IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

March 16, 2011

Demaris Luttenegger, Administrator
Senior Suites of Urbandale
4700 84th Street
Urbandale, IA 50322

RE: Final Recertification Monitoring Evaluation Report – Senior Suites of Urbandale, Urbandale, IA

Dear Ms. Luttenegger:

Enclosed is the **Final Recertification Monitoring Evaluation 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.

DIA has completed the review of your Plan of Correction (POC) in response to the Preliminary Recertification Monitoring Evaluation Report. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0098** with effective dates of **November 2, 2010** through **November 1, 2012**.

If you have any questions in regard to this certification, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Recertification Monitoring Evaluation Report

Assisted Living Program:

Demaris Luttenegger, Administrator
Senior Suites of Urbandale
4700 84th Street
Urbandale, IA 50322

Date of Monitoring Visit:

February 8 and 9, 2011

Monitor(s):

Lori Miner, RN BSN

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 Recertification Monitoring Evaluation 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:

An on-site monitoring evaluation was conducted at Senior Suites of Urbandale on February 8th and 9th, 2011 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:	36
Current number of tenants with cognitive disorder:	2
Total Population:	38

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 – A meeting was held with 14 tenants. They indicated the best thing about the program was the people. Staff were described as cheerful and as treating the tenants well. The staff were seen as knowledgeable and trained to provide the services needed. The tenants generally felt safe, and night checks were done when requested. When needed, staff responded right away, usually in less than five minutes. The tenants indicated the building, grounds and apartments were kept clean and neat. The food was generally good, although more variety was needed with the evening meal and hot foods could be hotter. Most of the tenants indicated there were enough activities. The tenants were generally satisfied with the program and would recommend it to others.

Program History – The program did not receive any regulatory insufficiencies during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Evaluation of Tenant

Monitoring Observation: Tenant #1, an 86 year-old, was admitted to the program on 6-2-10 with diagnoses of: Parkinson's Disease, Dementia, Edema, Osteopenia, and Hypotension. The initial Mini Mental State Examination (MMSE), dated 5-27-10 indicated the tenant scored 19 out of 30. An MMSE dated 6-15-10 indicated the tenant scored 19/30. According to a notation on the service plan dated 6-10-10, the tenant was scored at two on the Global Deterioration Scale (GDS) which indicated very mild cognitive decline. A GDS scoring tool was not found in the tenant records. A Residence Facility Encounter Form dated 1-18-11 and signed by the health-care provider indicated the tenant was seen for follow-up of cellulitis of the right lower leg. The form indicated antibiotics had been started on 1-14-11. During this encounter, edema and scabs were noted on the right lower leg. Aquaphilic was ordered. The tenant complained of shortness of breath on exertion. Functional, cognitive and health evaluations were not completed with this change in condition.

Tenant #3, a 93 year-old, was admitted to the program on 10-26-07 with diagnoses of: Dementia, Left Femur Fracture, Hypertension (HTN), Diabetes, and Hypothyroidism. An MMSE dated 11-2-10 indicated the tenant scored 22/30 which indicated mild impairment. According to a notation on the service plan dated 11-2-10, the tenant was scored at four on the GDS which indicated moderate cognitive decline. A GDS scoring tool was not found in the tenant records. The annual functional evaluation was completed on 12-8-10 and the annual cognitive evaluation was completed on 11-2-10. The annual health evaluation was not completed.

Tenant #4, an 88 year-old, was admitted to the program on 2-12-07 with diagnoses of: HTN, Spinal Stenosis, Carpal Tunnel, Benign Tumor Right Eye, Cataract Removed Left Eye, Heart Murmur, and Neurogenic Bladder with self-catheterization. The Residence Facility Encounter Form indicated the tenant was hospitalized for a Urinary Tract Infection (UTI) and falls on 11-5-10. The returned to the program from a skilled nursing facility on 12-9-10. A note written by the nurse on 12-10-10 indicated the program would temporarily administer the tenant's medications. Functional, cognitive and health evaluations were not completed with significant change and upon return to the program. Nurse's notes dated 1-5-11 indicated the tenant was now using a wheelchair instead of a walker for self-transport and the program was continuing to administer medications to the tenant. On 1-5-11 functional and cognitive evaluations were completed and the service plan updated; however, a health evaluation was not completed.

Tenant #5, an 83-year-old, was admitted to the program on 1-15-10 with diagnosis of: Glioblastoma Multiforme, Carotid Vascular Disease, Right Bundle Branch Block, HTN, Gout, and Hypercholesteolemia. A physician's order dated 12-13-10 indicated the tenant was ordered the medication Paxil as the tenant was having signs and symptoms of Depression. The documentation lacked functional, cognitive, and health evaluations with this change of condition. On 1-4-11 the tenant returned to the program after a hospital stay. A function assessment was completed. According to nurse's notes dated 1-4-11 the tenant refused the MMSE assessment. The notes indicated there was a significant change. The documentation lacked an assessment of vital signs and review of systems. The documentation lacked a health assessment. On 1-6-11 the tenant was referred to hospice. On 1-10-11 the nurse's notes indicated the tenant was doing poorly and "not

arousable." The tenant died on 1-14-10. The documentation lacked functional, cognitive and health evaluations with a change of condition and the addition of hospice services.

- 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 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))

B. Service Plan

Monitoring Observation: Tenant #1was seen on 1-18-11 for follow-up of cellulitis of the right lower leg. Antibiotics had been started. The tenant was noted to have edema and scabs on the right lower leg. Aquaphilic was ordered. The Medication Administration Record (MAR) for January 2011 indicated TED hose were to be put on in the morning and removed in the evening. The service plan, dated 7-1-10, was not updated with a significant change. The service plan did not meet the specific service needs of the tenant related to care of the cellulitis and the use of TED hose. The service plan did not identify the tenant's preferences for nursing facility care.

The service plan for Tenant #3 was reviewed. The service plan contained the dates of 4-21-10 and 12-8-10. A 90-day evaluation, dated 10-15-10, indicated two persons close to the tenant, a sister and a friend, had died and the tenant was sad and weepy. The service plan was not updated to include the emotional needs of the tenant. The annual evaluation, dated 12-8-10, indicated the tenant was not always compliant with food choices related to Diabetes. The evaluation indicated the tenant was given smaller portions of food per staff. The evaluation also indicated the tenant had an episode of low blood sugar which required intervention. The service plan, dated 12-8-10, was not based on a health evaluation, and was not updated to include the needs of the tenant related to Diabetes. The tenant was scored at four on the GDS. The service plan was not updated to include the activity needs of the tenant. The service plan did not identify the tenant's preferences for nursing facility care.

The service plan for Tenant #4, dated 1-5-11, was reviewed. The service plan was not based on a health evaluation. The service plan lacked documentation of the tenant's need for self-catheterization, which was listed on the MAR. The tenant returned to the program on 12-9-10 from a hospitalization for a UTI and falls. Nurse's notes date 12-20-10, indicated the tenant was again receiving medication for at UTI. Nurse's notes dated 12-15-10 indicated the tenant had difficulty getting out of a recliner, notes dated 12-18-10 indicated the tenant got tired while walking and sat down on the floor, and notes dated 1-28-11 indicated tenant was found on floor. The service plan lacked documentation of care needed for urinary infections and falls. The service plan did not identify the tenant's preference for nursing facility care.

The service plan for Tenant #5, dated 1-4-11, was reviewed. The service plan was not based on a health evaluation. On 1-6-11 the tenant began with hospice services. Nurse's notes dated 1-6-11 indicated hospice was bathing the tenant. Notes dated 1-8-11 indicated the tenant was being turned every two hours. The service plan was not updated to identify hospice services which included bathing assistance, and the tenant's need to be turned every two hours. The service plan was not updated to include the tenant's need for comfort measures at the end of life. The service plan did not identify the tenant's preference for nursing facility care.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance; any services and care to be provided pursuant to the occupancy agreement; the service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy; for tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests; and preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. (IAC r. 481-69.26(4)(a-e)

C. Medications

Monitoring Observation: The MAR for Tenant #1, dated January 2011, indicated TED hose were to be put on in the morning and removed in the evening. There was no documentation on the MAR that the TED hose had been applied or removed.

Physician's orders for Tenant #3, dated 1-19-11, indicated vital signs were ordered monthly. A review of the MAR dated January, 2011 contained the order for the vital signs. There was no documentation on the MAR to indicate the vital signs had been checked. The MAR for Tenant #3 indicated that on 1-21-11, the tenant received PRN (as needed) Acetaminophen. The MAR lacked documentation of the time the medication was given, the reason for and the effectiveness of the medication. .

Physician's orders for Tenant #4, dated 1-19-11, indicated Vitamin C 500 mg was to be given three times a day. The MAR indicated Vitamin C 500 mg, twice a day. The MAR contained documentation that the medication was given twice a day. The medication was not administered according to the physician's orders.

- Regulatory Insufficiency: Each program shall follow its own written medication policy, which shall include the following: (IAC r. 481-67.5) When medications are administered traditionally by the program the administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655—Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

D. Nurse Review

Monitoring Observation: A 90-day nurse review for Tenant #1 was completed on 12-31-10. The review lacked an evaluation of the tenant's health status, including skin condition following a diagnosis of cellulitis.

A 90-day nurse review for Tenant #3 was completed on 10-18-10. The review lacked an evaluation of the tenant's health status. The physician's orders, dated 1-19-11, lacked documentation of time, date, and signature by the nurse.

Physician's orders for Tenant #4, dated 1-19-11 with a stamped physician's signature indicated Vitamin C 500 mg was to be given three times a day. The MAR indicated Vitamin C 500 mg, twice a day. The physician's order form contained two orders for Acetaminophen: Acetaminophen 500 mg, one tablet every four hours as needed, not to exceed four grams in 24 hours, and Tylenol (brand name for Acetaminophen) one to two tablets every four hours as needed for pain or fever. The MAR listed Tylenol 500 mg every four hours as needed. The MAR did not indicate the dose of one to two tablets, not to exceed four grams in 24 hours, or that the medication could be used for pain or fever. The MAR also listed Phenergan 25 mg as needed for nausea and vomiting with an order date of 1-6-11. The physician's order dated 1-19-11 did not include Phenergan. The physician's orders, dated 1-19-11 lacked documentation of time, date, and signature by the nurse. The program failed to ensure that medication orders were current.

Nurse's notes dated 1-4-11 indicated Tenant #5 was able to refuse the MMSE. Tenant #5 was admitted to hospice care on 1-6-11 and hospice staff began bathing the tenant. Notes dated 1-8-11 indicated the tenant was being turned every two hours. By 1-10-11, the nurses notes indicated the tenant was "not arousable." The tenant died on 1-14-11. A nurse review was not completed with the decline in condition.

A nurse review was not completed with admission to hospice.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the

prescription medications are administered consistent with such orders; and to ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program; and to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; and to provide the program with written documentation of the activities under the service plan, as set forth in rule 481—69.26(231C), showing the time, date and signature. (IAC r. 481-69.27(1-4))

Dated this 15th day of March, 2011.