IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 40022-C

September 5, 2012

Ms. Mary Jo Pipkin, Administrator
Keystone Cedars Assisted Living
6325 Rockwell Drive N.E.
Cedar Rapids, IA 52402

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

Dear Ms. Pipkin:

I. Final Complaint/Incident Investigation Report – Keystone Cedars Assisted Living, Cedar Rapids, 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: Policies and Procedures, Program Reporting to Department and Life Safety.

Keystone Cedars Assisted Living is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1). The Program failed to comply with regulatory requirements. The non-compliance resulted in imminent danger or a substantial probability of resultant death or physical harm to a tenant. A Tenant eloped from an exit door that had been deactivated. The Program did not report the elopement.

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 three hundred twenty five dollars ($325) 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 $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on August 28, 2012, has been reviewed and will constitute the final POC related to the on-site visit of July 30, 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: **Complaint/Incident Intake #:** 40022-C

Mary Jo Pipkin, Administrator
Keystone Cedars Assisted Living
6325 Rockwell Drive N.E.
Cedar Rapids, IA 52402

Date of Complaint/Incident Investigation:

July 30, 2012

Monitor(s):

Hal L. Chase, RN BSN MPH

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.

and when she returned she realized Tenant #1 wasn't in the dining room. She searched the dementia unit and Tenant #1 was not found. She notified the Administrator and Program's registered nurse (RN) Tenant #1 was missing. Staff began looking outside and saw the Administrator talking to Tenant #1 who had been sitting in a car belonging to staff. The Administrator escorted Tenant #1 back to the dementia unit. Staff #3 inspected the south door and found the door alarm was not functioning.

A monitor inspected the dementia unit entrance and exit doors and found all doors to be locked and alarmed. The south exit door was checked and tested. The door alarm was activated when the door exit bar was pushed. The door opened after a 15 second delay.

The Program RN was interviewed and reported an incident report was not completed to record the elopement of Tenant #1. A monitor requested the Program RN to prepare a written statement giving the date of Tenant #1's elopement and relevant facts associated with the elopement. In a prepared written statement, the Program RN indicated on 7-12-12, at approximately 4:30 p.m., staff was assisting tenants to the dining room for the evening meal. Staff noted Tenant #1 wasn't sitting at the dining table. Staff initiated a search of the unit and the adjacent outside patio, but did not find Tenant #1. Staff notified the Program RN and the Administrator that Tenant #1 was missing. Staff found the south exit door open and the door alarm had been de-activated. At 4:37 p.m. Tenant #1 was found sitting in a parked car belonging to staff. The Administrator escorted Tenant #1 back to the dementia unit.

Tenant #1 was given water and two servings of watermelon and evaluated by the Program RN. The Program RN reported the south exit door alarm was not "engaged at the time of the incident, to alert staff of attempted exit."

The air temperature was 90 degree Fahrenheit, sunny, with a 5 mile per hour wind and 65% humidity. The distance from the program exit door to the parked car where Tenant #1 was found was less than 150 feet.

The Program RN and Administrator reported an incident report was not completed related to Tenant #1's elopement of 7-12-12.

- Regulatory Insufficiency: The program's policies and procedures on incident reports, at a minimum, shall include the following: (e) all accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. (IAC r.481-67.2(1)(e))

B. Program Reporting to the Department

During the course of the investigation the following information was obtained.

- Monitoring Observation: Staff #2 was interviewed by a monitor and reported Tenant #1 had eloped from the program. Staff #2 was unsure of the specific date of the elopement. The Program RN and Administrator reported Tenant #1 had eloped from the dementia unit through the south exit door. The south exit door alarm had been de-

activated. The Administrator and Program RN reported they had not reported to the department of Tenant #1's elopement.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available when a tenant elopes from a program. (IAC r.481-67.4)

C. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant was unable to assist in his/her own transfers, two staff were needed to safely transfer a tenant from bed to wheelchair or to the toilet and the tenant was unable to communicate his/her needs effectively and could not use the staff paging system.

Complaint/Incident Allegation: It was alleged a tenant was verbally and physically aggressive when staff assisted the tenant with activities of daily living (ADLs). A tenant frequently needed two staff to assist with transfer to bed. It was difficult for the tenant to stand independently and staff would often bathe and change incontinent undergarments while the tenant was in bed. The tenant was unable to communicate his/her needs and was unable to use the emergency paging system.

- Monitoring Observation: Four tenant files were reviewed. No issues were found with Tenant #1 and Tenant #4. Tenant #2, a 97 year old, was admitted on 2-12-09 and had diagnoses of: Hypertension (HTN), Gastro Esophageal Reflux Disease, Osteoporosis and Depression. Tenant #2 was admitted to hospice on 2-18-12 with an admitting diagnosis of Chronic Obstructive Pulmonary Disease. A GDS was completed on 7-26-11 and staged Tenant #2 at five, which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit.

  Functional and health evaluations and a service plan of 7-26-22 indicated Tenant #2 was a routine one-staff assist with transfer and ambulation and needed assistance with ADLs. A 90-day nurse review indicated no change in health status. Staff #1, #2 and #3 reported Tenant was a routine one-staff assist with transfer and ambulation. Tenant #2 needed occasional two –staff assistance when Tenant #2 had a bowel movement. Tenant #3 could bear weight and pivot with transfer. Tenant #2 used a wheel-chair for mobility.

  Tenant #2 was not verbally or physically aggressive toward staff. Tenants residing in the dementia unit were checked on frequently throughout the day and evening hours and were toileted every two hours.

  During the monitoring visit, a monitor observed at least three separate occasions of one staff safely transferring Tenant #2 from bed to wheelchair and from wheelchair to toilet.

  Tenant #3, a 100 year old, was admitted on 4-23-05 and had diagnoses of: Dementia, Arthritis, Vaginal Prolapse, HTN, Eczema and Agitation. A GDS was completed on 5-7-12 and staged Tenant #3 at six, which indicated severe cognitive decline. Tenant #3 resided in the dementia unit.

Functional and health evaluations and a service plan of 5-7-12 indicated Tenant #3 needed one staff assist with ADL's including one staff stand by assist with transfer and ambulation. A 90-day nurse review of 5-7-12 indicated no change in health status.

Staff #1, #2 and #3 reported Tenant #3 needed one staff assistance with ADL's and transfer, occasionally needing two staff to assist with transfers and needed stand by assistance with ambulation. Tenant #3 was able to stand and bear weight, but was unable to follow directions related to pivot when assisted with transfer.

Staff #1 reported Tenant #3 would sometime swing his/her hands at staff when staff assisted with cares. Staff #1 would often have Tenant #3 to hold onto something; giving Tenant #3 a book or magazine to hold onto when cares were done as this kept Tenant #3's hands busy. Staff #2 reported Tenant #3 was cooperative with cares, but there were times when Tenant #3 would raise his/her voice at staff and would occasionally swat at staff but never made contact. Staff #3 reported Tenant #3 would "flail" his/her hands toward staff, but never made contact.

A monitor observed Tenant #3 ambulated while in the dementia unit with the use of a walker with one staff stand by assistance. Tenant #3 was seen interacting with staff and Tenant #3 was cooperative no aggression was seen.

- Regulatory Insufficiency: None noted.

D. Life Safety

During the course of the investigation the following information was obtained.

- Monitoring Observation: The Administrator and Program RN reported a staff person who worked the night shift on 7-11-12 had deactivated the south door alarm of the dementia unit in order to go outside and smoke. On 7-12-12 at approximately 4:30 p.m. Tenant #1 had eloped from the unit by exiting the South door. The Administrator and Program RN reported staff was not aware the south door alarm had been deactivated.

- Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have (a.) written procedures regarding alarm systems and appropriate staff response when a tenant's service plan indicates a risk of elopement or a tenant exhibits wandering behavior. (IAC r. 481-69.32(a))