IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 25907-C

May 7, 2010

Ms. Tiffany Federspiel, Administrator
Beehive Home Assisted Living
2116 1st Avenue East
Spencer, IA 51301

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

Dear Ms. Federspiel:

I. Final Complaint Investigation Report – Beehive Home Assisted Living, Spencer, IA

Enclosed is the **Final Complaint 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 Record Checks. **Beehive Home Assisted Living** ("Program") is being assessed a $500 civil penalty.

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 **Tamara Halvorson** and remit the civil penalty assessed by check or money

order in the amount of three hundred twenty five ($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. The Plan of Correction (POC) submitted on May 7, 2010, has been reviewed and will constitute the final POC related to the on-site visit of April 5, 2010.

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 Certification Coordinator, Tamara Halvorson, at 515/281-5721.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #: 25907-C**

Beehive Home Assisted Living
Ms. Tiffany Federspiel, Administrator
2116 1st Ave. E
Spencer, IA 51301

Date of Investigation:

April 5, 2010

Monitor(s):

Hal L. Chase, RN BSN MPH

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. IAC r. 481-67.10(5). 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 a Complaint 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 481 IAC chapter 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 or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Beehive Home Assisted Living on April 5, 2010. In preparing this report, the following information was considered:

Current Program Census

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

Current number of tenants without cognitive disorder:	12
Current number of tenants with cognitive disorder:	0
Total Population:	12

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.**

Tenant/Family Satisfaction Results – Not applicable

Program History – There were substantiated regulatory insufficiencies found in the areas of Occupancy Agreement, Evaluation of Tenant and Service Plans this certification period.

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

A. Staffing

Complaint Allegation: It is alleged Staff #3 yelled at Tenant #1 to take his/her teeth out.

- Monitoring Observation: Tenant #1, a 79 year old, was admitted on 3-1-09 and has diagnoses of: Diabetes Mellitus Type II, Stable Chronic Kidney Disease, Stable Senile Dementia, Hypertension, Hyperlipidemia and a History of Colonic Polyps. The tenant was staged at three on the Global Deterioration Scale (GDS) on 3-4-10, which indicated minimum cognitive impairment. A service plan of 11-23-09 indicated the tenant needed staff assistance with personal and health related cares. The tenant was interviewed privately and stated staff were respectful, polite, courteous and kind. Staff have never yelled or lost their temper and have treated him/her "like family." The tenant's family member was interviewed and stated staff had never physically harmed, yelled or swore at the tenant. Staff were polite, treated his/her family member with respect and truly cared about his/her family member.

  Tenant #2's family member was visiting the program during the onsite investigation. The family member was interviewed and stated staff were polite and courteous.

  The Administrator stated staff had not been reprimanded for acting inappropriately with tenants. The Registered Nurse (RN) stated there had been no conflicts or inappropriate behavior from staff toward tenants. Staff #4 stated she was not aware of any conflicts or inappropriate behavior between staff and tenants. Tenants had not complained of being mistreated by staff.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It is alleged Staff #5 administered medications to tenants without any instruction from the RN.

- Monitoring Observations: Five staff files were reviewed. Staff #5's term of employment was 6-30-06 through 10-7-09. Review of Staff #5's file revealed no documentation of training by the RN on medication administration. File review of Staff #1, #2, #3 and #4 did not reveal documentation of medication administration training by the RN. The RN stated staff who administered medications were trained on medication administration which included: a review of the program's medication procedures, training on OPUS system of administering tenant's medications, the five rights of medication administration and how medication errors could occur. Staff were shown a training video on medication administration and were given a written post quiz.

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

File review of Staff #1 indicated a medication post quiz was taken on 4-12-10, but no other medication quiz was found in Staff #2, #3, #4 and #5's file. The RN stated staff did not return demonstration of their competency to her on the administration of medications to tenants. Staff #4 stated she was trained on medication administration. She watched a video on medication administration, reviewed what she had learned from the video with the RN. Staff #4 stated she did not return demonstration of administering medications to tenants. Staff #4 stated she would be "followed" by another staff when they administered medications to tenants.

File review of Staff #1, #2, #3, #4 and #5 did not include documentation staff had been trained by the RN on giving personal and health related cares to tenants. The RN stated staff were trained on personal and health related cares but staff did not return demonstration of their competency on giving such cares.

Staff #4 stated she received training on personal and health related cares from the RN but did not return demonstration of giving cares to the RN.

- Regulatory Insufficiency: The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. (IAC r. 481-69.29 (3))

B. Record Checks

Complaint Allegation: It is alleged the program did not follow up with the Department of Human Services (DHS) when a criminal background check, for Staff #5, required a record check evaluation for possible child abuse.

- Monitoring Observation: Staff #5's date of employment was 6-30-06 through 10-7-09. A criminal background check was completed on 6-12-06 and indicated further research was required from the Department of Criminal Investigations (DCI) and the DHS. The program completed a follow-up record check with DCI on 6-14-06 but Staff #5's file did not reveal the program had requested an evaluation from DHS to determine if Staff #5 could work at the program.

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

- Monitoring Observation: Staff #2's date of employment was 10-15-09. A review of Staff #2's personnel file revealed a criminal background check was not in the personnel file. The Administrator stated a criminal background check had been completed, but she was unable to locate the document during this onsite investigation.

  Staff #6 was hired 6-28-09 through 2-9-10. Staff #6's file revealed a criminal background check was completed on 6-26-09 and indicated further research was required from DCI. The program received confirmation of a criminal history on 6-30-09, which required a request for evaluation from DHS. Staff #6's file did not

reveal the program had requested an evaluation from DHS to determine if Staff #6 could work at the program.

- Regulatory Insufficiency: Pursuant to Iowa Code section 135C.33, a prospective employee of a program shall have a criminal history check, dependent adult abuse check, and child abuse check performed before the prospective employee begins work. If a prospective employee has a criminal history or an abuse history, the prospective employee shall not be employed by the program unless the department of human services has performed an evaluation and determined that the record does not warrant the employment prohibition. Proof of the pre-employment background check shall be maintained in the program's employee file. The program must meet all requirements of Iowa Code section 135C.33 and administrative rules adopted pursuant to Iowa Code section 135C.33. (IAC r. 481-67.9 (3))

Dated this 13th day of April, 2010.