IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

November 27, 2012

Complaint/Incident Intake #: 41078-C
41080-I

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

RE: Final Complaint/Incident Investigation and Recertification Monitoring Evaluation Report – Senior Suites of Urbandale, Urbandale, IA

Dear Ms. Luttenegger:

Enclosed is the **Final Complaint/Incident Investigation and 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 Complaint/Incident Investigation and 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, 2012** through **November 1, 2014**.

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 Complaint/Incident Investigation and Recertification Report

Assisted Living Program:

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

Complaint/Incident Intake #:

41078-C
41080-I

Date of Complaint/Incident Investigation:

October 9, 2012

Monitor(s):

Lori Miner, RN BSN
Joyce Kix, RN

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:	33
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	35
TOTAL census of Assisted Living Program	35

Program History – There were no regulatory insufficiencies during this certification period.

Tenant/Family Satisfaction Results – A community meeting was held with 25 tenants. They reported the program was neat, clean and safe and they liked everything at the program. Nursing staff responded to calls within minutes and provided excellent care. The tenants had some concerns regarding food not always being served hot. The tenants were generally satisfied and would recommend the program to friends.

Complaint/Incident Investigation – The Complaint/Incident investigators made the observations detailed in the following areas:

A. Evaluation

Complaint/Incident Allegation 41080-I and 41078-C: The program reported a tenant fell, sustained a head injury and later died at the hospital. It was alleged the program failed to assess and intervene after a tenant fell two different times with injuries resulting in bruising on the head and neck.

- Monitoring Observation: Incident reports for the prior three months were reviewed.

  Tenant #1, a 93 year old, was admitted 5-1-12 with diagnoses of: Acute Stress Disorder, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Depression and Hypertension. Tenant #1 scored 28 of 30 questions correctly on the Mini-Mental State Examination (MMSE) which indicated no or mild cognitive decline. The service plan of 8-28-12 documented Tenant #1 was independent with transfer and ambulation using a wheeled walker and was continent of bowel and bladder independently. An Incident Report dated 9-24-12 documented Tenant #1 fell sustaining an injury to the right occipital area. Neurological checks were completed by the Staff #1, registered nurse (RN), every 15 minutes for one hour and then every 30 minutes for two hours and then every hour for four hours. During these assessments, Tenant #1 was complaining of a headache but performing activities of daily living independently. A Nurse's Note on 9-25-12 documented Tenant #1 was feeling better but was bruised at the right ear and below down the neck and had

redness at the right eye. It was also noted that Tenant #1 took Coumadin (a blood thinner which can make the bruising more extensive). The family and physician were notified of the fall and resultant headache. The physician ordered Tylenol 650 milligrams (mg) three times a day.

An incident report dated 10-2-12 at 12:15 p.m. documented Tenant #1 was found lying on the floor in his/her apartment. Initially Tenant #1's blood pressure was 132 over 42 sitting and 88 over 40 standing. (This finding indicates orthostatic hypotension) Staff #2, a certified medication aide (CMA) assessed Tenant #1's blood pressure one hour after the fall but did not check both sitting and standing blood pressures. The reading was 128 over 50 but did not indicate what position the tenant was in. The note also documented that Staff #1 RN assessed the tenant; however, the clinical record contained no documentation of that assessment.

The clinical record lacked evidence of completion of any neurological checks completed by program staff. Staff #3, RN documented at 3:25 p.m. on 10-2-12 that Tenant #1 complained of a headache. Staff #3 noted that Tenant #1 had taken routine Tylenol and Tramadol at 12:00 noon. Tenant #1's blood pressure at 3:25 p.m. was documented at 155 over 52. No further treatment or assessment was documented.

The Nurse's Note completed by Staff #2 CMA (with no time indicated) 10-2-12 documented Tenant #1 was found in his/her apartment seated in a recliner and "not very responsive". The note indicated that vital signs were taken. Tenant #1 had difficulty raising his/her head, walking and had been incontinent of urine. An ambulance was called and Tenant #1 was transported to the emergency room. Later the family reported that Tenant #1 had sustained a brain bleed. Tenant #1 died on 10-3-12 at 1:30 a.m.

The program failed to complete and document appropriate health evaluations after Tenant #1 sustained two falls, exhibited orthostatic blood pressure changes and complained of a headache.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall 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. Policies and Procedures

- Monitoring Observation: The program policy for Neurological Assessment dated 10-6-10 directed to treat any un-witnessed accident as though a head injury had occurred and complete neurological checks at the time of the initial assessment and at least every shift for three days and then at least once daily for 10 days. The procedure for neurological assessment when a head injury is confirmed directed for checks every 15

minutes times four, every 30 minutes times four, every hour for four hours, every shift for two days and then once a day for 10 days.

An Incident Report dated 9-24-12 documented Tenant #1 fell sustaining an injury to the right occipital area. Neurological checks were completed by the RN every 15 minutes for one hour and then every 30 minutes for two hours and then every hour for four hours. Physical assessments were also documented on 9-25-12 at 8:30 a.m. and on 9-26-12 at 8:30 a.m. and 12:00 noon. No further neurological assessments were documented.

An incident report dated 10-2-12 at 12:15 p.m. documented Tenant #1 was found lying on the floor in his/her apartment. The clinical record lacked evidence of completion of neurological checks for an un-witnessed fall.

The program failed to follow written policies and procedures for witnessed and un-witnessed falls with potential for head injury.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by the program. (IAC r 481-67.2)

C. Staffing

- Monitoring Observation: The personnel files for four certified nurse aides (CNAs) were reviewed. The files for Staff #2, #4, #5 and #6, all CNAs, lacked documentation of completion of delegation by the RN. The clinical record of Tenant #1 identified Staff #2 completed neurological checks. Staff #1, the delegating RN, reported she had not completed delegation of neurological assessment with Staff #2. The RN thought she had done the delegations for other tasks but could not provide documentation for any employees at the time of the survey.

- 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))

E. Nurse Review

- Monitoring Observation: During interview, Staff #3, RN, stated that on 10-2-12 at about 3:35 p.m. she evaluated Tenant #1 following Tenant #1's report of a headache after a fall. Staff #3 said she checked the tenant's pupils, hand grips and eye coordination. Staff #3 stated that she placed a cold compress on Tenant #1's forehead. Staff #3 did not document the assessment or the intervention.

  At approximately 5:15 p.m. Staff #3, was informed of a change in Tenant #1's condition. She went to Tenant #1's apartment and found the tenant able to speak but distant. The tenant's head was slumped forward and he/she was slow to answer. Tenant #1 was too weak to walk to the bathroom and had been incontinent in the recliner. Staff #3 stated it was unusual for Tenant #1 to be incontinent. Staff #3 and

Staff #4, CNA, assisted Tenant #1 to the bathroom via wheelchair and had to totally lift the tenant's weight. Tenant #1 was taken by wheelchair to the activity room to await the ambulance's arrival.

An undated note found in Tenant #1's clinical record signed by Staff #1, regarding family notification, lacked documentation of the date or the time of the entry.

A Nurse's note dated 10-2-12 written by Staff #2 found in the clinical record regarding a change in Tenant #1's condition lacked documentation of the time of the entry.

The clinical record lacked completion of documentation by the RN of her assessment with the change in Tenant #1's condition. All documentation completed by program personnel failed to identify the date and time of the entry.

- Regulatory Insufficiency: To assess and document 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))

- Regulatory Insufficiency: 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 (4))