required for one tenant exhibiting changes in condition.

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 to the State of Iowa in the amount of six hundred fifty dollars ($650) 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 $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on August 8, 2012, has been reviewed and will constitute the final POC related to the on-site visit of July 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, 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:

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

Complaint/Incident Intake #: 39886-I

Date of Complaint/Incident Investigation:

July 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.

General Population Program	
Number of tenants without cognitive disorder:	35
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	38

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	6
TOTAL census of Assisted Living Program	44

Program History – The program received regulatory insufficiencies in the areas of Policy and Procedures, Transportation, Evaluations, Service Plans, Program Reporting to the Department, Medications, Staffing, Food Service and Dementia Specific Education 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: On 7-3-12 Tenant #1 fell in the apartment. Tenant #1 sustained a skin tear, but no other injuries were noted. On 7-5-12 Tenant #1 complained of hip pain and the tenant was transported to the hospital. On 7-6-12 Tenant #1 was diagnosed with a pubic ramus fracture. The program reported the injury to the department on 7-6-12.

- Monitoring Observation: Tenant #1, a 94 year-old, was admitted on 5-20-10 and had diagnoses of: Gastroesophageal Reflux Disease, Anxiety, Hypertension, and Dementia. Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. An incident report dated 4-22-12 and timed at 8:15 p.m. revealed Tenant #1 was found on the floor in the apartment. According to the program, Tenant #1 did not use the call button to request assistance. At the time of the incident, Tenant #1 resided in the general population. Tenant #1 was reported to be confused and didn't know how he/she ended up on the floor. Tenant #1 said the left shoulder, elbow, and hip hurt, but got up slowly and walked to the bed. Nurse's notes dated 4-23-12 and timed 8:30 a.m. documented a second event and indicated Tenant #1 was lying on the left side on the floor. Tenant #1 stated he/she fell out of bed. Tenant #1 was assisted to stand, and then to sit in a chair. Tenant #1 had a bruise on the left elbow and left side of the head.

The physician was notified. On 4-23-12 at 1:10 p.m. nurse's notes documented Tenant #1 moved slowly, had stand-by assistance for ambulation, and was unsteady on the feet. On 4-24-12, Tenant #1 was unsteady on the feet. On 4-26-12, Tenant #1 was seen by a physician, and according the nurse's notes, no fracture was found. According to Nurse #1, Tenant #1 had been wearing dirty clothes and did not appear to be participating in "personal care ie: bathing" and Tenant #1 was reported to have body odor. Nurse #1 suggested to the family that Tenant #1 could move into the secured dementia unit. The family reportedly agreed. The 4-26-12 nurse's notes also requested a physical therapy (PT) evaluation. Nurse's notes dated 5-3-12 indicated evaluations were completed for a change of condition, a PT evaluation and moving to the secured dementia unit. The evaluations completed 5-3-12 indicated Tenant #1 had a vertebral compression fracture as a diagnosis. Tenant #1 had a shuffling gait and PT was ordered. The functional evaluation indicated Tenant #1 needed cueing for bathing, dressing, and grooming, and was independent for mobility and transfers.

On 6-10-12 nurse's notes revealed Tenant #1 had a productive, wet cough. An antibiotic was started. 6-12-12 functional, cognitive, and health evaluations were completed. Tenant #1 was again staged at five on the GDS. Tenant #1 was noted to have a shuffling gait and occasionally hold onto the wall while ambulating. Tenant #1 was independent with grooming and dressing and the need for assistance with bathing was not assessed. The evaluations were completed by Nurse #2. Nurse's notes dated 6-30-12 indicated Tenant #1 was having pain in the mid-back. Tenant #1 was grimacing and catching breath with movement. Tenant #1 transferred with "a lot of pain." The physician was notified and a muscle relaxant was ordered. According to the documentation by Nurse #1 on 6-30-12, Tenant #1 was encouraged to use the call button for assistance with ambulation for the "next few days." Tenant #1 was also encouraged to visit the physician "next week."

A fax to the physician dated 7-2-12 revealed over the weekend, the on-call physician had ordered the muscle relaxant and after four doses, only a little relief was obtained. The fax indicated Tenant #1 did not want to move at all and was eating very little. Tenant #1 was reported to cry out in pain. The physician ordered Vicodin for pain every four hours and indicated an x-ray showed an old compression fracture.

On 7-3-12, nurse's notes documented by Nurse #2 at 2:00 p.m. indicated Tenant #1 was hallucinating, was speaking rapidly and could not stop to eat. Tenant #1 complained of rib pain. The hallucinations continued as documented at 5:30 p.m. The physician was contacted and the muscle relaxant and the Vicodin were discontinued according to the nurse's notes. According to the documentation by Nurse #2, Tenant #1 would be monitored for response to pain and continued "delusional thoughts." An incident report dated 7-3-12 and timed 7:35 p.m. revealed Tenant #1 fell inside the apartment because a knee gave way. A skin tear was noted on the elbow. Three staff members assisted Tenant #1 to bed.

An interview with Staff #1 revealed Tenant #1 continued to hallucinate on 7-4-12.

Nurse's notes dated 7-5-12 and completed by Nurse #3 revealed Tenant #1 ambulated without difficulty but began to complain of pain in the right hip. Tenant #1 was transferred to the hospital for evaluation.

The assessment completed by the physician indicated Tenant #1 had subtle left pelvic rami fractures, had advanced dementia and appeared to be hallucinating. Tenant #1 was transferred to a higher level of care. On 7-10-12 Tenant #1 was discharged from the program.

On 4-22-12 and 4-23-12 Tenant #1 was found on the floor. Tenant #1 was transferred to the secured dementia unit and PT was ordered. The clinical record contained no documentation of the completion of PT or Tenant #1's response to therapy. Beginning 6-30-12, Tenant #1 complained of back pain unrelieved by muscle relaxants. Tenant #1 was eating very little and was crying out in pain according to notations on a fax dated 7-2-12. Nurse #2 encouraged Tenant #1 to use the call button and request assistance with ambulation. Documentation of 7-3-12 revealed Tenant #1 was hallucinating. Evaluations were not completed for the change of condition beginning 6-30-12.

- 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: Evaluations for Tenant #1were completed on 5-3-12 and the service plan was updated following two falls, a PT referral and documentation that Tenant #1 was not participating in personal cares. Tenant #1 moved into the secured dementia unit. The service plan dated 5-3-12 indicated Tenant #1 needed prompts for bathing, reminders to change clothing if it was soiled, and was independent with mobility but hung onto the railing in the hallway for stability. PT was ordered. The service plan noted Tenant #1 was sometimes anxious and needed reassurance. Evaluations were again completed 6-12-12. Tenant #1was staged at five on the GDS. The functional assessment dated 6-12-12 did not document whether or not Tenant #1 was independent with bathing or required assistance. According to the updated service plan of 6-12-12 Tenant #1 was independent with bathing, dressing, grooming, ambulation, eating, and toileting.

  Nurse's notes dated 6-30-12 indicated Tenant #1 was having pain in the mid-back. Tenant #1 was grimacing and catching breath with movement. Tenant #1 transferred with "a lot of pain." The physician was notified and a muscle relaxant was ordered. According to the documentation by Nurse #1 on 6-30-12, Tenant #1 was encouraged to use the call button for assistance with ambulation for the "next few days." A fax to the physician dated 7-2-12 revealed over the weekend, the on-call physician had ordered the muscle relaxant and after four doses, only a little relief was obtained.

The fax indicated Tenant #1 did not want to move at all and was eating very little. Tenant #1 was reported to cry out in pain. The physician ordered Vicodin for pain every four hours and indicated an x-ray showed an old compression fracture.

On 7-3-12, nurse's notes documented by Nurse #2 at 2:00 p.m. indicated Tenant #1 was hallucinating, was speaking rapidly and could not stop to eat. Tenant #1 complained of rib pain. The hallucinations continued as documented at 5:30 p.m. The physician was contacted and the muscle relaxant and the Vicodin were discontinued according to the nurse's notes. According to the documentation by Nurse #2, Tenant #1 would be monitored for response to pain and continued "delusional thoughts."

An interview was conducted with Staff #1. She stated Tenant #1 had good days and bad, and some days Tenant #1 required stand-by assistance with ambulation. Staff #1 stated Tenant #1 was hallucinating and picking at the air on 7-4-12. Staff #1 made sure Tenant #1was eating, provided assistance with ambulation and made sure Tenant #1 had plenty of fluids. On the day Tenant #1 left the program, according to Staff #1, Tenant #1 was in so much pain, Tenant #1 was given a bed bath and transported by ambulance to the hospital.

Staff #2 was interviewed and stated prior to the fall of 7-3-12, Tenant #1 had packed belongings to leave and Staff #2 provided redirection. Staff #2 reported Tenant #1 had been hallucinating.

The service plan did not contain interventions as indicated by Nurse #2 to use a call button to request assistance with ambulation and to monitor pain and delusional thoughts. The service plan did not identify staff response to hallucinations. The service plan did not identify interventions for Tenant #1 who was in pain, not eating, and moving very little, according to Nurse #2.

The functional evaluation did not assess Tenant #1's ability to bathe independently. The service plan did not meet the identified needs of Tenant #1.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1))