IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #: 51893-I

March 3, 2015

Ms. Randee Blietz, Director
Garden View Senior Community
800 Darby Drive
Monona, IA 52159

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - GARDEN VIEW SENIOR COMMUNITY
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Blietz:

I. Final Complaint/Incident Investigation Report – Garden View Senior Community, Monona, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("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 **February 18, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Service Plans and Nurse Review.

Garden View Senior Community ("Program") is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.17(1)(a), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) 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 determination of a **$1,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, the Program failed to assess a tenant who had eloped for an unknown length of time. Program failed to develop a service plan to meet the safety needs of a tenant following an elopement.

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 481–67.17(5). 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 **six hundred and fifty ($650)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report.

IV. Conclusion

The Program is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

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 as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0215	A. BUILDING: _____ B. WING _____	C 02/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW SENIOR COMMUNITY	800 DARBY DRIVE MONONA, IA 52159

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-69 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 17 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 19 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 6 TOTAL census of Assisted Living Program: 25 The following regulatory insufficiencies were cited during the Incident Investigation of #51893-I:	A 000		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) 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. This REQUIREMENT is not met as evidenced	A 083		

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A 083	Continued From page 1 by: Based on staff interviews and record review, the Program did not develop a service plan for each tenant designed to meet the specific service needs. Concerns were noted for Tenant #1 who exited the building unnoticed by staff. Findings include: According to documentation in the medical record, Tenant #1 entered the Program on 11-23-2014 and had diagnoses which included: Alzheimer's disease, vascular dementia, anxiety, hypertension, osteoporosis, depression, macular degeneration and memory change. According to documentation in a Baseline Assessment form dated 11-13-2014, Tenant #1 was independent with dressing, grooming and hygiene, bathing, toileting, ambulation and transferring. A mini mental exam dated 11-13-2014, indicted Tenant #1 scored 11 (of a possible 16) indicating mild confusion. Documentation in the progress notes for Tenant #1 indicated staff completed a 30 day review on 12-17-14, which included a nurse review, tenant assessment, mini-mental exam, medication review and service plan review. Documentation in the mini-mental exam dated 12-17-14, indicated Tenant #1 scored 11 (of a possible 16) indicating mild confusion. Documentation in the nurse's note dated 12-17-14 indicated staff demonstrated the use of the shower repeatedly as Tenant #1 is not able to complete the task independently. Documentation also indicated Tenant #1 was at risk for elopement due to prior history of wandering and personal preference for walking outside. The nurse's note indicated Tenant #1's	A 083		

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A 083	Continued From page 2 service plan was updated to include staff to assist with showers two times a week. During an interview on 02-18-15 at 12:44 p.m., the nurse manager indicated Tenant #1's service plan was updated (at the 30 day review) for bathing and redirecting due to Tenant #1's repetitive behavior becoming more frequent. The nurse manager stated no specific interventions were put into place due to Tenant #1's wandering. The program nurse manager stated Tenant #1 had a history of wandering and "going for walks" per family. The nurse manager also stated that Tenant #1 would stand and look outside but had never attempted to leave the building. She stated on days when the weather was nice, staff had accompanied Tenant #1 on walks outside. Documentation in the nurse's notes dated 01-12-15 at 12:41 p.m. indicated staff reported an episode of increased anxiety and agitation during the afternoon of 01-11-15. Staff offered multiple interventions to keep Tenant #1 from disrupting a private party in the second floor dining room. Tenant #1 became angry with verbal outbursts; staff offered a prn (as needed) anti anxiety medication which Tenant #1 refused. Documentation in the nurse's notes dated 01-19-15 at 4:19 p.m. indicated Tenant #1 demonstrated significant short-term memory loss, repeatedly asking multiple staff members "Now, what time do we have supper?" and "Where do we have supper?" A late entry for 02-14-15 at 3:00 p.m. indicated Tenant #1 was observed to be outdoors, outside the dining room without appropriate clothing in place. Another tenant 's family alerted staff who directed Tenant #1 back into the building. Tenant	A 083		

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A 083	Continued From page 3 #1 stated at the time, "It's too cold to be outside" but was unable to relate the length of time Tenant #1 was outdoors. During an interview on 02-18-15 at 11:51 a.m., the state climatologist indicated the temperature at that time was 7 degrees Fahrenheit with wind at 24 miles per hour resulting in a wind chill of negative 10 degrees Fahrenheit. Documentation dated 02-16-15 at 10:44 a.m. indicated staff completed a mini-mental exam at this time and Tenant #1 scored 9 (of a possible 16) indicating mild confusion and representing a decrease in cognitive function from 2 months ago. Staff completed a Global Deterioration Scale (GDS) for further assessment in which Tenant #1 presented at stage 5, indicating moderately severe decline (early dementia). The nurse's note indicated Tenant #1 exhibited increasing difficulty with ADL's (activities of daily living) of bathing and dressing, disorientation to time, place and situation, difficulty counting backwards, inability to choose proper clothing for situation and late day confusion/agitation. Upon interview, Tenant #1 had no immediate recall of going outdoors two days prior, but with prompting stated, "I wanted to check on things. When questioned what Tenant #1 could do to prevent recurrence, Tenant #1 stated "I will check the weather" and "I will wear the right clothes." Staff advised Tenant #1 to alert staff of a plan to go outside. Documentation in the nurse's notes dated 02-17-15 at 10:03 a.m., (late entry for 02-16-15 at 1:00 p.m.) indicated Tenant #1 exhibited an increase in restless behavior following a visit for Tenant #1's family. Tenant #1 was pacing in the corridor with coat on, purse in hand after family departed. Tenant #1 had no recollection of family	A 083		

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A 083	Continued From page 4 leaving and clearly saying "good-bye". Staff had 1:1 conversation with Tenant #1 for 15 minutes which was effective in calming Tenant #1 for a short time. At 3:30 p.m. Tenant #1 was again pacing in the corridor with coat on, stating "I'm looking for the way to get out of here, I'm going home." The notation indicated Tenant #1 declined to attend an activity and was re-oriented to Tenant #1's apartment location three times. Staff implemented hourly checks for Tenant #1's safety. During an interview on 02-18-15 at 12:44, the nurse manager indicated staff had implemented the documentation of hourly safety checks while awake for Tenant #1's safety. According to documentation on the program's "monitoring log" staff intiated checks on 02-16-15 at 5:00 p.m. Only three entries were documented for 02-16-15. Documentation for 02-17-15 was initiated at 7:00 a..m. and completed at 7:00 p.m. (indicating Tenant #1 was in the apartment from 7:00 p.m. until 7:00 a.m; however, the nurse manager confirmed that staff did not enter tenant's apartment during the overnight hours to observe or check on tenants. The nurse manager stated she was talking with family and actively looking for other placement for Tenant #1 but had no further interventions in place to ensure Tenant #1 would not exit the building again, or if Tenant #1 exited the building, there was no system in place to alert staff that Tenant #1 had exited.	A 083		
A 094	481-69.27(1) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but	A 094		

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A 094	Continued From page 5 an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(1) To monitor, at least every 90 days, or after a significant change in the tenant ' s condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the Program failed to conduct a nurse review when Tenant #1, a tenant with impaired decision making ability, eloped from the Program and returned after an unknown length of time. Findings include: According to documentation in the medical record, Tenant #1 entered the Program on 11-23-2014 and had diagnoses which included: Alzheimer's disease, vascular dementia, anxiety, hypertension, osteoporosis, depression, macular degeneration and memory change. According to documentation in a Baseline Assessment form dated 11-13-2014, Tenant #1 was independent with dressing, grooming and hygiene, bathing, toileting, ambulation and transferring. A mini mental exam dated 11-13-2014, indicted Tenant #1 scored 11 (of a possible 16) indicating mild confusion.	A 094		

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A 094	Continued From page 6 A late entry nurse's note for 02-14-15 indicated Tenant #1 was observed to be outdoors, outside the dining room without appropriate clothing in place. Another tenant 's family alerted staff who directed Tenant #1 back into the building. Tenant #1 stated at the time, "It's too cold to be outside" but was unable to relate the length of time Tenant #1 was outdoors. An incident report dated 02-14-2015 at 3:00 p.m. indicated Tenant #1 had been outdoors for an undetermined amount of time. The incident report (completed by Staff A) documented the following action taken: Talked to tenant about not going outside, being too cold outside (a negative 30 degrees Fahrenheit). Staff A indicated she asked Tenant #1 to please come get a staff member to go with him/her. Staff A indicated she reported the incident to the Executive Director. The RN added to the incident report on 02-16-2015 indicating Tenant #1 had "no injuries". The RN completed a Nurse Review of Health Status/Systems on 02-17-2015 at 10:00 a.m. indicating Tenant #1 presented with a significant change with safety concerns. During an interview on 02-18-2015 at 11:53 a.m. Staff A indicated a family member informed her that Tenant #1 had been outside and was pounding on the door (to get in). The family member let Tenant #1 in the building and alerted Staff A. Staff A stated Tenant #1 had on pants and a sweater, shoes and socks. Staff A stated Tenant #1 didn't seem cold, but did seem nervous. Staff A stated she told Tenant #1 it was thirty below zero out, and Tenant #1 stated he/she just wanted to go for a walk around the building.	A 094		

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A 094	Continued From page 7 Review of documentation did not include an assessment of Tenant #1 in a timely manner, after being outside in sub zero temperatures for an undetermined amount of time.	A 094		

March 6, 2015

Rose Boccella
Iowa Department of Inspections & Appeals
Health Facilities Division
321 East 12th Street
Des Moines, IA 50319-0083

Dear Rose Boccella,

Below is the Plan of Correction for Garden View Senior Community in response to the Final Complaint/Incident Investigation Report received on March 3, 2015.

Service Plan

- Tenant #1 A service plan will be developed to meet the specific service needs of the individual when the tenant is at risk for elopement due to prior history of wandering and personal preference for walking outside.
    a. Attached is a copy of the flow chart provided by the Dept. of Inspections & Appeals that will be used to determine if an evaluation does warrant a service plan update.
    b. Periodic monitoring of files will be conducted by corporate RN consultant.
    c. On 2/20/2015, an update to the service plan was completed by the Director of Health Services according to Tenant #1's needs.

Nurse Review

- Tenant #1 At the time of a tenant elopement, a nurse review will be conducted to determine if there has been a change in the tenant's condition.
    a. Attached is a copy of the flow chart provided by the Dept. of Inspections & Appeals that will be used to determine if an evaluation and/or nurse review needs to be completed.
    b. Periodic monitoring of files will be conducted by corporate RN consultant.
    c. On 2/17/2015, a Nurse Review and updated evaluation of Tenant #1's functional, cognitive, and health status was completed by the Director of Health Services.

This concludes Garden View Senior Community's Plan of Correction in response to the Final Complaint/Incident Investigation Report.

Sincerely,

Randee Blietz, Executive Director
Garden View Senior Community
randee.blietz@twls.com