DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	280422	A. BUILDING: _____ B. WING _____	C 06/10/2019

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PENN CENTER	2237 245TH STREET DELHI, IA 52223

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R 000	Initial Comments The following deficiencies were cited during the investigation of Complaint 83189-C.	R 000		
R 834	481-57.22(3)c Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to modify service plans as needs changed for 2 of 5 residents reviewed (Residents #2 and	R 834	Plan of Correction is attached DD — 8/16/19	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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R 834	Continued From page 1 #4). Findings follow: 1. Resident #2 was admitted to the facility on 3/15/18 with a diagnosis of disorganized schizophrenia. A review of Interdisciplinary Team Progress Notes on 5/29/19 revealed the following. - On 1/21/19, Resident #2 was up and down the hallways, agitated, very hard to redirect. He was in and out of other consumer's rooms. He went into a female peer's room several times. At one point, Resident #2 came to the nurse's desk demanding to know where "that queer is" threatening to assault the resident. - Staff A and Staff B met with Resident #2 on 1/22/19 to address what occurred the night before. Resident #2 denied many of the concerns brought up by staff. Staff A noted she would continue to monitor the situation. - A note on 2/16/19 revealed Resident #2 continued to walk the halls all night. - On 2/23/19 it was noted Resident #2 roamed the halls at night going into others' rooms while they sleep. He stood over peers as they slept, sometimes leaning over close to their face. Other residents were upset with Resident #2. - A note on 3/16/19 documented staff witnessed Resident #2 chasing a female peer down to the dining room. - On 3/17/19, Resident #2 was seen hovering over the same female peer. - Resident #2 was walking the halls, talking gibberish and entering peers' rooms on 4/1/19. - He was seen walking into a male peer's room twice on 4/15/19. - An update on 4/27/19 noted Resident #2 often paced the hallways, going in and out of peers' rooms, touching everything on the walls. - A note on 5/9/19 identified Resident #2 would	R 834		

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R 834	Continued From page 2 stay up most of the night roaming the hallways. "He does have a tendency to go (sneak) into the rooms of others" On 5/29/19 at 2:47 PM Staff C confirmed she was aware Resident #2 had been entering other male residents' rooms. During an interview with Staff D on 5/29/19 at 2:20 PM, she reported hearing Resident #2 had been found in Resident #6's room performing oral sex on him. On 5/29/19 at 11:40 AM,. Resident #7 reported waking up one night about a week earlier to find Resident #2 touching his penis. Resident #7 did not report this to staff. Resident #2 had a service plan dated 4/25/19 which did not address him entering other residents' rooms. 2. Resident #4 was admitted to the facility on 2/6/18. He was diagnosed with antisocial personality disorder and mood disorder. A review of Interdisciplinary Team Progress Notes for Residents #3, #4 and C-1 on 5/29/19 revealed the following: - On 3/2/19, Staff F overheard Resident C-1 (former resident) tell his dad, "I have to get out of here for awhile. I'm sick of watching my roommates molest each other." - A note dated 3/18/19 documented Resident #4's roommates had several complaints of Resident #4 being inappropriate with Resident #3 by saying inappropriate sexual things, putting his arms around Resident #3 and laying on Resident #3's bed. Resident C-1 had also complained of Resident #4 being inappropriate towards	R 834		

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R 834	Continued From page 3 Resident #3. Staff D noted she talked with Resident #4 about the behavior and he said he'd stop. - Staff D approached Resident #3 on 3/21/19 and asked if Resident #4 continued to touch him inappropriately and Resident #3 said the behaviors had stopped. - Staff D noted on 3/25/18 she was approached by Resident #3 about Resident #4 being inappropriate towards him and putting his arms around him. When Staff D went to talk with Resident #4, he was in the middle of trying to put his arms around Resident #3. Staff D told Resident #4 that was inappropriate and he needed to stay in his own area and keep his hands to himself. Resident C-1 asked Staff D to "please do something. It's been going on too long." - Staff A and Staff B met with Resident #4 about his interactions with staff and peers on 4/9/19. The note documented Resident #4 has had a roommate that had expressed concern over Resident #4's roughhousing and touching him more than what he felt was appropriate. Multiple staff had also expressed concern with Resident #4's comments on staffs' appearances. During the meeting, Staff A and Staff B reminded Resident #4 to be respectful of his peers' personal space and to stop if someone tells him to stop. - On 4/15/19 Staff D was approached by a female resident who said Resident #4 walked up and kissed her without her permission. Staff D addressed the behavior with Resident #4. Another female resident came to Staff D later the same night and said Resident #4 had attempted to kiss her but she dodged it. - On 4/21/19, Staff E walked into Resident #4's room (which he shared with three roommates	R 834		

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R 834	Continued From page 4 including Residents #3, #8 and C-1) and saw Resident #3's bed rocking. Resident #4 jumped out of Resident #3's bed and claimed he had just sat down at that time. Staff E said he would need to discuss this further with Staff A and Staff B. On 5/6/19, the Administrator, Staff A and Staff B met with Resident #4 after learning that Resident #4 and Resident #3 had continued with the "inappropriate rough-housing" despite direction to stop. Resident #4 was moved to another room within the facility. When interviewed on 5/28/19 at 10:40 AM Resident C-1 reported seeing Resident #4 do things such as hugging, kissing and hitting Resident #3. He also was aware of Resident #4 humping Resident #3 in his bed about "ten times." Resident C-1 believed these actions were unwanted. Resident C-1 also reported seeing Resident #4 hug Resident #8 about 5 times and also believed this touching was unwanted. On 5/29/19 at 8:45 AM Resident #8 reported Resident #4 got into Resident #3's bed every night and "grinded on him" with his underwear pulled down. Resident #8 knew Resident #3 did not like this because Resident #3 would tell Resident #4 to stop. Resident #8 said Resident #4 got into his (Resident 8's) bed "a couple times" and rubbed his body on him. Resident #8 did not tell anyone about the actions of Resident #4 because he believed Resident #4 was "sick." On 5/28/19 at 4:20 PM, Resident #3 reported Resident #4 got in his bed more than fifty times. Resident #3 said Resident #4 got into his bed when he was almost asleep. He described Resident #4 as weighing almost 260 pounds and	R 834		

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R 834	Continued From page 5 being too big to push off him. He stated Resident #4 did things like grind on him, rub his testicles against him and get naked in the bed. Resident #3 said he did not like it when Resident #4 touched him in a sexual manner. Resident #3 believed Resident #8 was also touched in a sexual manner. When interviewed on 5/30/19 at 10:10 AM Resident C-3 (former resident) reported being "fondled" on two occasions by Resident #4 against his will. Resident C-3 said he complained to staff about this, specifically Staff B. Resident C-3 said he was switched to another room in the facility after he reported the behavior to Staff B. On 5/29/19 at 2:20 PM Staff D reported Resident #4 had touched residents without their permission in a sexual manner. Resident #3 had reported to her Resident #4's touching had gone "too far" but he later denied anything happened. Resident C-1 also reported concerns with Residents #3 and #4 having sex together. Resident #4 had made sexual comments to many female staff. Staff D did recall Resident C-3 wanting to switch rooms because Resident #4 was acting in a sexual manner to Resident C-4. On 5/29/19 at 9:52 AM the Director of Nursing (DON) said Staff D came to her and said Resident #3 was upset because Resident #4 was trying to hump him. The DON and Staff A then visited with Resident #3 about his reports. The DON described Resident #3 as not overly concerned about the actions of Resident #4. He said things were no big deal and when Resident #3 was given the option of switching rooms, he	R 834		

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R 834	Continued From page 6 did not want to do so. When interviewed on 5/28/19 at 4:15 PM Staff H reported seeing Resident #4 shirtless on Resident #3's bed one or two times. She also found Resident #4 in Resident #3's bed once and the bed was "rocking." Staff H stated Resident #4 "preys on the quiet ones." Resident #4 was interviewed on 5/29/19 at 12:50 PM. He confirmed he had touched Residents #3 and #8 in a way they did not want. Resident #4 said he had lived at the facility for over a year. He was bored there and tired with horseplay with the other residents. Resident #4 then turned to doing "inappropriate things" such as punching people in the groin and exposing himself once. Resident #4 said he believed he got in Resident #3's bed about thirty times in the five months they shared a room. He said he would be in Resident #3's bed from one to five minutes doing sexual things and making inappropriate movements. Resident #4 said he was aware Resident #3 did not like these things because after awhile he would tell him to get off. Resident #4 also pointed out Resident #3 did not do anything to "ward it off." Resident #4 said he gave Resident #8 hugs, an occasional butt slap and was in Resident #8's bed once. He said Resident #8 "wasn't into it" and did not want his sexual attention. He denied touching any other residents in a sexual manner. Resident #4's service plan, dated 2/21/19, was not updated to address his "unhealthy/inappropriate sexual gestures and comments" until 5/7/19. 3. On 5/30/19 at 9:25 AM the Administrator, Staff	R 834		

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R 834	Continued From page 7 A and Staff B confirmed service plans were not updated as needs changed.	R 834		
R1024	481-57.34(3)c Safety 481-57.34(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II, III) 57.34(3) Resident safety. c. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to adequately supervise 2 of 13 current and former residents reviewed in order to keep all residents safe (Residents #2 and #4). Findings follow: 1. Resident #2 was admitted to the facility on 3/15/18 with a diagnosis of disorganized schizophrenia. A review of Interdisciplinary Team Progress Notes on 5/29/19 revealed the following. - On 1/21/19, Resident #2 was seen up and down the hallways, agitated, very hard to redirect. He was in and out of other consumer's rooms. He went into a female peer's room several times. At one point, Resident #2 came to the nurse's desk demanding to know where "that queer is" threatening to assault the resident. - Staff A and Staff B met with Resident #2 on 1/22/19 to address what occurred the night	R1024		

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R1024	Continued From page 8	R1024		

before. Resident #2 denied many of the concerns brought up by staff. Staff A noted she would continue to monitor the situation.

- A note on 2/16/19 revealed Resident #2 continued to walk the halls all night.
- On 2/23/19 it was noted Resident #2 roamed the halls at night going into others' rooms while they sleep. He stood over peers as they slept, sometimes leaning over close to their face. Other residents were upset with Resident #2.
- A note on 3/16/19 documented staff witnessed Resident #2 chasing a female peer down to the dining room.
- On 3/17/19, Resident #2 was seen hovering over the same female peer.
- Resident #2 was walking the halls, talking gibberish and entering peers' rooms on 4/1/19.
- He was seen walking into a male peer's room twice on 4/15/19.
- An update on 4/27/19 noted Resident #2 often paced the hallways, going in and out of peers' rooms, touching everything on the walls.
- A note on 5/9/19 identified Resident #2 would stay up most of the night roaming the hallways. "He does have a tendency to go (sneak) into the rooms of others."

On 5/29/19 at 2:47 PM Staff C confirmed she was aware Resident #2 had been entering other male residents' rooms.

During an interview with Staff D on 5/29/19 at 2:20 PM, she reported hearing Resident #2 had been found in Resident #6's room performing oral sex on him.

On 5/29/19 at 11:40 AM,. Resident #7 reported waking up one night about a week earlier to find Resident #2 touching his penis. Resident #7 did

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R1024	Continued From page 9 not report this to staff. 2. Resident #4 was admitted to the facility on 2/6/18. He was diagnosed with antisocial personality disorder and mood disorder. A review of Interdisciplinary Team Progress Notes for Residents #3, #4 and C-1 on 5/29/19 revealed the following: - On 3/2/19, Staff F overheard Resident C-1 (former resident) tell his dad, "I have to get out of here for awhile. I'm sick of watching my roommates molest each other." - A note dated 3/18/19 documented Resident #4's roommates had several complaints of Resident #4 being inappropriate with Resident #3 by saying sexual things, putting his arms around Resident #3 and laying on Resident #3's bed. Resident C-1 had also complained of Resident #4 being inappropriate towards Resident #3. Staff D noted she talked with Resident #4 about the behavior and he said he'd stop. - Staff D approached Resident #3 on 3/21/19 and asked if Resident #4 continued to touch him inappropriately and Resident #3 said the behaviors had stopped. - Staff D noted on 3/25/18 she was approached by Resident #3 about Resident #4 being inappropriate towards him and putting his arms around him. When Staff D went to talk with Resident #4, he was in the middle of trying to put his arms around Resident #3. Staff D told Resident #4 that was inappropriate and he needed to stay in his own area and keep his hands to himself. Resident C-1 asked Staff D to "please do something. It's been going on too long." - Staff A and Staff B met with Resident #4 about his interactions with staff and peers on 4/9/19. The note documented Resident #4 has had a	R1024		

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R1024	Continued From page 10	R1024		

roommate that had expressed concern over Resident #4's roughhousing and touching him more than what he felt was appropriate. Multiple staff had also expressed concern with Resident #4's comments on staffs' appearances. During the meeting, Staff A and Staff B reminded Resident #4 to be respectful of his peers' personal space and to stop if someone tells him to stop.

- On 4/15/19 Staff D was approached by a female resident who said Resident #4 walked up and kissed her without her permission. Staff D addressed the behavior with Resident #4. Another female resident came to Staff D later the same night and said Resident #4 had attempted to kiss her but she dodged it.

- On 4/21/19, Staff E walked into Resident #4's room (which he shared with three roommates including Residents #3, #8 and C-1) and saw Resident #3's bed rocking. Resident #4 jumped out of Resident #3's bed and claimed he had just sat down at that time. Staff E said he would need to discuss this further with Staff A and Staff B.

On 5/6/19, the Administrator, Staff A and Staff B met with Resident #4 after learning that Resident #4 and Resident #3 had continued with the "inappropriate rough-housing" despite direction to stop. Resident #4 was moved to another room within the facility.

When interviewed on 5/28/19 at 10:40 AM Resident C-1 reported seeing Resident #4 do things such as hugging, kissing and hitting Resident #3. He also was aware of Resident #4 humping Resident #3 in his bed about "ten times." Resident C-1 believed these actions were unwanted. Resident C-1 also reported seeing Resident #4 hug Resident #8 about 5 times and also believed this touching was

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R1024	Continued From page 11 unwanted. Resident C-1 stated a nurse overheard him tell his dad about the sexual activity occurring between his roommates but the nurse said she didn't want to hear about it. He reported telling a staff member about Resident #4's actions on another date but felt his allegation was ignored. Resident C-1 was unsure of whom he made this report to or on what date he made the report. On 5/29/19 at 8:45 AM Resident #8 reported Resident #4 got into Resident #3's bed every night and "grinded on him" with his underwear pulled down. Resident #8 knew Resident #3 did not like this because Resident #3 would tell Resident #4 to stop. Resident #8 said Resident #4 got into his (Resident 8's) bed "a couple times" and rubbed his body on him. Resident #8 did not tell anyone about the actions of Resident #4 because he believed Resident #4 was "sick." On 5/28/19 at 4:20 PM, Resident #3 reported Resident #4 got in his bed more than fifty times. Resident #3 said Resident #4 got into his bed when he was almost asleep. He described Resident #4 as weighing almost 260 pounds and being too big to push off him. He stated Resident #4 did things like grind on him, rub his testicles against him and get naked in the bed. Resident #3 said he did not like it when Resident #4 touched him in a sexual manner. Resident #3 believed Residents #8 was also touched in a sexual manner. Resident #3 believed Resident C-1 had reported the concerns about Resident #4 to his parents who then notified staff. When interviewed on 5/30/19 at 10:10 AM Resident C-3 (former resident) reported being "fondled" on two occasions by Resident #4	R1024		

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R1024	Continued From page 12 against his will. Resident C-3 said he complained to staff about this, specifically Staff B. Resident C-3 said he was switched to another room in the facility after he reported the behavior to Staff B. When interviewed on 6/20/19 at 4:12 PM. Staff B said Resident C-3 did report to her he was not comfortable with the relationship between Resident #4 and Resident C-4 and wanted to switch rooms. Staff B believed Resident #4 and Resident C-4 had a friendship. She denied knowledge of Resident C-3 being fondled by Resident #4. On 5/29/19 at 2:20 PM Staff D reported Resident #4 had touched residents without their permission in a sexual manner. Resident #3 had reported to her Resident #4's touching had gone "too far" but he later denied anything happened. Resident C-1 had also reported concerns with Residents #3 and #4 having sex together. Resident #4 had made sexual comments to many female staff. Staff D did recall Resident C-3 wanting to switch rooms because Resident #4 was acting in a sexual manner to Resident #C-4. On 5/29/19 at 9:52 AM the Director of Nursing (DON) said Staff D came to her and said Resident #3 was upset because Resident #4 was trying to hump him. The DON and Staff A then visited with Resident #3 about his reports. The DON described Resident #3 as not overly concerned about the actions of Resident #4. He said things were no big deal and when Resident #3 was given the option of switching rooms, he did not want to do so. On 5/29/19 at 10:08 AM Staff G reported being	R1024		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	280422	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENN CENTER	2237 245TH STREET DELHI, IA 52223

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R1024	Continued From page 13 aware Staff J heard Resident C-1 tell his father he wanted to get out of the facility because his roommates were molesting each other. Staff G stated all residents knew they were not allowed to be on each other's beds. Early in May, Staff G believed Resident C-1's mother called the facility to report her son's roommates were molesting each other. Staff G also believed discharged residents C-3 and C-5 had both asked to have their room assignments changed due to concerns about sexual activities going on between Resident #4 and Resident C-4. When interviewed on 5/28/19 at 4:15 PM Staff H reported seeing Resident #4 shirtless on Resident #3's bed one or two times. She also found Resident #4 in Resident #3's bed once and the bed was "rocking." Staff H stated Resident #4 "preys on the quiet ones." During an interview on 5/29/19 at 10:35 AM, Staff I reported being aware Staff C took a call from the mother of Resident C-1 making complaints about the actions of Resident #4 toward other residents. On 5/28/19 at 4:00 PM Staff J reported hearing Resident C-1 tell his dad something wrong was going on with his roommates and he had to get out of the facility. During an interview with the complainant on 5/29/19 at 8:45 AM, he/she recalled reporting concerns regarding Resident #4 to a nurse at the facility. The complainant said the nurse stated she could not comment on the reports due to privacy concerns, but told the complainant six times that the issues with Resident #4 were not happening.	R1024		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R1024	Continued From page 14 Resident #4 was interviewed on 5/29/19 at 12:50 PM. He confirmed he had touched Residents #3 and #8 in a way they did not want. Resident #4 said he had lived at the facility for over a year. He was bored there and tired with horseplay with the other residents. Resident #4 then turned to doing "inappropriate things" such as punching people in the groin and exposing himself once. Resident #4 said he believed he got in Resident #3's bed about thirty times in the five months they shared a room. He said he would be in Resident #3's bed from one to five minutes doing sexual things and making inappropriate movements. Resident #4 said he was aware Resident #3 did not like these things because after awhile he would tell him to get off. Resident #4 also pointed out Resident #3 did not do anything to "ward it off." Resident #4 said he gave Resident #8 hugs, an occasional butt slap and was in Resident #8's bed once. He said Resident #8 "wasn't into it" and did not want his sexual attention. He denied touching any other residents in a sexual manner. During an interview with the Administrator, Staff A and Staff B on 5/30/19 at 9:25 AM, they denied being aware of the extent of the actions of Residents #2 and #4.	R1024		

An Affiliate of UnityPoint Health

Penn Center, Inc.

Residential Care Facility
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Delhi, IA 52223
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abbehealth.org

Penn Center RCF DIA Incident Number FC # 7009 Plan of Correction

1. Retrain staff on ISP Addendum Policy by July 31, 2019.
2. Update Resident Incident Report Form and retrain staff on Incident Reporting Policy and form update by August 16, 2019.
3. Implement a training program for residents and staff regarding Relationships and Sexuality and Sexual Abuse Prevention. This training will be completed routinely throughout the year to capture new admissions and keep staff up to date. The training Attendance Sheets will be monitored at least quarterly by the Administrative Assistant to ensure staff and residents are receiving the training. This initial training will be completed with residents by August 2, 2019 and with staff by August 16th.

Angela L. Gudenkauf 7-26-2019

Angela Gudenkauf, Administrator Date

8/20/19 8/16/19