IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #: 59692-I

May 10, 2016

Mr. Derrick Johnson, Interim Director
3801 Grand
3801 Grand Avenue
Des Moines, IA 50312

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

Dear Mr. Johnson:

I. Final Recertification & Complaint/Incident Investigation Report – 3801 Grand, Des Moines, IA

Enclosed is the **Final Recertification & 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 **April 28 and May 3, 2016.** The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights, Record Checks, Evaluation of Tenant, Criteria for Admission/Retention of Tenants and Life Safety.

3801 Grand ("Program") is being assessed a **$3,000 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 **$3,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, an 85 year old Tenant with dementia eloped. The exit door was not alarmed, the courtyard gate was not alarmed and hourly checks were not completed for the Tenant as directed in the service plan.

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 **one thousand nine hundred and fifty dollars ($1,950)** 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 **$3,000 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
	S0003	A. BUILDING. _____ B. WING _____	C 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: 49 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 50 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 7 Total Population of Program at time of on-site: 10 TOTAL census of Assisted Living Program: 60 During the recertification to determine compliance with certification of an Assisted Living Program and the Incident investigation 59692-I, the following regulatory insufficiencies were cited.	A 000		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: (Incident 59692-I and Recertification)	A 013		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 013	Continued From page 1 Based on review of tenant documents and interviews, the Program did not ensure tenants received services as directed by service plans. Tenants did not receive care, treatment and services which were adequate and appropriate. This affected 2 of 6 tenants reviewed. 1. Tenant #1, an 85 year-old, was admitted on 2-4-15 and had diagnoses of: dementia, depression, and Chronic obstructive pulmonary disease. Tenant #1 was staged at four on the Global Deterioration Scale which indicated moderate cognitive decline. Tenant #1 resided in the dementia/memory care unit. Review of Tenant #1's service plan included a notation dated 4-18-16 directing staff to check on Tenant #1 hourly. While the service plan included this directive staff did not have a mechanism to record the checks had been completed. On 4-25-16 Tenant #1 eloped from the memory care unit via the courtyard gate. According to video footage, Tenant #1 walked through the an unalarmed door to the courtyard and out the courtyard gate at approximately 7:00 p.m. Staff working on the memory care unit did not realize Tenant #1 was gone until approximately 9:00 p.m. 2. Tenant #4, an 73 year-old was admitted on 6-9-15 and had diagnoses of: cerebrovascular accident and atrial fibrillation. During observations on 5-3-16 Universal Worker (UW) B administered hydrocodone to Tenant #4. Review of Tenant #4's functional assessment and service plan indicated Tenant #4 would be responsible for medications. When interviewed on 5-3-16 the Care Coordinator (CC) said the Program was	A 013		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 013	Continued From page 2 responsible for administering Tenant #4's medications but was unsure what date this change was made and she neglected to make a notation on Tenant #4's service plan. Review of Tenant #4's Medication Administration Record (MAR) for March showed Tenant #4 did not receive ten doses of ordered hydrocodone from 3-19-16 to 3-22-16. The notation on the MAR stated medication not available. When interviewed on 5-3-16 the CC confirmed the Program was responsible for ensuring Tenant #4 received medications and did not administer ten doses of medication order for pain because the medication was not available.	A 013		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: (Recertification) Based on review of staff files and staff interview the Program did not did not complete criminal, dependent adult abuse and child abuse checks prior to employment for one staff. (Staff C).	A 118		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 118	Continued From page 3 1. Staff C, a dietary aide/server was hired on 8-26-15. The Program completed the Single Contract License and Background check on 9-2-15. Therefore, the Program did not complete criminal, dependent adult abuse and child abuse checks prior to employment of Staff C. The Program did not complete required record checks prior to employment of staff.	A 118		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. 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. This REQUIREMENT is not met as evidenced by: (Incident 59692-I) Based on review of tenant files, functional, cognitive and health evaluations were not	A 037		

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A 037	Continued From page 4 completed as needed with significant change. 1. Tenant #1, an 85 year-old, was admitted on 2-4-15 and had diagnoses of: dementia, depression, and Chronic obstructive pulmonary disease. Tenant #1 was staged at four on the Global Deterioration Scale which indicated moderate cognitive decline. Tenant #1 resided in the dementia/memory care unit. Documentation explained Tenant #1 had become increasingly confused and disoriented since the death of Tenant #1's spouse. Tenant #1 was moved back onto the memory care unit on 3-11-16 due to several attempts to elope. The Program had contacted Tenant #1's daughter and physician. Review of nurse's notes included several additional attempts to elope. On 3-11-16 a noted stated Tenant #1 tried getting out several doors several times and did get out the memory care door one time. On 3-14-16 Tenant #1 got through the memory care unit door, was confused and said daughter was coming so they could go get the tenant's spouse. This note said Tenant #1 was very argumentative and later attempted two times to exit via the apartment/bedroom window. Staff found Tenant #1 trying to take the screen off the window. A note dated 4-18-16 explained that over the weekend Tenant #1 was able to get out of the Program and started down the street. Two staff were with the tenant trying to redirect and return to the building. Tenant #1 was combative and refused to return inside. Another staff arrived in a car and convinced Tenant #1 to go back to the building. Further information stated Tenant #1 also attempted to leave the memory care unit and when staff attempted to redirect, Tenant #1 hit and bit staff. Review of Tenant #1's service plan included a	A 037		

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A 037	Continued From page 5 notation dated 4-18-16 directing staff to check on Tenant #1 hourly. While the service plan included this directive staff did not record the checks had been completed. On 4-25-16 Tenant #1 eloped from the memory care unit via the courtyard gate. According to video footage, Tenant #1 walked through the an unalarmed door to the courtyard and out the courtyard gate at approximately 7:00 p.m. Staff working on the memory care unit did not realize Tenant #1 was gone until approximately 9:00 p.m. Functional, cognitive and health evaluations were not completed with a significant change.	A 037		
A 039	481-69.23(1)b Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: (Recertification) Based on tenant file reviews and staff interviews, the Program failed to discharge a tenant who exceeded the criteria for admission and retention. (Tenants #5). 1. Tenant #5, an 96 year-old, was admitted on 3-2-10 and had diagnoses of: dementia, hypertension, history of hallucinations, osteoporosis, and hyperlipidemia. Tenant #5 was	A 039		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 039	Continued From page 6 staged at five on the Global Deterioration Scale which indicated moderately severe cognitive decline. Tenant #1 resided in the memory care unit and admitted to hospice on 1-25-16. Review of Tenant #5's Medical History/Physical/Functional assessment dated 3-23-16 revealed the Tenant was dependent in the areas of transfer and ambulation. A notation next to ambulations stated, doesn't walk barely stands. Summary of conditions/functional status signed by the Care Coordinator (CC) included the following statements, Tenant #5 is an assist of two since going on hospice. When interviewed on 5-3-16 Universal Worker D said Tenant #5 requires two staff to transfer. When interviewed on 5-3-16 Certified Medication Aide E confirmed Tenant #5 needs assist of two staff. When interviewed on 5-3-16 the CC confirmed Tenant #5 requires assist of two staff for transfers and this has been the case since being admitted to hospice on 1-25-16.	A 039		
A 138	481-69.32(2) Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by:	A 138		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 138	Continued From page 7 (Incident #59692-I) Based on interviews, the Program's licensed practical nurse (LPN) Assistant Care Coordinator (ACA) used a key to disarm the alarm on a door leading to the a courtyard area in the dementia unit. 1. Tenant #1, an 85 year-old, was admitted on 2-4-15 and had diagnoses of: dementia, depression, and Chronic obstructive pulmonary disease. Tenant #1 was staged at four on the Global Deterioration Scale which indicated moderate cognitive decline. Tenant #1 resided in the dementia/memory care unit. Based on review video camera located in the memory care dining room, the Program reported on 4-25-16 at approximately 7:00 p.m. Tenant #1 walked through the memory care sunroom and sunroom carrying a jacket. No alarm sounded. Tenant #1 pushed through the gate in the memory care courtyard and no alarm sounded. Review of the video footage revealed the LPN ACA used a key to disarm the alarm at 4:26 p.m. and did not reset the alarm. Further review revealed the LPN ACA left the unit at 7:15 p.m. Universal Worker (UW) A remained on the memory care unit and the video showed seven tenants observed in the hallway and lounge area. UW A attempted to manage tenants and assist them to bed. UW A said she attempted to locate/call LPN ACA twice but LPN ACA did not answer. UW A called the Assisted Living Unit (ALU) Certified Medication Aide in an attempt to locate LPN ACA. Further review of the video indicated LPN ACA returned to the memory care unit at 8:57 p.m. At 9:20 p.m. LPN ACA noticed Tenant #1 was not in apartment/memory care unit. LPN ACA contacted the administrator at	A 138		

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A 138	Continued From page 8	A 138		

9:35 p.m. to inform her of the elopement. LPN ACA told the administrator that Tenant #1 had been gone 20 minutes and when they finished looking outside they would call the police. At 10:01 p.m. the administrator contacted the CMA for the ALU who was directed to search the video camera for the police. The administrator received a call at 11:15 p.m. from the police who said Tenant #1 was at Iowa Methodist Medical Center (IMMC) where a passerby took Tenant #1 after a fall to the sidewalk witnessed by the passerby. Tenant #1 was admitted at IMMC for observations for confusion and possible Urinary Tract Infection (UTI).

The temperature measured 69 degrees Fahrenheit (F) on 4-25-16 at 7:00 p.m. when Tenant #1 left the memory care unit. The distance between the memory care unit and IMMC is 2.3 miles. Streets along the route to IMMC to the Program are busy and have a speed limit of 35 miles per hour. It is unclear if Tenant #1 walked the entire route to IMMC or if the passerby found the Tenant somewhere along the route.

UW A was interviewed on 4-28-16 and said she worked the second shift on 4-25-16 on the memory care unit with LPN ACA. She said two staff normally work on the memory care unit. UW A explained that another tenant had attempted to go out to courtyard and LPN ACA responded and redirected the tenant back into the unit and she assumed LPN ACA ensured the alarm was reset. Shortly after the other tenant attempted to go outside her and the LPN ACA served the evening meal. UW A said she cleaned up after the meal and assisted tenants as needed. Around 7:00 p.m. the LPN ACA left the unit and did not return for almost two hours, during this time she

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A 138	Continued From page 9 attempted to locate the LPN ACA because she needed assistance with the tenants who were awake. She said Tenant #1 had gone to her/his apartment after the evening meal and she assumed Tenant #1 remained in the apartment. At approximately 9:00 p.m. when LPN ACA returned to the memory care unit, they realized Tenant #1 was not in the apartment. When interviewed on 4-28-16, the Executive Director (ED) said she had reviewed the video and interviewed LPN ACA. She confirmed the above information was an accurate account of what happened on 4-25-16. She also said that when they checked the alarm on the gate of the the memory care unit courtyard, the battery was dead and this explained why the alarm didn't sound. She explained that Tenant #1 had originally moved into the memory care unit with with a spouse in 2015 and when the spouse needed to move to a nursing facility Tenant #1 moved to the ALU, but after several attempts to elope Tenant #1 was moved back onto the memory care unit on 3-10-16. When interviewed on 4-28-16 the Care Coordinator (CC) said the Program had changed Tenant #1's service plan to include hourly checks by staff. Review of the service plan confirmed the change had been made on 4-18-16. Although the service plan directed staff to do hourly checks for Tenant #1 no documentation of the checks on 4-25-16 could be located. Documentation explained Tenant #1 had become increasingly confused and disoriented since the death of Tenant #1's spouse. Tenant #1 was moved back onto the memory care unit on 3-11-16 due to several attempts to elope. The Program had contacted Tenant #1's daughter and	A 138		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 138	Continued From page 10 physician. Review of nurse's notes included several additional attempts to elope. On 3-11-16 a noted stated Tenant #1 tried getting out several doors several times and did get out the memory care door one time. On 3-14-16 Tenant #1 got through the memory care unit door was confused and said daughter was coming so they could go get the tenant's spouse. This note said Tenant #1 was very argumentative and later attempted two times to exit via the apartment/bedroom window. Staff found Tenant #1 trying to take the screen off the window. A note dated 4-18-16 explained that over the weekend Tenant #1 was able to get out of the Program and started down the street. Two staff were with/following the tenant trying to redirect and return to the building. Tenant #1 was combative and refused to return inside. Another staff arrived in a car and convinced Tenant #1 to go back to the building. Further information stated Tenant #1 also attempted to leave the memory care unit and when staff attempted to redirect, Tenant #1 hit and bit staff. The Program was aware of Tenant #1's increased attempts to elope yet the door alarm was disarmed by staff, no documentation of hourly checks existed and the gate to the courtyard was not checked to ensure the alarm was functioning properly. This resulted in the Program being unaware Tenant #1 was not in the building for at least two hours before staff noticed. Tenant #1 left the building at 7:00 p.m. and the ED was notified at 11:15 p.m. Tenant #1 was at IMMC. Staff had noticed at 9:00 p.m. that Tenant #1 was not on the memory care unit but did not know Tenant #1's whereabouts.	A 138		

Plan of Correction
3801 Grand Assisted Living
Final Recertification & Complaint/Incident Investigation Report
Complaint Intake # 59692-I

1. Regulatory Insufficiency - 481-67.3(2) Tenant Rights
    a. Tenant #1 was discharged from the Program on May 17, 2016.
    b. In the future, if a service plan directs staff to perform hourly checks, a notation of those checks will be made and initialed by staff in the resident record or chart on a separate sheet of paper for each date listing the checks by hour. These check-sheets will be reviewed and initialed daily by the Program's RN or LPN. If the RN determines a tenant's condition is meeting discharge criteria, transfer to a higher LOC facility will be implemented.
    c. The Regulatory Insufficiency with respect to Tenant #1 was corrected May 17, 2016 with tenant's discharge from the Program.
    d. Tenant #4 - The Program's RN/Care Coordinator will monitor the supply of Tenant #4's hydrocodone medication to ensure the medication does not run out. Re-orders of the medication will be requested within a timeframe that allows the medication to arrive at the Program before the current supply is exhausted.
    e. The Regulatory Insufficiency with respect to Tenant #4 was corrected on April 24, 2016 and the hydrocodone medication is being administered as prescribed.

2. Regulatory Insufficiency - 481-67.19(3) Record Checks
    a. Staff C, a dietary aide/server was employed prior to receipt of the appropriate background check. In order to ensure this situation does not recur, all Program Department heads and Program Manager responsible for hiring staff must acknowledge receipt and review of the final approved background check prior to the new employee being allowed to begin work. A new procedure has been implemented for this process by including a separate line on the Program's internal Employee Summary Form (copy attached). This form is the mechanism by which employees are put on the payroll, and this process should prevent new hires from starting to work before their background checks have cleared. This process is effective beginning May 23, 2016.

3. Regulatory Insufficiency - 481-69.22(2) Evaluation of Tenant
    a. Tenant #1 was discharged from the Program on May 17, 2016.
    b. Program staff responsible to ensure timely completion of evaluations with regard to change in condition and for the appropriate implementation and documentation of same as well as staff who de-alarmed an exit door and failed to reset the alarm are no longer employed by the Program. This includes the LPN (Assistant Care Coordinator), RN, Nurse Manager (Care Coordinator) and the Program Manager. Staff have been retrained in the appropriate way to reset a door alarm. Evidence of that training was previously provided to the Department.
    c. The Regulatory Insufficiency with respect to Tenant #1 was corrected May 17, 2016 with the tenant's discharge from the Program.
    d. When a new Nurse Manager (RN) and LPN are hired for the Program, the management company's corporate RN will provide focused training, instruction and oversight in the areas of Evaluation of Tenant, Service Plan and Criteria for Admission/Retention of Tenants. In the interim, the management company's corporate RN has assumed responsibility for compliance and is retraining and coaching direct care staff as needed.

4. Regulatory Insufficiency - 481-69.23(111)b - Criteria for Admission/Retention of Tenants.
    a. With this POC, the Program is requesting a hospice waiver from the Department to allow Tenant #5 to remain in the Program. Tenant #5 is within days of end of life. If the waiver is not approved, the Program will initiate an involuntary transfer.
    b. The Regulatory Insufficiency with respect to Tenant #5 will be corrected with the receipt of the waiver from the Department or discharge from the Program.
    c. In the future, should a tenant's condition exceed retention criteria, the Program will initiate discharge/transfer procedures with the tenant and/or responsible party, or if the tenant is nearing end of life and has requested to remain within the Program, the Program will request a waiver from the Department pursuant to 481-67.7.

d. When the new Nurse Manager (RN) is hired for the Program, the management company's corporate RN will provide focused training, instruction and oversight in the area of tenant admission/retention.

5. Regulatory Insufficiency - 471069.32(2) Life Safety
   a. Tenant #1 was discharged from the Program on May 17, 2016.
   b. In the future, if a service plan directs staff to perform hourly checks, a notation of those checks will be made and initialed by staff in the resident record or chart on a separate sheet of paper for each date listing the checks by hour. These check-sheets will be reviewed and initialed daily by the Program's RN or LPN. If the RN determines a tenant's condition is meeting discharge criteria, transfer to a higher LOC facility will be implemented.
   c. The Regulatory Insufficiency with respect to Tenant #1 was corrected was corrected May 17, 2016 with tenant's discharge from the Program.
   d. Program staff responsible to ensure timely completion of evaluations with regard to change in condition and for the appropriate implementation and documentation of same as well as staff who de-alarmed an exit door and failed to reset the alarm are no longer employed by the Program. This includes the LPN (Assistant Care Coordinator), RN, Nurse Manager (Care Coordinator) and the Program Manager. Staff have been retrained in the appropriate way to reset a door alarm. Evidence of that training was previously provided to the Department.
   e. The Program has been advised by the Fire Marshal that it is acceptable to simply lock the courtyard gate in lieu of relying on an alarmed gate. All employees will carry a key associated with the lock and have the ability to access if needed. Effective May 24, 2016, the courtyard gate is secured with a lock.

THE NEWBURY COMPANIES

EMPLOYEE SUMMARY FORM

Current Date : _____ Prepared By : _____

Employee Name : _____

Employee Home Phone Number: _____

Location: _____ Entity: NMC ☐ 3801 ☐ MRC ☐

Start Date : _____ Job Title: _____

Scheduled Weekly Hours: 40 (FT) ☐ 30-39(PT1) ☐ 20-29(PT2) ☐ Under 20(PT2) ☐

Starting Wage: $ _____ Hour ☐ Month ☐ Year ☐

On Site Apartment: Site _____ Apt # _____ Type _____ Rent $ _____

Other Information:

Allocation of Time	
Project / District	% of Time
	100%

SENIORS ONLY
Department:
Scheduled Shift:

Background Check Complete & Cleared: Initial, circle, attach report YES NO

WAGE CHANGES AND SPECIAL PAY

*** Requires Approval of Newbury's President or Executive Vice President ***

Current Wage $ _____ Hour ☐ Year ☐ Effective Date: _____

Change Wage To $ _____ Hour ☐ Year ☐ Effective Date: _____

Bonus: $ _____ Date Payable: _____

Approved by: _____ Date: _____

TERMINATIONS

Date of Termination: _____

Type of Termination: Voluntary ☐ Involuntary ☐ Severance Pay (if any): $ _____

COMMENTS

Newbury
LIVING

Managing and
Developing
Communities
You're Proud to
Call Home

Debbie Fisher, Chief Operating Officer
dfisher@newburyliving.com | 515-698-9701

Newbury Living: 3408 Woodland Ave., Ste.504
West Des Moines, Iowa 50266

May 24, 2016

Ms. Rose Boccella, MS
Department of Inspections and Appeals
Adult Services Bureau
321 East 12th Street
Des Moines, IA 50319

Re: Demand Letter, Complaint Intake #59692-I
3801 Grand Final Recertification & Complaint/Incident Investigation Report

Dear Rose::

Please accept this letter and its related attachments as our response to DIA's May 10, 2016 Final Report. The Plan of Correction for each of the Regulatory Insufficiencies noted in the report is attached, together with a check in the amount of $1,950 related to the Civil Penalty pursuant to Section II of the letter.

If there are any questions or comments related to the POC, please let me know. Thank you.

Sincerely,

Debbie L. Fisher

Debbie L. Fisher