IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

May 9, 2013

Ms. Kerri Kofoot, Interim Director
Riverview Terrace Assisted Living
1501 St. Luke Drive
Spencer, IA 51301

RE: Final Recertification Monitoring Evaluation Report – Riverview Terrace Assisted Living, Spencer, IA

Dear Ms. Kofoot:

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 **S0040** with effective dates of **April 2, 2013** through **April 1, 2015**.

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:

Kerri Kofoot, Interim Director
Riverview Terrace Assisted Living
1501 St. Luke Drive
Spencer, IA 51301

Date of Monitoring Visit:

March 27th and 28th, 2013

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.

General Population Program	
Number of tenants without cognitive disorder:	51
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	56
TOTAL census of Assisted Living Program	56

Tenant/Family Satisfaction Results – A meeting was held with 17 tenants. The best thing about the program was the great people, having someone to take care of you, and having meals served. The housekeeping was completed to the tenants' satisfaction in apartments and common areas. The building was recently painted and new carpeting was installed. Tenants used a call button to request assistance and staff was reported to respond in less than five minutes. Staff provided good care and treated the tenants kindly and respectfully. The food was described as mostly good with a variety of foods offered. Food was not always served hot and the tenants requested fewer "tater tots." There were enough activities offered and no suggestions were given for improvement. The tenants reported feeling safe and would generally recommend the program to others.

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 76 year-old, was admitted on 9-6-11 and had diagnoses of: Bipolar Disease, Hypertension (HTN), Diabetes, Atrial Fibrillation, Osteoporosis, Asthma, and Paranoia. Tenant #1 underwent a mastectomy on 3-12-13 for Breast Cancer. Registered Nurse (RN) #1 documented a visit in the hospital on 3-15-13. At that time, Tenant #1 was planned to be discharged from the hospital to the nursing home for continued care. RN #1 documented in nurse's notes on 3-18-13 Tenant #1 refused to go to the nursing home, and the hospital reported Tenant #1 was ambulatory and would have a drain in place at the surgical site. At 2:00 p.m. on 3-18-13 RN #1 documented on a flow sheet the condition of the surgical dressing and the fluid in the drain. The nurse's notes dated 3-18-13 contained documentation by Licensed Practical Nurse (LPN) #1 of a nursing assessment timed at 3:30 p.m. Functional, cognitive, and health evaluations were not completed upon return to the program with a change of condition, postoperative mastectomy with a drain in place.

Nurse's notes dated 3-19-13 documented by LPN #2 indicated clarification was requested from the physician regarding dressing changes to the surgical wound and care of the dressing during a shower.

Nurse's notes dated 3-21-13 indicated a Personal Service Attendant (PSA) reported to LPN #1 a blood clot was present in the drain bag. Nurse's notes documented LPN called RN #1 and was instructed to notify the physician. LPN #1 documented the physician's office was notified and instructions were received to "strip" the drain tubing to get clots out. LPN #1 documented she talked with LPN #2 who knew how to "strip" the tubing, so the LPN's proceeded to get clots out of the drain tubing.

In nurse's notes dated 3-21-13, LPN #1 documented concerns about Tenant #1 taking Hydrocodone as needed. Tenant #1 requested a pain pill every time someone checked in on Tenant #1 according to the nurse's notes. LPN #1 documented requesting an evaluation from physical/occupational therapy (PT/OT) to assist with moving and walking.

Nurse's notes dated 3-22-13 documented Tenant #1 refused to take self to the bathroom, refused to care for the drain at the surgical site, refused to get up, and refused some medications. When LPN #1 entered the apartment, Tenant #1 refused to use the bathroom and was incontinent of urine. LPN #1 documented Tenant #1 had an oximetry reading of 89%, but a respiratory rate was not obtained. After getting Tenant #1 "up and moving" the oximetry reading was 94%, but no respiratory rate was obtained. RN #1 documented a visit on 3-22-13, but did not include evaluations of function, cognition, or health.

RN #2 documented evaluations of function, cognition, and health on 3-26-13, eight days after Tenant #1 returned to the program following surgery for breast removal.

Evaluations of function, cognition, and health were not completed by an RN following a change of condition.

Tenant #6, a 93 year-old, was admitted on 6-1-09 and had diagnoses of: HTN, Arthritis, Parkinson's Disease, Hypothyroidism, and Diabetes. Tenant #6 was admitted to the hospital on 2-3-13 with weakness and returned to the program on 2-5-13. Functional, cognitive, and health evaluations were completed on 2-5-13 by RN #2.

Nurse's notes dated 2-9-13 documented Tenant #6 had vomited and was sitting on the walker asleep. LPN #2 tried to awaken Tenant #6; Tenant #6 only opened eyes and complained of chest discomfort. Nitroglycerin spray was administered. Tenant #6 continued to be silent. Tenant #6 had an oximetry reading of 86%; the respiratory rate was not checked. Tenant #6 also had a temperature of more than 103 degrees. The ambulance was called and Tenant #6 was admitted to the hospital. According to a physician's progress note and a PT note, Tenant #6 was admitted to the hospital with Pneumonia. Nurse's notes dated 2-14-13 indicated Tenant #6 would be returning to the program on 2-15-13. A functional and health evaluation form was completed on 2-14-13.

A cognitive evaluation was contained in the clinical record however, it was not dated. According to RN #2, Tenant #6 was evaluated to determine if Tenant #6 met criteria to return to the program. The evaluations indicated Tenant #6 was on continuous oxygen while hospitalized. The health evaluation did not document a respiratory rate as indicated on the health form. Pneumonia was circled on the respiratory portion of the form, but Tenant #6's breathing including respiratory rate, cough, shortness of breath either at rest or with activity, or lung sounds were not assessed. Nurse's notes indicated Tenant #6 was not discharged from the hospital until 2-18-13. LPN #2 documented medication changes as well as blood pressure of 95/72 and an oximetry reading of 92% on room air with wheezing in the upper lobes.

An incident report dated 2-19-13 at 4:05 a.m. documented Tenant #6 got up to go to the bathroom, turned around, lost balance and fell. The incident report documented Tenant #6 had a laceration on the left shin, a pulse rate of 75, a respiratory rate of 93 which is above normal, and blood pressure of 122/86. Tenant #6's temperature was not checked. At 10:30 a.m., LPN #2 found Tenant #6's blood pressure to be 88/76 and oximetry reading to be 94% on room air. A respiratory rate was not documented by LPN #2. The incident report indicated Tenant #6 would be awakened twice during the night and the physician would be contacted to obtain a PT/OT referral.

Nurse's notes dated 2-20-13 by LPN #1 indicated Tenant #6 appeared to not feel well, was extremely tired, and was falling asleep.

The service plan indicated Tenant #6 was started on PT on 2-21-13.

An incident report dated 2-27-12 at 6:30 a.m. documented Tenant #6 turned on the call light and was found on the floor. It was documented it took four persons and two gait belts to get Tenant #6 off the floor. The incident report documented Tenant #6 had a respiratory rate of 26 and a blood pressure of 136/80. LPN #1 documented Tenant #6 had complaints of right and left knee pain with movement within normal limits. LPN #1 also documented Tenant #6 was confused.

Evaluations of function, cognition, and health were not completed by an RN upon Tenant #6's return to the program following hospitalization for pneumonia, two falls, the initiation of PT/OT, and continued weakness, and confusion, a change of condition.

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: Tenant #1 returned to the program on 3-18-13, following a mastectomy for Breast Cancer. The service plan was updated on 3-18-13 to include assistance with ambulation, and PT/OT was added on 3-22-12. Changes were made to bathing needs to include protection of the surgical dressing and drain during showers on 3-20-13. Care of the surgical drain was added to the service plan on 3-18-13. The service plan was updated but was not based on evaluations of function, cognition, or health.

The service plan for Tenant #6 was dated 2-6-13 with a notation the service plan had been reviewed on 2-14-13 with no changes at that time. The service plan for Tenant #6 was updated on 2-19-13 for staff assist to the bathroom twice during the night; on 2-21-13 to indicate PT had been ordered; on 2-27-13 for triangle bed assist device placement on the bed, and on 3-4-13 to remind Tenant #6 to go for a walk twice a day. The service plan updates were not based on evaluations of function, cognition, and health. Tenant #6 did not sign the service plan after 2-6-13.

Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(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))

C. Nurse Review

Monitoring Observation: Tenant #2, a 97 year-old, was admitted on 7-2-11 and had diagnoses of: HTN, Coronary Disease, Hiatal Hernia, Diverticulosis, Heart Murmur, Gastroesophageal Reflux Disease (GERD), Lymphoma, and Chronic Pleural Effusion with chest drainage tube in place. The program provided assistance with personal cares. The nurse review dated 2-6-13 lacked an evaluation of health every 90 days.

The review indicated Tenant #2 was weak and a PT/OT evaluation was requested. PT/OT was discontinued on 2-25-13 according to the service plan. A nurse review was not completed at the end of therapy to determine its effectiveness or to determine if other services were needed.

Tenant #3, a 103 year-old, was admitted on 4-10-99. The medication profile indicated Tenant #3 was on medications for HTN, Urinary Frequency, Congestive Heart Failure, GERD and Arthritis. Tenant #3 was staged at 4.4 on the Global Deterioration Scale (GDS) which indicated moderate cognitive impairment. A 90-day nurse review was completed on 1-8-13. The review lacked an evaluation of Tenant #3's health.

Tenant #5, a 90 year-old, was admitted on 11-28-12 and had diagnoses of: Osteoporosis, HTN, Compression Fracture of the Back, and Mild Dementia. Tenant #5 had lived independently until a fall resulted in a broken back. Tenant #5 received skilled care and then moved into the program. Tenant #5 was using a torso brace and was using a walker for ambulation according to the 30-day evaluations.

The nurse's notes documented the following: On 12-17-12 the pain medication Tramadol was clarified and ordered at one tablet every six hours. On 12-19-12 nurse's notes documented Tenant #5 had not had pain medication in 24 hours. Tenant #5 was also noted to be wearing the back brace less per physician's orders. The service plan indicated Tenant #5 received PT for back stabilization and strengthening beginning and weaning from the back brace beginning 1-8-13. According to the service plan, PT was completed on 1-28-13.

Tenant #5 was admitted following a fall resulting in a back fracture. A nurse review was not completed to determine the ability to ambulate safely following the removal of the back brace, a decrease in pain medication and the completion of physical therapy.

A 90-day nurse review was completed for Tenant #6 on 1-3-13. The nurse review lacked documentation of Tenant #6's health status.

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 a 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))