5/30/18 OK 5/25/18

PRINTED: 05/18/2018
FORM APPROVED

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
	S0017	A. BUILDING: _____ B. WING _____	C 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 19 TOTAL Census of Assisted Living Program for People with Dementia: 24 The recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program resulted in regulatory insufficiencies. The investigation of Complaints #75208-C, #75209-C, 75823-C and Incident #75340-I resulted in regulatory insufficiencies.	A 000	See attached POC 6/15/18	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. 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 a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.	A 003		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure completion of incident reports for all incidents as required according to Program policy. This pertained to 3 of 7 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Record review of Tenant #1's Nurse's Notes revealed the following: a. On 4-12-18 staff reported Tenant #1 found in Tenant #3's apartment with his/her pants were off and hung in Tenant #3's closet. Tenant #3's pants were on his/her head. Staff was instructed to keep Tenant #1 on his/her side of the building. b. On 4-14-18 staff reported Tenant #1 made sexual comments to staff. Staff was instructed to keep Tenant #1 in the coloring area and to contact his/her spouse to come and sit with him/her. Tenant #1's spouse came in for the remainder of the day. c. On 4-15-18 Tenant #2 was found sitting on Tenant #1's bed. Staff removed Tenant #2 and redirected Tenant #1 to the coloring area. The apartment door was locked and Tenant #1's family came in. d. On 4-20-18 staff found Tenant #1 holding hands with Tenant #2 in the television area. 2. Record review of a staff communication book revealed the following additional incidents : a. On 4-12-18 Tenant #2 was physically	A 003		

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A 003	Continued From page 2 aggressive and attempted to bite staff as they attempted to dress him/her. b. On 4-14-18 during second shift, the book noted, "(Tenant #1) needs to be watched around (Tenant #2)," as Tenant #1 kept trying to kiss Tenant #2. At 3:55 p.m., staff documented Tenant #1 and Tenant #2 were found in Tenant #1's apartment. Tenant #2 was in Tenant #1's bed. Staff assisted Tenant #2 up, and he/she went to his/her apartment. Tenant #1 tried to follow, but staff locked Tenant #2's door. Tenant #1 then went into another tenant's bed and staff assisted him/her out. c. On 4-14-18 Tenant #2 tried to bite staff, screamed and tried to attack staff. d. On 4-15-18 Tenant #1 stalked Tenant #2, pulled on him/her. Staff noted Tenant #1 fixated on Tenant #2 and unable to be redirected. Tenant #1's family was called and came in to redirect Tenant #1. It was noted to write down (time and date) every time something happened between Tenant #1 and Tenant #2. e. On 4-18-18 another tenant grabbed Tenant #2 out of a chair, squeezed him/her and pushed him/her. f. On 4-19-18 Tenant #1 got "inappropriate" with Tenant #2. Staff moved Tenant #1 to back room to color and play games. It was also noted Tenant #1 tried to take Tenant #2 to his/her apartment. 3. Further record review revealed there no	A 003		

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A 003	Continued From page 3 incident reports related to the incidents above. Continued record review revealed the Program's policy and procedure for incident reporting. The policy defined an incident as: " any happening out of the ordinary such as a fall, someone becoming ill, a change in behavior, etc. All incidents are to be handled to provide for the well-being of the tenant." The procedure directed only supervisors or department managers completed incident reports. Part of the investigation should be to interview any caregivers and/or witnesses that had relevant information. Incident reports should be fully completed and should include: how, when and where the incident occurred, the nature of the injury, what was done for the tenant and date/time of the notification of the responsible party. 4. When interviewed on 5-3-18 at 11:10 a.m. the Wellness Director confirmed the Program failed to complete incident reports according to Program policy.	A 003		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 013		

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A 013	Continued From page 4 Program failed to ensure tenants received adequate and appropriate care. The Program failed to ensure appropriate supports and supervision of tenants to ensure safety. Additionally, the Program failed to ensure appropriate medical follow up after alleged sexual assault. This affected 2 of 2 tenants (Tenant #1 and Tenant #3) reviewed as a result of investigations #75208-C, 75209-C, 75823-C, and 75340-I. Findings follow: Record review revealed A Resident Incident Report dated 4-22-18 at 6:20 p.m. Staff A washed dishes in the dining room when Tenant #4 notified staff Tenant #1 "molested" Tenant #3. Staff immediately dropped everything and ran to the other area of the building where the tenants were located. Staff found Tenant #3 with Tenant #1's shirt halfway over Tenant #3's head. Tenant #1 adjusted his/her clothes. The incident report indicated the Nurse was notified at 6:30 p.m. The incident report indicated the tenant's physician was not notified of the incident, nor was Tenant #3 taken to the hospital. The Executive Director (ED) on 4-25-18 and documented, "IR signed after connecting with associate to further clarify. It did not jive with the verbal report given to the ED the evening of the possible appropriateness [sic] on 4-22-18." Continued record review revealed the Program's inquiry into the incident with Tenant #1 and Tenant #2. Statements were provided by involved parties and revealed the following: a. Staff A's statement, dated 4-22-18 at 6:20 p.m., revealed Staff A washed dishes when Tenant #4 approached her and stated Tenant #1 "molested" Tenant #3. Staff A ran to the other	A 013		

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side of the building and found Tenant #3 half nude with Tenant #1's pants around his/her legs. Tenant #1 stood next to Tenant #3 and adjusted the pants. Staff A looked for Tenant #3's clothes and found them in Tenant #1's apartment on the floor. Staff A found feces on the bed in Tenant #1's apartment; Staff A noted the feces on the bed because Tenant #3 was impacted prior to the incident.

b. The Nurse's statement, dated 4-22-18 at 7:00 p.m., revealed she was notified Tenant #3 was found in the fish tank room with only a protective undergarment on. Staff reported to The Nurse Tenant #3 was with another tenant who attempted to put a shirt on him/her. The Nurse went to the Program to assess the tenant. The tenant was in bed. The Nurse woke Tenant #3 and explained she needed to check him/her. She assessed the tenant and noted no visible injuries. Tenant #3 had no stool on his/her body. When the Nurse attempted to assess Tenant #3's genitals, he/she clamped his/her knees together and refused. The Nurse dressed Tenant #3 and told him/her goodnight. The Nurse checked Tenant #3's protective undergarment removed prior to bed and noted smeared stool. No other visible body fluids were noted.

An additional statement from the Nurse, dated 4/22/18 at 7:00 p.m. revealed the Nurse took Tenant #1 to the restroom with another staff member. The nurse examined his/her body for stool and injuries. No injuries were noted and no stool was found on any part of his/her body including hands and nail beds. The Nurse asked Tenant #1 if he/she undressed Tenant #3 and he/she said, "Yes. I wanted to see (him/her) naked." The Nurse asked Tenant #1 if he/she

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A 013	Continued From page 6 and Tenant #3 had sex and he/she stated, "No!" Tenant #1 expressed his/her spouse would be upset. When asked if he/she engaged in sexual intercourse with any other tenants, he/she replied, "No!" The Nurse dressed Tenant #1 and returned him/her to the A side television room under supervision. The Nurse documented she returned to Tenant #1's room and found a white protective undergarment with hard stool in the wastebasket. The bed was made with no indication any laid on the bed. At the edge of the bed, the Nurse noted a large pile of dark brown stool. No stool was noted on the floor or surrounding sheets. The Nurse examined the protective undergarment in the wastebasket for bodily fluids, and found none other than the previously noted stool. c. A typed statement from the ED indicated she was notified on 4-22-18 at 6:30 p.m. of the possibility of inappropriate behavior between tenants. The Nurse was asked to come in and assess both tenants. The ED arrived at about 6:40 p.m. and spoke with the tenant who allegedly had inappropriate behavior towards another tenant, the tenant who witnessed the incident and the staff. The ED visited with Tenant #1 and asked him/her if he/she remembered what happened that evening and Tenant #1 said no. Tenant #1 was asked if he/she removed clothing of a tenant of the opposite sex and Tenant #1 said yes. When asked why, Tenant #1 said he/she wanted to undress and re-dress the other tenant. Tenant #1 said he/she did not do anything to the other tenant. The ED spoke with Tenant #4, who witnessed the incident. Tenant #4 reported he/she saw Tenant #3 walk down the hallway from east to west into	A 013		

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A 013	Continued From page 7 the fish tank area in one of the neighborhoods. Tenant #3 was nude from the waist up, but had on pants. Tenant #4 saw Tenant #1 walk from the same direction with a shirt in his/her hand. Tenant #1 attempted to put the shirt on Tenant #3. Tenant #4 walked down the hall to report the incident to staff. Tenant #4 told the staff he/she saw Tenant #1 "molesting" Tenant #3. When asked what Tenant #4 meant he/she said it was because Tenant #3 was nude from the waist up. Tenant #4 did not witness anything other than that. Tenant #4 said he/she used that language to get the attention from the staff. Staff A reported to the ED that she was approached by a witness as she did dishes in a different neighborhood. She saw Tenant #1 attempt to put the shirt on Tenant #3. She observed feces on Tenant #1's bed. There were shoes and an undergarment on the floor in that room. There was a soiled protective undergarment in the garbage. Both families were contacted by the ED and she and Wellness Director met face to face with Tenant #1's family and met with Tenant #3's family on 4-24-18. d. A typed statement signed by Tenant #4 indicated Tenant #4 watched television in the common area of one of the neighborhoods. He/she observed Tenant #3 walk down the hallway and go into the fish tank area. Tenant #3 was nude from the waist up and had on pants. Tenant #1 walked from the same direction and went towards the fish tank area, with a shirt in his/her hand. Tenant #1 attempted to put the shirt back on Tenant #3. Tenant #4 walked down the hall to get Staff A. Tenant #4 told Staff A that Tenant #3 was being "molested" by Tenant #1. He/she did not see any molestation but wanted to get Staff A's attention, which was why he/she	A 013		

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A 013	Continued From page 8 said Tenant #3 was being "molested." Record review revealed Tenant #1 moved into the Program on 4-6-18 to receive respite services. Tenant #1 had diagnoses including early onset Alzheimer's disease without behavioral disturbance. Tenant #1 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #1 moved out of the Program on 4-26-18. A contract was signed for respite care from 4-6-18 to 4-20-18. There was no additional signed contracts for respite care for Tenant #1 despite Tenant #1 did not move out of the Program until 4-26-18, six days after the initial respite contract expired. Record review revealed Tenant #3's diagnoses included dementia. Tenant #3 was staged at a six on the GDS, which indicated severe cognitive decline. Tenant #3's service plan reflected staff changed his/her protective undergarment and provided perineal care. The service plan also indicated staff picked out clothing, provided cues, reminders and hands on assistance with dressing. Tenant #1 was independent with ambulation and tended to walk the building and would occasionally go into other tenant apartments. The ALP Monitoring Entrance Form completed by the Program indicated there was one staff in each neighborhood (four total) on second shift. Review of staff schedules reflected one staff for two neighborhoods at the time of incident on 4-22-18. When interviewed Staff A reported she worked a 12 hour shift for two neighborhoods. Dinner was	A 013		

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served around 4:30 p.m. Staff A assisted Tenant #3 with toileting after supper at 6:00 p.m. and noted Tenant #3 was impacted. A white protective undergarment was applied. Staff A then assisted another tenant with toileting. Tenant #3 usually wandered around but usually did not get into anything. Tenant #1 finished supper early, went to the bathroom and was last seen around 5:30 p.m. While doing dishes Staff A was notified by Tenant #4 that Tenant #1 was "molesting" Tenant #3. Staff A ran to the opposite side of the building and found Tenant #3 in the fish tank area. Tenant #3 had Tenant #1's shirt around his/her neck, had Tenant #1's pants around his/her ankles, a protective undergarment on (gray), and no shoes. Tenant #1 was fully dressed and tried to get a shirt on Tenant #3. Staff A called Staff H for assistance. Staff A and Staff H went to Tenant #1's apartment to find Tenant #3's clothes. Tenant #3's shoes, undergarment were on the floor in Tenant #1's apartment. There was feces in the middle of the bed. Tenant #1's white protective undergarment was in the garbage. Staff H took Tenant #1 to a different building. Tenant #3 was taken to the bathroom to assist with pajamas and to get a new protective undergarment. There was bowel movement in between his/her legs. The incident report was completed and ED and the Nurse arrived. Staff A hugged Tenant #3 and provided reassurance. Tenant #3 looked frightened and exhausted.

When interviewed on 4-26-18 at 9:17 a.m. the Nurse reported she received a call from Staff A on 4-22-18 at 7:00 p.m. regarding a problem with Tenant #1. Staff A informed the Nurse she found Tenant #3 in the fish tank area. Tenant #3 did not wear clothes, but wore Tenant #1's gray protective undergarment. Tenant #1 was clothed.

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A 013	Continued From page 10 Staff redirected Tenant #1 and took Tenant #3 to clean up. Staff A went to Tenant #1's apartment and found Tenant #3's white protective undergarment in Tenant #1's garbage. Tenant #3's undergarment and shoes were on the floor. There was a hard stool in the protective undergarment and a large soft stool on the bed. Staff A worked in two neighborhoods in the building that weekend, as staff was cut down. There had been a loss of three tenants on that side of the building. The Nurse reported she arrived to the Program about 8:00 p.m. and Tenant #1 was in a different part of the building. The Nurse took Tenant #1 into the restroom with Staff H. There were no apparent injuries and no stool noted on Tenant #1 during the assessment. When asked by the Nurse, Tenant #1 said he/she had undressed Tenant #3 and that he/she undressed Tenant #3 because he/she wanted to see Tenant #3 naked. Tenant #1 was adamant that he/she did not have sex with Tenant #3 and said Tenant #3 said no. The Nurse went to Tenant #3's apartment and she assessed his/her skin and attempted to examine his/her groin and Tenant #3 said no. The staff reported Tenant #3 had stool on his/her legs. She removed the gray protective undergarments from the garbage. She observed no blood or bodily fluids, but did observe a smear of stool. She kept the protective undergarments at that time; however, someone had since thrown them away. The Nurse told the ED Tenant #3 needed to be sent to the hospital for a "rape kit." She felt Tenant #3 had not been physically abused, but recommended to send him/her. The ED and Nurse went to Tenant #1's apartment and observed a white protective undergarment in the garbage. Tenant #1 wore gray protective undergarments and Tenant #3 wore white protective undergarments. Tenant #3	A 013		

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had problems with stools. She reported Tenant #3's stools were round, hard stools and at times were digitally removed. The white protective undergarment in Tenant #1's garbage had hard, dark stool. There was a large soft stool on the edge of the bed. The bed was made and there was a smooth rounded area. It appeared Tenant #3 had sat down and thought the bed was a toilet. Staff was to check on Tenant #1 every 15 minutes after the incident, and was told to shut the door between the two neighborhoods. She called back on third shift to ensure Tenant #1 was where he/she needed to be. On Monday the Wellness Director took over the process. She asked the ED about the "rape kit" and was told the Regional Director of Operations did not feel it was needed. The Nurse felt it was needed to protect Tenant #1, Tenant #3 and the Program. Tenant #3 could not remove or apply a protective undergarment and could not remove his/her shoes. Tenant #3 was not oriented to person, place or time. Tenant #1 was oriented to person, but not place or time.

When interviewed the ED revealed she received a telephone call at about 6:30 p.m. on 4-22-18 regarding a potential incident between Tenant #1 and Tenant #3. She directed staff to call the Nurse. She arrived less than 20 minutes later and visited with Tenant #1. He/she could not recall what happened. Tenant #1 said he/she removed Tenant #3's shirt and nothing else occurred. Staff A informed her Tenant #4 reported Tenant #1 was "molesting" Tenant #3 and she responded. Tenant #3 was nude from the waist up and Tenant #1 was clothed. Staff A observed Tenant #1 attempt to put a shirt on Tenant #3. Staff A went to Tenant #1's apartment and found Tenant #3's undergarment and shoes on the

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floor, feces on the bed and a protective undergarment in the garbage. Tenant #4 reported Tenant #3's shirt was off and he/she had pants on but was nude from the waist up. Tenant #4 told her he/she saw Tenant #3 walk into the fish tank area and went to get Staff A. Tenant #4 reported Tenant #1 was "molesting" Tenant #3. When she asked Tenant #4 if he/she saw anything he/she said no and he/she used the word for attention. The Nurse completed an in depth physical exam of Tenant #1 and Tenant #3. The ED and Nurse went to Tenant #1's apartment and observed Tenant #3's undergarment and shoes on the floor and a white protective undergarment in the garbage with feces in it. The comforter and top sheet were folded over on the bed and there was feces on the chux. The Nurse suggested an emergency room visit for Tenant #3. The Regional Director of Operations was consulted and decided they would not end Tenant #3 to the emergency room, as they did not believe there was not any indication at that time. Tenant #1 was placed on 15 minute checks. A message was left for Tenant #3's family at 9:00 p.m. on Sunday and the family called on Monday. She talked with Tenant #3's family on Monday and advised the family of what happened and let them know Tenant #3 was ok. She let them know the other tenant would be leaving the Program. Prior to the incident a plan was in place to extend Tenant #1's respite and to sign paperwork on Monday 4-23-18. On 4-24-18 Tenant #1's family was told of the incident and informed Tenant #1 needed a higher level of care. On 4-23-18 additional family members of Tenant #3 stopped by and felt the investigation of the incident need to continue.

When interviewed on 4-30-18 at 1:23 p.m. the

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Wellness Director revealed on a weekend she was called by the ED and informed of an incident between Tenant #1 and Tenant #3. On Monday (4-23-18) the ED and Wellness Director met with Tenant #1's spouse and told the spouse that the Program could not meet Tenant #1's needs and the spouse was given resources for placement. On Tuesday (4-24-18) the ED and Wellness Director met with Tenant #3's family. It was shared with them what Staff A had reported. The family asked to speak with the Nurse and Staff A. The Nurse came in and said a white protective undergarment was in Tenant #1's garbage, belonging to Tenant #3. There was feces in it and there was feces on Tenant #3. Family felt they did not have the full picture. The ED and Wellness Director spoke with Staff A and Staff A reported Tenant #3 was in the fish tank area, without a shirt or undergarment on and had on Tenant #1's protective undergarment. Tenant #1 was attempting to put his/her shirt on Tenant #3. Tenant #3 had Tenant #1's pants on at his/her feet. In Tenant #1's apartment she found an undergarment on the floor, a pile of feces on the bed and the bed was made. On Tuesday the ED called Staff H and Staff H reported Tenant #3 was naked and had Tenant #1's protective undergarment on him/her. Tenant #4 had reported to a staff member that he/she saw Tenant #1 "humping" Tenant #3. When interviewed Tenant #4 said that he/she did not see that. The Nurse mentioned a couple of times that Tenant #3 should have had a "rape kit."

When interviewed Staff B said she arrived at 6:20 p.m. to 6:30 p.m. and Tenant #1 stood in the fish tank area "messing around" with his/her belt. Staff A came from down the hallway and reported Tenant #1 had "molested" Tenant #3. Staff A was

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A 013	Continued From page 14 in the bathroom with Tenant #3. Another staff called management staff and took Tenant #1 to the other building. The ED and Nurse arrived while Staff A completed her report. Staff A reported Tenant #4 reported to her that Tenant #1 "molested" Tenant #3. When Staff A had Tenant #3 in the bathroom it was noted Tenant #3 had on a gray protective undergarment. Tenant #1 was the only tenant with gray briefs. The Nurse wanted to send Tenant #3 out to be seen at the hospital. Staff B went to Tenant #1's apartment and Tenant #3's shoes and undergarment was on the floor. His/her shirt was in the chair. There was stool on the bed, approximately four to five inches from the edge into the center. Tenant #3 was taken to the bathroom and Staff B said he/she did not want her "down there." Normally it was not an issue with Tenant #3. Staff B said Tenant #3 was up a lot in bed that night and did not sleep like his/her normal self. At one point Tenant #3 sat on the edge of the bed, mumbled and jerked all of the sudden as if he/she was scared. Staff B said Tenant #3 was not his/her normal self that night. At 11:00 p.m. Tenant #1 was brought back to other building. His/Her laundry was done and his/her bed was made close to 1:00 a.m. At approximately 1:30 a.m. Tenant #1 sat with staff in the common area and said his/her spouse was going to be mad. When staff asked why Tenant #1 said, "Because I raped (Tenant #3) tonight and kissed (him/her) twice." When interviewed Staff C reported she worked on 4-23-18, after the incident, and heard Tenant #1 might have "molested" Tenant #3. Staff C overheard Tenant #4 tell a staff that Tenant #1 was on top of Tenant #3. Tenant #4 met with management staff and the story changed. When Staff C assisted Tenant #3 with toileting the day	A 013		

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after the incident, Tenant #3 tried to hit when his/her pants were pulled down. At a meal, Tenant #3 balled up his/her fist at staff. It was not a normal reaction for Tenant #3. Tenant #3 could not undress or redress himself/herself. Tenant #3 could not remove his/her shoes. The Nurse wanted Tenant #3 to be checked and a conclusion was reached to not send Tenant #3 out.

When interviewed Staff D said she found out about the incident when she arrived at work. It was very upsetting to staff. She overheard Tenant #4 tell another staff that Tenant #1 was on top of Tenant #3. Tenant #4 knew names and remembered quite well. Staff D did not think Tenant #4 would fabricate it. Management staff talked with Tenant #4 and his/her story changed. Tenant #3 was not able to undress and dress himself/herself. After toileting Tenant #3 would try to pull up the protective undergarment or pants but could not take it off. The day after the incident Tenant #4 did not want to sit by Tenant #1 at meals. Tenant #3 yelled when staff tried to assist with toileting. It was not normal for Tenant #3 and he/she was protective of himself/herself.

When interviewed Staff E said she arrived at work at 11:20 p.m. on 4-22-18 and Staff B told her what happened. Staff B asked Tenant #1 what his/her spouse would think and asked why Tenant #1 was in the room with Tenant #3. Tenant #1 responded he/she wanted to make love to Tenant #3. Staff E reported Tenant #3 was combative the next morning which was not normal for Tenant #3.

When interviewed Staff F reported Tenant #3 would not be able to undress or dress

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himself/herself. Tenant #3 had white protective undergarments. Tenant #1's protective undergarments were gray.

When interviewed Staff G reported the staffing ratio had always been four staff on second shift. At the time of the incident between Tenant #1 and Tenant #3 there was only three staff. There was one person for two neighborhoods. Staff G did not feel it was safe with three staff before 8:00 p.m.

When interviewed Staff J reported it was a safety issue with one staff in one building (two neighborhoods). Staff J worked with Tenant #3 the day after the incident and said it was a normal day for Tenant #3.

When interviewed on 5-3-18 at 10:25 a.m. the Regional Director of Operations revealed on the evening of 4-22-18 the ED called her and reported a tenant was in a room with a tenant of the opposite sex and his/her shirt was off. On Monday the ED called and the Regional Director of Operations told her to report it to the Department. The ED said there was something about respite care in the regulations. It was determined further investigation was needed and it needed to be reported. She told the ED to get witness statements and have the Nurse complete assessments. She reported she and the ED did not discuss if Tenant #3 should have been sent out to be seen at the hospital.

Attempts were made to interview Tenant #1 and Tenant #3, but did not reveal any information related to the incident.

When interviewed Tenant #4 reported the written

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A 013	Continued From page 17 statement (noted above) that he/she signed was accurate. When interviewed, Tenant #3's family reported they received a message on the evening of 4-22-18 from the Program requesting a call back. On Monday a telephone conversation occurred between the family and the Program. The family was informed someone removed Tenant #3's shirt, but told there was no reason to believe any sexual acts occurred. The Program reported an examination occurred and there was no indication anything happened. Tenant #3's family reported throughout additional discussions, different accounts of the incident were revealed. The Program did not mention Tenant #3 being nude from the waist down, nor did the Program mention "possible rape." The Program did not offer for Tenant #3 to be seen medically. The family reported there were staff that felt Tenant #3 should have gone to the hospital. The family felt the full story was not given, that the incident was being covered up and minimized. In summary, an incident occurred on the evening of 4-22-18 between Tenant #1 and Tenant #3, while one staff was on duty for two neighborhoods. Tenant #3 was found in a state of undress in a common area of the building, and Tenant #1 was observed attempting to redress Tenant #3. Tenant #3 was found wearing a gray protective undergarment, which was the color of protective undergarment Tenant #1 wore. Prior to the incident, staff assisted Tenant #3 with toileting and a white protective undergarment was applied. A white protective undergarment was found in Tenant #1's garbage. Clothing items belonging to Tenant #3 were found in Tenant #1's apartment, as well as feces (believed to be that	A 013		

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A 013	Continued From page 18 of Tenant #3) on the bed. Tenant #1 acknowledged he/she undressed Tenant #3; however, denied anything more occurred. Staff indicated Tenant #3 would not be able to undress or dress self or apply or remove a protective undergarment. A physical assessment after the incident noted no injuries of Tenant #1 and Tenant #3; however, Tenant #3 declined assessment of his/her genital area. The Nurse recommended Tenant #3 be sent out to the hospital. Program staff reportedly decided Tenant #3 did not need to be evaluated by medical professionals.	A 013		
A 058	481-67.9(4)a Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed ensure the newly hired registered nurse (RN) conducted a review within 60 days of	A 058		

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A 058	Continued From page 19 employment to ensure staff were sufficiently trained and competent in tasks. This pertained to 2 of 3 staff (Staff K & Staff L) employed by the Program at the time of the RN's hire. Findings follow: Record review revealed the current Wellness Director was hired on 4-12-18. Continued record review revealed the following: a. Staff K, hired 3-14-17, received delegation on tasks on 3-14-17 by the former registered nurse. Additional review could not be located. b. Staff L, hired 8-10-09, received delegation on tasks on 3-23-12 by the former registered nurse. Additional review could not be located. When interviewed on 5-3-18 at 9:45 a.m. the Sales Director, Regional Director of Operations and Wellness Director confirmed the RN failed to ensure staff were sufficiently trained and competent.	A 058		
A 149	481-67.9(6) Staffing 481-67.9(231B,231C,231D) Staffing. (6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received required training of identification and reporting	A 149		

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A 149	Continued From page 20 requirements of dependent adult abuse within 6 months of hire and every five years thereafter. This affected 5 of 8 staff reviewed (Staff D, I, K, L and O). Findings follow: Review of personnel files revealed the following: a. Staff D was hired on 9-28-17. Continued record review failed to disclose dependent adult abuse training completed by Staff D. b. Staff I was hired on 3-5-13. Continued record review revealed Staff I completed dependent adult abuse training on 4-11-13. Additional training in the past five years could not be located. c. Staff K was hired on 3-14-17. Continued record review failed to reveal the completion of dependent adult abuse training. d. Staff L was hired on 8-10-09. Continued review of Staff L's personnel file revealed no evidence of completion of dependent adult abuse training. e. Staff O was hired on 3-14-17. Continued record review revealed no evidence of completion of dependent adult abuse training. When interviewed on 5-2-18 at 8:45 a.m. the Executive Director confirmed the Program failed to ensure staff completed dependent adult abuse training as required.	A 149		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A	A 037		

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A 037	Continued From page 21 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 4 of 4 permanent tenants reviewed (Tenants #2, #3, #5 and #6). Findings follow: 1. Record review revealed Tenant #2's Nurse's Notes indicated the following: a. On 4-14-18 Tenant #2 was found sitting in a tenant's apartment of the opposite sex. Tenant #2 was redirected, the door was locked and Tenant #2's family was notified. b. On 4-23-18 a verbal order from the doctor was received to start Alprazolam 0.5 milligram, take a 1/2 tablet one hour before showers and shampooing.	A 037		

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A 037	Continued From page 22 Record review of a staff communication book indicated the following: a. On 4-12-18 Tenant #2 bit staff and was physically aggressive towards staff who tried to get him/her dressed. b. On 4-14-18 Tenant #1 needed to be watched around Tenant #2 and he/she kept trying to kiss Tenant #2. Tenant #1 and Tenant #2 were in Tenant #1's apartment and Tenant #2 was in Tenant #1 bed and Tenant #1 was not. Tenant #2 went to his/her apartment and Tenant #1 tried to go in there too. c. On 4-14-18 Tenant #2 tried to bite staff, screamed and tried to attack staff. d. On 4-15-18 Tenant #1 was stalking Tenant #2, pulled on Tenant #2 and fixated on Tenant #2. Staff could not redirect Tenant #1. Tenant #1's family was called and came in to redirect Tenant #1. It was noted to write down (time and date) every time something happened between Tenant #1 and Tenant #2. e. On 4-19-18 Tenant #1 was "getting inappropriate" with Tenant #2 and Tenant #1 was moved to back room to color and play a game. Tenant #1 tried to take Tenant #2 to his/her apartment. Continued record review revealed evaluations not completed as needed with Tenant #2's behaviors towards staff, behaviors between Tenant #1 and Tenant #2 and the administration of Alprazolam prior to bathing. 2. Record review revealed a Resident Incident	A 037		

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A 037	Continued From page 23 Report dated 4-22-18 at 6:20 p.m. Staff A was in the dining room washing dishes when Tenant #4 notified staff that Tenant #1 "molested" Tenant #3. Staff immediately dropped everything and ran to another area of the building and found Tenant #3 with Tenant #1's shirt halfway over Tenant #3's head and Tenant #1 adjusted his/her clothes. A Witness Statement dated 4-22-18 at 6:20 p.m. revealed Staff A washed dishes and Tenant #4 approached her and stated Tenant #1 had "molested" Tenant #3. Staff A ran to the other side of the building and found Tenant #3 half nude with Tenant #1's pants around Tenant #3's legs and Tenant #1 stood next to Tenant #3 and adjusted his/her pants. Staff A looked for Tenant #3's clothes and found them in Tenant #1's apartment on the floor. There was feces on the bed and it was noted Tenant #3 was impacted prior to the incident. A Witness Statement dated 4-22-18 at 7:00 p.m. revealed the Nurse was notified Tenant #1 was found in the fish tank room with another tenant, who was unclothed except for a protective undergarment. The Nurse went to the Program to investigate. She took Tenant #1 into the restroom and examined his/her body for stool and injuries. No injuries were noted and no stool was found on any part of his/her body including hands and nail beds. Tenant #1's protective undergarment did not have any stool or other bodily fluids. When asked if Tenant #1 undressed Tenant #3 he/she said yes and it was because he/she wanted to see Tenant #3 in the nude. Tenant #1 denied having sex with Tenant #3 and said his/her spouse would be upset. The Nurse asked if he/she had sex with other tenants and Tenant #1 said no. Tenant #1 was dressed and returned to	A 037		

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a television room in a different part of the Program. The Nurse went to Tenant #1's apartment and found a white protective undergarment with a dark brown hard stool in the waste basket. The bed was made and there was no indication of anyone laying on the bed. At the edge of the bed there was a large pile of dark brown stool. There was no stool on the floor or surrounding sheets. The protective undergarment was examined for bodily fluids and none was found with the exception of the dark brown stool.

A Witness Statement dated 4-22-18 at 7:00 p.m. revealed the Tenant #3 was awake in bed when the Nurse came to assess him/her. Tenant #3's skin was assessed and no visible injuries were noted and no stool was found on his/her body. When the Nurse attempted to look at his/her groin, Tenant #3 clamped his/her legs together and said no. The protective undergarment that was removed prior to bedtime cares was observed and only a smeared stool was visible. No other visible bodily fluids were noted.

Evaluations were not completed as needed with significant change for Tenant #3 after the incident that occurred on 4-22-18.

3. Record review revealed Tenant #5's Resident Incident Reports indicated the following:

a. On 1-9-18, Tenant #5 pulled his/her fist back like he/she was going to hit Tenant #6.

b. On 1-11-18, Tenant #5 punched Tenant #6 in the stomach several times.

c. On 3-9-18, Tenant #5 attacked three employees.

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	S0017	A. BUILDING: _____ B. WING _____	C 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR	900 W 46TH ST DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 037	Continued From page 25 An interview with Staff P on 5-1-18 at 1:38 p.m. revealed Tenant #5 chased her down the hall. Tenant #5 asked Staff P if he/she had scared Staff P, which he/she did. Staff P witnessed Tenant #5 get in the face of another tenant when Tenant #5 thought the tenant was wearing his/her coat. Additional record review revealed no indication of evaluations completed as warranted by Tenant #5's behavior towards staff and peers, a significant change. 4. Continued review of Tenant #5's Resident Incident Reports indicated the following: a. On 1-30-18, Tenant #5 rolled out of bed. The nurse added Tenant #5 would be working with physical therapy. b. On 3-14-18, Tenant #5 was found on the ground following a fall. c. On 4-12-18, Tenant #5 attempted to sit in a chair, missed it and fell on the floor. Continued record review revealed a Nurses' Note on 2-12-18 documented the RN called to assess resident after a fall. The note documented complaints of pain with movement of left lower extremity. Tenant #5 was sent to ER via ambulance. Tenant #5 returned to the program later that day without injuries. Record review revealed Tenant #5 was evaluated for Physical Therapy and began receiving the service on 1/23/18.	A 037		

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A 037	Continued From page 26 Continued record review revealed evaluations not completed as needed with falls or the addition of physical therapy. 5. Record review revealed Tenant #6's Nurses' Notes indicated the following: a. On 1-11-18, Tenant #6 had been experiencing an increase in behaviors and outbursts. b. On 1-18-18, Tenant #6 received a new order for Xanax, 1 tab, twice daily PRN. When interviewed, Staff F revealed Tenant #6 experienced hallucinations during the month of January 2018 which resulted in Tenant #6 being loud and talking to his/her self. Tenant #6 also scratched a lot in January 2018, which still occurred multiple times a day. Record review revealed no completion of evaluations a warranted by Tenant #6's increased behaviors. 6. Continued review of Nurses' Notes revealed on 11-13-17, Tenant #6 began exhibit symptoms of a sore neck. Review of Tenant #6's service plan revealed: a. Physical therapy was added on 11-15-17. b. A Neck brace was added on 11-17-17. Staff F reported Tenant #6 was fine one day and the next day was unable to lift his/her head which caused issues with his/her ability to eat. Staff F	A 037		

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A 037	Continued From page 27 believed Tenant #6 was seen by a doctor, who ordered Tenant #6 to wear a neck brace. According to Staff F, Tenant #6 received physical therapy to address this condition, but Staff F did not note any improvement. Staff F believed the physical therapist recommended against use of the neck brace. Record review revealed evaluations not completed as needed with Tenant #6's concerns with his/her neck and issues with eating. When interviewed on 5-3-18 at 11:10 a.m. the Wellness Director confirmed the above findings for Tenant #2 and #3.	A 037		
A 071	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurses' notes by exception. This pertained to 4 of 4 permanent tenants (Tenants #2, #3, #5 and #6). Findings follow:	A 071		

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A 071	Continued From page 28 1. Record review revealed the following regarding Tenant #2: a. Tenant #1's nurses' notes documented on 4-15-18 Tenant #2 was found sitting on Tenant #1's bed. Staff removed Tenant #2 and redirected Tenant #1 to the coloring area. The apartment door was locked and Tenant #1's family came in. b. Tenant #1's nurses' notes documented on 4-20-18 staff found Tenant #1 holding hands with Tenant #2 in the television area. Review of the staff communication book indicated the following: c. On 4-12-18 Tenant #2 bit staff and was physically aggressive towards staff who tried to get him/her dressed. d. On 4-14-18 Tenant #2 tried to bite staff, screamed and tried to attack staff. e. On 4-15-18 Tenant #1 was stalking Tenant #2, pulled on Tenant #2 and fixated on Tenant #2. Staff could not redirect Tenant #1. Tenant #1's family was called and came in to redirect Tenant #1. It was noted to write down (time and date) every time something happened between Tenant #1 and Tenant #2. f. On 4-18-18 another tenant grabbed Tenant #2 out of a chair, squeezed him/her and pushed him/her. g. On 4-19-18 Tenant #1 was "getting inappropriate" with Tenant #2 and Tenant #1 was moved to back room to color and play game.	A 071		

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A 071	Continued From page 29 Tenant #1 tried to take Tenant #2 to his/her apartment. Record review of Tenant #2's nurses' notes revealed no entries related to the incidents listed above. The Program failed to document nurses' notes by exception. 2. Record review of Tenant #1's nurses' notes revealed on 4-12-18 staff reported Tenant #1 was found in Tenant #3's apartment. Tenant #3's pants were off and hung in Tenant #3's closet. Tenant #3's pants were on his/her head. Staff was instructed to keep Tenant #1 on his/her side of the building. Continued record review of Tenant #3's nurses' notes revealed no entry found related to the incident above. 3. Record review for Tenant #5 revealed the following: a. A Resident Incident Report dated 1-9-18 revealed Tenant #5 pulled his/her fist back like he was going to hit Tenant #6. b. A Resident Incident Report dated 1-11-18 revealed Tenant #5 hit Tenant #6 in the stomach several times. c. Documentation from Kindred at Home dated 1-23-18 revealed Tenant #5 evaluated for Physical Therapy. Tenant #5 received physical therapy from that date until 3-20-18. d. A Resident Incident Report dated 2-3-18	A 071		

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A 071	Continued From page 30 revealed Tenant #5 complained of not feeling well, passed out and hit his/her head on the table. Tenant #5 was taken to the hospital via ambulance. e. A Resident Incident Report dated 3-9-18 revealed Tenant #5 attacked three staff. Continued record review of Tenant #5's nurses' notes revealed no entries related to the incidents listed above. The Program failed to document nurses' notes by exception. 4. Record review for Tenant #6 revealed the following: a. An entry on Tenant #6's service plan indicated the tenant began physical therapy on 11-15-17. b. An entry on Tenant #6's service plan indicated the tenant began wearing a neck brace on 11-15-17. An interview conducted with Staff F revealed Tenant #6 was fine one day in November and the next day was unable to lift his/her head which caused issues with Tenant #6 being able to eat. Staff F believed Tenant #6 was seen by a doctor, who ordered Tenant #6 to wear a neck brace. Tenant #6 had physical therapy, according to Staff F, to address the condition but it did not improve. Staff F believed the physical therapist recommended against use of the neck brace. Record review of Tenant #6's nurses' notes revealed a note dated 11-13-17 revealed Tenant #6 had a sore neck and an appointment was scheduled for the following date. Not additional	A 071		

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A 071	Continued From page 31 entries could be located. When interviewed on 5-3-18 at 11:10 a.m. the Wellness Director confirmed the above findings for Tenants #2 and #3.	A 071		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to develop service plans to appropriate reflect the specific service needs of the tenants. This pertained to 3 of 4 permanent tenants reviewed (Tenant #2, #5 and #6). Findings follow: 1. Record review revealed Tenant #2's nurses' notes indicated the following: a. On 4-14-18 Tenant #2 was found sitting in a tenant's apartment of the opposite sex. Tenant #2 was redirected, the door was locked and Tenant #2's family was notified. Continued record review revealed the staff	A 083		

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A 083	Continued From page 32 communication book provided the following information: a. On 4-14-18 Tenant #1 needed to be watched around Tenant #2, as he/she kept trying to kiss Tenant #2. Tenant #1 and Tenant #2 were in Tenant #1's apartment. Tenant #2 was in Tenant #1's bed, but Tenant #1 was not. Tenant #2 went to his/her apartment and Tenant #1 tried to follow. b. On 4-19-18 Tenant #1 was "getting inappropriate" with Tenant #2 and Tenant #1 was moved to back room to color and play a game. Tenant #1 tried to take Tenant #2 to his/her apartment. Additional record review revealed Tenant #2's service plan failed to reflect the behavior between Tenant #2 and Tenant #1 and failed to provide interventions related to the behavior. 2. Record review revealed Tenant #2's nurses' notes indicated the following: a. On 4-23-18 a verbal order from the doctor was received to start Alprazolam 0.5 milligram, take a 1/2 tablet one hour before showers and shampooing. Continued record review of the staff communication book indicated the following: a. On 4-12-18 Tenant #2 bit staff and was physically aggressive towards staff who tried to get him/her dressed. b. On 4-14-18 Tenant #2 tried to bite staff, screamed and tried to attack staff. Further record review revealed Tenant #2's service plan failed to reflect Tenant #2's	A 083		

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A 083	Continued From page 33 behaviors towards staff, as well as the administration of Alprazolam prior to bathing. 3. Record review revealed the following incident reports for Tenant #5: a. On 1-9-18, Tenant #5 jumped up and pulled his/her fist back like he/she was going to hit Tenant #6. b. On 1-11-18, Tenant #5 hit Tenant #6 in the stomach several times. c. On 3-9-18, Tenant #5 tried attacking three staff and another tenant intervened to protect the staff members. An interview with Staff P on 5-1-18 at 1:38 p.m. revealed Tenant #5 had chased her down the hall. Tenant #5 asked Staff P if he/she had scared Staff P, which he/she did. Staff P witnessed Tenant #5 get in the face of another tenant when Tenant #5 thought the tenant was wearing his/her coat. Further record review revealed Tenant #5 's service plan, dated 12-15-17, failed to address the tenant 's aggression toward other tenants or staff. 4. Record review revealed incident reports indicated Tenant #5 experienced falls on 1-30-18, 3-14-18 and 4-12-18. Additional record review revealed documentation from Kindred at Home, dated 1-23-18, reflected Tenant #5 was being evaluated for Physical Therapy. Tenant #5 received physical therapy	A 083		

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A 083	Continued From page 34 from that date until 3-20-18. Continued record review revealed Tenant #5's service plan identified the tenant as independent in mobility. The service plan also indicated Tenant #5 had no known history of falls. 5. Observation on 5-1-18 from 11:45 a.m. to 12:05 p.m. at lunch revealed Tenant #6 with his/her head bent forward and chin almost touching his/her chest. Staff L provided verbal prompting for Tenant #6 to raise his/her head, which Tenant #6 did not do. Staff L encouraged Tenant #5 to pick up a spoon to eat, which Tenant #6 did not do. Staff L was able to feed Tenant #6 three bites of food. Record review of Nurse's Notes revealed an entry dated 1-11-18 documented Resident #6 had an increase in behaviors and outburst. When interviewed Staff F reported Tenant #6 was fine one day and the next day was unable to lift his/her head which caused issues with Tenant #6 being able to eat. Staff F believed Tenant #6 was seen by a doctor, who ordered Tenant #6 to wear a neck brace. According to Staff F, Tenant #6 received physical therapy to address this condition,; however, Staff F did not note any improvement. Staff F believed the physical therapist recommended against use of the neck brace. An interview conducted with the Wellness Director on 5-2-18 at 2:40 p.m. revealed Tenant #6 does "shriek" at times. A Nurse Review dated 3-1-18 stated, "Resident scratches crotch and bottom".	A 083		

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A 083	Continued From page 35 Further record review revealed Tenant #6 's service plan, dated 9-1-17, identified Tenant #6 required frequent cueing and reminders to eat. The serviced plan failed to include any updates to address Tenant #6 's neck condition or the difficulties this caused with eating. 6. When interviewed on 5-2-18 at 2:40 p.m. and on 5-3-18 at 11:10 a.m. the Wellness Director confirmed service plans had not been updated with a significant change.	A 083		
A 104	481-69.28(5) Food Service 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide an orientation on safe food handling prior to serving meals. This pertained to 3 of 3 staff hired since September 2017 (Staff D, Staff J and Staff M) . Findings follow: 1. Record review revealed Staff D was hired on 9-28-17. Staff D's job responsibilities included serving food.	A 104		

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A 104	Continued From page 36 Continued record review revealed no indication Staff D received training on sanitation and safe food handling prior to handling tenant food. 2. Record review revealed Staff J was hired on 11-22-17. Staff J's job responsibilities included serving food. Continued record review revealed no indication Staff J received training on sanitation and safe food handling prior to handling tenant food. 3. Record review revealed Staff M was hired on 3-14-18. Staff M's job responsibilities included serving food. Continued record review revealed Staff M did not receive training on sanitation and safe food handling prior to handling tenant food. When interviewed on 5-2-18 at 8:45 a.m., the Executive Director confirmed the Program failed to ensure staff received training regarding safe food handling.	A 104		
A 107	481-69.28(5)a(3) Food Service 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. a. In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection	A 107		

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A 107	Continued From page 37 program by: (3) Successfully completing an ANSI-accredited certified food protection manager program meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another program may be substituted if the program's curriculum includes substantially similar competencies to a program that meets the requirements of the Food Code and the provider of the program files with the department a statement indicating that the program provides substantially similar instruction as it relates to sanitation and safe food handling. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure the Dietary Manager completed a state-approved food protection program. Finding follows: Record review revealed the Dietary Manager initially hired by the Program on 12-4-11, as certified nursing assistant. Continued record review revealed the Dietary Manager was promoted to her current position on 1-8-17. Additional record review revealed no indication the Dietary Manager completed a state-approved food protection program. When interviewed on 5-1-18 at 11:45 a.m. the Executive Director confirmed the Program failed to ensure the Dietary Manager completed	A 107		

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A 107	Continued From page 38 required training.	A 107		
A 121	481-69.30(1) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received dementia-specific education within 30 days of employment. This pertained to 6 of 6 newly hired staff (Staff D, J, K, M, N and O). Findings follow: 1. Record review revealed Staff D was hired on 9-28-17. Continued record review failed to produce evidence to indicate completion of dementia training. 2. Record review revealed Staff J was hired on 11-22-17. Continued record review revealed the Program could not provide evidence of completion of dementia training.	A 121		

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A 121	Continued From page 39 3. Record review revealed Staff K was hired on 3-14-17. Continued record review failed to produce evidence of dementia training. 4. Record review revealed Staff M was hired on 3-14-18. Continued record review revealed the program failed to provide dementia training to Staff M. 5. Record review revealed Staff N was hired on 3-5-18. Continued record review revealed the Program failed to provide dementia training to Staff N. 6. Record review revealed Staff O was hired on 3-14-17. Continued record review failed to produce evidence of dementia training for Staff O. When interviewed on 5-2-18 at 8:45 a.m., the Executive Director confirmed the Program failed to provide dementia training.	A 121		
A 123	481-69.30(3)a Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(3)a Except as otherwise provided in this subrule, all personnel employed by or	A 123		

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A 123	Continued From page 40 contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide dementia-specific continuing education on an annual basis for long-term staff. This pertained to 2 of 2 long-term staff reviewed (Staff I and Staff L). Findings follow: 1. Record review revealed Staff I was hired on 3-5-13. Continued record review revealed Staff I received dementia specific training on 2-21-17; however, no additional documented training could be located. 2. Record review revealed Staff L was hired on 8-10-09. Continued record review revealed Staff L received dementia specific training on 2-21-17; however, no additional documented training could be located. When interviewed on 5-2-18 at 8:45 a.m., the Executive Director confirmed these findings.	A 123		
A 183	481-69.39(1) Respite Care Services	A 183		

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A 183	Continued From page 41 481-69.39(231C) Respite care services. 69.39(1) Length of stay. Respite care services shall be provided for no more than 30 consecutive days and for a total of no more than 60 days in a consecutive 12-month period. The 12-month period begins on the first day of the respite care individual ' s stay in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure provision of respite services did not exceed the allowable length of stay. This pertained to 2 of 3 tenants reviewed receiving respite care services (Tenants #7 and #8). Findings follow: 1. Record review revealed a tenant list provided by the Program listed Tenant #7 as "Day Respite" with an admission date of 9-14-16. Continued record review revealed Tenant #7 's Power of Attorney (POA) signed an Assisted Living Residence and Services Agreement on 9-11-16 to receive respite service on a daily basis. When interviwed Staff L revealed Tenant #7 came to the Program daily from sometime after breakfast until 3:00 p.m. 2. Record review revealed a tenant list provided by the Program listed Tenant #8 as "Day & Overnight Respite," with an admission date of 8-25-17. Continued record review revealed Tenant #8 's	A 183		

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A 183	Continued From page 42 POA signed an Assisted Living Residence and Services Agreement on 8-23-17 to receive day and overnight respite as needed. The agreement listed the dates of services as 8-25-17 to "TBD" (To be determined). When interviewed, Staff L revealed Tenant #8 came to the Program usually after lunch until 7:00 p.m. and on some weekends. When interviewed on 5-3-18 at 9:45 a.m. the Sales Director, Regional Director of Operations and Wellness Director confirmed the tenants received respite care services in excess of 60 days in a 12-month period.	A 183		
A 189	481-69.39(4) Respite Care Services 481-69.39(231C) Respite care services. 69.39(4) Written direction to staff. The program nurse shall document the care needs of the respite care individual based on the assessment conducted pursuant to subrule 69.39(3) and provide the documentation to staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document the care needs of respite care individuals based on the assessment. This pertained to 1 of 3 respite care tenants reviewed (Tenant #1). Findings follow: 1. Record review revealed Tenant #1 moved into the Program on 4-6-18 as a respite care individual. Tenant #1 had a diagnosis of early	A 189		

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A 189	Continued From page 43 onset Alzheimer's disease without behavioral disturbance. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #1 moved out of the Program on 4-26-18. Record review of Tenant #1's Nurse's Notes revealed the following: a. On 4-12-18 staff reported Tenant #1 was found in Tenant #3's apartment. Tenant #1's pants were off and hung in Tenant #3's closet. Tenant #3's pants were on his/her head. Staff was instructed to keep Tenant #1 on his/her side of the building. b. On 4-14-18 staff reported Tenant #1 made sexual comments to staff. Staff was instructed to keep Tenant #1 in the coloring area and to contact his/her spouse to come and sit with Tenant #1. Tenant #1's spouse came in for the remainder of the day. c. On 4-15-18 Tenant #2 was found sitting on Tenant #1's bed. Staff removed Tenant #2 and redirected Tenant #1 to the coloring area. The apartment door was locked and Tenant #1's family came in. d. On 4-20-18 staff found Tenant #1 holding hands with Tenant #2 in the television area. 2. Record review of a staff communication book indicated the following: a. On 4-14-18 Tenant #1 needed to be watched around Tenant #2, as he/she kept trying to kiss Tenant #2. While Tenant #1 and Tenant #2 were in Tenant #1's apartment, Tenant #2 was in	A 189		

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A 189	Continued From page 44 Tenant #1's bed. Staff directed Tenant #2 to his/her apartment and Tenant #1 tried to follow. Tenant #1 also got into another tenant's bed and staff directed him/her out. b. On 4-15-18 Tenant #1 stalked Tenant #2, pulled on Tenant #2, and fixated on Tenant #2. Staff could not redirect Tenant #1. Tenant #1's family was called and came in to redirect Tenant #1. It was noted to write down (time and date) every time something happened between Tenant #1 and Tenant #2. c. On 4-19-18 Tenant #1 was "getting inappropriate" with Tenant #2 and was moved to the back room to color and play a game. Tenant #1 tried to take Tenant #2 to his/her apartment. 3. Continued record review revealed a Resident Incident Report, dated 4-22-18 at 6:20 p.m., documented Staff A washed dishes in the dining room when Tenant #4 notified staff Tenant #1 "molested" Tenant #3. Staff immediately dropped everything and ran to another area of the building and found Tenant #3 with Tenant #1's shirt halfway over Tenant #3's head and Tenant #1 adjusted his/her clothes. When interviewed Staff A reported she worked a 12 hour shift for two neighborhoods. Dinner was served around 4:30 p.m. Staff A assisted Tenant #3 with toileting after supper at 6:00 p.m. and noted Tenant #3 was impacted. A white protective undergarment was applied. Staff A then assisted another tenant with toileting. Tenant #1 finished supper early, went to the bathroom and was last seen around 5:30 p.m. While doing dishes Staff A was notified by Tenant #4 that Tenant #1 was "molesting" Tenant #3. Staff A ran to the opposite	A 189		

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A 189	Continued From page 45 side of the building and found Tenant #3 in the fish tank area. Tenant #3 had Tenant #1's shirt around his/her neck, had Tenant #1's pants around his/her ankles, a protective undergarment on (gray), and no shoes. Tenant #1 was fully dressed and tried to get a shirt on Tenant #3. Staff A called Staff H for assistance. Staff A and Staff H went to Tenant #1's apartment to find Tenant #3's clothes. Tenant #3's shoes, undergarment were on the floor in Tenant #1's apartment. There was feces in the middle of the bed. Tenant #1's white protective undergarment was in the garbage. Staff H took Tenant #1 to a different building. Tenant #3 was taken to the bathroom to assist with pajamas and to get a new protective undergarment. There was bowel movement in between his/her legs. The incident report was completed and ED and the Nurse arrived. Staff A hugged Tenant #3 and provided reassurance. Tenant #3 looked frightened and exhausted. When interviewed on 4-26-18 at 9:17 a.m. the Nurse reported she received a call from Staff A on 4-22-18 at 7:00 p.m. regarding a problem with Tenant #1. Staff A informed the Nurse she found Tenant #3 in the fish tank area. Tenant #3 did not wear clothes, but wore Tenant #1's gray protective undergarment. Tenant #1 was clothed. Staff redirected Tenant #1 and took Tenant #3 to clean up. Staff A went to Tenant #1's apartment and found Tenant #3's white protective undergarment in Tenant #1's garbage. Tenant #3's undergarment and shoes were on the floor. There was a hard stool in the protective undergarment and a large soft stool on the bed. Staff A worked in two neighborhoods in the building that weekend, as staff was cut down. There had been a loss of three tenants on that	A 189		

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side of the building. The Nurse reported she arrived to the Program about 8:00 p.m. and Tenant #1 was in a different part of the building. The Nurse took Tenant #1 into the restroom with Staff H. There were no apparent injuries and no stool noted on Tenant #1 during the assessment. When asked by the Nurse, Tenant #1 said he/she had undressed Tenant #3 and that he/she undressed Tenant #3 because he/she wanted to see Tenant #3 naked. Tenant #1 was adamant that he/she did not have sex with Tenant #3 and said Tenant #3 said no. The Nurse went to Tenant #3's apartment and she assessed his/her skin and attempted to examine his/her groin and Tenant #3 said no. The staff reported Tenant #3 had stool on his/her legs. She removed the gray protective undergarments from the garbage. She observed no blood or bodily fluids, but did observe a smear of stool. She kept the protective undergarments at that time; however, someone had since thrown them away. The Nurse told the ED Tenant #3 needed to be sent to the hospital for a "rape kit." She felt Tenant #3 had not been physically abused, but recommended to send him/her. The ED and Nurse went to Tenant #1's apartment and observed a white protective undergarment in the garbage. Tenant #1 wore gray protective undergarments and Tenant #3 wore white protective undergarments. Tenant #3 had problems with stools. She reported Tenant #3's stools were round, hard stools and at times were digitally removed. The white protective undergarment in Tenant #1's garbage had hard, dark stool. There was a large soft stool on the edge of the bed. The bed was made and there was a smooth rounded area. It appeared Tenant #3 had sat down and thought the bed was a toilet. Staff was to check on Tenant #1 every 15 minutes after the incident, and was told to shut

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A 189	Continued From page 47 the door between the two neighborhoods. She called back on third shift to ensure Tenant #1 was where he/she needed to be. On Monday the Wellness Director took over the process. She asked the ED about the "rape kit" and was told the Regional Director of Operations did not feel it was needed. The Nurse felt it was needed to protect Tenant #1, Tenant #3 and the Program. Tenant #3 could not remove or apply a protective undergarment and could not remove his/her shoes. Tenant #3 was not oriented to person, place or time. Tenant #1 was oriented to person, but not place or time. When interviewed the ED revealed she received a telephone call at about 6:30 p.m. on 4-22-18 regarding a potential incident between Tenant #1 and Tenant #3. She directed staff to call the Nurse. She arrived less than 20 minutes later and visited with Tenant #1. He/she could not recall what happened. Tenant #1 said he/she removed Tenant #3's shirt and nothing else occurred. Staff A informed her Tenant #4 reported Tenant #1 was "molesting" Tenant #3 and she responded. Tenant #3 was nude from the waist up and Tenant #1 was clothed. Staff A observed Tenant #1 attempt to put a shirt on Tenant #3. Staff A went to Tenant #1's apartment and found Tenant #3's undergarment and shoes on the floor, feces on the bed and a protective undergarment in the garbage. Tenant #4 reported Tenant #3's shirt was off and he/she had pants on but was nude from the waist up. Tenant #4 told her he/she saw Tenant #3 walk into the fish tank area and went to get Staff A. Tenant #4 reported Tenant #1 was "molesting" Tenant #3. When she asked Tenant #4 if he/she saw anything he/she said no and he/she used the word for attention. The Nurse completed an in	A 189		

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A 189	Continued From page 48	A 189		

depth physical exam of Tenant #1 and Tenant #3. The ED and Nurse went to Tenant #1's apartment and observed Tenant #3's undergarment and shoes on the floor and a white protective undergarment in the garbage with feces in it. The comforter and top sheet were folded over on the bed and there was feces on the chux. The Nurse suggested an emergency room visit for Tenant #3. The Regional Director of Operations was consulted and decided they would not end Tenant #3 to the emergency room, as they did not believe there was not any indication at that time. Tenant #1 was placed on 15 minute checks. A message was left for Tenant #3's family at 9:00 p.m. on Sunday and the family called on Monday. She talked with Tenant #3's family on Monday and advised the family of what happened and let them know Tenant #3 was ok. She let them know the other tenant would be leaving the Program. Prior to the incident a plan was in place to extend Tenant #1's respite and to sign paperwork on Monday 4-23-18. On 4-24-18 Tenant #1's family was told of the incident and informed Tenant #1 needed a higher level of care. On 4-23-18 additional family members of Tenant #3 stopped by and felt the investigation of the incident need to continue.

When interviewed on 4-30-18 at 1:23 p.m. the Wellness Director revealed on a weekend she was called by the ED and informed of an incident between Tenant #1 and Tenant #3. On Monday (4-23-18) the ED and Wellness Director met with Tenant #1's spouse and told the spouse that the Program could not meet Tenant #1's needs and the spouse was given resources for placement. On Tuesday (4-24-18) the ED and Wellness Director met with Tenant #3's family. It was shared with them what Staff A had reported. The

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A 189	Continued From page 49 family asked to speak with the Nurse and Staff A. The Nurse came in and said a white protective undergarment was in Tenant #1's garbage, belonging to Tenant #3. There was feces in it and there was feces on Tenant #3. Family felt they did not have the full picture. The ED and Wellness Director spoke with Staff A and Staff A reported Tenant #3 was in the fish tank area, without a shirt or undergarment on and had on Tenant #1's protective undergarment. Tenant #1 was attempting to put his/her shirt on Tenant #3. Tenant #3 had Tenant #1's pants on at his/her feet. In Tenant #1's apartment she found an undergarment on the floor, a pile of feces on the bed and the bed was made. On Tuesday the ED called Staff H and Staff H reported Tenant #3 was naked and had Tenant #1's protective undergarment on him/her. Tenant #4 had reported to a staff member that he/she saw Tenant #1 "humping" Tenant #3. When interviewed Tenant #4 said that he/she did not see that. The Nurse mentioned a couple of times that Tenant #3 should have had a "rape kit." When interviewed Staff B said she arrived at 6:20 p.m. to 6:30 p.m. and Tenant #1 stood in the fish tank area "messing around" with his/her belt. Staff A came from down the hallway and reported Tenant #1 had "molested" Tenant #3. Staff A was in the bathroom with Tenant #3. Another staff called management staff and took Tenant #1 to the other building. The ED and Nurse arrived while Staff A completed her report. Staff A reported Tenant #4 reported to her that Tenant #1 "molested" Tenant #3. When Staff A had Tenant #3 in the bathroom it was noted Tenant #3 had on a gray protective undergarment. Tenant #1 was the only tenant with gray briefs. The Nurse wanted to send Tenant #3 out to be seen at the	A 189		

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A 189	Continued From page 50 hospital. Staff B went to Tenant #1's apartment and Tenant #3's shoes and undergarment was on the floor. His/her shirt was in the chair. There was stool on the bed, approximately four to five inches from the edge into the center. Tenant #3 was taken to the bathroom and Staff B said he/she did not want her "down there." Normally it was not an issue with Tenant #3. Staff B said Tenant #3 was up a lot in bed that night and did not sleep like his/her normal self. At one point Tenant #3 sat on the edge of the bed, mumbled and jerked all of the sudden as if he/she was scared. Staff B said Tenant #3 was not his/her normal self that night. At 11:00 p.m. Tenant #1 was brought back to other building. His/Her laundry was done and his/her bed was made close to 1:00 a.m. At approximately 1:30 a.m. Tenant #1 sat with staff in the common area and said his/her spouse was going to be mad. When staff asked why Tenant #1 said, "Because I raped (Tenant #3) tonight and kissed (him/her) twice." When interviewed Staff C reported she worked on 4-23-18, after the incident, and heard Tenant #1 might have "molested" Tenant #3. Staff C overheard Tenant #4 tell a staff that Tenant #1 was on top of Tenant #3. Tenant #4 met with management staff and the story changed. When Staff C assisted Tenant #3 with toileting the day after the incident, Tenant #3 tried to hit when his/her pants were pulled down. At a meal, Tenant #3 balled up his/her fist at staff. It was not a normal reaction for Tenant #3. Tenant #3 could not undress or redress himself/herself. Tenant #3 could not remove his/her shoes. The Nurse wanted Tenant #3 to be checked and a conclusion was reached to not send Tenant #3 out.	A 189		

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A 189	Continued From page 51 When interviewed Staff D said she found out about the incident when she arrived at work. It was very upsetting to staff. She overheard Tenant #4 tell another staff that Tenant #1 was on top of Tenant #3. Tenant #4 knew names and remembered quite well. Staff D did not think Tenant #4 would fabricate it. Management staff talked with Tenant #4 and his/her story changed. Tenant #3 was not able to undress and dress himself/herself. After toileting Tenant #3 would try to pull up the protective undergarment or pants but could not take it off. The day after the incident Tenant #4 did not want to sit by Tenant #1 at meals. Tenant #3 yelled when staff tried to assist with toileting. It was not normal for Tenant #3 and he/she was protective of himself/herself. When interviewed Staff E said she arrived at work at 11:20 p.m. on 4-22-18 and Staff B told her what happened. Staff B asked Tenant #1 what his/her spouse would think and asked why Tenant #1 was in the room with Tenant #3. Tenant #1 responded he/she wanted to make love to Tenant #3. Staff E reported Tenant #3 was combative the next morning which was not normal for Tenant #3. When interviewed Staff F reported Tenant #3 would not be able to undress or dress himself/herself. Tenant #3 had white protective undergarments. Tenant #1's protective undergarments were gray. 4. Further record review revealed New Resident Notification for Tenant #1 documented a move-in date of 4-6-18. The document noted Tenant #1 may ask if he/she could have a kiss and instructed staff to politely decline and remind him/her he/she was married. The plan failed to	A 189		

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A 189	Continued From page 52 provide interventions to address inappropriate behavior towards other tenants. Tenant #1's service plan, dated 4/5/18, failed to note Tenant #1's inappropriate behavior towards staff and peers. A note added 4-24-18 noted Tenant #1 would have 15 minute checks, but failed to disclose why. When interviewed on 4-26-18 at approximately 9:20 a.m., the Nurse reported she completed Tenant #1's pre-admission evaluation. During the evaluation, Tenant #1 told the Nurse he/she wanted to kiss her lips, as well as other comments of that nature. When interviewed on 5-3-18 at 11:10 a.m. the Wellness Director confirmed the service plan failed to reflect Tenant #1's behavior.	A 189		
A 191	481-69.39(6)a Respite Care Services 481-69.39(231C) Respite care services. 69.39(6) Contract. The program shall have a contract with each respite care individual. The contract shall, at a minimum, include the following: a. The time period during which the individual will be considered to be receiving respite care services, not to exceed 30 consecutive days. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 191		

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A 191	Continued From page 53 Program failed to have a contract with each respite care individual. This pertained to 1 of 3 respite care tenants reviewed (Tenant #1). Findings follow: 1. Observation on 4-25-18 and 4-26-18 revealed Tenant #1 present at the Program. Record review revealed Tenant #1's Assisted Living Residence and Services Agreement, signed by Tenant #1's Power of Attorney (POA) 4-6-18. The agreement documented Tenant #1's respite stay for 4-6-18 - 4-20-18. Additional record review revealed no additional contracts for services after 4-20-18. Observation revealed Tenant #1 moved out of the Program on 4-26-18. When interviewed on 4-26-18 at 11:54 a.m. the Executive Director confirmed the Tenant #1 had one respite care contract and a new contract was not signed.	A 191		
A 203	481-69.39(8) Respite Care Services 481-69.39(231C) Respite care services. 69.39(8) Level of care criteria. Respite care individuals must meet the criteria found in subrule 69.23(1) for admission and retention of tenants. Respite care services shall not be provided by an assisted living program to persons requiring a level of care which is higher than the level of care the program is certified to provide. This REQUIREMENT is not met as evidenced	A 203		

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A 203	Continued From page 54 by: Based on interview and record review the Program failed to ensure tenants receiving respite care services met level of care criteria for admission and retention. The Program admitted and continued to provide respite care services to a tenant, despite the tenant's chronic sexually aggressive behavior. This pertained to 1 of 3 respite care tenants reviewed (Tenant #1). Findings follow: 1. Record review revealed Tenant #1 moved into the Program on 4-6-18 as a respite care individual. Tenant #1 moved out of the Program on 4-26-18. 2. Record review of Tenant #1's Nurse's Notes revealed the following: a. On 4-12-18 staff reported Tenant #1 found in Tenant #3's apartment. Tenant #1's pants were off and hung in Tenant #3's closet. Tenant #3's pants were on his/her head. Staff was instructed to keep Tenant #1 on his/her side of the building. b. On 4-14-18 staff reported Tenant #1 made sexual comments to staff. Staff was instructed to keep Tenant #1 in the coloring area and to contact his/her spouse to come and sit with Tenant #1. Tenant #1's spouse came in for the remainder of the day. c. On 4-15-18 Tenant #2 was found sitting on Tenant #1's bed. Staff removed Tenant #2 and redirected Tenant #1 to the coloring area. The apartment door was locked and Tenant #1's family came in. d. On 4-20-18 staff found Tenant #1 holding hands with Tenant #2 in the television area.	A 203		

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A 203	Continued From page 55 3. Continued record review of the staff communication book indicated the following: a. On 4-14-18 Tenant #1 needed to be watched around Tenant #2, as he/she kept trying to kiss Tenant #2. Tenant #1 and Tenant #2 were in Tenant #1's apartment. Tenant #2 was in Tenant #1's bed. Tenant #2 went to his/her apartment and Tenant #1 tried to follow. Tenant #1 also went into another tenant's bed and staff got him/her out. b. On 4-15-18 Tenant #1 stalked Tenant #2, pulled on Tenant #2, and fixated on Tenant #2. Staff could not redirect Tenant #1. Tenant #1's family was called and came in to redirect Tenant #1. It was noted to write down (time and date) every time something happened between Tenant #1 and Tenant #2. c. On 4-19-18 Tenant #1 was "getting inappropriate" with Tenant #2. Tenant #1 was moved to back room to color and play a game. Tenant #1 tried to take Tenant #2 to his/her apartment. 4. Further record review revealed an initial Mini Mental Status Examination, dated 3-30-18 (prior to respite care services), indicated when asked to write a sentence Tenant #1 wrote he/she wanted to kiss on the lips. 5. A New Resident Notification document, dated 4-6-18 indicated Tenant #1 was "Respite for now." The documented noted Tenant #1 might ask if he/she could have a kiss and staff was to politely decline and remind him/her that he/she was married.	A 203		

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A 203	Continued From page 56 6. A Resident Incident Report dated 4-22-18 at 6:20 p.m. Staff A washed dishes in the dining room when Tenant #4 notified her Tenant #1 "molested" Tenant #3. Staff immediately dropped everything and ran to another area of the building. Staff found Tenant #3 with Tenant #1's shirt halfway over Tenant #3's head. Tenant #1 adjusted his/her clothes. When interviewed Staff A reported she worked a 12 hour shift for two neighborhoods. Dinner was served around 4:30 p.m. Staff A assisted Tenant #3 with toileting after supper at 6:00 p.m. and noted Tenant #3 was impacted. A white protective undergarment was applied. Staff A then assisted another tenant with toileting. Tenant #3 usually wandered around but usually did not get into anything. Tenant #1 finished supper early, went to the bathroom and was last seen around 5:30 p.m. While doing dishes Staff A was notified by Tenant #4 that Tenant #1 was "molesting" Tenant #3. Staff A ran to the opposite side of the building and found Tenant #3 in the fish tank area. Tenant #3 had Tenant #1's shirt around his/her neck, had Tenant #1's pants around his/her ankles, a protective undergarment on (gray), and no shoes. Tenant #1 was fully dressed and tried to get a shirt on Tenant #3. Staff A called Staff H for assistance. Staff A and Staff H went to Tenant #1's apartment to find Tenant #3's clothes. Tenant #3's shoes, undergarment were on the floor in Tenant #1's apartment. There was feces in the middle of the bed. Tenant #1's white protective undergarment was in the garbage. Staff H took Tenant #1 to a different building. Tenant #3 was taken to the bathroom to assist with pajamas and to get a new protective undergarment. There was bowel movement in between his/her legs. The incident report was completed and ED and the	A 203		

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A 203	Continued From page 57 Nurse arrived. Staff A hugged Tenant #3 and provided reassurance. Tenant #3 looked frightened and exhausted. When interviewed on 4-26-18 at 9:17 a.m. the Nurse reported she received a call from Staff A on 4-22-18 at 7:00 p.m. regarding a problem with Tenant #1. Staff A informed the Nurse she found Tenant #3 in the fish tank area. Tenant #3 did not wear clothes, but wore Tenant #1's gray protective undergarment. Tenant #1 was clothed. Staff redirected Tenant #1 and took Tenant #3 to clean up. Staff A went to Tenant #1's apartment and found Tenant #3's white protective undergarment in Tenant #1's garbage. Tenant #3's undergarment and shoes were on the floor. There was a hard stool in the protective undergarment and a large soft stool on the bed. Staff A worked in two neighborhoods in the building that weekend, as staff was cut down. There had been a loss of three tenants on that side of the building. The Nurse reported she arrived to the Program about 8:00 p.m. and Tenant #1 was in a different part of the building. The Nurse took Tenant #1 into the restroom with Staff H. There were no apparent injuries and no stool noted on Tenant #1 during the assessment. When asked by the Nurse, Tenant #1 said he/she had undressed Tenant #3 and that he/she undressed Tenant #3 because he/she wanted to see Tenant #3 naked. Tenant #1 was adamant that he/she did not have sex with Tenant #3 and said Tenant #3 said no. The Nurse went to Tenant #3's apartment and she assessed his/her skin and attempted to examine his/her groin and Tenant #3 said no. The staff reported Tenant #3 had stool on his/her legs. She removed the gray protective undergarments from the garbage. She observed no blood or bodily fluids, but did	A 203		

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A 203	Continued From page 58	A 203		

observe a smear of stool. She kept the protective undergarments at that time; however, someone had since thrown them away. The Nurse told the ED Tenant #3 needed to be sent to the hospital for a "rape kit." She felt Tenant #3 had not been physically abused, but recommended to send him/her. The ED and Nurse went to Tenant #1's apartment and observed a white protective undergarment in the garbage. Tenant #1 wore gray protective undergarments and Tenant #3 wore white protective undergarments. Tenant #3 had problems with stools. She reported Tenant #3's stools were round, hard stools and at times were digitally removed. The white protective undergarment in Tenant #1's garbage had hard, dark stool. There was a large soft stool on the edge of the bed. The bed was made and there was a smooth rounded area. It appeared Tenant #3 had sat down and thought the bed was a toilet. Staff was to check on Tenant #1 every 15 minutes after the incident, and was told to shut the door between the two neighborhoods. She called back on third shift to ensure Tenant #1 was where he/she needed to be. On Monday the Wellness Director took over the process. She asked the ED about the "rape kit" and was told the Regional Director of Operations did not feel it was needed. The Nurse felt it was needed to protect Tenant #1, Tenant #3 and the Program. Tenant #3 could not remove or apply a protective undergarment and could not remove his/her shoes. Tenant #3 was not oriented to person, place or time. Tenant #1 was oriented to person, but not place or time.

When interviewed the ED revealed she received a telephone call at about 6:30 p.m. on 4-22-18 regarding a potential incident between Tenant #1 and Tenant #3. She directed staff to call the

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A 203	Continued From page 59	A 203		

Nurse. She arrived less than 20 minutes later and visited with Tenant #1. He/she could not recall what happened. Tenant #1 said he/she removed Tenant #3's shirt and nothing else occurred. Staff A informed her Tenant #4 reported Tenant #1 was "molesting" Tenant #3 and she responded. Tenant #3 was nude from the waist up and Tenant #1 was clothed. Staff A observed Tenant #1 attempt to put a shirt on Tenant #3. Staff A went to Tenant #1's apartment and found Tenant #3's undergarment and shoes on the floor, feces on the bed and a protective undergarment in the garbage. Tenant #4 reported Tenant #3's shirt was off and he/she had pants on but was nude from the waist up. Tenant #4 told her he/she saw Tenant #3 walk into the fish tank area and went to get Staff A. Tenant #4 reported Tenant #1 was "molesting" Tenant #3. When she asked Tenant #4 if he/she saw anything he/she said no and he/she used the word for attention. The Nurse completed an in depth physical exam of Tenant #1 and Tenant #3. The ED and Nurse went to Tenant #1's apartment and observed Tenant #3's undergarment and shoes on the floor and a white protective undergarment in the garbage with feces in it. The comforter and top sheet were folded over on the bed and there was feces on the chux. The Nurse suggested an emergency room visit for Tenant #3. The Regional Director of Operations was consulted and decided they would not end Tenant #3 to the emergency room, as they did not believe there was not any indication at that time. Tenant #1 was placed on 15 minute checks. A message was left for Tenant #3's family at 9:00 p.m. on Sunday and the family called on Monday. She talked with Tenant #3's family on Monday and advised the family of what happened and let them know Tenant #3 was ok. She let them know

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A 203	Continued From page 60 the other tenant would be leaving the Program. Prior to the incident a plan was in place to extend Tenant #1's respite and to sign paperwork on Monday 4-23-18. On 4-24-18 Tenant #1's family was told of the incident and informed Tenant #1 needed a higher level of care. On 4-23-18 additional family members of Tenant #3 stopped by and felt the investigation of the incident need to continue. When interviewed on 4-30-18 at 1:23 p.m. the Wellness Director revealed on a weekend she was called by the ED and informed of an incident between Tenant #1 and Tenant #3. On Monday (4-23-18) the ED and Wellness Director met with Tenant #1's spouse and told the spouse that the Program could not meet Tenant #1's needs and the spouse was given resources for placement. On Tuesday (4-24-18) the ED and Wellness Director met with Tenant #3's family. It was shared with them what Staff A had reported. The family asked to speak with the Nurse and Staff A. The Nurse came in and said a white protective undergarment was in Tenant #1's garbage, belonging to Tenant #3. There was feces in it and there was feces on Tenant #3. Family felt they did not have the full picture. The ED and Wellness Director spoke with Staff A and Staff A reported Tenant #3 was in the fish tank area, without a shirt or undergarment on and had on Tenant #1's protective undergarment. Tenant #1 was attempting to put his/her shirt on Tenant #3. Tenant #3 had Tenant #1's pants on at his/her feet. In Tenant #1's apartment she found an undergarment on the floor, a pile of feces on the bed and the bed was made. On Tuesday the ED called Staff H and Staff H reported Tenant #3 was naked and had Tenant #1's protective undergarment on him/her. Tenant #4 had	A 203		

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A 203	Continued From page 61 reported to a staff member that he/she saw Tenant #1 "humping" Tenant #3. When interviewed Tenant #4 said that he/she did not see that. The Nurse mentioned a couple of times that Tenant #3 should have had a "rape kit." 7. When interviewed Staff A revealed Tenant #1 frequently asked for a kiss and had sexual urges. Tenant #1 always wanted sex. Tenant #1 had told a staff to have sex with him/her now. A document that was provided to staff when Tenant #1 moved in identified Tenant #1 frequently asked for a kiss. Management staff was aware of the behavior and the day Tenant #1 was interviewed (admission to respite care) he/she asked for a kiss. Other tenants did not like to be around Tenant #1. When interviewed Staff B revealed Tenant #1 made sexual comments to staff on a daily basis and would say "let's have sex." When interviewed Staff C revealed Tenant #1 told staff they were going to have sex with him/her. Tenant #1's comments towards staff occurred once per day. A document, normally kept in the medication room, identified Tenant #1 would try to kiss and to tell him/her no and his/her spouse would not like it. Staff C had heard Tenant #1 was in Tenant #2's apartment. Tenant #1 would try and get to Tenant #2. When interviewed Staff D revealed Tenant #1 followed Tenant #2 a lot. Tenant #1 was also around Tenant #3, would be close to him/her and it made staff uncomfortable. When interviewed Staff E revealed Tenant #1 made sexual comments towards staff more than	A 203		

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A 203	Continued From page 62 a couple times per week. It was noted on an information paper that Tenant #1 would ask for a kiss and staff was to redirect him/her. When interviewed Staff F revealed Tenant #1 was seated next to Tenant #2 and tried to kiss him/her, was pulling at Tenant #2. Tenant #1 got very mad when staff redirected and yelled he/she was going to have sex with the staff. Tenant #1's spouse was called. When interviewed Staff J revealed Tenant #1 had asked Staff J to sleep with him/her one time and he/she was redirected. Staff J found Tenant #2 in Tenant #1's bed. Tenant #1 was by the closet and both tenants were dressed. When interviewed on 4-26-18 at 9:17 a.m. with the Nurse said when Tenant #1 was assessed at an adult day services program, the first thing he/she said was "I want to kiss your lips." The Nurse discussed it with staff at the adult day services program and was told he/she made comments but was easily redirected. The Nurse told the Sales Director she did not think they should take him/her. Tenant #1 was admitted for respite care services for a short term stay. After a week she thought Tenant #1 needed one to one care and was not appropriate. When interviewed on 5-3-18 at 11:10 a.m. the Wellness Director confirmed Tenant #1 exceeded the level of care. In summary, Tenant #1 displayed behavior at the initial screen for admission and was accepted for respite care services. During the time of the respite care services Tenant #1 remained at the Program despite sexually aggressive behaviors	A 203		

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A 203	Continued From page 63 displayed towards to staff and tenants. Tenant #1 did not move out until 4-26-18, six days after the initial respite contract expired.	A 203		

OK
6/25/18
5/30/18

COUNTRY MANOR
MEMORY CARE

900 West 46th Street | Davenport, Iowa | p: 563-391-1111 | f: 563-391-6267

May 22, 2018

Iowa Department of Inspection & Appeals
Catie Campbell
Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

Dear Ms. Campbell,

Please see below this the Plan of Correction for the regulatory insufficiencies cited during the recertification and complaint survey conducted by the Department of Inspection and Appeals (DIA) between April 25 through May 3, 2018 at Country Manor Memory Care in Davenport, IA.

Incident Reports-A-003
481-67.2(1)d Program Policies and Procedures
(Incident Reports)

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. Following the results of our most recent onsite visit, along with reviewing our policies, Wellness Director or RN and Interim Executive Director will follow the Grace Management Incident Reporting Policy and Procedure. (see attached policy)

    b. The Wellness Director or RN will ensure Incident Reports and Witness Statements will be gathered for all incidents that occur. All staff will be retrained on proper documentation of Incident Reports, re-educated on guidelines for reports and when to properly use the reports by May 30th, 2018.

2. What measures will be taken to ensure the problem does not recur?
    a. All Incident Reports will be reviewed for completion by the Wellness Director or RN and the Interim Executive Director within 24 hours or the next business day.

3. How the program plans to monitor performance to ensure compliance.
    a. Wellness Director or RN will meet with the Interim Executive Director during daily meeting, or next business day, to review all Incident Reports and Witness Statements to ensure steps taken to prevent reoccurrence.

4. Date by which the regulatory insufficiency will be corrected?
    a. Training and review of Incident Reporting Policy and Procedures will be completed by all staff by May 30, 2018. Training will be conducted by Regional Director of Operations, Wellness Director and Interim Executive Director.

Tenant Rights A 013

481-67.3 Tenant rights: All tenants have the following rights: To receive care, treatment and services which are adequate and appropriate.

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. Staff will notify Wellness Director or RN and Interim Executive Director of all Incidents with residents.
    b. Wellness Director or RN will advise on what medical attention needs to be taken to ensure resident's safety.

2. What measures will be taken to ensure the problem does not recur?
    a. Appropriate staffing to meet the needs of the residents on each shift.
    b. In-service will be held on May 30, 2018 with all staff to review tenant rights (along with incident reporting training noted above).

3. How the program plans to monitor performance to ensure compliance.
    a. Wellness Director or RN will review, date and initial the 24-hour report every business day to ensure resident care plans are followed and no unusual incidents have occurred.

4. Date by which the regulatory insufficiency will be corrected?
    a. By May 30, 2018 all staff will be trained on the Iowa Tenant Rights by the Wellness Director and/or Interim Executive Director.

Staffing A 058

481-67.9 Staffing: 67.9 Nurse Delegation Procedures

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. Wellness Director will delegate all wellness staff by June 11, 2018.

b. All new hires providing direct care will be delegated within 30 days of hire.

2. What measures will be taken to ensure the problem does not recur?
   a. Wellness Director and Interim Executive Director will document on a calendar to ensure direct care staff are delegated within 30 days of hire, calendar will be checked weekly by Interim Executive Director and by Wellness Director weekly.

3. How the program plans to monitor performance to ensure compliance.
   a. All direct care staff will be fully delegated by June 11, 2018.

4. Date by which the regulatory insufficiency will be corrected?
   a. June 11, 2018 for all direct care staff and within 30 days of hire for all newly hired direct care staff.

Staffing A 149
481-67 Staffing: Dependent Adult Abuse Training

1. Elements detailing how the program will correct the regulatory insufficiency.
   a. Dependent Adult Abuse training courses have been assigned in Relias (Grace Managements e-learning system) to all staff members.

2. What measures will be taken to ensure the problem does not recur?
   a. Interim Executive Director and Wellness Director will ensure all staff complete these courses within 6 months of hire and every five years thereafter.

3. How the program plans to monitor performance to ensure compliance.
   a. The Interim Executive Director and Wellness Director will ensure all staff have completed training. The Interim Executive Director will print a Course Completion Report from Relias, sign and date and keep in a file in Executive Director's office.

4. Date by which the regulatory insufficiency will be corrected?
   a. All staff will complete Dependent Adult Abuse training courses by June 15, 2018.

Evaluation of Tenant A037
481-69.22 Evaluation of Tenant

1. Elements detailing how the program will correct the regulatory insufficiency.
   a. Wellness Director or RN will ensure all resident 30, 90, annual, and any change of condition evaluations will be completed timely.

2. What measures will be taken to ensure the problem does not recur?
    a. Wellness Director or RN will make an annual calendar log that will indicate when all residents are due for their functional, cognitive, and health status update, calendar log will be checked weekly by Wellness Director.
    b. Wellness Director or RN will monitor 24-hour report for significant change in resident condition.

3. How the program plans to monitor performance to ensure compliance.
    a. Wellness Director or RN will document with each condition change and notify appropriate parties.
    b. Wellness Director or RN will review the 24-hour report each business morning, date and initial 24- hour report to ensure it has been reviewed. All direct care staff have been informed/educated to notify On-Call Nurse, as needed and for emergency situations or significant changes in resident condition.

4. Date by which the regulatory insufficiency will be corrected?
    a. Wellness Director will have all resident assessments in compliance no later than June 15, 2018.

Tenant Documents A071

481-69.25(4) Tenant Documents

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. The 24-hour report was implemented on May 1st to serve as a communication tool between shifts.
    b. Wellness Director or RN will review the 24-hour report each business day to follow-up and document in resident chart as appropriate. Wellness Director/RN will date and initial report once reviewed.

2. What measures will be taken to ensure the problem does not recur?
    a. 24-hour report has been placed in each neighborhood.
    b. Wellness Director or RN will review each 24-hour report at the start of each business day. Wellness Director will date and initial report once reviewed.

3. How the program plans to monitor performance to ensure compliance.
    a. Wellness Director or RN will sign and date 24-hour report after review.

4. Date by which the regulatory insufficiency will be corrected?
    a. Revised 24-hour was implemented on May 1, 2018.

Service Plans A083

481-231C) Service Plans

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. Wellness Director or RN will make sure all resident service plans are current, accurate and specific to individual care required.

2. What measures will be taken to ensure the problem does not recur?
    a. Wellness Director or RN will update service plans with any change of condition or behavior.

3. How the program plans to monitor performance to ensure compliance.
    a. Wellness Director or RN will document any change in condition and notify appropriate parties.
    b. Wellness Director or RN will monitor the 24-hour report each business morning. Wellness Director/RN will date and initial report after each review of 24-hour report.

4. Date by which the regulatory insufficiency will be corrected?
    a. All service plans will be current by June 15, 2018.

Food Service A-104

481-69.28(231C) Food Service

1. Elements detailing how the program will correct the regulatory insufficiency
    a. Safe Food Handling training courses have been assigned in Relias (Grace Managements e-learning system) to all staff.

2. What measures will be taken to ensure the problem does not recur?
    a. Community will hold annual in-service training on Safe Food Handling, food protection and sanitation with all staff.

    b. Interim Executive Director, Dietary Manager, and Wellness Director will ensure all staff complete the Safe Food Handling class through Relias within 30 days of hire.

3. How the program plans to monitor performance to ensure compliance.
    a. The Interim Executive Director and Wellness Director will ensure all staff have completed training. The Interim Executive Director will print a Course Completion Report from Relias, sign and date and keep in a file in Executive Director's office.

4. Date by which the regulatory insufficiency will be corrected?
    a. Safe Food Handling courses and training will be completed by June 15, 2018.

Food Service A107

481-69.28(231C) Food Service

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. Dietary Manager will complete state-approved Serv Safe course scheduled on May 21 and May 24, 2018.

2. What measures will be taken to ensure the problem does not recur?
    a. Should there be a change in Dietary Manager, Interim Executive Director will ensure Serv Safe course is completed within 30 days of hire (if the individual does not already have the Serv Safe certification).

3. How the program plans to monitor performance to ensure compliance.
    a. Interim Executive Director will ensure Dietary Manager completes course and passes final exam. Community will maintain the certificate on file.

4. Date by which regulatory insufficiency with be corrected?
    a. May 24, 2018

Education A-121

481-60.30(231C) Dementia-specific education for program personnel.

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. All staff will complete the dementia-specific education training by June 15th, 2018. All new hires will complete training within 30 days of hire.
    b. The training will be completed through the Relias e-learning system.

2. What measures will be taken to ensure the problem does not recur?
    a. All new staff will take two four-hour courses within 30 days of hire through Relias Learning system.

3. How the program plans to monitor performance to ensure compliance?
    a. The Interim Executive Director and Wellness Director will ensure all staff have completed training. The Interim Executive Director will print a Course

Completion Report from Relias, sign and date and keep in a file in Executive Director's office.

4. Date by which regulatory insufficiency will be corrected?
    a. All training will be completed by June 15, 2018. New hires will complete training within 30 days of hire.

Education A123

481-69.30(3) Dementia Specific Education for personnel

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. Interim Executive Director will ensure all staff have the minimum of two hours of dementia related training, and all direct-care staff have the minimum of eight hours continuing education annually.

2. What measures will be taken to insure the problem does not recur?
    a. Interim Executive Director will ensure all staff have the appropriate amount of dementia related training per regulations.

3. How the program plans to monitor performance to monitor compliance.
    a. The Interim Executive Director and Wellness Director will ensure all staff have completed training by June 15, 2018. The Interim Executive Director will print a Course Completion Report from Relias, sign and date and keep in a file in Executive Director's office.

4. Date by which regulatory insufficiency will be corrected?
    a. All staff will complete all dementia related training by June 15, 2018. New hires will complete within 30 days of hire.

Respite Care Services A183

481-69.39(1) Respite Care Services

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. Respite residents that exceed 30 consecutive days and a total of more than 60 days in a consecutive 12-month period will be considered a permanent resident and will be required to complete/sign a permanent Residency Agreement.

2. What measures will be taken to ensure the problem does not recur?
    a. All residents that are admitted to the community for 30 consecutive days (or longer) or 60 days in a calendar year will sign a Residency Agreement stating they are a permanent resident.

3. How the program plans to monitor performance to ensure compliance?
    a. Respite Agreements are for those individuals residing at the Community for 30 or less consecutive days.
    b. Any resident that resides at the Community longer than 31 days will sign a permanent Residency Agreement.

4. Date by which regulatory insufficiency will be corrected?
    a. As of May 23, 2018, all current residents are considered permanent residents. There are no respite residents residing at the Community at this time.

Respite Care Services A189

481-69.39(4) Respite Care Services

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. All Respite residents will have a completed health, functional, and cognitive assessment performed by the Wellness Director or RN prior to admission.
    b. All staff will observe and watch for any significant health or behavior changes during the respite stay and will notify the Wellness Director or RN immediately. Direct care staff will document observations in the 24-hour report.

2. What measures will be taken to ensure the problem does not recur?
    a. As with all permanent residents, care plans and documentation will be completed for all Respite residents.

3. How the program plans to monitor performance to ensure compliance?
    a. All admission documents, assessments and care plans will be completed for all Respite residents.
    b. Wellness Director or RN will ensure all Respite resident documentation and care plans are accurate.

4. Date by which regulatory insufficiency will be corrected?
    a. The community implemented the Respite resident admission and care plan documentation procedures effective May 15, 2018.

Respite Services A191

481-69.39(231C) Respite Care Services

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. All residents that are admitted to the community for more than 30 consecutive days or 60 days in a consecutive calendar year will sign a Residency Agreement confirming they are a permanent resident.
    b. The respite agreement will not exceed more than 30 consecutive days.

2. What measures will be taken to ensure the problem does not recur?
    a. Interim Executive Director will monitor the contracts closely to ensure the stay does not exceed the discharge date on contract for each Respite resident.

3. How the program plans to monitor performance to ensure compliance?
    a. Interim Executive Director will ensure and monitor all respite agreements are within the date/stay limits set forth on each respite agreement.
    b. Interim Executive Director will ensure the dates do not exceed the residents current stay as documented in the agreement.

4. Date by which regulatory insufficiency will be corrected?
    a. The community implemented the Respite resident agreement procedures effective May 15, 2018.

Respite Care Services A203

481-69.39(8) Respite Care Services

1. Elements detailing how the program will correct the regulatory insufficiency.
    a. All Respite residents will have a completed health, functional, and cognitive assessment performed by the Wellness Director or RN prior to admission.

2. What measures will be taken to ensure the problem does not recur?
    a. All Respite residents will have a completed health, functional, and cognitive assessment performed by the Wellness Director or RN prior to admission.
    b. Assessments will be maintained in the resident's chart/file.

3. How the program plans to monitor performance to ensure compliance?
    a. Wellness Director will ensure all assessments are maintained in the resident chart/file.

4. Date by which regulatory insufficiency will be corrected?
    a. The community implemented the Respite resident admission assessment procedures effective May 15, 2018.

Thank you for your time and consideration in reviewing this Plan of Correction for Country Manor Memory Care in Davenport, IA. Please contact me at 563-391-1111 if any follow-up information is required. The civil money penalty check has been prepared and has been addressed/sent to Tamara Brockob on May 22, 2018.

Interim Director will review all of the above with Executive Director upon her return to the community on August 1, 2018.

Sincerely,

Lori Bader

Interim Executive Director

Attachments:
Grace Management Incident Reporting Policy and Procedure