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 #: 40056-C**

October 3, 2012

Ms. Jane Pantzke, Manager
Willow Pointe Senior Living
17396 Kingbird Avenue
Mason City, IA 50401

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

Dear Ms. Pantzke:

**I. Final Complaint/Incident Investigation Report – Willow Pointe Senior Living, Mason City, 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.

**Willow Pointe Senior Living** is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). 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 update evaluations and service plans with significant changes in tenants' 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 **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 September 28, 2012, has been reviewed and will constitute the final POC related to the on-site visit of August 14, 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:**

Jane Pantzke, Manager
Willow Pointe Senior Living
17396 Kingbird Avenue
Mason City, IA 50401

**Complaint/Incident Intake #:** 40056-C

**Date of Complaint/Incident Investigation:**

August 14, 2012

**Monitor(s):**

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

**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: | 17 |
| Number of tenants with cognitive disorder: | 1 |
| Total Population of Program at time of on-site | 18 |
| **TOTAL census of Assisted Living Program** | 18 |

**Program History** – During the Recertification on-site of April 26, 2011, the program received regulatory insufficiencies in the areas of: Occupancy Agreement, Service Plan, Food Service, Record Checks, and Other (failure to document Mandatory Reported training)

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

**A. Evaluation**

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

- Monitoring Observation: Four tenant files were reviewed. The Assistant Manager and the RN identified a conflict between Tenants #2, #3 and #4.

  Tenant #1, a 73 year old, was admitted on 10-28-08 and diagnoses include: Depression, Schizoaffective Disorder and Bipolar Disorder. Functional and cognitive evaluations were completed on 10-26-11. According to the Nurses Notes dated 7-30-12 (a late entry for 7-26-12), a quarterly assessment was completed and the service plan had changed. Tenant #1 was up and about with walker and Tenant #1 now took own medication. A functional evaluation was completed on 7-30-12. A service plan was completed on 7-30-12 that reflected Tenant #1 used a cane for short distances and took own medication. Program staff provided applesauce to take with medication. A cognitive and health evaluation was not completed as needed.

  Tenant #2, a 79 year old, was admitted on 4-2-10 and diagnoses include: Type II Diabetes Mellitus, Hypertension, Dyslipidemia, Peripheral Vascular Disease and Obesity. A health evaluation was completed on 3-13-12 and a functional evaluation was completed on 3-29-12. An annual service plan was completed on 3-29-12. A cognitive evaluation was completed but was not dated.

  According to Nurse's Notes from 7-8-12 through 7-31-12 there were situations documented regarding Tenant #2's behavior. The behaviors Tenant #2 exhibited included being argumentative with others and engaging in verbal confrontations with

peers and staff. Evaluations were not completed as needed with changes in Tenant #2's behavior.

Tenant #3, a 75 year old, was admitted on 3-1-12 and diagnoses include: Depressive Disorder, Epilepsy and Hypothyroidism. According to Nurse's Notes from 5-17-12 through 6-6-12 there were entries regarding Tenant #3's behavior. The behaviors included Tenant #3 had been very irritable, short with peers, families and staff. Tenant #3 became very tearful and loud, swearing at staff, threatening to slap anyone who got in Tenant #3's way. Tenant #3 was verbally upset and physically threatening towards staff, raised Tenant #3's closed fist and was threatening to hit. On 5-18-12 a fax was sent to the doctor regarding an increase in behaviors. Sertraline 50 mg every day, start ½ tablet first two days and then a full tablet was ordered. Nurse's Notes from 6-11-11 (6-11-12) through 7-22-12 indicated Tenant #3 was belligerent, cursing at staff. Tenant #3 was stalking staff, threatening with closed fist and verbiage. There was a verbal confrontation between Tenant #3 and a peer. On 6-7-12 a fax was sent to the doctor regarding behaviors. Sertraline 100 mg every day was ordered. According to Nurse's Notes dated 8-9-12, Tenant #3 had several loud outbursts that morning and yesterday. On 8-9-12 a fax was sent to the doctor regarding increased verbal aggression the past two days towards peers and staff without provocation. Seroquel was increased to 25 mg twice daily. On 8-10-12 Tenant #3 continued to be sullen, easily agitated and verbally loud. Evaluations were not completed as needed with changes in Tenant #3's behavior.

Tenant #4, a 79 year old, was admitted on 12-9-11 and diagnoses include: Insulin Dependent Diabetes Mellitus, Cerebral Artery Occlusion and Cerebral Infarction. Nurse's Notes dated 7-6-12 at 11:30 a.m., indicated Tenant #4 reported elevated blood sugars since 5:00 a.m. and included readings of 481 and 460. According to Nurse's Notes dated 7-6-12 at 1:40 p.m., Tenant #4 left to go to the doctor's appointment with a family member and Tenant #4's blood sugar was 509. Nurse's Notes dated 7-31-12 at 7:30 a.m. (a late entry for 7-31-12 at 5:05 a.m.), indicated Tenant #4 was unresponsive and the blood sugar was 40. Staff was advised to call 911 for paramedics and notify Tenant #4's family. On 7-31-12 at 11:30 a.m. Tenant #4 was up in a chair, showered and dressed. Tenant #4's blood sugar before breakfast was 411 and the blood sugar after breakfast was 472. Tenant #4 was too weak to walk to the dining room and a room tray was delivered. Evaluations were not completed as needed with fluctuations in blood sugars.

Tenant files reviewed did not reflect evaluations were completed for each tenant's functional, cognitive and health status as needed with significant change and annually.

- 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 evaluations 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 information was obtained:

- Monitoring Observation: Four tenant files were reviewed. The Assistant Manager and the RN identified a conflict between Tenants #2, #3 and #4.

  Tenant #2's file was reviewed. According to Nurse's Notes from 7-8-12 through 7-31-12 there were situations documented regarding Tenant #2's behavior. The behaviors Tenant #2 exhibited included being argumentative with others and engaging in verbal confrontations with peers and staff.

  According to the service plan completed on 3-29-12, Tenant #2 had a very negative attitude and outlook on life. Tenant #2 felt everyone was against Tenant #2 and the doctor was advised. The service plan indicated staff to encourage activities, monitor for any changes in mood and Tenant #2 would maintain mental status and interest in activities. The service plan was not updated as needed with changes in Tenant #2's behavior. The service plan did not reflect Tenant #2's behavior and conflict interventions related to the behaviors.

  Tenant #3's file was reviewed. According to Nurse's Notes from 5-17-12 through 6-6-12 there were entries regarding Tenant #3's behavior. The behaviors included Tenant #3 had been very irritable, short with peers, families and staff. Tenant #3 became very tearful and loud, swearing at staff, threatening to slap anyone who got in Tenant #3's way. Tenant #3 was verbally upset and physically threatening towards staff, raised Tenant #3's closed fist and was threatening to hit. On 5-18-12 a fax was sent to the doctor regarding an increase in behaviors. Sertraline 50 mg every day, start ½ tablet first two days and then a full tablet was ordered. Nurse's Notes from 6-11-11 (6-11-12) through 7-22-12 indicated Tenant #3 was belligerent, cursing at staff. Tenant #3 was stalking staff, threatening with closed fist and verbiage. There was a verbal confrontation between Tenant #3 and a peer. On 6-7-12 a fax was sent to the doctor regarding behaviors. Sertraline 100 mg every day was ordered. According to Nurse's Notes dated 8-9-12, Tenant #3 had several loud outbursts that morning and yesterday. On 8-9-12 a fax was sent to the doctor regarding increased verbal aggression the past two days towards peers and staff without provocation. Seroquel was increased to 25 mg twice daily. On 8-10-12 Tenant #3 continued to be sullen, easily agitated and verbally loud.

  The service plan indicated staff to encourage activities, monitor for any changes in mood and Tenant #3 would manage his/her own well-being and attend activities of choice. The service plan was not updated as needed with changes in Tenant #3's behavior. The service plan did not reflect Tenant #3's behavior and conflict and interventions related to the behaviors.

  Tenant #4's file was reviewed. Nurse's Notes dated 7-6-12 at 11:30 a.m., indicated Tenant #4 reported elevated blood sugars since 5:00 a.m. and included readings of 481 and 460. According to Nurse's Notes dated 7-6-12 at 1:40 p.m., Tenant #4 left to go to the doctor's appointment with a family member and Tenant #4's blood sugar

was 509. Nurse's Notes dated 7-31-12 at 7:30 a.m. (a late entry for 7-31-12 at 5:05 a.m.), indicated Tenant #4 was unresponsive and the blood sugar was 40. Staff was advised to call 911 for paramedics and notify Tenant #4's family. On 7-31-12 at 11:30 a.m. Tenant #4 was up in a chair, showered and dressed. Tenant #4's blood sugar before breakfast was 411 and the blood sugar after breakfast was 472. Tenant #4 was too weak to walk to the dining room and a room tray was delivered.

The service plan reflected Tenant #4 was diabetic and would administer the insulin injections. The service plan also indicated the Program staff set up medications. The service plan did not address blood sugar checks and fluctuations in Tenant #4's blood sugars. The Medication Administration Records (MARs) reflected Tenant #4 self administered a nasal spray, staff recorded Tenant #4's blood sugars and staff initialed on the MARs for several oral medications. The MARs also reflected Tenant #4 self administered insulin and took some oral medications independently. The Assistant Manager said Tenant #4 took his/ her own blood sugars and staff recorded the blood sugars on the MARs. She said Tenant #4 administered insulin independently. The service plan did not reflect who was involved with all aspects of medication administration. The service plan was not updated as needed and did not reflect the fluctuation of Tenant #4's blood sugars. The service plan did not reflect Tenant #4's behavior and conflict and interventions related to the behaviors.

Tenant files reviewed indicated the service plans did not identify the conflict between the tenants and did not provide interventions related to the conflict. Tenant files reviewed indicated the service plans were not updated as needed and were not individualized to meet the tenant's identified needs.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be undated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

## C. Criteria for Admission and Retention

Complaint/Incident Allegation #40056-C: It was alleged the Program had a tenant who exceeded the level of care.

- Monitoring Observation: Four tenant files were reviewed.

Review of tenant files (Tenants #1, #2, #3 and #4) did not reveal any tenants that exceeded the level of care.

Staff #1, #2, the RN and Assistant Manager did not identify anyone who exceeded the level of care. Staff #1, #2 and the RN did not identify any tenants who had harmed staff or tenants. The Assistant Manager did not identify any tenants that were harmful to self or others. Staff #1, #2 and the RN said there were no restrictions in place for tenants' movement throughout the building. The Assistant Manager said

Tenant #3 was asked to stay out of the library for a couple of days but tenants could go to any public space within the building.

The Assistant Manager and the RN identified a conflict between Tenants #2, #3 and #4.

The Assistant Manager said she had never witnessed any physical contact between Tenant #2 and Tenant #3. She had told Tenant #2, who was fearful, that Tenant #3 was not a danger to self or others. The Assistant Manager said there was no potential for the situation to go beyond verbal as Tenant #3 loved it at the Program and wouldn't do anything that would result in having to leave. The Assistant Manager did not think the situation was abusive. The Assistant Manager said Tenant #2 continued to be involved in activities but had chosen to no longer play cards. She said Tenant #2 was negative and refused antidepressant therapy.

Review of tenant files and staff interviews did not reveal any tenants that exceeded level of care.

- Regulatory Insufficiency: None noted.