IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

November 28, 2012

Mr. Greg Witte, Administrator
Risen Son Christian Village
3000 Risen Son Blvd.
Council Bluffs, IA 51503

RE: Final Recertification Monitoring Evaluation Report – Risen Son Christian Village, Council Bluffs, IA

Dear Mr. Witte:

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 **S0200** with effective dates of **November 12, 2012** through **November 11, 2014**.

If you have any questions in regard to this certification, 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 Recertification Monitoring Evaluation Report

Assisted Living Program:

Greg Witte, Administrator
Risen Son Christian Village Assisted Living
3000 Risen Son Blvd
Council Bluffs, IA 51503

Date of Monitoring Visit:

October 25, 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 were provided by the Program at the time of the on-site.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	6
Number of tenants with cognitive disorder:	16
Total Population of Program at time of on-site	22
TOTAL census of Assisted Living Program	22

Tenant/Family Satisfaction Results – Private interviews were held with two tenants. The best thing about the program was the kind staff and assistance was available. Staff members were reported to respond immediately to requests for assistance. Housekeeping was completed to the tenants' satisfaction. The food was described as good. During the course of the monitoring visit, staff were observed to be courteous and caring to the tenants, and tenants responded positively. Medication administration was done in a professional manner. Tenants appeared to enjoy socialization at the noon meal and seemed to enjoy the food. Common areas and apartments were clean and free of clutter.

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

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

A. Evaluation of Tenant

Monitoring Observation: Tenant #1, a 91 year-old, was admitted on 3-4-12 and had diagnoses of: Dementia, Anemia, History of Anemia, History of Hypokalemia, Hyperlipidemia, History of Chronic Renal Failure, Arteriosclerotic Cardiovascular Disease, Gastroesophageal Reflux Disease, Osteoporosis, and History of Colitis. Tenant #1 was staged at 5.4 on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline.

Nurse's notes for Tenant #1 documented the following: 7-31-12, Tenant #1 found on floor, had a noticed decline in strength. Physician was contacted about starting Physical Therapy (PT) again as well as an order for Acetaminophen for back and knee pain. 8-1-12, order for PT and Acetaminophen received. 8-9-12, Tenant #1 had fallen after getting self out of bed. 8-12-12, Ativan was given for agitation. 8-13-12 Seroquel 50 milligrams (mg) was ordered three times a day, a change from 50 mg each morning and 100 mg at bedtime. 8-16-12, found on floor, with an abrasion to the back. 8-22-12 Staff continued to state Tenant #1 was uncooperative with cares, hitting, kicking and yelling at staff. Seroquel was increased and a urinalysis was obtained. 8-24-12, Cipro was ordered for a urinary tract infection (UTI).

Nurse's notes 8-25 and 8-26-12 indicated fluids were encouraged. 9-18-12, alarm sounded, Tenant #1 found on floor. 9-22-12, Tenant #1 was agitated when being toileted and began to swing arms at staff, but hit the wall instead, causing a skin tear. 9-27-12, alarm sounded, Tenant #1 found on floor. 9-29-12, assist of two for activities of daily living, uncooperative, Ativan given. 10-18-12, Tenant #1 found sitting on floor. Nurse's notes documented Tenant #1 being found on the floor or falling six times between 7-31-12 and 10-18-12.

Behavior records dated 7-20-12 to 8-5-12 indicated Tenant #1 tried to hit staff several times, yelled, and called staff names. Behavior records dated 8-10-12 to 8-30-12 documented Tenant #1 was a two-person assist with transfers and Tenant #1 was unable to bear weight. Aggressive behaviors were also documented. Behavior records beginning 9-7-12 no longer documented two-person transfers, and there were shifts where no behaviors were noted.

The PT discharge summary indicated Tenant #1 was discharged from PT on 8-30-12 with a recommendation that Tenant #1 be discharged to long-term care. In an interview with the Program Nurse, she stated social services had discussed transfer from assisted living with Tenant #1's family, although there was no documentation of the discussion. The Program Nurse stated Tenant #1 was no longer a two-person transfer and had shown improvement, so was no longer being considered for transfer out of the program.

Evaluations of function, cognition, and health were completed on 6-3-12 and 9-11-12 for Tenant #1. Nurse's notes and behavior records documented six falls, aggressive behavior, weakness resulting in a PT consult, and documented two-person assists. Seroquel orders were changed. PT recommended transfer to long-term care. Evaluations were not done with changes of condition, when PT was started or discontinued, with continued aggressive behaviors despite Seroquel and Ativan, with a UTI, with the documented need for assist of two staff, and the return to an assist of one. Evaluations were not completed with changes of condition.

Tenant #2, a 90 year-old, was admitted on 5-6-11 and had diagnoses of: Dementia, Left Temporal Lobe Infarct, Hypertension, and Overactive Bladder. Tenant #2 also had a positive screening for Methicillin Resistant Staphylococcus Aureus (MRSA). Tenant #2 was staged at 4.6 on the GDS which indicated moderate to moderately severe cognitive decline. Tenant #2 was admitted to hospice on 11-30-11 for debility and according to the program, failure to thrive.

Visit notes from a physician dated 7-25-12 documented Tenant #2 was seen for aggressive behavior. Risperdal was started at a dosage of 0.25 mg on 7-13-12, was increased to 0.5 mg on 8-24-12 and 1 mg on 9-18-12. Hospice progress notes dated 8-16-12 and 8-20-12 documented Tenant #2 was agitated and aggressive, yelling and coming at an aide. Progress notes dated 8-27-12 documented Tenant #2 refused to come out of the apartment for meals for the past week. Behavior monitoring records dated 8-22-12 to 9-1-12 indicated Tenant #2 was yelling at staff about a chair cushion. Behavior records 8-22-12 to 9-8-12 documented Tenant #2 did not come out of the apartment for meals. Hospice notes dated 9-17-12 revealed aggressive behaviors had escalated. Behavior records 9-21-12 to 10-1-12 documented Tenant #2 was yelling and cursing. The behavior record for 10-10-12 documented Tenant #2 hit staff in the stomach.

Evaluations were completed as part of a nurse review on 8-10-12, but were not completed after medication changed on 8-24-12 and 9-18-12 and continued aggressive behaviors. Nurse's notes documented a conversation between the nurse and the Power of Attorney (POA) for Tenant #2 on 9-18-12, which indicated an increase in medication would be beneficial. The nurse review of 8-10-12 indicated Tenant #2 was no longer yelling and was not resisting cares; however documentation after 8-10-12 indicated behaviors continued or increased. Evaluations were not completed with a change in condition.

Tenant #3, an 89 year-old, was admitted on 4-18-12 and had diagnoses of: Alzheimer's Dementia, Acute Meniscal Tear, Depression, History of Breast Cancer, and Urinary Incontinence. Tenant #3 was staged at 5.4 on the GDS which indicated moderately severe cognitive decline. The forms indicated the initial assessment of function, cognition, and health was completed by a Licensed Practical Nurse (LPN). The pre-admission assessment form and the cognitive rating scale were also signed by a registered nurse (RN). The initial evaluations of function, cognition, and health were not completed by a health or human service professional.

An initial evaluation was not completed by a health care or human service professional. Evaluations were not completed with a change of condition.

Regulatory Insufficiency: A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. (IAC r. 481-69.22(1))

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: The service plan for Tenant #1, dated 9-11-12, indicated reassurance and redirection were to be used for behaviors. The service plan did not identify specific interventions for the yelling and hitting. The service plan identified Tenant #1 had a pressure pad on the bed to alert staff when Tenant #1 got up. Nurses notes dated 8-6-12 indicated staff members were instructed to check on Tenant #1 "more frequently" and 12 entries in the nurse's notes 8-1-12 to 10-21-12 documented Tenant #1 was to be encouraged to use the call light.

The service plan only identified the pressure pad as a fall intervention. The service plan dated 9-11-12 was not signed by the tenant or the tenant's legal representative.

The clinical record for Tenant #2 includes documentation of aggressive behaviors, refusal to come out of the apartment, and increasing the dosage of medication for outbursts that dated from July through October 12, 2012. In physician visit notes dated 10-17-12, the physician documented speaking with staff members about interventions for Tenant #2 related to behavior and refusal of personal cares. The current service plan dated 5-6-12 and reviewed 8-10-12 indicated for behaviors staff members were to offer reassurance and redirect as needed. The service plan did not identify specific interventions related to aggressive behaviors and refusal of cares. The service plan did not identify care needs related to a diagnosis of MRSA.

The service plan indicated Tenant #3 needed assistance with bathing and medications. The Resident Assessment Summary and Service Plan were dated 4-18-12, the date of admission to the assisted living program. The initial service plan indicated the assessment was completed by an LPN, and the LPN signed the service plan as the "licensed nurse." RNs signed the service plan as center director and director of nursing. The service plan was not updated within 30 days of admission. The service plan lacked documentation of Tenant #3's preference for a nursing facility.

Service plans did not meet identified needs of tenants, were not completed by a health care or human service professional, were not updated at 30 days, were not signed by the tenant or representative, did not identify outside service providers, and did not identify a nursing facility preference.

Regulatory Insufficiency: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

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 not 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; and (e) 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. Staffing

Monitoring Observation: Staff #2 was hired as a Certified Medication Aide (CMA) on 6-2-11. Staff #3 was hired 12-4-03 as a CMA. Staff #4 was hired 9-10-07 as a Certified Nursing Assistant (CNA). Staff #5 was hired 2-6-06 as a CNA. Staff #6 was hired 6-30-12 as a CMA but did not begin working in the assisted living program until July 2012 according to the Director of Nursing.

The Program Nurse began employment in the assisted living program in July 2012. During the onsite visit, Staff #3 was observed passing medications and performing a blood sugar check. During interview, Staff #3 and #4 stated they assisted tenants with personal cares such as bathing. Staff training records for Staff #2, #3, #4, and #5 lacked documentation by the current nurse of nurse-delegation related to personal and health-related tasks.

Regulatory Insufficiency: Any nursing services shall be provided in accordance with Iowa Code chapter 152 and 655—Chapter 6. (IAC r. 481-67.9(5))

D. Dementia-Specific Education for Program Personnel

Monitoring Observation: Staff #2 was hired as a CMA on 6-2-11, Staff #3 was hired as a CMA 12-4-03, Staff #4 was hired 9-10-07 as a CNA and Staff #5 was hired 2-6-06 as a CNA. The program identified itself as dementia-specific by dedication. Staff training records for Staff #2, #3, #4, and #5 lacked documentation of eight hours of annual dementia training.

Regulatory Insufficiency: All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. (IAC r. 481-69.30(3))

E. Transportation

Monitoring Observation: The program identified Staff #1 used the program van to transport tenants as a part of the employment responsibilities. Staff #1's driver's license was an Iowa Class C, non-commercial license.

The State of Iowa requires persons to have a class D (Chauffeur's) driver's license with endorsement 3, allowing non-commercial use of a vehicle when transporting less than 16 passengers for hire.

Regulatory Insufficiency: When transportation services are provided directly or under contract with the program, the driver shall have a valid and appropriate driver's license or commercial driver's license as required by law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated. (IAC r. 481-69.33(6))