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
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #:
56530-C
56613-I

December 15, 2015

Ms. Megan Pedersen, Administrator
Eagle Pointe Place
2700 Matthew John Drive
Dubuque, IA 52002

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - EAGLE POINTE PLACE
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Pedersen:

I. Final Complaint/Incident Investigation Report – Eagle Pointe Place, Dubuque, 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 **December 8, 2015.** Based on review of tenant files, review of incident reports, review of policies and procedures, staff interviews and management interviews, the following was found:

Allegation: Level of Care
Findings: Not substantiated
Comments: Review of two tenant files was completed. All tenants had been assessed appropriately. One tenant continued to meet the criteria to reside within an assisted living program. One of the tenants was currently at a rehabilitation center and would be re-assessed prior to readmission to the assisted living program. The Program provided the name of one tenant who received wound care. Cares were provided by a home health agency twice a week and the Program provided cares one day per week per

physician orders. Discussions were being held regarding the addition of services at a wound clinic prior to the tenant being transferred to a hospital and subsequent rehabilitation center. Interviews conducted with staff, the Health Care Coordinator and the Executive Director indicated there were no tenants who exceeded level of care. No concerns with level of care were identified.

The Report notes a Regulatory Insufficiency in the area(s) of: Staffing.

Eagle Pointe Place ("Program") is being assessed a **$6,000 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 **$6,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, a tenant was injured while riding in the Program's vehicle after the tenant's wheelchair tipped over. The wheelchair had not been appropriately secured and staff had no documented training regarding transporting tenants safely. The tenant had a C2 fracture.

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 **three thousand nine hundred dollars ($3,900)** 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 **$6,000 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, 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
	S0348	A. BUILDING: _____ B. WING _____	C 12/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE POINTE PLACE	2700 MATTHEW JOHN DRIVE DUBUQUE, IA 52002

(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	481-67 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: 41 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 45 TOTAL census of Assisted Living Program: 45 No regulatory insufficiencies were cited during the investigation of Complaint #56530-C. The following regulatory insufficiency was cited during the investigation of Incident #56613-I.	A 000		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants ' identified needs. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, review of incident reports, review of investigation documents, review of policies and procedures, review of personnel training records, interviews with staff, Maintenance Director and Executive Director and monitor observations, the Program failed to have a sufficient number of trained staff available to fully meet the tenants' identified	A 055		

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A 055	Continued From page 1 needs. Staff A did not have appropriate training in regards to properly and securely transporting tenants in wheelchairs on the bus. 1. Tenant #1, an 89 year old, was admitted on 10-26-15 and diagnoses included: renal failure and diabetes. According to a Universal Incident/Occurrence Report dated 11-25-15 at 11:30 a.m., Tenant #1 fell out of a wheelchair onto the floor of the bus when the bus made a turn onto a street. Tenant #1 was sent to the hospital and evaluated for a C2 fracture. According to Tenant Services Notes dated 11-25-15, Tenant #1's wheelchair tipped over in the bus. At 4:00 p.m. a call from the ER indicated Tenant #1 had a C2 fracture. On 11-26-15, Tenant #1's family called and stated Tenant #1 would not need surgery but was very weak. 2. On 12-8-15 at 11:53 a.m., Staff A was interviewed and stated he was hired as a driver and sometimes helped with kitchen or maintenance jobs. He stated he really didn't have a lot of training. He went with the previous driver for half a day or one full day. She showed him how to put restraints on the wheelchair in the old bus. About two to three weeks later the Program got a new bus. One day the Maintenance Director talked with him about the brackets on the floor but didn't do a demonstration on how to secure the brackets. Staff A stated he normally used four hooks when transporting a tenant in a wheelchair, would make sure the wheelchair was secure but only used the four hooks. He did not use the shoulder or lap straps. He stated in August or September the Executive Director (ED) came out to the bus after he asked her what would happen	A 055		

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A 055	Continued From page 2 to a tenant if he had to slam on the brakes while driving the bus. He reported to the ED he did not know how to use the shoulder straps correctly. The ED did not know the proper way to use the shoulder strap either. The ED and Maintenance Director figured it out and they showed Staff A how to use the shoulder straps and lap straps about one week ago. He stated on the day of the incident, around 11:00 a.m., he picked up two tenants both in wheelchairs. He used two floor restraints on each wheelchair and used a shoulder strap on Tenant #1. The first tenant was dropped off at a medical appointment and Staff A continued on to the next destination. When he turned the corner he heard a crash and looked in the rear view mirror and could not see Tenant #1. He pulled the bus over onto a side street and found Tenant #1 laying on the floor of the bus, legs between the seats and head was towards the back door. Tenant #1 had oxygen on and the tubing was tangled in the wheelchair. Staff A asked Tenant #1 if Tenant #1 was okay and Tenant #1 responded "fine." Tenant #1 slipped out from under the shoulder strap and the wheelchair was on it's side. Staff A was not able to lift Tenant #1 and knew an ambulance was needed. Staff A saw some blood on Tenant #1's head and on the collar of the jacket. On 12-8-15, the monitor observed Staff A show the location on the bus where Tenant #1's wheelchair was located, at the back of the bus, directly behind the driver side of the bus. Tenant #1 faced forward into the bus. Two floor brackets were pulled up and attached to the right side of Tenant #1's wheelchair and the shoulder strap coming down from the ceiling of the bus was laid	A 055		

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A 055	Continued From page 3 across Tenant #1's chest. To fit properly the shoulder strap needed to be engaged into a receptacle coming up from the floor but according to Staff A, it was not hooked as it should have been. A lap belt was not used. Staff A showed where Tenant #1's head was laying towards the side door at the back of the bus, with both legs in the aisle. Staff A said the first thing he had to do was untangle the oxygen tubing that was caught in the wheelchair. The oxygen tank was on the back of the wheelchair. Staff A stated he was "shook up" and tried to lift Tenant #1 but when he was unable to do so, he noticed blood on the left side of Tenant #1's head and blood on the jacket collar. Staff A called the Program, gave them his location and waited for the ambulance to arrive. Once the EMT's were on the bus, he stepped aside. The EMT's directed him to open the back bus door so they could remove Tenant #1. The EMT's also took Tenant #1's wheelchair. On 12-8-15 at 12:35 p.m., the Concierge was interviewed and stated she answered the Program's phone when Staff A called and reported Tenant #1 fell out of the wheelchair, hit head and was bleeding. She stated she would call an ambulance. She called 911, reported the incident and provided the address where the ambulance could meet the bus. On 12-8-15 at 11:35 a.m., the Maintenance Director was interviewed and stated when Staff A was hired he showed Staff A how to hook up the brackets in the bus. He told Staff A to take them out of the bag and use four brackets per wheelchair. He stated he demonstrated how to hook the brackets and asked Staff A to do a return demonstration. The Maintenance Director	A 055		

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A 055	Continued From page 4 assumed the previous ED did some training but has no idea as there is no documentation of any training. The Program had no videos, no policy, no procedure and no spot checks, nothing at all regarding training of how to secure a wheelchair in the bus. Since the incident with Tenant #1, the Maintenance Director watched videos he found on the Internet, then demonstrated with a wheelchair and a passenger and had Staff A return the demonstration. The Maintenance Director also rode along with Staff A two times and observed Staff A properly restrain one passenger prior to going to an appointment and completed the task again on the return trip. Both times Staff A completed the tasks appropriately. On 12-8-15 at 1:15 p.m., the ED was interviewed and stated the Concierge answered the phone when the call came in and told her there had been an incident with the bus. Tenant #1 fell out of the wheelchair and 911 was called. When Staff A returned to the Program she had him show her what happened. The wheelchair had tipped over. She wondered what Tenant #1 had hit head on so spoke with Staff A. Staff A stated he heard a thud and Tenant #1 was down. Staff A did not see what had happened. She asked the Maintenance Director to re-educate Staff A, demonstrating how to put the brackets on for one wheelchair and how to put them on for two wheelchairs. She sat in the wheelchair to demonstrate how to use the lap belt in differing scenarios. The Maintenance Director rode along for the next pick up and searched for a video. On 11-30-15 the video was watched. After the incident, either the Maintenance Director, the Health Care Coordinator (HCC) or the ED rode with Staff A to observe him properly secure tenants who rode in the bus in a wheelchair. She	A 055		

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A 055	Continued From page 5 stated Staff A was probably not trained appropriately, none of them were trained as thoroughly or accurately as they should have been. On 12-8-15 at 11:12 a.m., the HCC was interviewed and stated the ER nurse informed her Tenant #1 had a C2 fracture and was being life flighted to another hospital. Tenant #1 did not have surgery and after five days at the hospital was transferred to a skilled nursing facility because Tenant #1 was a two person transfer. Tenant #1's goal is to return to the Program. 3. A review of Staff A's personnel file revealed a General Orientation Record completed on 5-12-15 and 6-1-15. The orientation covered two days of training for a total of eight hours. The training did not include any aspects of driving the bus, securing tenants on the bus or any topics related to bus operations or safety. The document was signed and dated by Staff A and the ED on 6-1-15. A Continuing Education Summary document dated 11-30-15 indicated a Q-Straint Video lasting 19 minutes covered securing a wheelchair, seat belts and Q-Straints was watched by Staff A and the ED. 4. A review of the Staffing For Care And Services policy indicated the ED is responsible for ensuring that team members are trained and qualified to provide care and services, meeting the requirements mandated by both state regulation and community policy and that proper documentation of such is maintained.	A 055		

December 21, 2015

Ms. Rose Boccella, Program Coordinator

Adult Services Bureau

Iowa Department of Inspections and Appeals

Lucas State Building

321 East 12th Street

Des Moines, IA 50319-0083

RE: Eagle Pointe Place Plan of Correction

Dear Ms. Boccella

Enclosed is the required "Plan of Correction" regarding the Final Complaint/Incident Investigation Report at Eagle Pointe Place which was conducted on December 8th, 2015. Submission of this response of the Plan of Correction is not a legal admission that a deficiency exists, or that the Statement of Deficiencies was correctly cited, and is also not to be constructed as an admission against interest by the residence, or any employees, agents or other individuals who drafted or may be discussed in the response on the Plan of Correction. In addition, preparation and submission of the Plan of Correction does NOT constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

IAC r 481-67.9(1) – Staffing

- Staff A was re-educated by the community maintenance technician on the q-straint straps via q-straint training downloads at http://www.qstraint.com/en_na/training/downloads. This was started on 11/25/15.
- The Regional Director of Facilities will train and complete the QRT Max Trainer Manual, QRTMAX-Driver-Operator-Instruction-Guide, and QRTMAX-Work-book-for-trainees with the Executive Director, Community Maintenance Technician and Staff A on 12/22/15.
- QRT training will be completed regarding securing of all wheelchairs with the q-straint straps and knowledge of proper van operations will be conducted at driver's orientation and annually by the Executive Director.
- The Regional Director of Facilities and/or The Regional Director of Operations will conduct an on the spot training of securing a wheelchair and an audit the drivers records quarterly for the next four quarters.

Date of completion for the Plan of Correction is January 20th,2016.

Sincerely,

Megan Pedersen/Executive Director/Eagle Pointe Place