IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

September 11, 2008

Complaint Intake: #15910R

Jackie Vaske, Housing Director
Summit Pointe Senior Living
3505 English Glen Avenue
Marion, IA 52302-4711

RE: I. Final Complaint Investigation Revisit and 2nd Initial Certification Revisit Report – #15910R
II. Immediate Sanction - Conditional Operation
III. Civil Penalty
IV. Hearings and Appeals
V. Conclusion

Dear Ms. Vaske:

I. Final Complaint Investigation Revisit and 2nd Initial Certification Revisit Report – #15910R Summit Pointe Senior Living, Marion, IA

Enclosed is the **Final Complaint Investigation Revisit and 2nd Initial Certification Revisit Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2007) and Iowa Administrative Code, chapters 321—25, pertaining to assisted living programs and 321—26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. The Final Report notes **Regulatory Insufficiencies** in the areas of: Evaluation of Tenants, Service Plans, Medications, Structural Requirements and Other.

DIA is accepting the Request for Reconsideration in relation to Life Safety and Staffing. DIA is denying your Request for Reconsideration under Medications, due to the medication issues. The Plan of Correction (POC) has been accepted.

II. Immediate Sanction - Conditional Operation

As reflected in this Report, the program failed to comprehensively follow the regulations in 321 IAC Chapter 25. Due to the program's noncompliance, current Regulatory Insufficiencies and the findings of the on-site monitoring visit of June 23 &24, 2008, Summit Pointe Senior Living's Conditional Certificate, effective April 4, 2008, is being extended.

In addition, the program will be required to submit documentation of new staff training in regard to fire safety, submit documentation of all future completed fire drills, complete monthly nurse review in order to determine changes in condition and follow through with appropriate assessments and complete service plans in regard to those changes and the administrator and nurses for the program will need to attend management training and provide documentation of completion to DIA. The Conditional Certificate is issued as an alternative to denial, suspension or revocation pursuant to Iowa Code section 231C.10(2).

The program may appeal these sanctions by filing an appeal within 30 days of issuance of this letter.

III. Civil Penalty

If no appeal is requested within 30 days of receipt of this Final Report the civil penalty obligation, in the amount of two thousand ($2,000.00) dollars, is required.

IV. Hearings/Appeals

The Program may appeal the DIA decision as related to the sanctions in accordance with 321 IAC 26.4, within 30 days of notice, by submitting a request for hearing to the DIA. Hearings will be held pursuant to 481 IAC Chapter 10. If the program appeals, the civil penalty will be suspended, pending appeal. If the program does not appeal, the fine is due within 30 days of notice.

V. Conclusion

The Plan of Correction submitted, is accepted. The Request for Reconsideration is accepted, in part, and denied in part, as explained in section one. The Conditional Certificate and above sanctions remain.

DIA may revisit the program to confirm compliance in fulfilling the POC's corrective measures. If the program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

Summit Pointe Senior Living is being assessed a $2,000.00 civil money penalty.

If you have any questions in regard to these matters, please contact me at (515) 281-5077.

Sincerely,

Rise Borcelh for

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint Investigation Revisit & 2nd Initial Certification Revisit

Assisted Living Program: **Complaint Intake #: 15910R**

Jackie Vaske, Housing Director
Summit Pointe Senior Living
3505 English Glen Avenue
Marion, IA 52302-4711

Date of Investigation:

June 23 & 24, 2008

Monitor(s):

Stephanie Cummins, SW MA
Lincoln Newsom, RN

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site revisit was conducted at Summit Pointe Senior Living on June 23 & 24, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	85
Current number of tenants with cognitive disorder:	1
Total Population:	86

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	6
Current number of tenants without cognitive disorder:	1
Total Population:	7

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There were Regulatory Insufficiencies this certification period in the areas of: occupancy agreement, evaluation of tenant, tenant documents, service plan, nurse review, food service, staffing, dementia-specific education for program personnel, transportation, record checks and other.

The Initial Certification Monitoring Report conducted on October 22, 2007 resulted in the Regulatory Insufficiencies as noted above.

The Complaint Investigation and Initial Certification Revisit conducted on February 18, 19, 20 & 21, 2008, resulted in: issuance of a Conditional Certificate, effective April 11, 2008. Additional requirements include the program submitting documentation of staff training in regard to fire safety and documentation of all future completed fire drills to DIA, completion of monthly nurse review in order to determine changes in tenant conditions and to follow through with appropriate assessments and service plans in regard to those changes and the administrator and nurse are to attend management training and provide documentation of such to DIA. A $5,500.00 civil penalty was also issued.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Occupancy Agreement – The program shall enter into an occupancy agreement with the tenant or tenant's legal representative, if applicable, prior to the tenant's taking occupancy that clearly describes the rights and responsibilities of the tenant and of the program, and shall sign a managed risk policy disclosure statement. [321 IAC 25.22]

The program received a regulatory insufficiency at the time of the February, 2008 on-site related to not consistently enter into an occupancy agreement prior to the tenant taking occupancy, signed by the tenant or tenant's legal representative, if applicable, that clearly describes the rights and responsibilities of the tenant and the program.

During the course of the investigation, the following information was obtained.

Monitoring Observation: Tenant #14, a 91 year old was admitted to the general population on 4-11-08 with diagnoses of: Seizure Disorder, Coronary Heart Disease (CAD) and Dementia. On 5-29-08, the tenant was moved to the dementia unit. A cognitive evaluation was completed on 5-29-08 staging the tenant at a two on the Global Deterioration Scale (GDS), indicating very mild cognitive decline. The Occupancy Agreements of 4-10-08 and 5-29-08 were both signed appropriately.

Tenant #15, a 79 year old, was admitted on 5-29-08 and diagnoses include: Alzheimer's Disease, Hypertension (HTN) and Hypothyroidism. The tenant was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive impairment. The tenant resided in the dementia unit. The tenant's occupancy agreement was signed on 5-27-08, prior to taking occupancy.

- Regulatory Insufficiency: None noted.

B. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

The program received a regulatory insufficiency at the time of February, 2008 on-site in regard to Tenants #1, #2, #5, #8 and #10 related to not consistently evaluating each tenant's functional, cognitive and health status within 30 days of occupancy, as needed, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any modifications to needed services. The evaluation shall be conducted by a health care professional or a human service professional.

Monitoring Observation: Tenant #8's move out date was 4-7-08. Tenant #10's move out date was 3-1-08.

Tenants #1 and #2 had evaluations completed appropriately.

Tenant #5, an 86 year old, was admitted on 9-13-07 and diagnoses include: Cerebrovascular Accident (CVA) with Aphasia and Hypertension (HTN). The tenant was staged at a four on the GDS, which indicates moderate cognitive impairment. The tenant resided in the dementia unit. According to notes dated 3-20-08, a Physical Therapy (PT) referral was requested and showers were increased to three showers per week. According to the nurse, the tenant was seen by a home health agency on 3-26-08

and was discharged from PT on 3-31-08, after being seen by a physical therapist. Evaluations were not completed with the start of service or when services were discontinued or with an increase in bathing services. According to notes dated 4-3-08, the tenant was diagnosed with a sprained ankle and had an air splint on for increased stabilization. The note also indicated weekly weights and blood pressures were to be taken every three days. Evaluations were not completed, as needed. According to a note dated 6-13-08 by the nurse, the tenant had become increasingly more incontinent most of the time, especially of stool. Review of the staff communication log revealed the tenant was frequently incontinent. Staff interviews with Staff #3, #11 and #13 indicated the tenant was incontinent most of the time. Evaluations were not completed, as needed.

During the course of the investigation, the following information was obtained.

Tenants #9, #11, #12 and #14 had evaluations completed appropriately.

Tenant #15 was refusing toileting and was incontinent most of the time of bladder and bowel, according to notes dated 6-13-08 signed by the nurse. Review of the staff communication log indicated the tenant was frequently incontinent of bladder and bowel, at times the tenant refused toileting assistance and indicated frequent staff assistance with clean up. Staff #3, #11 and #13 stated the tenant was incontinent 50%-80% of the time. The evaluation at admission indicated, under Resident Strengths, the tenant was continent (usually) and if there were accidents the tenant helped himself/herself. Evaluations were not completed, as needed.

- Regulatory Insufficiency: The program did not consistently evaluate each tenants' functional, cognitive and health status as needed, to determine the tenants' continued eligibility for the program and to determine any modifications to the services needed. (25.23(2))

C. Criteria for exclusion of tenants - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

The program received a regulatory insufficiency at the time of the February, 2008 on-site, in regard to Tenant #4, with the program knowingly admitting or retaining a tenant who requires routine two-person assistance with standing, transfer or evacuation.

Monitoring Observation: Tenant #4's move out date was 3-14-08. Staff interviews with Staff #3, #11 and #13 indicated none of the tenants exceeded the appropriate level of care. Review of eight tenant files indicated tenants were appropriate for this level of care.

- Regulatory Insufficiency: None noted.

D. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

The program received a regulatory insufficiency at the time of February, 2008 on-site in regard to Tenants #1, #2, #3 #4 #5, #7, #8, #10, #11 and #12 related to not consistently updating the tenants' service plans prior to the tenant signing the occupancy agreement

and taking occupancy. A preliminary service plan shall be developed prior to the tenant taking occupancy, by a health care professional or human service professional in consultation with the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. The service plan shall subsequently be updated at least annually and whenever changes are needed. When a tenant needs personal or health-related care, the service plan shall be updated within 30 days of occupancy and as needed, but not less than annually, by a multidisciplinary team that consists of no fewer than three individuals, including a health care professional and other staff appropriate to meet the needs of the tenant, in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative.

The program also received a regulatory insufficiency related to not consistently developing a service plan that is individualized and indicates, at a minimum, the tenant's identified needs and the tenant's requests for assistance and expected outcomes.

The program received a regulatory insufficiency related to not consistently developing service plans based on evaluations conducted in accordance with 25.23(1) and 25.23(2) and designed to meet the specific service needs of the individual tenant.

The program also received a regulatory insufficiency related to not consistently developing service plans that identified tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests.

Monitoring Observation: Tenant #3's move out date was 6-8-08. Tenant #4's move out date was 3-14-08. Tenant #7's move out date was 6-4-08. Tenant #8's move out date was 4-7-08. Tenant #10's move out date was 3-1-08.

Tenant #1 had a service plan change made on 5-22-08, however the service plan was not developed based on functional, cognitive and health evaluations as they were completed on 5-29-08. The current service plan referenced a leisure activity plan and the leisure activity plan provided planned and spontaneous activities for the tenant.

Tenant #2 had service plans completed appropriately.

Tenant #5's notes dated 3-20-08, indicate a PT referral was requested and showers were to be increased to three showers per week. According to the nurse, the tenant was seen by a home health agency on 3-26-08 and was discharged from PT on 3-31-08, after being seen by a physical therapist. The service plan was not updated, as needed, with the start of PT services or when PT services were discontinued or with an increase in bathing services. According to notes dated 4-3-08, the tenant was diagnosed with a sprained ankle and had an air splint on for increased stabilization. The note also indicated weekly weights and blood pressures were to be completed every three days. Evaluations were not completed as needed. According to a note dated 6-13-08 by the nurse, the tenant had become increasingly more incontinent most of the time, especially of stool. A review of the staff communication log indicates the tenant was frequently incontinent. Staff interviews with Staff #3, #11 and #13 indicated the tenant was incontinent most of the time. The service plan was not updated, as needed, and did not reflect the needs of the

tenant. The current service plan referenced a leisure activity plan and the leisure activity plan provided planned and spontaneous activities for the tenant.

Tenant #11, an 84 year old, was admitted on 1-16-08 with diagnoses of: Arthritis, Left Total Hip Arthoplasty, HTN, Osteoarthritis, Hyperlipidemia and Atrial Fibrillation. A service plan up-date was completed on 3-18-08 and included all the required signatures.

Tenant #12, a 90 year old, was admitted on 2-14-08 and diagnoses include: HTN, Anxiety, Dementia and Paranoia. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. The tenant resided in the dementia unit. A service plan was not developed within 30 days of taking occupancy. The current service plan referenced a leisure activity plan and the leisure activity plan provided planned and spontaneous activities for the tenant.

During the course of the investigation, the following information was obtained.

Tenants #9 & #14 had service plans completely appropriately.

Tenant #15 was refusing toileting and was incontinent, most of the time, of bladder and bowel, according to notes by the nurse, dated 6-13-08. Review of the staff communication log indicated the tenant was frequently incontinent of bladder and bowel, at times refused toileting assistance and frequent staff assistance was needed with clean up. Staff #3, #11 and #13 stated the tenant was incontinent 50%-80% of the time. The initial service plan indicated staff were to remind the tenant to toilet every two hours and assist with good peri-care. The service plan also indicated staff were to assist with a.m. and p.m. cares, including toileting and peri-care. The service plan was not updated, as needed, and did not reflect the needs of the tenant. The service plan referenced a leisure activity plan and the leisure activity plan provided planned and spontaneous activities for the tenant.

- Regulatory Insufficiency: The program did not consistently develop service plans for tenants, as needed, when a tenant needs personal care or health-related care. (25.28(3))

- Regulatory Insufficiency: The program did not consistently develop service plans based on evaluations conducted in accordance with 25.23(1) and 25.23(2) that were designed to meet the specific service needs of the individual tenant. (25.28(1))

- Regulatory Insufficiency: The program did not consistently develop service plans that meet the identified needs of the tenants. (25.28 (4)a)

E. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

Complaint #15910R: The administration of medications shall be provided by an Iowa-licensed registered nurse or advanced registered nurse practitioner registered in Iowa or the authorized agent in accordance with 655—subrule 6.2(5) and 655—subrule 6.3(1) and Iowa Code chapter 155A and in executing the medical regimen as prescribed by the

physician, the registered nurse shall exercise professional judgment in accordance with minimum standards of nursing practice related to when medications are administered or stored by the program, the registered nurse shall recognize and understand legal implications of accountability and the licensed practical nurse shall recognize and understand the legal implications within the scope of nursing practice. The licensed practical nurse shall perform services in the provision of supportive or restorative care under the supervision of a registered nurse or physician as defined in the Iowa Code.

Monitoring Observation: Tenant #10's move out date was 3-1-08. According to the nurse, there were no tenants that received services from Hospice.

Staff #9 no longer worked at the program. According to an interview with the nurse, medications are not administered prior to being on the Medication Administration Record (MAR). Staff interview with Staff #3, #11 and #13 indicated medications were on the MAR before they were administered. Review of tenant files indicated medications were transcribed appropriately.

According to an interview with the nurse, medications were not administered unless there was a physician's order. Staff interviews with Staff #3, #11 and #13 indicated medications were not administered unless there was a physician's order.

Tenant #2, an 86 year old, was admitted on 6-21-07, with diagnoses of HTN, Congestive Heart Failure (CHF), Cerebral Vascular Accident (CVA) and Pernicious Anemia. An in interview with the programs Registered Nurse and another RN indicated they are the only ones to administer B12 injections. Accuchecks were discontinued on 2-20-08. The nurse indicated in an interview, B12 injections were administered as ordered.

Tenant #9, a 94 year old, was admitted on 4-12-07 with diagnoses of: Chronic Obstructive Pulmonary Disease (COPD) and Diabetes. The MAR of February, 2008, indicated an Antibiotic was to be given prior to dental appointments. According to the nurse, tenants received Antibiotics prior to dental appointments as ordered.

Tenant #11's MAR's for April, May and June were reviewed and indicated medications had been given and there was no documentation related to medications being left in medication cups. In staff interviews staff indicated they have not seen medications being left in medication cups in the medication box.

A review of Tenants # 2, #9, and #11's MAR's, from April to June 2008 indicated there had been various medications not available to the tenants. In staff interviews, staff stated the nurse orders the medications. The nurse stated she was responsible for ordering the medications and there had been a few incidences where she forgot to order the medications or staff had failed to advise her that certain medications needed ordered. According to the nurse, medications were available in the medication boxes. According to staff interviews with Staff #3, #11 and #13, medications were available in the medication boxes.

Review of MARs for Tenants #1, #2, #5, #9, #11, #12, #14 and #15 indicated medications were appropriately documented and administered.

- Regulatory Insufficiency: The administration of medications shall be provided by an Iowa-licensed registered nurse or advanced registered nurse practitioner registered in Iowa or the authorized agent in accordance with 655-subrule 6.2(5) and 655-subrule 6.3(1) and Iowa Code chapter 155A.

During the course of the investigation, the following information was obtained.

Monitoring Observation: Four medication passes were observed. During two of the four medication passes appropriate medication protocol was not consistently followed. For example, Staff #3 administered medications in the dementia unit and signed off medications prior to administering them to the tenants.

- Regulatory Insufficiency: The administration of medications shall be provided by an Iowa-licensed registered nurse or advanced registered nurse practitioner registered in Iowa or the authorized agent in accordance with 655—subrule 6.2(5) and 655—subrule 6.3(1) and Iowa Code chapter 155A and in executing the medical regimen as prescribed by the physician, the registered nurse shall exercise professional judgment in accordance with minimum standards of nursing practice as defined in these rules: 25.29(2)a, 655-6.2(5)e(152).

F. Nurse Review - Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. [321 IAC 25.30]

The program received a regulatory insufficiency at the time of the February, 2008 on-site in regard to Tenants #1, #2, #7, #8, #9 and #10 related to not consistently assessing and documenting the health status of each tenant, making recommendations and referrals as appropriate, and monitoring progress on previous recommendations at least every 90 days or if there are changes in health status.

Monitoring Observation: Tenant #7's move out date was 6-4-08. Tenant #8's move out date was 4-7-08. Tenant #10's move out date was 3-1-08.

Tenants #1, #2, #9, #11, #14 had nurse review completed appropriately.

- Regulatory Insufficiency: None noted.

The program received a regulatory insufficiency at the time of February, 2008 on-site in regards to Tenants #1, #2, #3, #4, #5, #7, #8, and #10 related to not consistently monitoring, at least every 90 days or after a change in condition, each tenant receiving program-administered prescription medications for adverse reactions to program-administered medications and make appropriate interventions or referrals and ensure that the prescription medications are administered consistent with such orders.

Monitoring Observation: Tenant #3's move out date was 6-8-08. Tenant #4's move out date was 3-14-08. Tenant #7's move out date was 6-4-08. Tenant #8's move out date was 4-7-08. Tenant #10's move out date was 3-1-08. Tenant #10's move out date was 3-1-08.

Tenants #1, #2, #5, #9, #11 and #12 had medication reviews completed appropriately.

- Regulatory Insufficiency: None noted.

G. Food Service – Program shall provide or coordinate with other community providers to provide hot or other appropriate meal(s) at least once a day or make arrangements for the availability of meals. Menus shall be appropriately planned. If applicable, therapeutic diets shall meet all requirements. Food preparation personnel shall meet all requirements. [321 IAC 25.32]

The program received a regulatory insufficiency at the time of the February, 2008 on-site related to not consistently providing staff that is responsible for preparing or serving food or both, an orientation on sanitation and safe food handling prior to handling food and an annual in service training on food protection. At a minimum, one person directly responsible for food preparation shall have successfully completed a state-approved food protection program.

Monitoring Observation: Staff #2 and Staff #5 no longer work at the program. Review of staff files indicated Staff #1, #3, #7, #12 and #13 had food safety training documented appropriately.

- Regulatory Insufficiency: None noted.

H. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation #15910: The program received a regulatory insufficiency at the time of the February 2008 on-site, related to not consistently provide sufficient trained staff at all times to fully meet the tenants' identified needs.

Monitoring Observation: Review of staff files indicated Staff #1, #3, #7, #11, #12 and #13 had nurse delegated tasks documented appropriately.

According to an interview with the nurse, the dementia unit was never left unattended. According to staff interviews with Staff #3, #11 and #13 the dementia unit was never left unattended. Staff #9 no longer worked at the program.

According to staff interviews with Staff #3, #11 and #13 there were no issues or problems with the call lights. Staff indicated the receptionist or another staff notified staff if they had not heard the call light. According to a program document, the program had a receptionist at the front desk from 8:00 a.m. to 9:30 p.m. seven days a week. After hours phone calls are transferred to the dementia unit or can be picked up from the cordless phone carried by staff. According to two tenant interviews, staff respond quickly. One tenant indicated the staff response had improved since his/her admission. The tenant stated staff response to the call lights was longer on the weekends; however, was still under 15 minutes.

According to a nurse interview, the staffing in the dementia unit was sufficient. Staff interviews with Staff #3, #11 and #13 indicated there was sufficient staffing.

- Regulatory Insufficiency: None noted.

The program received a regulatory insufficiency at the time of the February 2008 on-site related to the owner or Management Company not consistently ensuring that all personnel employed by or contracting with the program receive appropriate training to assigned tasks and the target population.

Monitoring Observation: According to an interview with the nurse, she had training from the Corporation and one corporate staff spent time every other week at the program. The nurse indicated she had adequate training to do her job.

- Regulatory Insufficiency: None noted.

The program received a regulatory insufficiency at the time of the February 2008 on-site related to not consistently ensuring all personnel of a program knew how to implement the program's accident, fire safety and emergency procedures.

Monitoring Observation: A review of staff files indicated Staff #1, #3, #7, #11, #12 and #13 had documented training on emergency procedures. Staff #3, #11 and #13 indicated they knew what to do for a fire drill. According to staff interviews, Staff #11 and #13 did not know what happens to the doors in the dementia unit in the event of a fire. Staff #11 stated she was not sure how many fire panels were in the program. She also stated if the alarms were to be activated they were to call maintenance, but she was unaware of how to silence them in the event maintenance was unavailable. The program has two fire panels, one located at the front entrance and the other in the dementia unit.

- Regulatory Insufficiency: In response to DIA's preliminary identification of a rule violation under Staffing, the program provided additional information that it was in compliance with the regulation at the time of the on-site. (25.33(8))

I. Dementia-specific education for program personnel – A dementia-specific program shall employ or contract with personnel who have received appropriate dementia-specific education and training. [321 IAC 25.34]

The program received a regulatory insufficiency at the time of the February 2008 on-site, related to not consistently providing a minimum of six hours of dementia-specific education and training, prior to or within, 90 days of employment.

Monitoring Observation: A review of staff files indicated Staff #1, #3, #7, #11, #12 and #13 had documented dementia training.

- Regulatory Insufficiency: None noted.

J. Life safety – The program shall follow written emergency policies and procedures and structural safety requirements. [321 IAC 25.37]

T he program received a regulatory insufficiency at the time of the February 2008 on-site, related to not conducting emergency egress and relocation drills not less than six times

per year on a bimonthly basis, with not less than two drills conducted when tenants are sleeping.

Monitoring Observation: A review of fire training documents indicated the program had completed five drills between 1-10-08 and 5-28-08 which included one drill that occurred during the hours of sleep.

- Regulatory Insufficiency: None noted.

The program received a regulatory insufficiency at the time of the February 2008 on-site, related to not consistently ensuring all personnel of a program knew how to implement the program's accident, fire safety and emergency procedures and did not follow written policies and procedures which included fire safety procedures.

Monitoring Observation: A review of staff files indicated Staff #1, #3, #7, #11, #12 and #13 had documented training on emergency procedures. Staff #3, #11 and #13 indicated they knew what to do for a fire drill. According to staff interviews Staff #11 and #13 did not know what happened to the doors in the dementia unit in the event of a fire. Staff #11 stated she was not sure how many fire panels were in the program. She also stated if the alarms were to be activated they were to call maintenance, but was unaware of how to silence the alarms in the event maintenance was unavailable. The program has two fire panels, one located at the front entrance and the other in the dementia unit.

- Regulatory Insufficiency: In response to DIA's preliminary identification of a rule violation under Life Safety, the program provided additional information that it was in compliance with the regulation at the time of the on-site. (25.33(8)) (25.37(i))

K. Activities – The program provides appropriate programming for tenants based on individual interests. Programming shall support the service plans, be consistent with the program statement and occupancy policies, and available in writing as required. [321 IAC 25.39]

The program received a regulatory insufficiency at the time of the February 2008 on-site, related to not consistently providing appropriate programming for each tenant. Programming did not reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement.

Monitoring Observation: According to staff interviews with Staff #3, #11 and #13, there were sufficient activities for those with dementing illness.

- Regulatory Insufficiency: None noted.

L. Structural requirements – The structure of the program shall be designed and operated to meet the needs of the tenants. The buildings and grounds shall be well-maintained, clean, safe and sanitary.

During the course of the investigation, the following information was obtained.

Monitoring Observation: An observation was made in the secured dementia unit, underneath the kitchen sink. The area contained a can of spray cleaner, a plastic bottle of spray disinfectant and silver polish. The program's Housing Director and nurse were made aware of the items and they were removed and secured elsewhere. Prior to the completion of the revisit, the cabinets were secured with locks and staff was given a key.

- Regulatory Insufficiency: The program did not consistently provide a building and grounds that are well maintained, clean, safe and sanitary. (25.40(1)d)

M. Other – The provisions of this section address the program's noncompliance with other applicable statutory and administrative rule requirements.

During the course of the investigation, the following information was obtained.

Monitoring Observation: The program did not consistently follow the written Plan of Correction (POC) that was submitted on April 23, 2008, regarding the complaint investigation and revisit conducted on February 18, 19, 20 & 21, 2008.

- Regulatory Insufficiency: The program did not fully implement the POC submitted in response to the previous complaint investigation and revisit. (26.2(6)a)

Dated this 11th day of September, 2008.