IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 41630-CR3

January 8, 2014

Ms. Annie Allen, Administrator
Linnwood Estates
700 North Linn
Glenwood, IA 51534

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL THIRD REVISIT COMPLAINT/INCIDENT INVESTIGATION REPORT – LINNWOOD ESTATES ASS ISTED LIVING
II. Reduction of Civil Penalty
III. Sanctions – Conditional Operation
IV. Appeals/Hearings
V. Conclusion

Dear Ms. Allen:

I. Final Third Revisit Complaint/Incident Investigation Report – Linnwood Estates Assisted Living, Glenwood, IA

Enclosed is the **Final Third Revisit Complaint/Incident Investigation Report** issued 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, following an investigation by DIA on **November 20, 25 and 26, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluations, Service Plans and Compliance with Plan of Correction.

Linnwood Estates Assisted Living ("Program") is being assessed a **$4,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.12(3)(a)(2), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. Program failed to update evaluations with change in condition for three tenants. Service plans were not updated for five tenants as required and the program failed to follow its plan of correction previously submitted to the Department.

The determination of a **$4,000 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Evaluations, Service Plans and Compliance with Plan of Correction. As the enclosed Report details, the Program failed to update evaluations with change in condition for three tenants. Service plans were not updated for five tenants as required and the program failed to follow its plan of correction previously submitted to the Department.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service 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 **two thousand six hundred dollars ($2,600)** within 30 days after the notice or service of this demand letter.

III. Sanctions – Conditional Operation

Due to the Program's noncompliance and current Regulatory Insufficiencies, the Program's Conditional Certificate remains in effect as of **December 23, 2013**.

Previous sanctions include: No new admissions. Proof of staff training on proper evaluations and service plan updates by an outside agency for all direct care workers and nursing staff within 30 days. The Program will have 30 days to complete the above training and provide proof of the training to the Department.

IV. Appeals/Hearings

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written 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 the notice or service of this demand letter.

V. Conclusion

The Program is being assessed a **$4000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Plan of Correction (POC) submitted on December 31, 2013, has been reviewed and will constitute the final POC related to the on-site visit of November 20, 25 and 26, 2013.

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 notice or service 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,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Third Revisit to a Complaint/Incident Investigation Report

Assisted Living Program: **Complaint/Incident Intake #: 41630-CR-3**

Annie Allen, Administrator
Linnwood Estates
700 North Linn
Glenwood, IA 51534

Date of Complaint/Incident Investigation:

November 20, 25, and 26, 2013

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:	22
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	27
TOTAL census of Assisted Living Program	27

Program History – There were regulatory insufficiencies cited in the area of Other (Dependent Adult Abuse Training), Staffing, Evaluations, Tenant Documents, Service Plans, Nurse Review, Transportation, Policy and Procedure and Managed Risk during this recertification period.

A. Evaluation

The program received regulatory insufficiency at the time of the onsite complaint investigation in December 2012 and was recited at the first onsite revisit completed on May 15 and 16, 2013 related to evaluations not being completed within 30 days of admission and with significant change related to Tenants #1, #3, and #6. The regulatory insufficiency was recited during the second onsite visit completed on July 8 and 9, 2013 related to evaluations not being completed with change of condition and by an RN related to Tenants #1, #3, and #10.

- Monitoring Observation: Tenant #1, an 85 year-old, was admitted on 2-10-12 and had diagnoses of: Hypertension (HTN), Osteoarthrosis, Anxiety, Chronic Venous Stasis Ulcers, Coronary Artery Occlusion and Urinary Retention resulting in Chronic Urinary Tract Infections. Tenant #1 answered all questions correctly when taking the Short Portable Mental Questionnaire (SPMSQ) on 7-29-13, indicating intact intellectual functioning.

  Evaluations of function, cognition, and health were completed on 7-29-13 and were completed by a Registered Nurse (RN). Evaluations were completed as indicated in the Plan of Correction (POC) and a review of the clinical record did not identify any changes in condition that warranted re-evaluation of function, cognition or health.

  Tenant #3, an 82 year-old, was admitted on 12-30-10 and had diagnoses of: Glaucoma, Hyperplasia of the Prostate, Dementia, and Parkinson's disease. Functional, cognitive, and health evaluations were completed by an RN on 7-25-13. The cognitive evaluation indicated intact intellectual functioning. Evaluations were completed as per the POC. A review of the clinical record did not reveal any changes in condition that warranted re-evaluations of function, cognition or health.

Tenant #8, an 89 year-old, was admitted on 7-11-11 and had diagnoses of: Hypertension, Diabetes, Depressive Disorder, and Dementia. On 11-5-13, Tenant #8 was staged at four on the Global Deterioration Scale which indicated moderate cognitive decline.

An incident report dated 10-24-13 and timed 5:25 p.m. documented Tenant #8 was found on the floor of the apartment. Tenant #8 reported losing balance and had no complaints of discomfort. An incident report dated 10-30-13 and timed 8:15 a.m. documented Tenant #8 was sitting on the bathroom floor and was unaware of what happened. Tenant #8 was taken to the hospital via ambulance. According to nurses notes dated 10-30-13 and timed 3:00 p.m., Tenant #8 returned to the program and had an unsteady gait and confusion. An incident report dated 10-30-13 and timed 7:30 p.m. documented Tenant #8 was found on the bathroom floor and was bleeding from the head. Tenant #8 was taken via ambulance to the hospital and admitted.

According to nurses notes dated 10-31-13, Tenant #8 was admitted to the hospital on 10-30-13 with urinary retention and dehydration. Tenant #8 had a small laceration to the head that did not require sutures. Tenant #8 returned to the program on 11-1-13. Nurse's notes timed 3:00 p.m. documented Tenant #8's mental status had improved. The notes also documented a health evaluation. A home health agency was to provide in-room service during the night at the family's request. Tenant #8 was to use a walker and have stand-by assist at all times. The service plan of 10-11-13, current as of 11-1-13 indicated Tenant #8 was independent with ambulation.

Tenant #8 sustained two falls on 10-30-13 one resulting in a small laceration to the head. Tenant #8 was noted to be confused, which was documented in nurse's notes to have improved upon return. A home health service was with Tenant #8 during the night shift. Tenant #8 required stand-by assistance and walker for ambulation, a change. Evaluations of function and cognition were not completed upon return from the hospital with a change of condition.

Tenant #9, an 87 year-old, was admitted on 6-4-04 and had diagnoses of: Depressive Disorder, Diabetic Retinopathy, HTN, Osteoarthrosis, Diabetes, and Dementia. On 4-10-13, Tenant #9 was staged at six on the Global Deterioration Scale (GDS) which indicated severe cognitive decline. According to the POC, evaluations of function, cognition, and health had been completed since the July 2013 visit. The clinical record lacked documentation of a functional, cognitive, and health evaluation completed after the last monitoring visit. The POC was not followed.

Tenant #10, a 91 year-old, was admitted on 12-1-08 and had diagnoses of: Parkinson's Disease, Chronic Duodenal Ileus, Diabetes, Osteoarthritis, and Neurogenic Bladder. Tenant #10 answered all questions but one correctly when taking the SPMSQ on 9-9-13, indicating intact intellectual functioning. Evaluations of function, cognition, and health were completed on 7-25-13, according to the POC.

Evaluations of function and health were completed on 9-6-13 and a cognitive evaluation was completed on 9-9-13 with a change of condition, the discontinuation of PT. The functional evaluation indicated Tenant #10 was independent with a walker for mobility. Tenant #10 was also able to self-manage bladder incontinence and was independent with hygiene.

Nurses notes dated 8-6-13 indicated Tenant #10 needed assistance out of bed to get to the bathroom. The bedding was observed to be "soaked." A fax to the physician dated 8-30-13 indicated Tenant #10 had reddened gluteal folds and Tenant #10 complained of pain when sitting and at times, a burning sensation. The Nurses notes of 9-6 and 9-9-13 indicated Tenant #10 had a urinary tract infection and the antibiotic was changed after the culture results were returned. A fax dated 9-23-13 indicated Tenant #10 had painful heels when sleeping in bed and a heel suspension boot was ordered. Clinical Nurses notes on 10-1-13 indicated Tenant #10 was to call for assistance at night so that staff members could remove the heel boot prior to ambulation to the bathroom. The fax of 10-18-13 indicated there was a scabbed area on Tenant #10's coccyx and the skin was red and tender around the area. Tenant #10 also had a burning sensation in the gluteal folds and it was difficult for Tenant #10 to sit for long periods of time. A fax of 10-31-13 indicated Tenant #10 had a swollen right groin that was red and hard, and tender to the touch. Drainage was noted from the area when pressed. Warm packs were prescribed in a separate fax of the same date. Clinical Nurses notes of 11-6-13 indicated the right groin had healed. Clinical Nurses notes of 11-13-13 indicated Tenant #10 required assistance turning over in bed and with position changes throughout the night. Staff also provided assistance with perineal care after toileting. On 11-15-13, Tenant #10 was noted to have a strong odor to the urine. An antibiotic was started for a urinary tract infection. On 11-19-13 nurses notes documented Tenant #10 had an infection that was resistant to antibiotic therapy.

In an interview with the RN/Director of Nursing, she stated Tenant #10 had a small body frame and sensitive skin and needed to change positions in bed. Tenant #10 was not to sit up "too long" because of skin problems. Odor was the only symptom of a urinary infection that Tenant #10 exhibited. Staff members were beginning to assist more because of Tenant #10's Parkinson's Disease.

Tenant #10 exhibited a change of condition because of changes to skin in the groin area, the coccyx, and required the use of a heel boot when sleeping. Tenant #10 had two urinary infections the last was documented as resistant to antibiotics. Tenant #10's only symptom was a strong urine odor. Staff members were providing more assistance related to change of position. Evaluations of function, cognition and health were not completed with the change of condition that occurred between 9-6 and 11-19-13.

- 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

The program received regulatory insufficiency at the time of the onsite complaint investigation in December 2012 and was recited at the first onsite revisit completed on May 15 and 16, 2013 related to service plans not based on evaluations, not completed within 30-days of admission, not updated with change in condition, not identifying outside service providers, not meeting identified tenant needs, and not identifying tenant preference for nursing facility care, and did not identify activities for a person with dementia as related to Tenants #1, #3, #6, and #9. The regulatory insufficiency was recited during the second onsite visit completed on July 8 and 9, 2013 related to outside service providers, no updates with changes in condition, not meeting identified needs of tenants, and service plans not based on evaluations related to Tenants #1, #9, and #10.

Monitoring Observation: Tenant #1 had functional, cognitive, and health evaluations completed by an RN on 7-29-13. The health evaluation indicated the blood pressure had been stable. At the end of July, Tenant #1 was receiving services from Physical (PT) and Occupational Therapy (OT). The service plan of the same date identified PT and OT as services received. A nurse review was completed on 9-6-13 and nurse's notes were reviewed from 8-1 through 11-20-13 with no further discussion of services received from PT and OT. The nurse review of 9-6-13 indicated Tenant #1 ambulated independently with a walker. The service plan was not updated to include the discontinuation of PT and OT services.

Tenant #1's health evaluation of 7-29-13 indicated staff members were to monitor a cyst on the right foot between the toes. The service plan did not identify a staff monitoring plan. The service plan did not meet the identified needs of Tenant #1.

Tenant #3's evaluations of 7-25-13 indicated Tenant #3's blood pressure had been more stable. The service plan of 7-25-13 indicated Tenant #3 was to be encouraged to drink fluids to maintain blood pressure. The POC was followed. The service plan met the needs of Tenant #3.

Tenant #8 returned to the program on 11-1-13 following hospitalization after two falls. Tenant #8 had been admitted for hydration and urinary retention. Tenant #8 returned and the family requested a home health agency provide in-room care during the night.

A notation was made on the service plan of 10-11-13 to include the stand-by assistance with a walker while Tenant #8 ambulated as well as the assistance of the home health agency. Functional and cognitive evaluations were not completed at the time of the updates to the service plan. The service plan was not based on evaluations.

Tenant #8 was staged at four on the GDS. The program was unable to provide documentation of an activated healthcare power-of-attorney form. The service plan of 10-11-13 was not signed by Tenant #8 and was not signed on 11-1-13 after updates were added.

Tenant #8 was observed to have small open spots on the thigh in a fax dated 11-22-13. A fax of 10-25-13 indicated Tenant #8 scratched "everywhere." Nurses notes of 10-21-13 documented an old scar on the abdomen opened up and Tenant #8 denied scratching it. Faxes dated 8-24, 8-29, and 9-3-13 indicated Tenant #8 had small open areas or dry scabbed areas on the abdomen. In an interview with the RN/Director of Nursing, she stated Tenant #8 was a "picker" and picked at the abdomen which resulted in scabs and open areas. The RN/Director of Nursing stated Tenant #8 needed reminders not to "pick." The service plans of 9-13 and 10-11-13 did not address the behavior of "picking." The service plan did not meet the identified needs of Tenant #8.

Tenant #9, an 87 year-old, was admitted on 6-4-04 and had diagnoses of: Depressive Disorder, Diabetic Retinopathy, HTN, Osteoarthrosis, Diabetes, and Dementia. On 4-10-13, Tenant #9 was staged at six on the GDS which indicated severe cognitive decline. Tenant #9's service plan was dated 6-14-13. Functional, cognitive, and health evaluations were not completed at that time. The service plan was not based on evaluations.

According to nurse's notes of 10-10-13 and a nurse review of 10-11-13, Tenant #9 was found in the program's laundry room with pants down urinating and defecating on the floor. Tenant #9 had been on a two-hour toileting schedule. Tenant #9 was voluntarily discharged to a higher level of care on 10-23-13.

According to the POC, evaluations of function, cognition, and health were completed after the July visit. The clinical record lacked documentation of the completion of evaluations after the citation in July 2013. Tenant #9 continued to have a service plan that was not based on evaluations. The program did not follow the POC.

Nurse's notes dated 10-21-13 documented Tenant #9 went to the nursing facility on campus "a couple days" to participate in meals and activities. In documentation dated 10-16-13 the family wanted Tenant #9 to acclimate to the new environment a couple hours a day. The service plan did not identify participation at the nursing facility. The service plan did not meet the identified needs of Tenant #9.

A nurse review dated 9-6-13 identified a review was done for a change of condition, discontinuation of PT for Tenant #10. Evaluations of health and function were completed on 9-6-13 and the service plan was updated. A cognitive evaluation was not completed until 9-9-13. The service plan for Tenant #10 was not based on a cognitive evaluation. The health evaluation of 9-6-13 identified Tenant #10 was to be monitored for swallowing difficulties related to the Parkinson's Disease. The service plan did not indicate Tenant #10 was to be monitored for swallowing difficulties. The service plan was not based on the health evaluation.

The service plan for Tenant #10, dated 9-6-13, did not identify Tenant #10 required assistance or reminders to change position to manage sensitive skin. The service plan did not identify a strong urine odor as a symptom of Tenant #10's frequent urinary tract infections. The service plan did not identify Tenant #10's need to call for assistance to remove the heel boot in order to ambulate to the restroom. The service plan did not meet the identified needs of Tenant #10.

Tenant #13, a 91 year-old, was admitted on 8-2-13 and had diagnoses of: Hypothyroidism, Hyperlipidemia, Esophageal Reflux, and Generalized Pain. The most recent cognitive screening tool dated 11-7-13 indicated Tenant #13 had intact intellectual functioning.

Clinical Nurses notes dated 10-7-13 indicated Tenant #13 was started on an antibiotic for pneumonia. Notes of 10-18-13 indicated the condition had resolved. Nurses notes dated 11-2-13 indicated Tenant #13 had been having episodes of dizziness. The blood pressure was noted to drop when Tenant #13 went from sitting to standing. Tenant #13 was instructed to ask for staff assistance when getting up, waiting for dizziness to subside before standing, and to stay hydrated. According to the current service plan with dates of 8-29 and 9-16-13, Tenant #13 had a history of falls prior to admission. The service plan did not identify interventions for dizziness related to position changes.

Clinical Nurses notes of 11-4-13 indicated Tenant #13 went to the see the physician. The clinical record contained discharge instructions for Aspiration Pneumonia dated 11-4-13. Tenant #13 also returned with an order for hospice and an order for a series of nitroglycerin tablets for chest pain. Tenant #13 was admitted to hospice on 11-5-13. Hospice notes of 11-12-13 indicated Tenant #13 had an open area on the right elbow to which a protective dressing was applied. Hospice notes dated 11-6-13 through 11-19-13 documented the use of oxygen for shortness of breath. Hospice recommended the use of oxygen at night and the use of the prescribed nitroglycerin for chest pain on 11-19-13.

The program completed evaluations of function, cognition, and health on 11-7-13 for a change of condition. The health evaluation indicated Tenant #13 had aspiration pneumonia and did not want treatment, and was on hospice. The health evaluation indicated Tenant #13 was to be watched for choking or swallowing difficulties.

A review of the current service plan with the most recent date of 9-16-13 did not identify the use of oxygen for shortness of breath or the use of nitroglycerin and the directions for use during an episode of chest pain. The service plan did not identify the treatment of the right elbow wound. The service plan did not meet the identified needs of Tenant #13.

- 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))

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

C. Compliance with Plan of Correction

The program received regulatory insufficiencies at the first onsite revisit completed on May 15 and 16, 2013 related to staffing, evaluation, tenant documents, service plan, nurse review, policies and procedures, and dependent adult abuse training. The program received regulatory insufficiencies at the second onsite revisit completed on July 8 and 9, 2013 related to evaluations and service plans.

- Monitoring Observation: The Program's Plan of Correction dated following the July 2013 monitoring visit included a plan to correct the cited insufficiencies related to evaluations and service plans.

  During the monitoring visit conducted 11-20, 11-25, and 11-26-13, the monitor continued to find discrepancies related to evaluation and service plan.

- 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))