IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 40549-1

October 11, 2012

Ms. Paula Fandry, Housing Director
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. Fandry:

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 **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 or **James.Berkley@dia.iowa.gov**

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:

Paula Fandry, Housing Director
Bethany Heights Senior Living
11 Elliott Street
Council Bluffs, IA 51503

Complaint/Incident Intake #: 40549-I

Date of Complaint/Incident Investigation:

September 5th and 6th, 2012

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:	57
Number of tenants with cognitive disorder:	15
Total Population of Program at time of on-site	72
TOTAL census of Assisted Living Program	72

Program History – The program received regulatory insufficiencies in the areas of Policy and Procedure, Staffing, Evaluations and Nurse Review during this recertification period.

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

A. Evaluation

Complaint/Incident Allegation: The Program reported Tenant #1was found sitting on the floor of the closet on top of an ankle. After an emergency room evaluation, Tenant #1 was diagnosed with a fractured right ankle.

- Monitoring Observation: Tenant #1, a 98 year-old, was admitted on 12-26-06 and had diagnoses of: Hyperlipidemia, Dementia, and Hypertension. The nurse reported Tenant #1 also had arthritis of the knees. Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. The Program provided the following incident reports:

Date:	Reported:
3-4-12 4:09 pm	Tenant #1 yelling, found on floor in apartment (apt), no injury
3-12-12	Functional, cognitive, and health evaluation completed
3-22-12 8:00 am	Tenant #1 yelling, found on floor in apt., call pendant on night stand, Tenant #1 didn't know how he/she got to floor, no injury
4-9-12 9:00 am	Pushed pendant, found on back in apt, got dizzy & fell, hit head on floor, no injury
6-2-12 6:48 pm	Pushed pendant, sitting on floor, slid off bed, no injury
6-12-12 4:15 am	Found on floor, didn't know what happened. No injury, but did complain of knee pain due to sitting on floor and trying to get up. Tenant #1 reminded to keep call pendant close "for time like this." Nurse's notes indicated Tenant #1 may have slid off the bed.
6-13-12 3:49 am	Found on floor beside bed, getting up to go to bathroom. No injury. Tenant #1 reminded to wear call pendant and to push for all transfers. Had knee pain from stiffness.

6-14-12	Functional, cognitive, and health evaluations completed
6-27-12 4:30 pm	Pushed pendant, sitting on floor next to chair, didn't know what happened. No injury. Nurse's notes documented Tenant #1 was rubbing his/her knees.
7-9-12	Functional, cognitive, and health evaluations completed for pain in the left axilla.
7-27-12 10:00 am	Tenant #1 getting out of shower, suddenly Tenant #1 fell backwards. Tenant #1 stated "everything just went white." Gently lowered to floor by staff member. No injury
7-30-12 1:54 pm	Pushed pendant, found on floor in apt. Getting out of chair, knees got "stuck" and fell. Had knee pain.
8-16-12	Functional, cognitive, and health evaluations completed
8-22-12 2:48 am	Tenant #1 yelling, found sitting on floor, slid off bed, no injury
8-25-12 4:49 pm	Tenant #1 calling for help, found sitting on floor in apt. with ankle twisted underneath. Tenant #1 doesn't know how fall happened. To hospital.

Nurse's notes dated 6-13-12 indicated staff was instructed to remind tenant to wear the call pendant at all times, and to push the call pendant for assistance with all transfers; however, the assessment of 6-14-12 indicated Tenant #1 was only able to understand and utilize the call pendant "at times." Tenant #1 was on every two hour safety checks. On 6-14-12 staff was to start stand-by assistance during the night for toileting and the Program placed handrails on the bed. The Program had already instituted the use of non-skid slippers and non-silky nightwear in an attempt to eliminate slips and falls. A lift chair was instituted in August 2012. According to the nurse, physical therapy had been attempted in the past, but Tenant #1 was not cognitively able to benefit from additional sessions.

Staff interviews were conducted. Staff #1 stated Tenant #1 had a hard time standing because of the knees which would give out. Staff #1 stated she walked with Tenant #1 because Tenant #1 had knee pain which was helped with acetaminophen. Tenant #1 had a hard time getting out of a chair. A lift chair was provided that Tenant #1 didn't operate well. After falls, Staff #1 kept a closer eye on Tenant #1 to make sure Tenant #1 was steady before starting to walk because Tenant #1 required help with balance before starting to walk.

Staff #2 stated Tenant #1 occasionally had a shuffling gait. Staff #2 reported Tenant #1 shuffled more when the knee was hurting. Acetaminophen provided some relief. A few times, Tenant #1 needed stand-by assistance. Staff #2 reported Tenant #1 had difficulty getting from a chair to standing, and Tenant #1 did better after the lift chair was obtained. After Tenant #1 had fallen, Staff #2 kept a closer eye on Tenant #1 and used a gait belt as needed.

Staff #3 stated Tenant #1's knees would give out, and at times acetaminophen would help. Tenant #1 was reported to have no pain when sitting. Staff #3 described Tenant #1 as having a slow, shuffling gait at times, and was slow getting to the dining room. Sometimes Staff #3 would walk with Tenant #1 to the dining room.

If the seat wasn't too low, Tenant #1 could get from a sitting to standing position, but sometimes needed a boost to get up. Staff #3 reported Tenant #1 did not always use the call pendant to request assistance, and was on every two hour checks.

Staff #4 stated Tenant #1 was able to walk independently with a walker, was steady on feet for the most part, but was a little "wobbly." Tenant #1 had difficulty getting up from a seated position and always said the knees were bothering him/her. Tenant #1 was also reported to have a shuffle gait. Staff #4 reported Tenant #1 did not always use the call pendant to request assistance. Tenant #1 didn't understand how to use the lift chair.

Staff #5 stated Tenant #1 received a lift chair "a couple weeks ago" but didn't understand how to use it. Tenant #1 was to have knee pain for some time. Because of the pain, Tenant #1 had difficulty getting up from the couch. Staff #5 described Tenant #1's knees as stiff and unable to bend. Tenant #1 used a walker for ambulation, but put the walker too far forward. Tenant #1 was reported to drag the feet.

A review of the medication administration record (MAR) for the month of August 2012 indicated Tenant #1 received a prescribed daily dose of acetaminophen. Tenant #1 had an as needed order for acetaminophen, one tablet every six hours as needed. Tenant #1 received six "as needed" doses from August 1st to the 25th.

Functional, cognitive, and health evaluations were completed on 3-12-12 as an annual assessment, on 6-14-12 after Tenant #1 fell twice; on 7-9-12 for pain in the left axilla but did not evaluate Tenant #1 for the fall that occurred on 6-27-12-the fourth fall in June 2012; and 8-16-12 for wandering and the use of a lift chair. All evaluations indicated Tenant #1 was independent with a walker. None of the evaluations assessed Tenant #1's gait, the ability to use a walker safely, leg strength to get up and down from a seated position, or knee pain and the effectiveness of the prescribed acetaminophen.

Functional and health evaluations were not completed with significant change.

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

- Monitoring Observation: Tenant #2, a 90 year-old, was admitted on 10-10-11 and had diagnoses of: Hypertension, Osteoarthritis, Hypercholesterolemia, and Dementia. Tenant #2 was staged at three on the GDS which indicated mild cognitive decline. An incident report dated 7-7-12 documented a staff member finding Tenant #2 in the doorway of the bedroom sitting on the left hip. Tenant #2 had a bruise on the forearm and complained of back pain. Tenant #2 was taken to the emergency room and returned with a diagnosis of heart failure. The physician ordered Tenant #2 to be weighed daily. Tenant #2 was sent back to the Program with a new medication order and discharge instructions that included reporting a weight gain of three pounds in one day, increased shortness of breath, a cough, swelling of hands or feet, or difficulty sleeping due to shortness of breath. Functional, cognitive, and health evaluations were completed on 7-10-12 related to the diagnosis of heart failure.

A respiratory rate of 26 was documented. The evaluations did not document lung sounds, whether or not Tenant #2 felt short of breath, had a cough, or swelling of the hands or feet. The evaluations documented Tenant #2 was independent with ambulation, but did not document whether or not Tenant #2 was short of breath with activity or how far Tenant #2 could walk before assistance was required.

Functional and health evaluations were not completed with significant change.

- 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 had not exhibited a significant change. (IAC r. 481-69.22(2))

B. Service Plans

- Monitoring Observation: Tenant #1 fell or was found on the floor 11 times between 3-4-12 and 8-25-12 as documented by incident reports. The fall in 8-25-12 resulted in a fractured ankle. Six of the incident reports documented Tenant #1 slid out of bed, or was getting out of a chair or bed. Nurse's notes dated 6-13-12 indicated staff was instructed to remind tenant to wear the call pendant at all times, and to push the call pendant for assistance with all transfers. The service plan dated 6-14-12 did not include direction for staff to assist with all transfers. The service plan dated 8-16-12 indicated staff was to assist with transfers as needed but did not direct staff as to how to identify when Tenant #1 would need assistance. The service plan did not direct staff members to make sure Tenant #1 had access to the call pendant or to remind Tenant #1 how to use the pendant.

  Nurse's notes dated 7-31-12 indicated staff put a folded blanket in Tenant #1's chair to help Tenant #1 get up easier. The service plan was not updated to include the blanket in the chair.

  Tenant #1 had a diagnosis of arthritis, and received a daily dose of acetaminophen as well as doses "as needed." The GDS staged Tenant #1 at five, which indicated Tenant #1 was cognitively impaired and had impaired decision making ability. Tenant #1 was also identified in nurse's notes as being confused at times. The service plan did not identify Tenant #1 as having pain or behaviors Tenant #1 would exhibit to trigger staff members to offer "as needed" doses of acetaminophen.

  The service plan did not meet the identified needs of the tenant.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: a. the tenant's identified needs and preferences for assistance. (IAC r. 481-69.26 (4)(a))