IOWA DEPARTMENT OF
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RODNEY A. ROBERTS, DIRECTOR

August 19, 2014

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

RE: Final Recertification Monitoring Evaluation Report – Bethany Heights Senior Living, Council Bluffs, IA

Dear Ms. Fandry:

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, following a survey by DIA on **August 6 & 7, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plan and Nurse Review.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

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.

Also enclosed you will find the Assisted Living Program Certificate **S0268** with effective dates of **February 25, 2014** through **February 24, 2016**.

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Recertification Monitoring Evaluation Report

Assisted Living Program:

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

Date of Monitoring Visit:

August 6th and 7th, 2014

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:	50
Number of tenants with cognitive disorder:	17
Total Population of Program at time of on-site	67
TOTAL census of Assisted Living Program	67

Tenant/Family Satisfaction Results – A meeting was held with 18 tenants. The best thing about the program was the security, the friendly staff, and that transportation was provided. Housekeeping was completed to tenants' satisfaction in apartments and common areas. Maintenance was reported to respond to requests in a timely fashion. Tenants used a call button to request assistance. It was reported staff responded in five to 10 minutes. Staff provided good care, and treated the tenants kindly and respectfully. The food was not always good with the hot foods not always being served hot. There was too much chicken, and too many starches served. There were many activities offered with no suggestions for any more activities. Sometimes music was too loud. Tenants reported feeling safe at the program, were generally satisfied, and would recommend the program to others.

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

A. Evaluation of Tenant

Monitoring Observation: Tenant #1, a 93 year-old, was admitted on 3-29-10 and had diagnoses of: End-stage Congestive Heart Failure from Severe Aortic Stenosis, Atrial Fibrillation, Anemia, and Hypertension. Tenant #1 was staged at four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. Evaluations of function, cognition, and health were completed on 3-11-14 with Tenant #1's admission into hospice.

A nurse review dated 6-7-14 documented Tenant #1 had poor skin turgor and wore skin sleeves for protection.

Nurse notes dated 6-24-14 documented Tenant #1 had a large purple bruise on the left inner thigh from mid-thigh extending below the knee. Tenant #1 did not recall falling or hitting the leg on anything. Program staff was to monitor the area daily until resolved.

On 6-30-14 nurse notes documented Tenant #1 had a bruise on the left hip/buttock area. Tenant #1 did not recall an injury to the area. The staff was to monitor the area daily until resolved.

Notes of 6-30-14 documented the hospice nurse noticed an open area to Tenant #1's coccyx and an ointment was ordered. There was no documentation included in the note to describe the extent of the open area.

On 7-2-14, notes documented Tenant #1 had a skin tear to the right forearm.

Notes of 7-14-14 documented the signed order was received for the ointment for the buttock/coccyx open area. There was no documentation related to the extent of the open area. Notes of 7-16-14 documented the program contacted hospice regarding orders for the treatment to the skin tear on the right forearm. Notes of 7-17-14 documented the skin sleeve was to be worn at all times.

Tenant #1 had multiple changes to the skin between 6-24-14 and 7-17-14 including two bruises that Tenant #1 was unable to explain, a skin tear to the right forearm and an open area to the coccyx. Evaluations were not completed following changes of skin condition.

Tenant #2, a 91 year-old, was admitted on 10-31-13 and had diagnoses of: Congestive Heart Failure, Hypertension, Benign Prostate Hyperplasia, Osteoarthritis, Chronic Obstructive Pulmonary Disease, and Neurogenic Bladder with Foley Catheter Placement.

Nurse notes dated 5-21-14 documented Tenant #2 was reported to have a "Stage 2" pressure ulcer on the buttocks. Notes of 5-25-14 documented staff reported to a Licensed Practical Nurse that tenant #2 had a sore on the right buttock. On 5-29-14 Tenant #2 complained of an area "burning" on the buttocks. Tenant #2 was encouraged to lie in bed and get the pressure off the buttocks. It was documented Tenant #2 thought an air cushion would be received for use to relieve buttocks pressure. On 6-3-14, notes documented Tenant #2 requested referral to a specific wound care program. On 6-6-14 notes documented Tenant #2 had been prescribed a protein supplement to aid in wound healing. Evaluations of function, cognition, and health were not completed with a significant change of condition, a pressure ulcer on the buttocks.

Tenant #4, an 85 year-old, was admitted on 11-29-13 and had diagnoses of: Hypertension, History of Breast Cancer, Osteoarthritis, Atrial Fibrillation, Anxiety, and Depression.

Evaluations dated 4-28 and 5-5-14 documented Tenant #4 had been hospitalized and required skilled care for back pain after a fall. Tenant #4 was hospitalized for a fracture of a thoracic vertebra and underwent a Vertebroplasty.

Nurse notes of 5-7-14 documented the physician thought Tenant #4 seemed confused and needed help with the administration of pain medication. On 5-8-14 the program contacted the physician requesting an order for the program to administer pain medication.

Notes of 5-10 documented Tenant #4 was found on the floor. A hematoma was noted on the back of the head and neurological checks were initiated. Notes of 5-13 documented Tenant #4 wanted to know how to get up by self despite the need for staff assist with all transfers. On 5-14, staff was checking on Tenant #4 every 15 minutes for safety. Tenant #4 was reminded to use the call pendant when getting up. Notes of 5-23 documented Tenant #4 did not follow instructions to use call pendant when finished in restroom.

Physician's orders of 5-21 indicated oxygen saturation levels were to be checked with activity and saturation levels were to be kept above 90%

Notes of 5-27-14 documented on 5-26 Tenant #4 was out with family and was not feeling well. Family took Tenant #4 to the hospital. Tenant #4 was admitted to the hospital for an initial diagnosis of Non-ST segment elevation Myocardial Infarction. Tenant #4 returned to the program on 5-27 and notes completed by an LPN documented Tenant #4 had an unsteady gait and was weak. Tenant #4 was to push the call pendant for all transfers. Tenant #4 was prescribed new medications and instructions for Physical Therapy (PT) and Occupational Therapy (OT) to consult.

On 6-5-15, according to notes, Tenant #4 was prescribed an antibiotic for a urinary infection. Notes of 6-9-14 documented Tenant #4 was found on the floor after getting up without assistance. Tenant#4 complained of tenderness on the back of the head. Staff was instructed to check vital signs frequently. The RN notified the family that when a person hits the head it was advisable to be seen in the emergency room. The family wanted to "wait and see."

Physician orders of 5-21-14 for Tenant #4 documented a request for a cushion gel to help decrease the risk of "sores on bottom." Notes of 6-30-14 documented an order had been received to assist Tenant #4 with repositioning and rolling over in bed. Tenant #4 responded that he/she liked sleeping in the recliner, and would not seek staff assistance to roll over. Notes of 7-1-14 documented a fax from the physician which was to encourage Tenant #4 to change positions at night and encourage to stay in bed. Notes of 7-1-14 documented a fax was sent to the physician to report the coccyx was reddened with no open areas, but treatment was needed.

Except for the notes of 6-9-14, nurse notes entries were completed by LPN's.

Between 5-5-14 and 7-1-14, notes for Tenant #4 documented two falls requiring frequent monitoring, the program's administration of Tenant #4's pain pills due to confusion, Tenant #4's repeated non-use of the call pendant to request assistance, hospitalization to rule out a heart attack, a urinary infection, and immobility resulting in a reddened coccyx requiring treatment. Evaluations of function, cognition, and health were not completed by an RN with significant changes of condition.

Tenant #6, a 77 year-old, was admitted on 4-16-14 and had diagnoses of: Breast Cancer, Dementia, and Hypertension. Tenant #6 was staged at six on the GDS which indicated severe cognitive decline.

Nurse notes dated 5-29-14 documented Tenant #6 was found sitting on the edge of the bed in respiratory distress. Tenant #6 was cold and clammy, and nail beds were blue. Pitting edema rated 3+ was present in the legs, and lung sounds indicated rales. Tenant #6 was transported to the hospital.

On 6-2-14, Tenant #6 was discharged from the hospital following emergent admission for increased shortness of breath and Congestive Heart Failure (CHF). The CHF was probably due to fluid overload related to medication. Tenant #6 returned to the program with changes to medications. Evaluations of function, cognition, and health were not completed by an RN with a significant 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 was observed to have an open area to the coccyx on 6-30-14. The service plan did not identify interventions for the specific care of the open area on the coccyx and prevention of open skin areas on the coccyx for Tenant #1. The service plan did not meet the identified needs of Tenant #1

Tenant #2 was noted to have a "Stage 2" pressure ulcer on the buttocks. Tenant #2 was encouraged to lie in bed to relieve pressure on the buttocks. Tenant #2 sought treatment from a wound-care program. The service plan did not identify Tenant #2 was using an outside provider for wound care. Notes of 6-11-14 documented Tenant #2 was to use a cushion in the chair, and special mattress on the bed. The service plan of 5-16-14 did not identify specific interventions for wound care to the buttocks. The service plan did not meet the identified needs of Tenant #2.

The service plan, updated 7-22-14, did not identify interventions for the prevention of buttocks ulcers. Nurse notes dated 7-28-14 documented the buttock wound had returned. The service plan did not meet the identified needs of Tenant #2.

Tenant #4 had a history of a fall which resulted in back pain. Tenant #4 was surgically treated with a Vertebroplasty. Tenant #4 returned to the program, and sustained two falls resulting in the need for frequent monitoring. It was documented Tenant #4 did not use the call pendant as instructed, and at one point Tenant #4 was on checks every 15 minutes. The service plan was not updated after 5-5-14 related to falls and mobility and did not identify fall prevention interventions. The service plan did not meet the identified needs of Tenant #4.

Tenant #4 slept in the recliner and the physician suggested a gel cushion on 5-21-14 as prevention of "sores on bottom." Tenant #4 was to be repositioned at night, according to physician orders. On 7-1-14, Tenant #4 was observed to have a reddened coccyx and treatment was needed. The service plan did not identify interventions for the prevention of skin breakdown related to immobility, nor care of the skin once reddened. The service plan did not meet the identified needs of Tenant #4

Tenant #5, a 93 year-old, was admitted on 1-16-13 and had diagnoses of: Dementia, History of Stroke, Hypertension, and Frequent Urinary Tract Infections. Tenant #5 was admitted into hospice care on 1-4-14 for Failure to Thrive. Tenant #5 was staged at six on the Global Deterioration Scale (GDS) which indicated severe cognitive decline. According to the service plan, Tenant #5 was to be encouraged to attend morning exercises, which Tenant #5 did not always wish to attend. The service plan did not

identify any other specific activities, planned or spontaneous, based on Tenant #5's abilities and interests.

Tenant #6 had a history of Breast Cancer. Nurse notes dated 4-17-14 documented Tenant #6 was to only have the blood pressure checked and lab drawn from the left arm. Tenant #6 had a diagnosis of Hypertension. Neither the service plan of 5-23 nor 7-17-14 identified only the left arm was to be used for blood pressure checks and lab draws. The service plan did not meet the identified needs of Tenant #6.

The service plans of 5-23 and 7-17-14 indicated activity staff would meet with Tenant #6, who had severe cognitive decline, for planned and spontaneous activities. The service plans did not identify specific planned and spontaneous activities based on Tenant #6's abilities and interests.

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))

Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. (IAC r. 481-69.26(4)(d))

C. Nurse Review

Monitoring Observation: Tenant #1 had multiple changes to the skin between 6-24-14 and 7-17-14 including two bruises that Tenant #1 was unable to explain, a skin tear to the right forearm and an open area to the coccyx. Nurse reviews were not completed to document the progress of the bruises and wounds, despite instructions to staff to monitor until resolved.

Tenant #4 was prescribed an antibiotic for a urinary infection on 6-5-14. A nurse review was not done following the completion of the antibiotic to monitor Tenant#4's health and progress related to the antibiotic order.

Tenant #4 was prescribed services from PT and OT. OT notes of 6-26-14 documented a tentative goal for discharge. A nurse review was not completed to monitor progress related to PT and OT services.

On 5-30-14, Tenant #5 was prescribed an antibiotic for a urinary infection. Tenant #5 exhibited signs of disorientation and agitation. A nurse review was not done following the completion of the antibiotic to monitor Tenant #5's health and progress related to the antibiotic order.

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: To assess and

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))