IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 39836-C

August 20, 2012

Ms. Stacy Hejda, Interim Administrator
The Shores at Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, IA 50327

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

Dear Ms. Hejda:

I. Final Complaint/Incident Investigation Report – The Shores at Pleasant Hill, Pleasant Hill, 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: Staffing and Life Safety.

Shores at Pleasant Hill is being assessed a $3,000 civil penalty pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC 67.12(3)(a)(1)(2). The Program failed to comply with regulatory requirements in the area of Life Safety. The non-compliance resulted in imminent danger or a substantial probability of resultant death or physical harm to a tenant. Program automatically deactivated a door alarm between the hours of 8 a.m. and 5 p.m. daily allowing free access to a courtyard by cognitively impaired elders.

The Program failed to comply with regulatory requirements in the area of Staffing 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. The Program left a tenant out in the

courtyard unsupervised for approximately 2 ½ hours without staff member knowledge that the tenant was outside at all. The tenant suffered mild sunburn, an elevated body temperature, dehydration and was unresponsive when found by staff members.

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 nineteen hundred fifty dollars ($1950) 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 $3,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on August 14, 2012, has been reviewed and will constitute the final POC related to the on-site visit of July 18, 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:

Stacy Hejda, Interim Administrator
The Shores at Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, Iowa 50327

Complaint/Incident Intake #:

39836-C

Date of Complaint/Incident Investigation:

July 18, 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:	47
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	49

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	17
Total Population of Program at time of on-site	18
TOTAL census of Assisted Living Program	67

Program History –The recertification visit of April 4, 2012 resulted in a regulatory insufficiency in the following area: Structural Requirements.

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

A. Staffing

Complaint/Incident Allegation: It was alleged a tenant with dementia exited the program's building without staff member knowledge. When later found by staff members, the tenant required transfer to an emergency room for medical evaluation.

- Monitoring Observation: The monitors reviewed the program's incident reports from the previous three month period and interviewed staff members working in the program's two dementia specific units. The incident reports included one incident, which occurred on 6-26-12, documenting Tenant #1 exited the courtyard doors off of the program's secured memory care unit (The Nest) without staff member knowledge. The report indicated staff members did not find Tenant #1 until several hours later. When staff members found Tenant #1, he/she was unresponsive, with elevated body temperature and reddened skin. Tenant #1 was transported to the emergency room for medical evaluation. Staff members reported three tenants, Tenants #1, #2 and #3 routinely went out into the secured courtyard outside of The Nest without staff member supervision.

  The monitors reviewed the clinical records of Tenants #1, #2 and #3. The monitors found no documentation indicating Tenant #2 or Tenant #3 had any recent incidents involving elopement from the program or injury secondary to being in the courtyard unsupervised.

Tenant #1, a 72 year old, was admitted to the program on 1-18-12 with the diagnoses of: Dementia and Seizures. Tenant #1 scored a 3 on the Global Deterioration Scale (GDS) completed on 4-27-12, indicating mild dementia. Tenant #1 scored a 4 on the GDS completed on 6-27-12, indicating moderate dementia. Tenant #1 resided in the secured memory care unit (AL- plus). On 6-14-12, the program initiated a trial period requiring Tenant #1 to be transported to the program's other secured memory care unit (The Nest) for lunch and supper each day. Tenant #1 was allowed to remain in The Nest for activities if Tenant #1 wished to participate.

Tenant #1's service plan, dated 4-27-12, indicated Tenant #1 ambulated independently in a brisk manner and had a tendency to wander into other tenant's apartments looking for snacks. Tenant #1 was allowed to leave the secured unit to go to the program's main dining room to eat all meals. The service plan directed staff members to accompany Tenant #1 at all times when leaving the secured memory care units due to Tenant #1's abilities to ambulate independently and previous wandering nature.

In April 2012, Tenant #1 began exhibiting an increase in repetitive behaviors in the late afternoon and early evening hours, such as clapping hands loudly together in a repetitive manner and repeating words loudly. Tenant #1 was exhibiting an increase in anxiousness and an increase in entering other tenants' apartments. Staff members observed Tenant #1 pacing up and down the hallways and Tenant #1 refused to remain seated during meals.

In May 2012, Tenant #1's behaviors continued to escalate. The physician ordered Depakote ER, and Namenda in late May in an attempt to decrease Tenant #1's behaviors. The behaviors lessened some but continued into June 2012. On 6-14-12 Staff #1, registered nurse (RN), initiated a trial period having Tenant #1 eat breakfast in AL- plus and go to The Nest for lunch and dinner meals. Tenant #1 was allowed to remain in The Nest to participate in afternoon activities if he/she was willing. Health Profile Notes indicated Tenant #1 enjoyed spending time sitting on the outside courtyard patio.

On 6-25-12, Staff #1, RN, documented Tenant #1 had exhibited increased anxiousness following the noon meal on 6-23 and 24-12 so Tenant #1 was taken back to the AL- plus unit. On 6-25-12, Tenant #1 remained in The Nest for the afternoon.

On 6-26-12, Tenant #1 was accompanied to The Nest for lunch around 11:00 a.m. Activity logs documented Tenant #1 did not participate in activities on the 7 a.m. to 3 p.m. shift on 6-26-12. The 24 hour Resident Report, dated 6-26-12, lacked any documentation on Tenant #1 for the 7 a.m. to 3 p.m. shift.

Video tape evidence showed Tenant #1 arrived in The Nest at approximately 11:00 a.m. and remained in The Nest during the rest of the 7 a.m. to 3 p.m. shift. The video tape showed Tenant #1 exiting unattended by staff members into the secured courtyard outside of The Nest as follows:

a. Out at 11:11 a.m. unattended by staff members- reentered program on own at 11:12 a.m. Tenant #1 drank some juice after reentering the program.

b. Out at 11:22 a.m. unattended by staff members- reentered program on own at 11:23 a.m.
c. Out at 11:38 a.m. attended by staff members- reentered program with staff members at 11:43 a.m.
d. Out at 11:55 a.m. unattended by staff members- reentered program on own at 11:56 a.m.
e. Out at 11:57 a.m. unattended by staff members- reentered program after staff members summoned at 11:58 a.m.
f. Out at 12:47 p.m. unattended by staff members- staff members went out at 12:56 p.m. and Tenant #1 reentered program with staff at 12:57 p.m.
g. Out at 1:22 p.m. unattended by staff members- reentered program on own at 1:23 p.m. Upon entering staff members gave Tenant #1 a drink.
h. Out at 1:40 p.m. with staff members- both staff and tenant reentered program at 1:45 p.m.
i. Out at 2:13 p.m. unattended by staff members- reentered program on own at 2:14 p.m.
j. Out with immediate return at 2:35 p.m. and 2:40 p.m.
k. Out at 2:48 p.m. unattended by staff members- staff members went to check outside at 5:10 p.m. and reentered program with Tenant #1 in wheelchair at 5:12 p.m.

During interview, Staff #2, care attendant (CA) reported Tenant #1 came to the Nest for lunch and dinner during a trial period. Tenant #1 sometimes returned to AL- plus in the afternoon if Tenant #1 did not wish to participate in activities or was exhibiting increased anxiety. Staff #2 reported the exit door to the outside courtyard was not alarmed from 8:00 a.m. to 5:00 p.m. to allow tenants to go outside without supervision. Staff #2 indicated staff members routinely check on the tenants when they are out in the courtyard approximately every 15 to 20 minutes. Staff #2 reported Tenant #1 came to The Nest on 6-26-12 and remained during the afternoon. Tenant #1 had been going in and out of the courtyard a lot during the 7 a.m. to 3 p.m. shift. Staff #2 reported she gave report to the oncoming shift medication aide, Staff #4, for all of the tenants who received medication administration during her shift, which would not have included Tenant #1. Staff #2 indicated she also told Staff #4 to "watch Tenant #1- been going into others' rooms and outside a lot. Keep an eye on Tenant #1." Staff #2 believed Tenant #1 was sitting on the couch in the main living room area of The Nest when she left work via the front doors of The Nest.

During interview, Staff #4 reported Tenant #1 came to the Nest for lunch and dinner during a trial period. Tenant #1 sometimes returned to AL- plus in the afternoon if Tenant #1 did not wish to participate in activities or was exhibiting increased anxiety. Staff #2 reported the exit door to the outside courtyard was not alarmed from 8:00 a.m. to 5:00 p.m. to allow tenants to go outside without supervision. Staff #2 indicated staff members routinely check on the tenants when they are out in the courtyard approximately every 15 to 20 minutes. Staff #4, CA, reported she came to work on 6-26-12 at approximately 2:50 p.m. Staff #4 denied seeing Tenant #1 in The Nest on 6-26-12. Staff #4 reported Staff #2 gave a verbal report for all tenants who resided in The Nest. Staff #2 did not mention Tenant #1 as Tenant #1 did not live in The Nest and would not have received medications in the unit. Staff #4 reported she believed Tenant #1 had most likely gone back to AL-plus for the afternoon, which was not an unusual occurrence.

During interview, Staff #5 reported Tenant #1 came to the Nest for lunch and dinner during a trial period. Tenant #1 sometimes returned to AL- plus in the afternoon if Tenant #1 did not wish to participate in activities or was exhibiting increased anxiety. Staff #5 reported the exit door to the outside courtyard was not alarmed from 8:00 a.m. to 5:00 p.m. to allow tenants to go outside without supervision. Staff #5 indicated staff members routinely check on the tenants when they are out in the courtyard approximately every 15 to 20 minutes. Staff #5, CA, reported she came to work on 6-26-12 at approximately 2:40 p.m. Staff #5 reported she saw Tenant #1 in the main living room area of The Nest upon entering the building. Staff #5 gave Tenant #1 a hug and then clocked in. Staff #5 did not get a verbal report from staff on 6-26-12 as Staff #3, CA, was arguing with the Administrator then left the building without giving the report. Staff #5 reported she noted the activity director getting a group of tenants ready to go on a walk inside the general population area of the program. Staff #5 reported she assumed Tenant #1 accompanied the group on the walk. The group left The Nest at approximately 3:00 p.m. Staff #5 reported she did not see Tenant #1 return with the group around 4:00 p.m. She reported she asked Staff #4 where Tenant #1 was and Staff #4 reported Tenant #1 had returned to AL-plus for the afternoon, which was not an unusual occurrence. At supper time, Staff #5 noted AL- plus staff members had not yet brought Tenant #1 back to The Nest. Staff #1, RN, went to AL-plus to accompany Tenant #1 to The Nest for supper.

During interview, Staff #1, RN, reported she went to AL- plus to accompany Tenant #1 to dinner in The Nest. Upon arriving in AL- plus, she was told Tenant #1 had not returned to AL- plus after lunch. Staff #1 called down to The Nest and instructed staff members to search for Tenant #1.

Staff #5, CA, located Tenant #1 in the outside courtyard off of The Nest. Tenant #1 was found slumped over on a rocking love seat located at the far end of the courtyard approximately 50 feet from the door exiting from the unit to the courtyard. Tenant #1's skin was reddened and felt "very, very hot to the touch". Tenant #1 was unresponsive. Staff #5 reentered the unit, summoned assistance and took a wheel chair from the unit to the courtyard to move Tenant #1 out of the heat and into the common living room area of the unit.

Staff #1, RN, assessed Tenant #1, determining a body temperature of 100.5 degrees. Staff members summoned the ambulance via 911. The ambulance arrived at 5:22 p.m. and transported Tenant #1 to the emergency room at 5:25 p.m. Tenant #1 was diagnosed with a body temperature of 101.0 degrees, mild sunburn and dehydration. Tenant #1 was kept overnight in the hospital and returned to the program late afternoon on 6-27-12.

According to the State Climatologist, on 6-26-12 the temperature in the Pleasant Hill area was 85 to 86 degrees between 3:00 p.m. and 5:00 p.m. with 5 percent humidity and partly cloudy skies.

Staff members were not aware of Tenant #1's whereabouts from 2:48 p.m. to 5:10 p.m. Tenant #1 was allowed to go outside into the secured courtyard without staff supervision. Tenant #1 was in the courtyard and exposed to the heat uninterrupted from 2:48 p.m. until 5:10 p.m. without staff knowledge. Tenant #1 required medical

evaluation and hospitalization overnight due to injury received from overexposure to the heat.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

During the course of the investigation, the monitors identified the following:

B. Life Safety

- Monitoring Observation: The program had an alarm system connected to the door which exited into a secured courtyard outside of the memory care unit (The Nest). Prior to 6-27-12, the alarm was automatically deactivated between the hours of 8:00 a.m. and 5:00 p.m. each day, allowing free access to the courtyard by cognitively impaired tenants.

  During interview, Staff #2, #3, #4 and #5 reported Tenants #1, #2 and #3, all cognitively impaired tenants residing in the program's secured memory care units, routinely went into the courtyard unsupervised by staff members. Each indicated using observation of each tenant going out the door or by hearing the door slam to identify when a tenant may be in the courtyard. Each indicated routinely checking approximately every 15 minutes when having knowledge of a tenant being in the courtyard unsupervised.

  On 6-26-12 Tenant #1 was out in the courtyard unsupervised for approximately 2 and one-half hours without staff member knowledge that Tenant #1 was outside at all. Tenant #1 suffered mild sunburn, an elevated body temperature, dehydration and was unresponsive when found by staff members.

  On 6-27-12 the program began keeping the doors to the courtyard locked at all times.

- Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. (IAC r. 481-69.32(2))