IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 39836-CR
40607-I
40706-C

October 19, 2012

Ms. Theresa Hogenson, Interim Administrator
Shores of Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, IA 50327

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

Dear Ms. Hogenson:

I. Final First Complaint Revisit and Complaint/Incident Investigation Report – Shores of Pleasant Hill, Pleasant Hill, IA

Enclosed is the **Final First Complaint Revisit and 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: Life Safety, Service Plans and Compliance with Plan of Correction.

Shores at Pleasant Hill is being assessed a $2500 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 had repeated regulatory insufficiencies in the areas of Service Plans and Life Safety.

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 one thousand six hundred and twenty five dollars ($1625) 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 $2500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on October 18, 2012, has been reviewed and will constitute the final POC related to the on-site visit of September 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, 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 First Complaint Revisit and Complaint/Incident Investigation Report

Assisted Living Program:

Theresa Hogenson, Interim Administrator
The Shores of Pleasant Hill
1500 Edgewater Dr.
Pleasant Hill, Iowa 50327

Complaint/Incident Intake #:

39836-CR
40607-I
40706-C

Date of Complaint/Incident Investigation:

September 17, 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:	41
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	42
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	60

Program History – The program received a regulatory insufficiency in the area of Structural Requirements during the Recertification visit of April 4, 2012.

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

A. Staffing

The program received a regulatory insufficiency related to not having a sufficient number of trained staff available at all times to fully meet Tenant #1's identified needs during the onsite July 2012 complaint investigation visit. (39836-CR)

- Monitoring Observation: At the time of the revisit, Tenant #1 continued to reside on the second floor memory care unit. Tenant #1 had no further documented elopements from the building. Tenant #1 remained on the second floor memory care unit at all times, receiving all meals on the unit and attending activities provided in the second floor memory care unit. Tenant #3 was the only tenant living in the second floor memory care unit that was being transported to the first floor memory care unit for activities and/or meals. Tenant #3 had no documented incidents indicating inadequate staff supervision.

Complaint/Incident Allegation: It was alleged the program did not have a sufficient number of trained staff available in the dining room area to provide emergency assistance. (40706-C)

Monitoring Observation: Tenant #4, an 83 year old, was admitted to the general population 1-21-11 with diagnoses of Blindness of the Left Eye, Alzheimer's Dementia, and Osteoarthritis. Tenant #4 scored 3 on the GDS conmpleted 8-24-12 which indicated mild cognitive decline. The service plan of the same date documented Tenant #4 was independent with all activities of daily living except medication administration. The monitors interviewed staff members who identified Tenant #4, who choked on food in the dining room area. Staff #1, dietary aide, Staff #2, administrative assistant, and Staff #3, cook, all reported working on the morning of 9-4-12. Staff #1, #2 and #3 witnessed Tenant #4 choking on food at approximately 8:15 a.m. Staff #3 requested the assistance of a nurse over the program's hand held communication device. All three staff members reported a nurse did not respond to the request. One care attendant responded she was unable to assist as she was the only staff member in the memory care unit and one care attendant responded to the request after the incident had resolved. The Health Services Director reported she was present in the building but did not hear the request. Tenant #4 spontaneously expelled the food item and did not appear to be in any distress. Staff #4, the previous dietary manager, reported the incident to the Health Services Director at approximately 9:15 a.m. The Health Services Director sought out Tenant #4, who indicated no ill effects from the choking incident and Tenant #4 refused an assessment by the nurse or transport for medical evaluation.

The program did not routinely train dietary staff members or care attendants to perform emergency medical assistance. The program had a policy, titled Emergency Contact Policy, which directed staff members to contact the registered nurse or 911 in the event of a medical emergency. The staff members attempted to contact the Health Services Director, who is a registered nurse. The nurse did not respond to the call; however, 911 was not required as Tenant #4 spontaneously expelled the food.

Complaint/Incident Allegation: The program reported a cognitively impaired tenant was left unattended in the dining room of the unsecured general population area. While left unattended, the tenant exited the program. (40607-I)

Monitoring Observation: The program identified seven cognitively impaired tenants residing in the second floor secured memory care unit (AL plus). Prior to 8-16-12, all seven tenants were transported to the unsecured general population dining room on the first floor for lunch and supper. Staff members were to monitor the tenants during the meal period and were to return each tenant back to the AL plus unit following completion of the meal. The Interim Administrator and the Health Services Director both reported one tenant, Tenant #2 eloped while unsupervised in the general population dining room on 8-16-12. The program immediately initiated meal service for the lunch and supper meals to be served on the second floor AL plus unit, thereby allowing cognitively impaired tenants to remain on the secured unit. The monitors reviewed the incident reports completed between 7-1-12 and 9-17-12.
The reports documented only one tenant, Tenant #2, eloped during that time period. The monitors reviewed the clinical records of Tenants #1, #2 and #3, all cognitively impaired tenants residing in the AL plus unit. Tenant #1 had previously eaten meals in the first floor memory care unit and currently ate all meals in the AL plus unit. Tenant #3 currently was transported by staff members to the first floor memory care unit per family request to eat meals and participate in activities. Tenants #1 and #3

had no documented incidents of being left unattended while away from the secured unit and had no documented elopements from the building.

Tenant #2, an 87 year old, was admitted to the program on 6-20-12 with diagnoses of: Dementia, Atrial Fibrillation and Coronary Heart Disease. Tenant #2 resided in the AL plus memory care unit on the second floor. Tenant #2 scored a 5 on the Global Deterioration Scale (GDS), completed on 7-20-12, indicating moderately severe cognitive decline. Tenant #2 previously resided in another assisted living program, that was not a secured building. According to administration at the previous assisted living, Tenant #2 began frequent exit seeking behavior and exited the program unattended by staff members on several occasions to look for his/her vehicle. Tenant #2 was transferred to the program to be placed in one of the program's secured memory care units.

Tenant #2's clinical record indicated Tenant #2 ate breakfast in the AL plus memory care unit and was accompanied by staff members to the general population dining room on the first floor for lunch and supper. On 8-16-12, staff members assisted Tenant #2 to the first floor dining room for the noon meal. While Tenant #2 remained in the first floor dining room, staff members left the area unattended. Tenant #2 ambulated independently with a walker. Tenant #2 left the dining room area while left unattended and ambulated to the front entrance of the program's general population area. Video, taped by the program, showed Tenant #2 exited the front door, assisted by another tenant, at 12:34 p.m. on 8-16-12. During interview, the receptionist who seated at the front desk, reported seeing a woman exit the building but did not recognize the tenant as a tenant requiring staff supervision; therefore, she did not intervene. At approximately 12:40 p.m., a volunteer music therapist arrived to assist with an activity in the first floor memory care unit. The volunteer music therapist recognized Tenant #2 as being a cognitively impaired tenant. The music therapist observed Tenant #2 in the parking lot in front of the first floor memory care unit front entrance, attempting to get into parked cars. The music therapist alerted staff members in the first floor memory care unit, who immediately retrieved Tenant #2. Video showed staff members bringing Tenant #2 back into the building at approximately 12:43 p.m.

Tenant #2 was left unattended in an unsecured area of the building despite Tenant #2's history of exit seeking behavior. Tenant #2 exited the building without staff member knowledge or intervention but was returned to a secured area of the program within approximately nine minutes with no harm.

- Regulatory Insufficiency: None noted.

B. Life Safety

The program received a regulatory insufficiency related to the program's failure to have an operating alarm system connected to each exit door in the memory care unit during the onsite July 2012 complaint investigation visit. (39836-CR)

- Monitoring Observation: During the initial complaint visit, the program was automatically disengaging the alarm to the courtyard exit door located in the secured

memory care unit during the day time hours, allowing tenants free unsupervised access to the outside courtyard. The program planned to keep the door alarmed at all times and monitor the alarmed doors in the unit at least monthly. The program monitored the door alarms for function on 8-15-12. The program had not rechecked the function again prior to the on-site revisit.

During the on-site revisit, the monitor pushed on the egress bar on the secured memory unit door exiting into an outside courtyard. The alarm did not sound. The door had a sign which indicated the door would alarm continuously while pushed for 15 seconds then the door would release. The monitor requested the Health Services Director assist with the courtyard door. The monitor pushed on the door's egress bar continuously for 15 seconds. The alarm did not sound and the door did not release. The Health Services Director and the monitor unsuccessfully attempted to get the door to alarm or open. Eventually, the monitor hit the bar with an open hand and the alarm chirped. The monitor was able to get the alarm to sound and release after 15 seconds. After the Health Services Director reset the alarm, the monitor again attempted to get the door to sound but was unsuccessfull. The program found the door alarm system to be malfunctioning and contacted their service provider. Later that day, the service provider readjusted the sensor and the alarm began to activate appropriately. The service provider told the program that changes in temperature may again cause the door to malfunction again, requiring further adjustment.

Since the program had not checked the alarm function since 8-15-12, the amount of time the alarm was non-functioning was unable to be determined. The exit door to the memory care unit courtyard was not operating appropriately upon initiation of the on-site revisit on 9-17-12.

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

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

C. Compliance with Plan of Correction

- Monitoring Observation: During the initial complaint visit, the program was automatically disengaging the alarm to the courtyard exit door located in the secured memory care unit during the day time hours, allowing tenants free unsupervised access to the outside courtyard. The program's plan of correction indicated the program planned to keep the door alarmed at all times and monitor the alarmed doors in the unit at least monthly, correcting the insufficiency by August 31, 2012. The program monitored the door alarms for function on 8-15-12. The program had not rechecked the function again prior to the on-site revisit.

  During the on-site revisit, the monitor pushed on the egress bar on the secured memory unit door exiting into an outside courtyard. The alarm did not sound. The door had a sign which indicated the door would alarm continuously while pushed for 15 seconds then the door would release. The monitor requested the Health Services Director assist with the courtyard door. The monitor pushed on the door's egress bar

continuously for 15 seconds. The alarm did not sound and the door did not release. The Health Services Director and the monitor attempted to get the door to alarm or open unsuccessfully. Eventually, the monitor hit the bar with an open hand and the alarm chirped. The monitor was able to get the alarm to sound and release after 15 seconds. After the Health Services Director reset the alarm, the monitor again attempted to get the door to sound but was unsuccessfull. The program found the door alarm system to be malfunctioning and contacted their service provider. Later that day, the service provider readjusted the sensor and the alarm began to activate appropriately. The service provider told the program that changes in temperature may again cause the door to malfunction again, requiring further adjustment.

Since the program had not checked the alarm function since 8-15-12, the amount of time the alarm was non-functioning was unable to be determined. The exit door to the memory care unit courtyard was not operating appropriately upon initiation of the on-site revisit on 9-17-12.

- Regulatory Insufficiency: The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. (IAC r. 481-67.10(8))

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

D. Service Plans

- Monitoring Observation: Tenant #1, a 73 year old, was admitted to the program on 1-18-12 with diagnoses of Dementia and Seizure Disorder. Tenant #1 resided in the program's second floor secured memory care unit (AL plus). Tenant #1 scored a 4 on the GDS completed on 6-27-12, indicating moderate cognitive decline.
Tenant #1's service plan, dated 6-27-12, documented Tenant #1 went to the program's first floor secured memory care unit for meals. Staff members were to accompany Tenant #1 to the unit and back to the AL plus unit, never leaving Tenant #1 unsupervised. The service plan indicated Tenant #1 went to the first floor secured memory care unit from 11:00 a.m. to 6:00 p.m. to participate in activities and meals as the first floor memory care unit could offer a quieter and more structured environment for Tenant #1. During interview, the Health Services Director reported Tenant #1 stopped going to the first floor secured memory care unit in the first week of July 2012. The activities in the AL plus unit were increased; therefore, the need for Tenant #1 to go to the other memory care unit ceased. Tenant #1 then began to go to the dining room area in the unsecured general population area for meals, accompanied and supervised by staff members. On 8-16-12, Tenant #1 began eating all meals in the AL plus unit due to another tenant elopement from the program while being left unsupervised in the general population dining room. Tenant #1's service plan had not been updated with either of the above stated changes. The Health Services Director reported she believed a previous nurse who primarily worked in the AL plus had made the changes. The Health Services Director reviewed Tenant #1's clinical record, concurring Tenant #1's service plans had not been updated with the changes.

Tenant #3, a 79 year old, was admitted to the program on 3-5-11 with diagnoses of Alzheimer's Type Dementia and Back Pain. Tenant #3 moved to the program's AL plus unit on 7-22-12. Tenant #3 scored a 5 on the GDS completed on 7-19-12, indicating moderately severe cognitive decline. Tenant #3's service plan, dated 7-23-12, documented Tenant #3 went to the program's first floor secured memory care unit for activities. On 9-17-12, the monitor observed Tenant #3 in the first floor secured dining room for lunch. During interview, the Health Services Director reported Tenant #3's family wanted the tenant to eat meals on the first floor. Tenant #3's service plan had not been updated with meal location preference or specific directions how Tenant #3 was to be transported from one place to the other. The Health Services Director reported she believed a previous nurse who primarily worked in the AL plus had made the changes. The Health Services Director reviewed Tenant #3's clinical record, concurring Tenant #3's service plans had not been updated with the changes.

- 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 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))

E. Food Service

Complaint/Incident Allegation: It was alleged the meals served to the second floor secured memory care unit (AL plus) tenants were cold by the time they were served. (40706-C)

- Monitoring Observation: The monitors requested a sample tray from the noon meal served on the AL plus floor. The monitor checked the temperatures of all items on the sample tray after all other tenants had been served the meal.
  The monitor found temperatures of the proteins and perishable food items to be within the required guidelines. The monitor tasted all food items, noting the temperature of the food to be adequate and the taste to be palatable.

- Regulatory Insufficiency: None noted.