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
CERTIFIED
Complaint Intake #: 40937-C

December 4, 2012

Ms. Anita Zemba-Schadt, Director
Petersen Commons
1607 West 12th Street
Davenport, IA 52804

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

Dear Ms. Schadt:

I. Final Complaint/Incident Investigation Report – Petersen Commons, Davenport, IA

Enclosed is the **Final Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69. The Report notes Regulatory Insufficiency in the area(s) of: Evaluations. **Petersen Commons** ("Program") is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

II. Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Jim Berkley** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of three hundred twenty five dollars ($325) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on November 28, 2012, has been reviewed and will constitute the final POC related to the on-site visit of October 29, 2012. The Request for Reconsideration has been reviewed and is denied based on fact that the Service Plans are generated by the tenant evaluations that are completed. They are not done simultaneously. The rules do not identify a specific form to be used but cannot double as the tenant evaluation.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Jim Berkley, at 515/281-4116.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program: **Complaint/Incident Intake #:** 40937-C

Anita Zemba-Schadt, Director
Petersen Commons
1607 West 12th Street
Davenport, IA 52804

Date of Complaint/Incident Investigation:

October 29, 2012

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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:	46
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	47
TOTAL census of Assisted Living Program	47

Program History – The program received regulatory insufficiencies during this certification period in the areas of Evaluation of Tenants, Service Plan, Medications, Nurse Review, Tenant Rights, Occupancy Agreement and Managed Risk.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged tenant rights were not upheld.

- Monitoring Observation: Four tenant files were reviewed.

  The Program provided a list of discharged tenants from 8-3-12 through 10-28-12, which included the reason for discharge. There were a total of ten discharged tenants. nine were voluntary discharges and one was an involuntary discharge. Four discharged tenant files were reviewed.

  Tenant #1, a 74 year old, was admitted on 9-1-12 and diagnoses included: Hypertension (HTN), Diabetes Mellitus (DM), History of Cerebral Vascular Accident, History of Pneumonia, Insomnia, Wound to the Left Foot, Atrial Fibrillation, Edema, Gout, Overactive Bladder, Pain and Hyperlipidemia. Incident reports indicated Tenant #1 fell or was found on the ground eight times from 9-2-12 to 10-15-12 with no injuries noted. Narrative Documentation dated 9-7-12 indicated Physical Therapy (PT) was ordered to improve gait and safety awareness. According to Narrative Documentation on 9-10-12, the Director and Staff #2 met with Tenant #1 and Tenant #1's family. Tenant #1's family lowered Tenant #1's bed, staff assisted Tenant #1 with showers, PT/Occupational Therapy (OT) was referred and they discussed possible medication changes. According to Narrative Documentation dated 10-15-12 (late entry for 10-12-12), a meeting was held with Tenant #1 and Tenant #1's family regarding Tenant #1's declining condition. Narrative Documentation indicated the physical therapist had treated Tenant #1 in the past and had great

concern for Tenant #1's safety and not seeing improvement as in the past. Family was not able to provide any outside assist and the Program was not able to permanently assist one to one with all transfers; it was agreed to do so until family and Tenant #1 found an appropriate long term care (LTC) setting. An addendum was completed and agreed upon for increased services while an alternate living situation was found. According to Narrative Documentation dated 10-15-12, Tenant #1 was admitted to the hospital for leg weakness and inability to stand. Narrative Documentation dated 10-23-12 indicated Tenant #1 was being transferred to another facility on 10-24-12. Tenant #1 was discharged on 10-15-12.

Tenant #2, an 87 year old was admitted on 5-30-06 and diagnoses included: Hemiplegia, Gait Abnormality, Aphasia, Dysphagia and Mononeuritis. Narrative Documentation dated 7-10-12 indicated Staff #2 spoke with Tenant #2's family member about Tenant #2 improperly disposing of protective undergarments. Tenant #2's family member had talked to Tenant #2 about it and told Tenant #2 if Tenant #2 kept doing it Tenant #2 would be asked to leave. Narrative Documentation dated 8-1-12 indicated a 90 day review was completed. It was stressed to Tenant #2 the importance to be able to manage Tenant #2's incontinence, throwing protective undergarments in the trash and not on the floor. Tenant #2 voiced understanding and stated Tenant #2 forgot but would try to throw them in the garbage in the bathroom. Narrative Documentation dated 8-30-12 indicated there had been a significant change and an increased incidence of bowel and bladder incontinence and increased difficulty managing the incontinence. There was an increased odor of urine in the apartment and also a recent incidence of bowel incontinence. The Director had discussed the issue with Tenant #2's family and potential need for benefits of moving to a place that offered a higher level of care and would assist with aspects of finding a proper facility. Narrative Documentation dated 9-1-12 (late entry), indicated the Director had called Tenant #2's family member after the incident of bowel incontinence and increased urine odor and the level of care Tenant #2 needed due to current needs. The family member asked if Tenant #2 would have to move and it was explained not right at that moment; however, within the near future looking for a level of care to match Tenant #2's current needs. The family member provided a preferred LTC facility and the Director indicated she could contact the facility to find out availability. No official 30 day notice was given; the conversation had just begun, according to Narrative Documentation. On 9-1-12, there was a rumor Tenant #2 was gone, the apartment was checked, some things were gone and family had not communicated anything regarding moving, according to the Narrative Documentation. According to the Nurse Review Report dated 8-30-12, Tenant #2 planned to move out tomorrow and the Program was unaware at that time, was waiting to hear from family and the other program to determine actual move. Tenant #2 was discharged on 8-31-12.

Tenant #3 was an 81 year old, admitted on 9-29-10 and diagnoses included: Parkinson's, Vascular-Waist Down, White Matter Disease, Diabetes and HTN. According to a service plan completed on 6-18-12, Tenant #3 was brought to meals and activities via wheelchair per staff. Narrative Documentation dated 7-2-12 indicated over the weekend Tenant #3 transported self across the street to a beauty shop in the wheelchair. Tenant #3 told staff Tenant #3 did not want to wait for an escort. On 7-2-12, Tenant #3 asked for help calling a cab to go to the bank.

Staff told Tenant #3 they were concerned about keeping Tenant #3 safe while being in the parking lot due to Tenant #3's hearing loss. According to the Narrative Documentation on 8-3-12. Tenant #3 moved out of the Program to receive a higher level of care to meet Tenant #3's current needs. Tenant #3 was discharged on 8-3-12.

Tenant #4 was a 64 year old, admitted on 5-22-07 and diagnoses included: Diabetes Type 1, Insulin Dependent DM. On 9-11-12 the Program issued a Non-Compliance Notice and Notice of Thirty (30) day Probationary Period due to an incident of unwanted and inappropriate touching. According to an Incident Report dated 10-1-12, a staff member reported Tenant #4 approached her with inappropriate and unwanted advances. According to a Notice of Termination of Tenancy dated 10-4-12, Tenant #4 was issued a 30 day notice of termination due to inappropriate behavior. Tenant #4 was discharged on 10-28-12.

Staff #1, Staff #2 and the Director stated tenant rights were upheld during the transfer process.

Review of four discharged tenant files and staff interviews were completed. Three files reviewed were of voluntary discharged tenants and one file was of an involuntary discharge. Tenant rights appeared to be upheld during the transfer and discharge process.

- Regulatory Insufficiency: None noted.

B. Evaluation

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Four discharged tenant files (Tenants #1, #2, #3 and #4) were reviewed.

  Tenant #1's file was reviewed. According to Narrative Documentation dated 10-13-12 (late entry), there was a significant change for Tenant #1 per PT. Tenant #1 had declined with abilities as far as transfers and ambulation. Tenant #1 needed a one to one assist with transfers and needed escorts to all meals in a wheelchair. Tenant #1 would use a wheelchair only for mobility and would also receive one to one assist with all toileting. Health and cognitive evaluations were completed and the service plan was updated. The service plan, health evaluation and cognitive evaluation indicated it was a significant change. A functional evaluation was not completed with a significant change.

  Tenant #2's file was reviewed. Narrative Documentation dated 8-30-12 indicated there had been a significant change. There was an increased incidence of bowel and bladder incontinence and increased difficulty managing. There was an increased odor of urine in the apartment and also a recent incidence of bowel incontinence. The Director had discussed the issue with Tenant #2's family and potential need for benefits of moving to a place that offered a higher level of care and would assist with aspects of finding a proper facility. A health evaluation was completed and service plan was updated. Functional and cognitive evaluations were not completed.

The health evaluation and service plan indicated there had been a significant change. Functional and cognitive evaluations were not completed with a significant change.

Review of tenant files indicated functional and cognitive evaluations were not completed as needed with a significant change.

- 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 a 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))