IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED

Complaint/Incident Intake #: 36279-I
36256-C

December 21, 2011

Mr. Scott Regenwether, Manager
Courtyard Estates Assisted Living
6132 NE 12th Avenue
Pleasant Hill, IA 50327

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

Dear Mr. Regenwether:

I. Final Complaint/Incident Investigation Report – Courtyard Estates Assisted Living, Pleasant Hill, 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 Insufficiencies in the area(s) of: Staffing and Structural Requirements. **Courtyard Estates Assisted Living** ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on December 12, 2011, has been reviewed and will constitute the final POC related to the on-site visit of October 17, 18 and 19, 2011. The Request for Reconsideration has been denied as the operating alarm system must be audible according to the State Fire Marshall.

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 **Rose Boccella** and remit the civil penalty assessed by check or money order in the amount of six hundred fifty dollars ($650) 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 $1,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on December 12, 2011, has been reviewed and will constitute the final POC related to the on-site visit of October 17, 18 and 19, 2011. The Request for Reconsideration has been denied as the operating alarm system must be audible according to the State Fire Marshall. It doesn't have to be a loud sound like a fire alarm that upsets or is disruptive to tenants. It could be a door bell sound or even a person's voice telling everyone in the area that someone has left the building.

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, Rose Boccella, at 515/281-7039.

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:

Scott Regenwether, Manager
Courtyard Estates Assisted Living
6132 NE 12th Ave.
Pleasant Hill, Iowa 50327

Complaint/Incident Intake #:

36279-I
36256-C

Date of Complaint/Incident Investigation:

October 17, 18 and 19, 2011

Monitor(s):

Maribeth Freland RN

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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	12
Number of tenants with cognitive disorder:	17
Total Population of Program at time of on-site	29
TOTAL census of Assisted Living Program	29

Program History – The program received a regulatory insufficiency in the area of Dementia specific Education during the Recertification visit of September 9, 2011.

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

A. Staffing

Complaint/Incident Allegation: It was alleged the program did not provide all tenants with emergency response system 24-hours daily, resulting in delayed response by staff members following one tenant's fall.

- Monitoring Observation: The monitor reviewed the clinical records of Tenants #1, #2, #3, #4, #5 and #6. The monitor interviewed tenants and staff members as applicable to the allegation. The monitor found no concerns related to the allegation when reviewing the care provided to Tenants #5 and #6.

  Tenant #1 (the Tenant), an 86 year old, was admitted 1-8-11 with diagnoses of: Alzheimer's Disease, Hypertension (HTN), Diabetes and History of a Stroke. The Tenant scored 5 on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline.

  The Tenant's service plan covering the months of July, August, September and October 2011 directed staff members to visually check the Tenant eight times per shift to ensure 24-hour safety/supervision due to the Tenant's dementia. The program utilized task sheets identifying times for the required checks for staff members to document the completion of each visual check.

  According to the task sheets for July, August, September and October 2011, staff members failed to document performance of the visual check between 3:00 PM and 4:00 PM on 7-5-11; between 2:00 PM and 10:00 PM on 7-30 and 31-11; between 6:00 AM and 1:00 PM on 8-25-11; between 2:00 PM and 10:00 PM on 9-24-11;

between 7:00 AM and 1:00 PM on 9-29-11; and between 6:00 AM and 2:00 PM on 9-30-11.

Tenant #2 (the Tenant), a 75 year old, was admitted 2-11-11 with diagnoses of: Diabetes, HTN, Congestive Heart Failure, Coronary Artery Disease, Dementia and Depression. The Tenant scored 5 on the GDS, which indicated moderately severe cognitive decline.

The Tenant's service plan covering the months of July, August, September and October 2011 directed staff members to visually check the Tenant eight times per shift to ensure 24-hour safety/supervision due to the Tenant's dementia. The program utilized task sheets identifying times for the required checks for staff members to document the completion of each visual check.

According to the task sheets for July, August, September and October 2011, staff members failed to document performance of the visual check between 2:00 PM and 10:00 PM on 7-30 and 31-11; between 3:00PM and 4:00PM on 8-21-11; between 11:00AM and 3:00 PM on 8-23-11; between 6:00 AM and 1:00 PM on 8-25-11; between 2:00 PM and 10:00 PM on 9-24-11; between 7:00 AM and 1:00 PM on 9-29-11; and between 7:00 AM and 2:00 PM on 9-30-11.

Tenant #3 (the Tenant), an 81 year old, was admitted 2-8-11 with diagnoses of: History of Polio, Chronic Pain Syndrome, Dementia and Depression. The Tenant scored 4 on the GDS, which indicated moderate cognitive decline.

The Tenant's service plan covering the months of July, August, September and October 2011 did not include any direction to staff members to visually check the Tenant eight times per shift to ensure 24-hour safety/supervision due to the Tenant's dementia; however, the program had utilized task sheets for the Tenant to document completion of eight times per shift visual checks.

According to the task sheets for July, August, September and October 2011, staff members failed to document performance of the visual check between 11:00 PM and 6:00 AM on 7-29-11; between 2:00 PM and 10:00 PM on 7-30-11; between 11:00AM and 3:00 PM on 8-23-11; and between 12:00 PM and 1:00 PM on 9-22-11.

Tenant #4 (the Tenant), an 86 year old, was admitted 3-8-07 with diagnoses of: Chronically Displaced Right Shoulder, Depression, HTN and Chronic Peripheral Edema. The Tenant scored 3 on the GDS, which indicated mild cognitive decline.

The Tenant's service plan, dated 9-16-11, indicated the Tenant required assistance with bathing, dressing and required the assistance of one person to transfer but used a wheelchair for mobility that the Tenant self-propelled. The same service plan directed staff members to provide the Tenant with an emergency pendant.

According to the Incident Report, dated 10-4-11, staff members entered the Tenant's apartment at approximately 6:30 AM to count narcotic medications when the Tenant yelled for assistance. The staff members found the Tenant sitting on the floor beside the bed with his/her wheelchair directly in front of the Tenant. The Tenant indicated

he/she attempted to get up toilet and his/her feet slid resulting in the Tenant going to the floor. The incident report documented no injuries.

On 10-17-11 at 5:45 PM, the Tenant confirmed he/she required the assistance of one person to transfer safely from one surface to another. The Tenant indicated he/she usually had an emergency pendant to wear around the neck for easy access if an emergent situation should occur; however, during the evening of 10-3-11, Staff #5, a universal worker, assisted the Tenant with a shower and dressing. During the shower, Staff #5 removed the Tenant's emergency pendant. Staff #5 failed to replace the pendant around the Tenant's neck when redressing the Tenant. Later in the night, Tenant #4 reported he/she needed to toilet, noted the pendant missing from his/her neck and was unable to locate the pendant. The Tenant reported yelling out for staff member response however no one responded. The Tenant attempted to transfer his/her self from the bed into the wheelchair. Upon standing, his/her feet slipped and the Tenant landed in a sitting position on the floor beside the bed. He/she reported calling out verbally for assistance to no avail. The Tenant believed he/she sat on the floor beside the bed for approximately four hours before staff members entered his/her room, finding the Tenant on the floor.

The Manager and the Health Care Coordinator both concurred Staff #5 had failed to place the emergency pendant on Tenant #5 following a shower on 10-3-11.

Staff #5's personnel file lacked any documentation of follow up related to this incident. Staff #5's employment was terminated on 10-13-11 due to poor performance issues.

- Regulatory Insufficiency: Each tenant shall have access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch. In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s). (IACr. 481-69.29(1)and(2))

- Regulatory Insufficiency: A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's services plan. The staff shall check on tenants as indicated in the tenants' service plans. (IACr. 481-69.29(4))

B. Structural Requirements

Complaint/Incident Allegation: It was reported one tenant exhibiting dementia eloped from the program without staff member knowledge through an unlocked gait in the program's outdoor courtyard.

Monitoring Observation: Tenant #1 (the Tenant), an 86 year old, scored 5 on the GDS, which indicated moderately severe cognitive decline. The Tenant's service plan documented the Tenant was independent with transfers and ambulation and documented the Tenant wandered frequently and exhibited exit seeking behavior.

The plan directed staff members to attempt redirection by engaging in conversation about Tenant #1's family or if unsuccessful with this, to offer to assist the Tenant out into the program's secured outdoor courtyard. The Tenant did have a reported history of leaving out the front main door with visitors in the past; however, never without staff observing this occur and returning the Tenant back inside the program immediately.

On 10-11-11 at approximately 6:55 PM, Staff #1, the program's Culinary Coordinator, found Tenant #1 (the Tenant), a cognitively impaired tenant, walking along a road way approximately 1 and 2/10 of a mile from the program. The Culinary Coordinator returned to the program with Tenant #1, noting no obvious injury to the Tenant. The Culinary Coordinator contacted the program Manager and the Health Care Coordinator and both immediately arrived to assess the Tenant and the situation.

According to the State Climatologist, it was 70 degrees at 6:54 PM on 10-11-11 and mostly clear skies with winds from the south at 6 miles per hour (mph). The sun set at 6:40 PM.

Tenant #1 traveled south up the program's driveway, which is approximately 1/10 of a mile. He/she then traveled east on NE 12th Ave. approximately 1 and 1/10 miles before being observed by the Culinary Coordinator. NE 12th Ave. is a two lane paved road with no sidewalk areas. The speed limit on this street is 35 mph. NE 12th Ave. runs parallel with Highway (Hwy) 163, which is a four lane highway with a posted speed limit of 55 mph. The Tenant had passed one access to Hwy 163 at 64th St. and was within approximately 300 yards of NE 70th St., which has a posted speed limit of 55 mph. The area is heavily wooded with surrounding corn fields. The site where the staff member found Tenant #1 was next to a man made pond on the property of a local business.

The Manager initiated an immediate internal investigation into Tenant #1's elopement. Upon initiation of the program's investigation, the Manager noted the outside courtyard gate to be unlocked. The Manager found the gate doors to be in the closed position; however, noted the two keyed padlocks usually securing the gate were not latched and had been placed in a way to allow the doors latches to open both doors.

The gates had been unlocked on 9-22-11 to allow lawn care professionals to enter through the gate with large equipment to perform lawn care inside the courtyard and had inadvertently been left unlocked following the lawn care on 9-22-11. The program did not have a system in place prior to 10-12-11 to ensure the gate doors were secure prior to allowing tenants to go into the courtyard unattended. The program reported two universal workers, two dietary staff and the program's manager were onsite at the believed time of Tenant #1's elopement from the program.

All exit doors in the building are alarmed. The front main entrance, front staff entrance and the two rear exit doors are alarmed with a system allowing a code to be put in to bypass the alarm. The alarm does not sound if the code is correctly input; however, a message is sent to pagers carried by staff members. If the code is not put in and the door handles are turned to open the door, an audible alarm sounds for 15

seconds. After 15 seconds, the door will open, the audible alarm continues to sound and a message is sent to staff members' pagers. The front main entrance is locked, preventing entrance even with a code, from 8:30 PM to 7:00 AM.

The two doors exiting into the outdoor courtyard do not have a code system. Tenants and staff are able to go out the doors freely from 7:00 AM to 8:30 PM; however, a message is sent to staff members' pagers when the door is opened. Both doors are always locked from the courtyard side; therefore, persons are unable to freely enter the building.

All universal workers carry a pager while working. The Manager, the Health Care Coordinator and one kitchen employee keeps a two way radio with them so if the universal workers are unable to timely respond to a pager message, they can call for assistance.

Staff #4, a dietary aide, reported Tenant #1 had been pushing on the alarmed front entrance door in an attempt to exit the program around 4:30 PM on 10-11-11. Staff #4 indicated the Tenant ceased pushing on the door when the alarm sounded. Tenant #1 continued to express a wish to leave the program, so Staff #4 reported assisting Tenant #1 out into the courtyard and left the Tenant there alone. Staff #4 returned to the dining room area to prepare tables for the supper meal. Approximately five minutes later, Tenant #1 reportedly knocked on the door to come back in to the building. Staff #4 responded however two other tenants opened the door first to allow Tenant #1 back into the building. Staff #4 reported observing Tenant #1 at supper and dessert, both which end approximately 5:30 PM. Staff #4 denied seeing Tenant #1 after 5:30 PM that evening.

Staff #1, the Culinary Coordinator, reported at approximately 6:30 PM on 10-11-11, Tenant #1 asked to leave and pointed to the front main door stating "I can't go that way." The Culinary Coordinator assisted the Tenant into the outside courtyard and left the Tenant unattended. She reported it was still light outside at this time. The Culinary Coordinator returned to the kitchen area to clean up the supper meal remains prior to leaving for the evening. The Coordinator reported she observed Staff #3, a universal worker, opened the courtyard door and attempted to get Tenant #1 to come back inside; however , shedid not wait to see if the Tenant returned.

Staff #3 reported he got Tenant #1 to come inside around 6:30 PM and left the Tenant sitting at a table in the dining room with two other tenants. Staff #3 left the area to assist another tenant and when returned to the dining room area, noted Tenant #1 was no longer seated at the table; however, he had no concerns with this as the Tenant often wandered around the program. Staff #3 reported he did not receive a page after this time indicating the courtyard door had been opened.

The Manager reported leaving the program at approximately 6:40 PM, observing Tenant #1 standing in the dining room area upon his exit from the building. Staff #2, a universal worker, reported observing Tenant #1 sitting at a table in the dining room on 10-11-11 at approximately 6:45 PM.

The Manager and all staff members interviewed indicated the courtyard is considered to be secure therefore multiple tenants spend time in the courtyard while unattended when the weather is nice.

The program's Alarm Response Reports for 10-11-11 documented Tenant #1's door to his/her room opened and closed at 6:00 PM, 6:37 PM and again at 6:38 PM. The reports showed the courtyard door opened and closed at 4:04 PM, 4:09 PM and again at 4:31 PM. The report documented the courtyard doors opened and closed again at 5:54 PM, 5:56 PM and 5:58 PM. The report lacked any further documentation of the courtyard doors opening until 8:28 PM.

The monitor walked the distance from the site where the Culinary Coordinator found Tenant #1 to the program's outside courtyard gate, taking 22 minutes to arrive. The monitor walked at a brisk, even pace.

Tenant #1's service plan addressed the Tenant's wandering and exit seeking behaviors. The plan identified ways to redirect the Tenant and suggested assisting the Tenant to the secured courtyard if exit seeking persists. Staff followed the direction given on the service plan; however, they failed to assure the gate doors were in fact secured. The program failed to secure the courtyard doors by leaving them unlocked for 19 days prior to Tenant #1's elopement. Staff members reported multiple tenants routinely used the courtyard unattended as the weather had been nice.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IACr. 481-69.35(1)(b))