IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 37280-C

March 30, 2012

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

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

Dear Ms. Reiter:

I. Final Complaint/Incident Investigation Report – BeeHive Home Assisted Living, Spencer, 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: Evaluation, Tenant Documents, Service Plans and Nurse Review. **BeeHive Home Assisted Living** ("Program") is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

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 **Jim Berkley** and remit the civil penalty assessed by check or money order in the amount of three hundred twenty five dollars ($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 pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on February 23, 2012, has been reviewed and will constitute the final POC related to the on-site visit of February 1 & 2, 2012.

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, Jim Berkley, at 515/281-4116.

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: **Complaint/Incident Intake #:** 37280-C

Tiffany Reiter, Administrator
BeeHive Home Assisted Living
2116 1st Ave. East
Spencer, IA 51301

Date of Complaint/Incident Investigation:

February 1-2, 2012

Monitor(s):

Hal L. Chase, RN BSN MPH

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.

General Population Program	
Number of tenants without cognitive disorder:	9
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	10
TOTAL census of Assisted Living Program	10

Program History – There were regulatory insufficiencies found in the areas of Service Plan, Food Service and Record Checks during this certification period.

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

A. Occupancy Agreement

Complaint/Incident Allegation: It was alleged tenants occupancy agreements were incorrect as to what agency was responsible for payment of services performed by the Program.

- Monitoring Observation: Tenant #1 through #9's files were reviewed and indicated on 12-31-11, the Program corrected each tenant's occupancy agreement and identified the correct payor for services under the elderly waiver program and the monthly rate paid under the elderly waiver program.

- Regulatory Insufficiency: None noted.

B. Evaluation

Complaint/Incident Allegation: It was alleged a tenant was hospitalized for Pneumonia and was a "strong" two-person transfer. The Administrator assessed the tenant and wanted to re-admit the tenant to the Program, even though the family wanted the tenant to go to a skilled nursing facility.

- Monitoring Observation: Nine tenant files were reviewed. Tenant #2's, #3's and #6's files were reviewed and indicated concerns. Tenant #1's, #4's, #5's, #7's, #8's, and #9's files indicated evaluations were completed appropriately.

  Tenant #6, a 93 year-old, was admitted on 2-26-10 and had diagnoses of: History of Coronary Disease, Hypertension (HTN) and a History of Myocardial Infarction. A cognitive status assessment was completed on 11-23-11. Functional, cognitive and health evaluations were last completed on 11-23-11 by the registered nurse (RN).

On 12-13-11, Tenant #6 was seen by his/her physician and diagnosed with Pneumonia. The physician reported Tenant #6 did not want to be hospitalized. The physician ordered the Program to monitor for increased signs and symptoms of illness, to increase fluid intake and for Tenant #6 to rest. The Administrator reported on 12-17-11, Tenant #6's family decided Tenant #6 was to be seen at the hospital emergency room and was admitted for hospital care. Tenant #6 was later discharged to a local skilled nursing facility. Tenant #6 did not return to the program.

The Program did not complete a functional, cognitive and health evaluation when Tenant #6 was diagnosed with a change in health status.

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

- Monitoring Observation: Tenant #2, a 91 year-old, was admitted on 7-21-11 and had diagnoses of: History of Cystectomy, Atrial Fibrillation, History of Left Cataract Surgery, HTN, Hypothyroidism, Ischemic Heart Disease, Diverticulosis, Anemia, Chronic Cough, Hyperlipidemia, History of Urinary Incontinence, Arthritis, Gastro Esophageal Reflux Disease and History of Hiatal Hernia. Nurse's notes of 11-15-11 indicated Tenant #2 was admitted to the hospital and would go to a nursing facility before returning to the Program. Nurse's notes of 12-21-11 indicated Tenant #2 returned to the Program on 12-21-11. The Administrator and Program RN reported Tenant #2's health status declined between 12-21-11 through 12-25-11, when Tenant #2 was admitted to the hospital. The Administrator reported Tenant #2 was not returning to the Program.

  Tenant #2 was hospitalized on 11-15-11, went to a nursing facility after hospitalization and returned to the Program on 12-21-11. Functional and health evaluations were completed on 12-21-11 and indicated no change in Tenant #2's condition. The Administrator and Program RN reported Tenant #2's condition worsened beginning 12-21-11 through 12-25-12. On 12-25-11 Tenant #2 was hospitalized and was later admitted to a nursing facility. Tenant #2 would not be returning to the Program. The Program did not evaluate Tenant #2's cognitive status when Tenant #2 returned from the hospital on 12-21-11.

  Tenant #3, an 83 year-old, was admitted on 10-16-06 and had diagnoses of: Tremors, Degenerative Joint Disease of the Right Hip, a history of Hysterectomy and a Colostomy. An annual functional and health evaluation was completed but an annual cognitive evaluation was not completed. The last cognitive evaluation was completed on 10-21-10.

- 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 profession. 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))

C. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged Tenant #6 was a "strong" transfer of two staff when hospitalized. It was alleged the Administrator assessed Tenant #6 in order to readmit Tenant #6 back to the program.

- Monitoring Observation: Tenant #6's service plan of 2-28-11 indicated Tenant #6 ambulated with the use of a walker and was full weight bearing. A functional evaluation of 11-23-11 indicated Tenant #6 used a walker when ambulating and needed some assistance with ambulation. Tenant #6's physician was notified on 10-14-11 of Tenant #6's increased incontinence and reddened perineal area. Documentation on 10-21-11revealed the RN notified the physician of Tenant #6's verbal outbursts toward staff. Zoloft 25mg daily was ordered. On 12-13-11, Tenant #6 was seen by his/her physician and diagnosed with Pneumonia. The physician reported Tenant #6 did not want to be hospitalized. The physician ordered the Program to monitor for increased signs and symptoms of illness, to increase fluid intake and for Tenant #6 to rest. The Administrator reported on 12-17-11 Tenant #6's family decided Tenant #6 was to be seen at the hospital emergency room and was admitted for hospital care.

  The Administrator reported she went to the hospital to see Tenant #6 and asked if Tenant #6 could return to the program. The Administrator reported she did not evaluate Tenant #6. Tenant #6 was later discharged from the hospital to a local skilled nursing facility. Tenant #6 did not return to the Program.

  The Program Administrator, program RN and Staff #1 and #2 reported Tenant #6 used a walker to ambulate independently throughout the Program. Each stated Tenant #6 walked out of the Program on 12-17-11 when he/she went to the hospital.

- Regulatory Insufficiency: None noted.

D. Tenant Documents

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

- Monitoring Observation: Nine tenant files were reviewed. Tenant #3's, #4's, #7's #8's and #9's files were reviewed and indicated no concerns. Tenant #1, an 87 year-old, was admitted on 4-2-11 and had diagnoses of: Alzheimer's Dementia, Status Post Cerebro Vascular Accident, History of Mastectomy and Left Breast Cancer and Metastatic Cancer. A Global Deterioration Scale (GDS) was completed on 11-18-11 and staged the tenant at five, which indicated moderately severe cognitive decline.

  A hospice care plan of 11-18-11 indicated interventions for pain management, nutrition and fluid intake, elimination of bowel and bladder, activity tolerance and safety, increased confusion and medication administration.

The hospice RN stated she expected the Program to be the primary care provider and hospice staff would provide supplemental care when needed. A review of Tenant #1's file, including nurse's notes, indicated the Program did not have a hospice care plan during the time the tenant was receiving hospice care. At the time of the monitoring visit a monitor requested hospice to forward a copy of the initial assessment, hospice care plan and hospice care notes by fax to the program. The Program did not have the hospice care plan and did not document cares established from the hospice care plan.

Tenant #2 was hospitalized on 11-15-11, went to a nursing facility after hospitalization and returned to the Program on 12-21-11. The Administrator and Program RN reported Tenant #2's condition worsened beginning 12-21-11 through 12-25-12, when, on 12-25-11 Tenant #2 was hospitalized. The Administrator reported Tenant #2 did not return to the Program.

The Program did not document why Tenant #2 was hospitalized, did not document or maintain documentation of hospital/nursing facility discharge orders and did not document Tenant #2's status between 12-21-11 and 12-25-11. Tenant #2 was admitted to the hospital on 12-25-11 and did not return to the Program.

Tenant #5, an 81 year-old, was admitted on 3-1-09 and had diagnoses of: Hyperparathyroidism, Kidney Disease and Edema. Tenant #5 was sent to the hospital for evaluation on 10-13-11 related to altered mental status. Tenant #5 returned the same day. Discharge instructions included a diagnosis of Trans Ischemic Attack. The Program did not document Tenant #5's status prior to going to the hospital and his/her return to the program.

Tenant #6 was seen by his/her physician on 12-13-11and was diagnosed with Pneumonia. The physician reported Tenant #6 did not want to be hospitalized. The physician ordered the Program to monitor for increased signs and symptoms of illness, to increase fluid intake and for Tenant #6 to rest. The Administrator reported on 12-17-11 Tenant #6's family decided Tenant #6 was to be seen by at the hospital emergency room and was admitted for hospital care. Tenant #6 was later discharged to a local skilled nursing facility. Tenant #6 did not return to the Program. The Program did not document Tenant #6's status when family took Tenant #6 to the hospital, did not document staff had notified the Program RN of Tenant #6's status and did not document Tenant #6 had been discharged from the Program.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include (i) when any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy and medication; and nurses' notes written by exception. (IAC r. 481- 68.16(1)(i))

E. Service Plans

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

- Monitoring Observation: Nine tenant files were reviewed. Tenant #2's, #3's, #5's, #7's and #8's files were reviewed and indicated no concerns.
-

Tenant #1's nurse's notes of 11-11-11 indicated Tenant #1 was evaluated at a hospital and diagnosed with Metastatic Bone Cancer. On 11-18-11 Tenant #1 returned to the Program. Evaluations were completed and a service plan was updated. Tenant #1's records indicated Tenant #1 was admitted to hospice with an admitting diagnosis of Breast Cancer with Metastatic Cancer to the Bone. A service plan of 11-18-11 indicated Tenant #1 needed assistance with activities of daily living (ADLs) and hospice would play an active role in Tenant #1 life.

A hospice care plan of 11-18-11 indicated interventions pain management, nutrition and fluid intake, elimination of bowel and bladder, activity tolerance and safety, increased confusion and medication administration. The hospice RN stated she expected the program to be the primary care provider and hospice staff would provide supplemental care when needed.

The service plan of 11-18-11 did not include interventions established from the hospice care plan.

Tenant #4, a 93 year old, was admitted on 12-18-09 and had diagnoses of: Diabetes Mellitus Type II (DMII), Hypothyroidism, HTN, Hyperlipidemia, Degenerative Arthritis, and Carotid Stenosis, and Extreme Hard of Hearing, history of a Right Pelvic Fracture, Hyponatremia and Hypokalemia. A service plan was last completed on 12-14-10. An annual service plan was not completed in 2011.

Tenant #6's physician was notified 10-14-11 of Tenant #6's increased incontinence and reddened perineal area. On 10-21-11 the RN notified the physician of Tenant #6's verbal outbursts toward staff. Zoloft 25mg daily was ordered. On 12-13-11, Tenant #6 was seen by his/her physician and diagnosed with Pneumonia. The physician reported Tenant #6 did not want to be hospitalized. The physician ordered the Program to monitor for increased signs and symptoms of illness, to increased fluid intake and for Tenant #6 to rest.

A service plan of 2-28-11 indicated Tenant #6 was independent with toileting. The service plan was not updated to include interventions related to incontinence care, perineal care, interventions related to verbal outbursts and interventions related to Tenant #6's Pneumonia; including to monitor for increased signs and symptoms of associated with Pneumonia, to increase fluids and increased rest.

Tenant #9, a 69 year old, was diagnosed with Hypokalemia, DMII, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, HTN, Arthritis and Pneumonia. A service plan was last completed on 6-10-10. An annual service plan was not completed in 2011.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.221(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: When a tenant needs personal care or health-related care, the service plan shall be updated within 30-days of the tenant's occupancy and as needed with significant change, but no less than annually. (IAC r. 481-69.26 (3))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum a. The tenant's identified needs and preferences for assistance. c. The service provider(s), of other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy. (IAC r.481-69.26(4)(a)(c))

F. Staffing

Complaint/Incident Allegation: It was alleged staff talked about a tenant's need for cares when other tenants were present.

- Monitoring Observation: Staff #1 reported she hadn't heard of staff talk about other tenants in the presence of other tenants. Staff #2 reported the Program was small and voices carry, but staff has tried to be as confidential as possible. Tenant #3 reported he/she hadn't heard staff talk about other tenant's medical or personal care needs. Tenant #7 reported he/she hadn't heard of staff talking about other tenant's care needs or medical illnesses. Tenant #8 reported he/she has heard staff talk about other tenants, but this didn't happen very often if not rarely. When it has happened, no tenants were present, but everyone's voice can carry throughout the Program because the program is so small.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged the Administrator which wasn't working, was called to the Program because a tenant had passed away. The Administrator had been drinking alcohol and may have possibly worked while intoxicated.

- Monitoring Observation: The Administrator reported she had been out for dinner and drinks when she was called by staff of a tenant who passed away while under hospice care. She arrived at the Program and gave comfort to the tenant's family, but did not provide any personal or health-related care to any tenants.

- Regulatory Insufficiency: None noted.

G. Nurse Review

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

- Monitoring Observation: Tenant #2 was hospitalized on 11-15-11, went to a nursing facility after hospitalization and returned to the Program on 12-21-11. Functional and health evaluations were completed on 12-21-11 and indicated no change in Tenant #2's condition. A review of Tenant #2's file indicated no documentation was made of Tenant #2's status between 12-21-11 and 12-25-11. The Administrator and Program RN reported Tenant #2's condition worsened beginning 12-21-11 through 12-25-12, when, on 12-25-11 Tenant #2 was hospitalized.

  The Program did not complete a nurse review when a change in condition occurred between 12-21-11 and 12-25-11.

  Tenant #5 was sent to the hospital for evaluation on 10-13-11 related to altered mental status. Tenant #5 returned the same day. Discharge instructions included a diagnosis of Trans Ischemic Attack. The Program did not complete a nurse review when Tenant #5 returned.

- 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 registered nurse or a licensed practical nurse via nurse delegation (3.) 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))