IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED

Incident: #23893-I

December 17, 2009

Christine Vasquez, Administrator
Walden Point Assisted Living
1200 4th St
Des Moines, IA 50314-3102

RE: I. Final Incident Investigation Report, Walden Point Assisted Living, Des Moines, IA
II. Appeals/Hearings
III. Civil Penalty
IV. Conclusion

Dear Ms. Vasquez:

I. Final Incident Investigation Report, Walden Point Assisted Living, Des Moines, IA

Enclosed is the **Final Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C, 321 Iowa Administrative Code chapter 25 (pertaining to assisted living programs), and 321 Iowa Administrative Code chapter 26 (pertaining to monitoring, civil penalties, and complaints). The report notes Regulatory Insufficiency in the area of Other. Walden Point Assisted Living ("Program") is being assessed a $500.00 civil penalty.

DIA has reviewed the Plan of Correction (POC) and the Request for Reconsideration in response to the complaint investigation Report dated October 23 and 27, 2009. Based on the information provided, DIA denies the Request for Reconsideration as it relates to: Other. The Plan of Correction that was submitted is accepted.

II. Appeals/Hearings

The Program may appeal the DIA decision in accordance with 321 Iowa Administrative Code rule 26.4, within 30 days of notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to 481 Iowa Administrative Code chapter 10. If the Program appeals, the civil penalty will be suspended, pending appeal process.

III. Civil Penalty

If, within thirty (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 penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 231C.14. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send written notice to the Certification Coordinator and remit the penalty assessed by check or money order in the amount of three hundred twenty five dollars ($325.00) within 30 business days after the receipt of this demand letter.

IV. Conclusion

The Program is being assessed a $500.00 civil penalty. DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal or request a hearing on the final findings, the Program may do so within 30 days of this letter.

If you have any questions regarding this letter and report, please contact your Certification Coordinator, Connie Schaffer, at 515-281-5003.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation Report

Assisted Living Program:

Incident Intake #: 23893-I

Christine Vasquez, Administrator
Walden Point Assisted Living
1200 4th St
Des Moines, IA 50314-3102

Date of Incident Investigation:

October 23 & 27, 2009

Monitor(s):

Vickie Clingan, R.N., M.A.

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of an Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Walden Point on October 23 & 27, 2009. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	50
Current number of tenants with cognitive disorder:	2
Total Population:	52

Dementia Specific Program (DSP)* – Not applicable.

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There have been substantiated Regulatory Insufficiencies in the areas of: Staffing and Life Safety during this recertification period.

Incident Investigation – The investigator(s) made the observations detailed in the following areas.

A. Criteria for exclusion of tenants - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

Incident Allegation: The program reported Tenant #1 had several falls and was becoming increasingly dependent. The tenant was transferred to the hospital after a fall and no longer resides at the program.

- Monitoring Observation: Tenant #1, a 68 year old, was admitted on 4/30/09 and had the following diagnoses: Unspecified Hemiplegia Affecting Non-dominant Side, Mononeuritis of Unspecified Site, Late Effect of Fracture of Spine and Trunk Without Mention of Spinal Cord Lesion, Low Back Pain, and Wheelchair Dependence.

  According to Clinical Notes dated 6/9/09, Tenant #1 was found on the floor in the bathroom at 3:38 a.m. On 6/10/09 the Clinical Notes indicated the staff could not find Tenant #1 to give 9:30 p.m. medications and a search was conducted. The tenant was found in a restroom on the first floor and was sent by ambulance to the hospital. On 6/13/09 the Clinical Notes indicated the tenant had several falls and was becoming increasingly dependent. Staff transferred the tenant to the hospital and the tenant no longer resides in the program.

- Regulatory Insufficiency: None Noted.

B. Other – The provisions of this section address the program's noncompliance with other applicable statutory and administrative rule requirements.

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

- Monitoring Observation: Tenant #3, a 78 year old, was admitted on 9/29/08 and had the following diagnoses: Lumbosacral Neuritis, Alzheimer's Disease, Dementia and Hypertension. According to Clinical Notes dated 9/16/09, Tenant #3 was walking with a walker behind the dining room wall where the coffee is located. The tenant suddenly fell on the floor and was unable to get up or move. The tenant hurt the right hip, knee & ankle. The tenant rated the pain at a five on a scale of one to ten. Tenant #3 was transported to the hospital by ambulance. According to the OASIS assessment, the tenant was admitted to the hospital for a right hip fracture. During an interview on October 27, 2009, the Administrator stated she did not report the accident to DIA as they determined they did not have culpability.

- Regulatory Insufficiency: The program did not notify the Department of Inspections and Appeals within 24 hours, by the most expeditious means available of any accident causing substantial injury or death. (231C.12).

Dated this 17th day of December, 2009.