IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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January 29, 2013

Complaint/Incident Intake #: 41502-I

Ms. Sharon McRae, Director
Bryhl Assisted Living
7511 University Avenue
Cedar Falls, IA 50613

RE: Final Complaint/Incident Investigation and Recertification Monitoring Evaluation Report – Bryhl Assisted Living, Cedar Falls, IA

Dear Ms. McRae:

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 **S0251** with effective dates of **February 15, 2013** through **February 14, 2015**.

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 & Recertification Monitoring Report

Assisted Living Program: **Complaint/Incident Intake #:** 41502-I

Sharon McRae, Director of Assisted Living
Bryhl Assisted Living
7511 University Avenue
Cedar Falls, IA 50613

Date of Complaint/Incident Investigation/Monitoring Visit:

December 3 & 5, 2012

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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:	40
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	40
TOTAL census of Assisted Living Program	40

Tenant/Family Satisfaction Results – A community meeting with five tenants was held. The tenants requested some improvements with housekeeping including improved vacuuming, improved bed making, mopping of the floors and consistency with dusting. The tenants said the housekeeping services were not as good on the weekends. There were no issues with maintenance or laundry. At times the ice machines were broken or missing from the large lounge. Nursing services were available and the majority of the time staff responded within two to three minutes. There were two occasions where it took staff longer to respond. The tenants requested more help and there was staff turnover. One tenant said the staff did a fantastic job trying to please the tenants and staff bent over backwards to please everyone. The tenants received the services expected when the occupancy agreement was signed. They said the majority of the staff was good and staff had three days of training. They requested several improvements with the food including less canned soups, more variety of vegetables and butter for the rolls. There was too much sugar in or on the foods served and there was concern for diabetic diets. Fruit was requested for dessert; however, not canned fruit. Staff re-heated food if needed and at times the food cooled down by the time the tenants received it. The salad bar was enjoyed and tenants could ask for more food; however, there was too much food served. Activity calendars were provided and there were sufficient activities offered. They enjoyed Bingo but requested additional prizes besides fruit and candy. The tenants felt safe and made their own decisions. A suggestion was made to improve the lighting where tenants parked their cars and there were ruts in the cement by entrance eight which made it difficult to navigate with an assistive device. The tenants were generally satisfied with the Program and the majority of the tenants would recommend the Program to others.

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

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

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

A. Other

Complaint/Incident Allegation: The Program reported a tenant made a suicide attempt.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #1, a 74 year old, was admitted on 10-25-12 and diagnoses included: Hypothyroidism, Hypertension (HTN), Anxiety and Depression. Tenant #1 scored low risk on the cognitive evaluation. The service plan indicated Tenant #1 was independent with activities of daily living (ADLs) including medication administration.

  According to a Tenant Incident Report, on 11-2-12 at 3:00 p.m. during routine cleaning of Tenant #1's apartment staff found a note written by Tenant #1. The note indicated a possible suicidal ideation. Tenant #1 was sent earlier that morning to the emergency room (ER) for altered neurological status and low blood pressure. The ER was notified and the note was faxed for hospital information and assessment. The internal investigation revealed Tenant #1 appeared to be adjusting well to the move to Assisted Living (AL), was engaging in conversation with other tenants and was happy to be there. Tenant #1 was in good spirits and there was no evidence of depression or change in mood. Tenant #1 was assessed at 10:45 a.m. prior to finding the note. Tenant #1's blood pressure was 88/60 and pulse was 64. Tenant #1 had difficulty with transfers and was weak. Tenant #1 was alert but the response was delayed. Tenant #1 was found sitting in the recliner, was incontinent of bowel movement (BM), unable to transfer and complained of dizziness. Tenant #1's family and physician were notified.

  The Program completed an investigation regarding the incident on 11-2-12 with Tenant #1. Tenant #1 moved to the AL from the Independent Living (IL) and required no additional services and was independent in all ADLs including medication administration. On 11-1-12 staff reported Tenant #1 had one episode of loose stools. Tenant #1 wanted to know what to take for it, no treatment medications were recommended due to only having one episode. On 11-2-12 at approximately 8:00 a.m. staff checked on Tenant #1. Staff removed garbage and assumed staff had just woken Tenant #1 up and Tenant #1 verbally responded Tenant #1 was awake. At 10:30 a.m. staff approached the registered nurse (RN) with concerns something was wrong with Tenant #1. Tenant #1 was not able to transfer from the recliner and was not answering staff in Tenant #1's usual manner. The RN assessed Tenant #1 and Tenant #1 was observed seated/leaning backwards in the recliner. Tenant #1 was alert but verbal responses were delayed. Tenant #1 was disoriented to time and was noted to be incontinent of BM which was not typical for Tenant #1. Vital signs revealed Tenant #1 was hypotensive. Other vital signs were within normal limits and afebrile. Tenant #1 reported some tingling down the right arm. Tenant #1 had diarrhea yesterday and did not feel well. Grasps were equal but weak. Facial features were symmetrical and Tenant #1 had complaints of a headache. Tenant #1 was asked if Tenant #1 would be willing to be evaluated in the ER and Tenant #1 agreed. Tenant #1 was sent to the ER at 11:00 a.m. Tenant #1 did not mention or report any suicidal plan. Tenant #1's family and physician were updated.

On 11-2-12 at 3:00 p.m. staff reported to the RN that during cleaning of Tenant #1's apartment a note was found indicating a possible suicide. The pendant and car keys were on top of the note. The ER was contacted and given information regarding the note and a copy was faxed to the ER. Tenant #1's family was contacted and left a message to call the Program for new and updated information. An incident report was completed. On 11-2-12 information from the hospital indicated it was a suicide attempt by medication overdose and Tenant #1 was in the intensive care unit (ICU). The medication bottles in the apartment were found and all were empty but one. Staff interviews reported no information regarding depression or verbalization of intent to harm self. Staff reported Tenant #1 seemed to be happy in the apartment. Tenant #1 was observed to have engaged in conversation with other staff, came out to meals, did not isolate self in the apartment and was articulate in wanting to get the apartment further arranged. No indication was found to support any symptoms of depression prior to suicide attempt.

Staff #1 said she knocked on Tenant #1's door at 8:30 a.m. and Tenant #1 was sitting in the chair and responded back to Staff #1. Staff #1 said as long as the tenant responded when staff checked they were not supposed to wake anyone up. At 10:00 a.m. Tenant #1's friend asked for help to get Tenant #1 up. Staff #1 told Staff #2 who went right in to Tenant #1's apartment.

Staff #2 said Tenant #1 was independent in all cares and medications. Staff #2 was the Medication Manager the day of the incident. Tenant #1's friend came over and asked Staff #1 for assistance. Staff #1 was busy so Staff # 2 went to Tenant #1's apartment. Tenant #1 was in a chair and Staff #2 asked if Tenant #1 was alright. Tenant #1 answered but was slow and delayed in responses. Staff #2 could tell something wasn't right. She remembered asking Tenant #1 if Tenant #1 had been up and Tenant #1 said Tenant #1 had gotten up to go to the bathroom. Tenant #1's friend was not in the room during this time. Staff #2 left the apartment and went to get the Assistant Director.

Staff #3 said about 3:00 p.m. on a Friday, she went to Tenant #1's apartment to clean the room. When she went into the kitchen area, she saw a note on the table. Thinking the note was intended for staff; she read the note and then took it to the Assistant Director's office. Car keys and a car title were next to the note. After giving the note to the Assistant Director, Staff #3 went back to Tenant #1's apartment and finished cleaning the room. Staff #3 normally worked on second floor and Tenant #1 resided on first floor. Staff #3 had only introduced herself to Tenant #1 one time and served Tenant #1 a meal another time. Staff #3 said Tenant #1 was cheerful and happy to have moved from IL because Tenant #1 knew some of the AL tenants.

The Assistant Director said at 9:30 a.m. Staff #2 stopped by and said the Assistant Director needed to come in and look at Tenant #1. The Assistant Director went to the door and knocked and noticed a slurred and distant response. Tenant #1 was in the recliner by the window and Tenant #1 was slouched forward in the chair and had a dazed look on Tenant #1's face. The Assistant Director said Tenant #1 had delayed response which was not typical. The Assistant Director did an assessment of Tenant #1. The Assistant Director asked Tenant #1 to be evaluated and Tenant #1 agreed. Tenant #1 was taken out to the hospital. Staff came to see the Assistant Director after

3:00 p.m. and had found a note in Tenant #1's apartment on the routine cleaning day. The Assistant Director read the note and notified the ER immediately with the new information. The Assistant Director said Tenant #1 had visited with other tenants that sat at the same table, there had been no concerns expressed to staff and no plan to harm self. One staff saw Tenant #1 in the morning and verbalized Tenant #1 was up. Tenant #1 went to the hospital, then to ICU, then to behavioral health and was discharged to a nursing facility. Tenant #1 was then transferred to the hospital and was hospitalized at the time of the onsite.

The Program completed an incident report and reported the incident to the Department.

Review of the Program's investigation, incident report, staff interviews and review of Tenant #1's file did not reveal any previous comments Tenant #1 had made to harm Tenant #1. At the time of incident Tenant #1 had recently moved from IL to AL and evaluations were completed prior to taking occupancy. Tenant #1 was independent with personal cares including medication administration.

- Regulatory Insufficiency: None noted.

B. Evaluation of Tenant

Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

Tenant #2, a 93 year old, was admitted on 6-4-12 and diagnoses included: Left Hip Fracture with Surgical Repair, HTN, Hyperlipidemia, Fibromyalgia, Bilateral Hip Replacement, Stress Incontinence and Lumbar Spondylosis. Within 30 days of occupancy a health evaluation was completed on 7-3-12; however, cognitive and functional evaluations were not completed.

Tenant #3, an 89 year old, was admitted on 9-24-12 and diagnoses included: Pacemaker, Coronary Artery Bypass Grafting, Diabetes Mellitus Type II, History of Gangrene Lower Left Extremity, HTN, Hypothyroidism, Polymyalgia Rheumatica and Peripheral Vascular Disease. Within 30 days of occupancy a health evaluation was completed on 10-24-12; however, cognitive and functional evaluations were not completed.

Tenant #4, a 91 year old, was admitted on 9-12-12 and diagnoses included: Parkinson's Disease, HTN, Kidney Cancer with Nephrectomy and Status/Post Cerebral Vascular Accident with Left Sided Weakness. Within 30 days of occupancy a health evaluation was completed on 10-12-12; however, cognitive and functional evaluations were not completed.

Review of tenant files indicated functional and cognitive evaluations were not completed within 30 days of occupancy.

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))

C. Service Plans

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #1's file was reviewed. According to an evaluation dated 9-27-12, Tenant #1 did best around other people, just not alone. The evaluation indicated Tenant #1 had a history of Depression. Tenant #1 moved to be around people and had an appointment with a counselor in two to three weeks. According to a physician visit note (encounter date 9-14-12), Tenant #1 had started to have a lot of anxiety, went to the ER for an anxiety attack and felt overwhelmed by daily issues. Tenant #1 was referred to a mental health specialist, according to the visit note. The service plan reflected Tenant #1 would see a counselor as recommended by the physician. The service plan did not reflect the history of Depression, anxiety, feeling of being overwhelmed and not wanting to be alone. The service plan did not indicate the identified needs of Tenant #1.

  Tenant #2's file was reviewed. The service plan was not updated within 30 days of occupancy. A Nurse Review form was completed on 7-3-12 and the form indicated the service plan was reviewed and updates were made if necessary. The service plan was signed appropriately prior to taking occupancy; however, the service plan was not updated within 30 days of occupancy with appropriate signatures. Tenant Care Notes dated 10-4-12 indicated Tenant #2 was tearful and agitated regarding forgetting an appointment and wished the Lord would take Tenant #2. Tenant Care Notes from 10-17-12 to 11-16-12 also indicated Tenant #2 had over the counter medications in Tenant #2's possession and had complaints of abdominal pain. The service plan did not reflect the behaviors and abdominal pain. The service plan did not indicate the identified needs of Tenant #2.

  Tenant #3's file was reviewed. The service plan was not updated within 30 days of occupancy. A Nurse Review form was completed on 10-24-12 and the form indicated the service plan was reviewed and updates were made if necessary. The Nurse Review form indicated the service plan had been adjusted. The service plan reflected an update made on 10-24-12. Tenant #3 did not sign the service plan within 30 days of occupancy. The service plan was signed appropriately prior to taking occupancy; however, the service plan was not updated within 30 days of occupancy with appropriate signatures.

  Tenant #4's file was reviewed. A Nurse Review form was completed on 10-12-12 and the form indicated the service plan was reviewed and updates were made if necessary. The service plan was signed appropriately prior to taking occupancy; however, the service plan was not updated within 30 days of occupancy with appropriate signatures. Tenant Care Notes dated 11-8-12 indicated Tenant #4 was assessed for increased depression; staff and Tenant #4 reported episodes of crying recently. Tenant #4 was unsure about why crying more often other than the gradual

loss of mobility and falls. According to Tenant Care Notes dated 11-19-12, there was a new order for physical therapy (PT). The service plan did not reflect PT services. The service plan did not reflect episodes of crying and interventions related to the behavior. The service plan was not updated within 30 days with signatures and did not indicate the identified needs of Tenant #4.

- 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: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))