IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 36960-I

January 12, 2012

Ms. Kathy Dawson, Housing Manager
Bethany Heights Senior Living
11 Elliott Street
Council Bluffs, IA 51503

RE: Final Complaint/Incident Investigation Report, Bethany Heights Senior Living, Council Bluffs, Iowa

Dear Ms. Dawson:

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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Amended Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Kathy Dawson, Housing Manager
Bethany Heights Senior Living
11 Elliott Street
Council Bluffs, IA 51503

Complaint/Incident Intake #: 36960-I

Date of Complaint/Incident Investigation:

December 13, 2011

Monitor(s):

Lori Miner, RN BSN

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 Definition	
Number of tenants without cognitive disorder:	53
Number of tenants with cognitive disorder:	12
Total Population of Program at time of on-site	65
TOTAL census of Assisted Living Program	65

Program History – The program received no regulatory insufficiencies during this recertification period.

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

A. Policies and Procedures

During the course of the investigation, the following was noted:

- Monitoring Observation: On 12-5-11 the Program appropriately reported to the department the elopement of Tenant #1 on 12-3-11. 12-3-11 was a Saturday, and the Program reported the incident on the first business day following. The Program was asked to provide an incident report documenting the events of 12-3-11. Staff #1 stated an incident report had not been completed. The Program provided a copy of the Accident Procedure whose purpose was to provide for safety and assistance in emergency situations. The procedure indicated a Critical Incident Report was to be completed for all accidents. An incident report was not completed by staff on duty at the time of the incident outlining the details of the elopement. Witness statements were obtained on Monday but were not obtained at the time of the incident.

  The Program did not follow policies and procedures on incident reports.

- Regulatory Insufficiency: The program's policies and procedures on incident reports, at a minimum, shall include the following: An incident report shall be in detail and shall be provided on an incident report form. The person in charge at the time of the incident shall prepare and sign the report. The incident report shall include statements from individuals, if any, who witnessed the incident. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. (IAC r. 481-67.2(1)(b-e))

B. Staffing

During the course of the investigation, the following was noted:

- Monitoring Observation: The Program provided documentation of two staff persons working on each shift. During the onsite visit, Staff #2 was noted to be sitting at a desk near the front entrance. When asked, Staff #2 stated the desk was staffed during business hours Monday to Friday. There were no persons at the desk on the weekends. Staff #3 stated both staff persons on duty are in the dining room for meals. Noting the dining room is located on the second floor of the building, Staff #3 stated no staff persons would be on the first or third floors on the weekends during meal times except for a medication pass. Staff #4 was interviewed. She stated she checked on Tenant #1 at 5:50 p.m. on the first floor, and then returned to the second floor dining room. The other staff person, Staff #5 was also on the second floor. At the time of the elopement, Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. The Program was determined to be dementia-specific by definition. The Program indicated tenants with dementia reside on all three floors. The doors were not alarmed. It was observed that apartments on the first floor also have patio doors that access the outside. Tenant #1 eloped from the Program sometime between 5:50 p.m. and 6:15 p.m. Both staff members were in the dining room at the time.

  During meal times, there was no staff available to monitor tenant activity on the first and third floors.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

C. Evaluation

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1 (the Tenant), a 92 year-old, was admitted on 8-11-07 and had diagnoses of Dementia, Osteoporosis, Aortic Stenosis, Cancer of the Colon, Psoriasis, and Depression. The Tenant was staged at five on the GDS which indicated moderately severe cognitive decline. The Tenant lived in an apartment on the first floor of the building. The Program reported on the evening of 12-3-11 the Tenant was found outside in the parking lot of the adjacent nursing home. Staff #4, a Certified Medication Aide, (CMA) reported checking on the Tenant at 5:50 p.m. as the Tenant had not come to the dining room for dinner. The Tenant was noted to be in the restroom. Staff #4 ordered a room tray for the Tenant as it was getting late. Staff #4 returned to the second floor dining room where Staff #5, a Certified Nursing Assistant (CNA), was already working. Staff #6 was employed by the adjacent nursing home. Staff #6 left the nursing home at 6:15 p.m. on 12-3-11 to move her car. It was snowing at the time, and nursing home staff had received a call that someone was coming to move snow in the parking lot. When she reached her car, Staff #6 noticed a "resident" in the parking lot with a walker. The Tenant was wearing a button-down sweater, long pants, sandals, and TED hose. The TED hose could be seen on the foot. The Tenant was not wearing a coat.

The Tenant stated he/she got lost on the way to the dining room and for Staff #6 not to tell anyone. Staff #6 noted the Tenant had snow on his/her shoulders, but nowhere else. Because there was no snow other than the shoulders, Staff #6 did not believe the Tenant had suffered any falls. Staff #6 put her own coat on the Tenant, brought her car around, and drove the Tenant to the assisted living program. Staff #6 stated she believed the Tenant had exited the Program from a door located on the east side of the building. She stated another staff person; Staff #7, from the nursing home had also left the building to move his car. Staff #6 thought Staff #7 had followed the tracks in the snow back to the door. Staff #7 was interviewed and he stated he did not actually go to the east door, he assumed by the general direction of the tracks in the snow that the Tenant had exited the assisted living building through the east door. Staff #6 stated she thought she had given a report of the situation to a staff person from the Program because she recognized the person, but later learned the person was a volunteer at the nursing home. Staff #6 stated she later called and talked to Staff #5 by phone. After leaving the Program, Staff #6 parked her car and returned to the nursing home shortly after 6:30 p.m. Staff #4 stated she thought 15-20 minutes had passed between the time she checked on Tenant #1 and the time she was told the Tenant had been returned to the Program. Staff #5 stated she was notified "around 6:15 p.m." that Tenant #1 had been outside.

The State Climatologist reported the following weather conditions in Council Bluffs at 6:00 p.m. on 12-3-11: Temperature 30 degrees, humidity 80 %, winds out of the north at 15 miles per hour creating a wind-chill of 19 degrees. Light snow was falling. It had been snowing since 10:30 a.m. which created four inches of new snowfall.

Staff #5 described Tenant #1 as "tiny," about five feet tall. A nurse review dated 10-4-11 stated the Tenant's weight was 96 pounds, down three pounds in 90 days.

Upon hearing of Tenant #1's return to the building, Staff #5 stated she went to check on the Tenant. She stated the patio door in the Tenant's room was locked. She checked the Tenants feet and noted a TED sock on one, and a knee-high sock on the other. The socks were not removed, but Staff #5 stated the feet were dry. Staff #5 called the director of nursing and the Tenant was started on 15-minute checks. Staff #5 did not check the Tenant's vital signs. Staff #5 received a phone call around 10:00 p.m. from Staff #6. Staff #6 indicated the Tenant's toes should be checked for frostbite. Staff #5 checked to toes for frostbite and did not see any changes. When asked to describe what frostbite looks like, Staff #5 replied frostbite is black. Staff #5 stated she did not document her observations of the Tenant's feet. Staff #5 stated no nurse came to check on the Tenant. Staff #4 stated she did not check the Tenant's vital signs upon return to the Program. She stated the feet did not appear wet and she did not remove socks to check the feet at the time of return. Staff #4 stated the socks were removed at 9:00 p.m. and the feet looked "OK." When asked to describe frostbite, Staff #4 stated frostbite would turn the feet black. (In a condition of frostbite, the color black would be seen at later stages.)

Vital signs had been checked prior to the Tenant leaving the building. The Tenant's temperature was 97.3 degrees. There is no documentation the Tenant's temperature was checked after return to the building.

The Tenant did not have a health evaluation completed by a nurse upon return to the building. The Tenant was under-dressed for the weather conditions. The Tenant was described as "tiny," with a weight of 96 pounds.

The Program Nurse documented an evaluation of functional and cognitive status on 12-5-11. The Tenant was noted to have progressed to stage six on the GDS on the cognitive evaluation completed 12-5-11. The health/functional assessment form had documentation of vital signs, cognitive score and functional assessment dated 6-1-11. Updates to the form were made on 12-5-11. Vital signs and assessment of the current health status including an assessment after exposure to the cold was not documented on the form. The Tenant was discharged to a higher level of care on 12-10-11.

The Program did not complete a health evaluation with a change of condition.

- Regulatory Insufficiency: *Evaluation within 30 days of occupancy and with significant change.* 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))

D. Nurse Review

During the course of the investigation, the following was noted:

- Monitoring Observation: During review of the clinical record for Tenant #1, a fax dated 11-22-11 and approximately 10 days prior to the elopement, reported to the physician the Tenant had complained of urinary urgency and frequency and was noted to have increased incontinence. The Program requested an order for a urinalysis. Results of the urinalysis, noted 11-28-11, were negative. Staff #1 stated the Program suspected a urinary infection because the Tenant was applying lipstick to his/her hair. There was no documentation of a nurse review for the Tenant's behavior, the signs/symptoms of a urinary infection, or the Tenant's condition once the urinalysis results were obtained.

  A nurse review was not completed for a change in condition.

- 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 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. (IAC r. 481-69.27(3))