IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

September 24, 2008

CERTIFIED

Complaint #18716-C

Ms. Becky Butler, Administrator
Sylvan Woods Assisted Living
2 Pennsylvania Place
Ottumwa, IA 52501

RE: I. Final Complaint Investigation and Recertification Revisit Report, Sylvan Woods, Ottumwa, IA
II. Civil Penalty
III. Conclusion

Dear Ms. Butler:

I. Final Complaint Investigation and Recertification Revisit Report, Sylvan Woods, Ottumwa, IA

Enclosed is the **Final Complaint Investigation and Recertification Revisit Report** completed by the Department of Inspections and Appeals (DIA) in accordance with the Code of Iowa, Chapter 231C, Iowa Administrative Code, chapter 25, pertaining to assisted living programs and, chapter 26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. The report notes the Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Tenant Documents, Service Plan, Nurse Review, Food Service, Staffing and Other. A copy of the Final Report is enclosed.

DIA is accepting the Plan of Correction (POC) following the program's submission of additional information. DIA is denying the Request for Reconsideration relating to Tenant Documents as no documentation was provided by the program that shows the tenant refused to sign the paperwork at the time of admission.

II. Civil Penalty

If no appeal is requested within 30 days of receipt of this Final Recertification Monitoring Evaluation Report, the civil penalty obligation, in the amount of four thousand dollars ($4000), is required.

III. Conclusion

The Plan of Correction that was submitted is accepted and the Request for Reconsideration is denied. 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.

If you have any questions regarding this certification, please contact me at 515-281-5721.

Sincerely,

Tamara Halvorson

Tamara Halvorson
ASB Lead Certification Coordinator
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint Investigation & Recertification Revisit Report

Assisted Living Program: **Complaint Intake #:** 18716-C

Ms. Becky Butler, Administrator
Sylvan Woods Assisted Living
2 Pennsylvania Place
Ottumwa, IA 52501

Date of Investigation:

July 30, 2008

Monitor(s):

Hal L. Chase, RN BSN MPH
Michael Streepy, 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 and recertification revisit was conducted at Sylvan Woods Assisted Living on July 30, 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:	40
Current number of tenants with cognitive disorder:	0
Total population:	40

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:	9
Current number of tenants without cognitive disorder:	0
Total population:	9

***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 substantiated complaints in the areas of Evaluation of Tenants, Service Plans, Tenant Documents, Food Service, Nurse Review, Staffing, Managed Risk and Life Safety.

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

A. 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)]

Complaint Allegation 18716: It is alleged Tenant #6 was seen in a local hospital for chest pain, back pain and acute renal failure. Staff had noted the tenant was bruised from head to toe.

- Monitoring Observation: Tenant #6, an 84 year old, was admitted to the program on 02-27-07 with diagnoses including: Coronary Artery Disease, Congestive Heart Failure (CHF), Dementia and Hypothyroidism. The tenant's file did not indicate a GDS, but the functional evaluation of 07-09-08 indicated mild impairment. The program did not complete a functional, health and cognitive evaluation for the service plan of 03-08-08 and provided no documentation of cognitive and health evaluations for the service plan of 07-09-08. Review of nurse's notes dated 06-23-08 indicated unsteady gait and increased confusion. Nurse's notes of 06-30-08 indicate the tenant had stumbled into a ledge causing a red area on the lower right side. The tenant refused to go to the emergency room and the physician was notified of increased confusion. Nurse's notes of 07-07-08 indicate the tenant reported to staff of two falls. On 07-08-08 the tenant again declined to see the physician stating she/he had gotten feet tangled up. Nurse's notes of 07-10-08 indicate the tenant was found on the floor and stating he/she had rolled off the bed onto the floor with pain being at an 8 on a scale of 1 to 10. The tenant was sent to the emergency room at 6:00 p.m. Nurse's notes of 07-11-08 note the tenant being very unstable on his/her feet. Nurse's notes of 07-12-08 note the tenant unsteady and unable to walk alone with the staff providing a wheelchair to the dining room. Nurse's notes of 07-12-08 at 2:35 p.m. indicate the tenant was found on the floor and incontinent of bowel. Nurse's notes of 07-12-08 at 3:30 p.m. indicate the tenant was found on the floor stating he/she had fallen out of bed. He/she refused to go to the emergency room and staff began 1 hour checks. Nurse's notes on 07-12-08 at 10:05 p.m. indicate the tenant was found on the floor and sent to the emergency room. Nurse's notes of 07-13-08 at 2:00 a.m. indicate the tenant returned from the hospital. The tenant was very unsteady on his/her feet and was encouraged to call for assistance and to use a walker. Nurse's notes of 07-13-08 at 9:30 a.m. indicate the tenant was found on the floor with no noted request for assistance and not using oxygen. Review of hospital documentation and photos reveal multiple bruises to the tenant's back, hip and shoulders. The record contained no documentation of evaluations following the changes. The tenant was discharged to skilled care on 07-18-08.

The program received a regulatory insufficiency on 10-25-07 related to not consistently completing functional, cognitive and health evaluations as needed for Tenants #1, #2, #3 and #4.

- Monitoring Observation: Tenant #1, a 91 year old, was admitted on 2-12-07 and has diagnoses including: Diabetes Mellitus, Hypertension (HTN), History of Falls, Back Pain and a History of Prostate Cancer. The tenant scored 19 out of 30 on the Mini Mental Status Exam (MMSE) on 10-9-07 indicating moderate dementia. The program's Plan of Correction (POC) dated 2-12-08 indicated the program would complete functional, cognitive and health evaluations, which the program did not

complete. Resident notes of 6-15-08 indicated the tenant was hospitalized for a kidney infection, returning to the program on 6-17-08. Nurse's notes of 7-28-08 indicate Physical Therapy/Occupational Therapy (PT/OT) evaluation was ordered by the tenant's physician if the tenant agreed. Resident care notes of 7-1-08 and 7-13-08 indicate the tenant was incontinent of urine and had increased confusion. The program did not complete a functional, cognitive and health evaluation as stated in their POC of 2-12-08 and did not complete evaluations with a change in health status.

Tenant #2, a 76 year old was admitted to the program 07-09-07 with diagnoses including: Progressive Dementia, Anxiety and Depression. The tenant's cognition was evaluated on 07-28-07, using a MMSE. The tenant scored a six out of thirty with no key to indicate the value. Review of nurse's notes from 04-11-08 through 06-11-08, indicate a change in behaviors including spitting out medications, agitation, resisting cares, combativeness, a diagnosis of urinary tract infection, an episode of slurred speech, increased confusion, facial droop on the left side and an inability to grip. The tenant was sent to the emergency room at 12:15 p.m. and returning at 7:10 p.m. Nurse's notes of 05-26-08 indicate a cough, stomach pain and a complaint of sickness. Nurse's notes of 06-06-08 indicate the physician was notified of increased aggressive behaviors with the recommendation for a mental health or Vision Quest referral. Nurse's notes of 06-11-08 indicate the physician was notified of increased agitation. The physician requested the tenant be sent to the emergency room and admitted to Vision Quest. Nurse's notes of 07-10-08 indicate the tenant returned to the program and at 6:40 p.m. fell and broke his/her upper denture. The record contained no documentation of evaluations following the changes. The program nurse stated the tenant was discharged to long term care late on 07-10-08.

Tenant #3, an 87 year old, was admitted on 8-29-07 with diagnoses including: Dementia, Chronic Renal Insufficiency and HTN. The program's POC dated 2-12-08 indicated the program would complete functional, cognitive and health evaluations, which the program did not complete. Resident notes of 3-31-08 indicate the tenant was hospitalized for congestive heart failure, returning to the program on 4-3-08. Resident notes of 4-27-08 through 7-23-08 indicate the tenant was agitated and swearing with cares, combative, wandering and throwing objects. The program did not complete functional, cognitive and health evaluations as stated in their POC of 2-12-08 and did not complete evaluations with a change in health status.

Tenant #4, an 89 year old, was admitted on 1-17-07 with diagnoses including: Diabetes Mellitus, Diverticulitis and Severe Dementia. Resident notes of 10-30-07 through 12-3-07 indicate numerous incidents of aggression, agitation and combative with Activities of Daily Living (ADLs). The program did not complete functional, cognitive and health evaluations as stated in their POC of 2-12-08, and did not complete functional, cognitive and health evaluations with a change in health status. The tenant was discharged from the program on 12-31-07.

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

Tenant #5, an 85 year old, was admitted on 12-4-06 with diagnoses including: Pacemaker, Depression, Mild Dementia, Chronic Atrial Fibrillation, Osteoarthritis, Diabetes Mellitus II and History of Colon Cancer. The tenant was staged at two on the GDS. Resident care notes of 3-4-08 indicate the tenant had Conjunctivitis and received treatments of warm soaks and Gentamycin drops four times daily for five days. Resident care notes of 4-24-08 indicate wound care to the tenant's right toe. The program did not complete a functional, cognitive and health evaluation with a change in health status.

Tenant #7, an 89 year old was admitted to the program 06-27-08 with diagnoses including: Dementia and History of Coronary Bypass. Review of the tenant record revealed no documentation of functional and health evaluations within 30 days of occupancy. The tenant scored 20 out of 30 on the MMSE on 06-27-08 indicating mild dementia. Nurse's notes of 07-05-08 indicate a small laceration of the left ankle with treatment and bandage. Nurse's notes of 07-07-08 at 8:35 a.m. indicate small open areas at the left ankle and shin with dressings and an increase in confusion. Nurse's notes of 07-07-08 at 2:15 p.m. indicate the tenant was sent to the emergency room following complaints of chest pain. Nurse's notes of 07-08-08 indicate the tenant was moved from the general population to the memory care unit due to tenant's increased confusion. Nurse's notes of 07-27-08 at 1:16 p.m. indicate the tenant's legs were swollen. Nurse's notes of 07-28-08 at 8:30 a.m. indicate the tenant's legs again to be swollen and support hose applied. Nurse's notes of 07-28-08 at 9:15 p.m. indicate the tenant complaining of scrotal pain and the upper legs black and blue at the back and thigh area. The record contained no documentation of evaluations following the changes.

- Regulatory Insufficiency: The program did not consistently ensure evaluation of each tenant's functional, cognitive and health status within 30 days of occupancy and as needed, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any modifications to services needed. The evaluation shall be conducted by a health care professional or a human services professional. (25.23(2))

B. Tenant Documents – Program maintains a complete file for each tenant containing all appropriate documentation. [321 IAC 25.27]

The program received a regulatory insufficiency on 10-25-07 related to Tenant #5 not signing his/her code status form.

- Monitoring Observation: Tenant #5's file indicated the program did not correct the insufficiency by having the tenant sign the code status form as stated in the program's POC of 2-12-08.

- Regulatory Insufficiency: The program did not have the tenant sign their code status form. (25.27(1)(1)

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

The program received three regulatory insufficiencies on 10-25-07 related to not consistently developing services plans within 30 days of taking occupancy and as needed with a change in health status, not consistently developing services that reflect the current and identified needs of tenants and not consistently developing service plans signed by a health care professional, two staff and the tenant or the tenant's legal representative for Tenants #1, #3, #4 and #5.

- Monitoring Observation: Tenant #1's resident notes of 6-15-08 indicated the tenant was hospitalized for a kidney infection, returning to the program on 6-17-08. PT/OT evaluation was ordered by the tenant's physician if the tenant agreed. Resident care notes of 7-1-08 and 7-13-08 indicate the tenant was incontinent of urine and had increased confusion. The program did not complete a service plan update as stated in their POC of 2-12-08 and did not complete a service plan update to reflect a change in health status and identified needs.

  Tenant #3's resident notes of 3-31-08 indicate the tenant was hospitalized for congestive heart failure, returning to the program on 4-3-08. Resident notes of 4-27-08 through 7-23-08 indicate the tenant was agitated and swearing with cares, combative, wandering and throwing objects. The program did not complete a service plan update as stated in their POC of 2-12-08 and did not complete a service plan update to reflect a change in health status and identified needs.

  Tenant #4's resident notes of 10-30-07 through 12-3-07 indicate numerous incidents of aggression, agitation and combative with ADLs. The program did not complete a service plan update as stated in their POC of 2-12-08 and did not complete a service plan update with a change in health status. The tenant was discharged from the program on 12-31-07.

  Tenant #5's resident care notes of 3-4-08 indicate the tenant had Conjunctivitis and received treatments of warm soaks and Gentamycin drops four times daily for five days. Resident care notes of 4-24-08 indicate wound care to the tenant's right toe. The program did not complete a service plan update as stated in their POC of 2-12-08 and did not complete a service plan update to reflect a change in health status and identified needs.

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

  Review of Tenant #2's file revealed a service plan dated 07-10-08; however, it was not based on functional and cognitive evaluations. The service plan contained no interventions or expected outcomes addressing the behaviors or health issues identified. The service plan was not signed by the tenant or two additional staff.

  Review of Tenant #6's file revealed a service plan dated 03-08-08; however, it was not based on functional, health and cognitive evaluations and was not signed by two additional staff.

The tenant had a service plan dated 07-09-08 with no documentation of health and cognitive evaluations for the service plan. The service plan contained no interventions or expected outcomes related to the tenant's falls or refusals for preventive measures or therapies.

Review of Tenant #7's file revealed a service plan dated 07-07-08 with no documentation of functional and health evaluations. A cognitive evaluation dated 07-20-08 staged the tenant at a two on the GDS. The service plan did not address identified skin issues or contain interventions and expected outcomes. The initial service plan of 06-27-08 was not signed by the tenant or legal representative and the service plan of 07-07-08 was not signed by the health and human service professional.

- Regulatory Insufficiency: The program did not consistently ensure the service plan would be developed for each tenant 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. (25.28(1))

- Regulatory Insufficiency: The program did not consistently ensure that when a tenant needs personal care or health related care, the service plan would 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 3 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. (25.28(3))

- Regulatory Insufficiency: The program did not consistently ensure the service plan would be individualized and indicate, at a minimum, the tenant's identified needs and the tenant's requests for assistance and expected outcomes. (25.28(4)(a))

D. 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 on 10-25-07 related to not consistently assessing and documenting tenant's health related activities every 90 days and as needed with a change in health status for Tenants #4 and #5.

- Monitoring Observation: Tenant #4's resident notes of 10-30-07 through 12-3-07 indicated numerous incidents of aggression, agitation and combative with ADLs. The program did not complete a nurse review with a change in health status and did not complete a nurse review as stated in their POC of 2-12-08.

  Tenant #5's resident care notes of 3-4-08 indicated the tenant had Conjunctivitis and received treatments of warm soaks and Gentamycin drops four times daily for five days. Resident care notes of 4-24-08 indicated wound care to the tenant's right toe. The program did not complete a nurse review with a change in health status and did not complete a nurse review as stated in their POC of 2-12-08.

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

Tenant #2's nurse's notes indicate a change in behaviors including spitting out medications, agitation, resisting cares and combativeness from 04-11-08 through 06-11-08. Nurse's notes of 04-21-08 indicate a diagnosis of urinary tract infection with a physician order for Cipro 250 milligrams twice a day for 5 days. Nurse's notes indicate the tenant had a skin tear with staff treatment with peroxide, triple antibiotic ointment and a bandage from 05-05-08 through 05-15-08. Nurse's notes of 05-25-08 indicate an episode of slurred speech, increased confusion with facial droop on the left side and inability to grip. The tenant was sent to the emergency room at 12:15 p.m. and returned at 7:10 p.m. Nurse's notes of 05-26-08 indicate a cough, stomach pain and complaint of sickness with a Z-pack ordered per the emergency room and a physician diagnosis of Bronchitis. Nurse's notes of 06-06-08 indicate the physician was notified of increased aggressive behaviors with a recommendation for a mental health unit or Vision Quest referral. Nurse's notes of 06-11-08 indicate notification to the physician of increased agitation with the physician requesting the tenant be sent to the emergency room and admitted to Vision Quest. Nurse's notes of 07-10-08 indicate the tenant returned to the program at 1:00 p.m. At 6:40 p.m. the tenant fell and broke his/her upper denture. The record contained no documentation of nurse review following the changes in health status.

Tenant #6's nurse's notes dated 06-23-08 indicate unsteady gait and increased confusion. Notes of 06-30-08 indicate the tenant had stumbled into a ledge causing a red area on the lower right side. The tenant refused to go to the emergency room and the physician was notified of increased confusion. Nurse's notes of 07-07-08 indicate the tenant reported to staff two falls. On 07-08-08 the tenant again declined to see the physician stating she/he had gotten feet tangled up. Nurse's notes on 07-10-08 indicate the tenant was found on the floor stating he/she had rolled off the bed onto the floor with pain being at an eight on a scale of one to ten. The tenant was sent to the emergency room at 6:00 p.m. Nurse's notes of 07-11-08 note the tenant being very unstable on his/her feet. Nurse's notes of 07-12-08 in the a.m. note the tenant unsteady and unable to walk alone with the staff providing a wheelchair to the dining room. Nurse's notes of 07-12-08 at 2:35 p.m. indicate the tenant was found on the floor and incontinent of bowel. Nurse's notes of 07-12-08 at 3:30 p.m. indicate the tenant was found on the floor stating he/she had fallen out of bed. The tenant refused to go to the emergency room and staff began 1 hour checks. Nurse's notes on 07-12-08 at 10:05 p.m. indicate the tenant was found on the floor and sent to the emergency room. Nurse's notes of 07-13-08 at 2:00 a.m. indicate the tenant returned from the hospital and was very unsteady on his/her feet. The tenant was encouraged to call for assistance and to use a walker. Nurse's notes of 07-13-08 at 9:30 a.m. indicate the tenant was found on the floor with no noted request for assistance and not using oxygen. Review of hospital documentation and photos reveal multiple bruises to the tenant's back, hip and shoulders. The record contained no documentation of nurse review following the changes in health status.

Tenant #7's nurse's notes of 07-05-08 indicate a small laceration of the left ankle with treatment and bandage. Nurse's notes of 07-07-08 at 8:35 a.m. indicate small open areas at the left ankle and shin with dressings and an increase in confusion. Nurse's notes of 07-07-08 at 2:15 p.m. indicate the tenant was sent to the emergency room following complaints of chest pain. Nurse's notes of 07-08-08 indicate the

tenant was moved from the general population to the memory care unit due to the tenant's increased confusion. Nurse's notes of 07-27-08 at 1:16 p.m. indicate the tenant's legs to be swollen. Nurse's notes of 07-28-08 at 8:30 a.m. indicate the tenant's legs again to be swollen and support hose were applied. Nurse's notes of 07-28-08 at 9:15 p.m. indicate the tenant complained of scrotal pain with the upper legs black and blue at the back and thigh area. The record contained no documentation of nurse review following the changes in health status.

- Regulatory Insufficiency: The program did not consistently ensure a registered nurse would assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress or previous recommendations at least every 90 days or if there are changes in health status. (25.30(3))

E. 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 on 10-25-07 related to not consistently providing staff that are responsible for preparing or serving food or both an orientation on sanitation and safe food handling.

- Monitoring Observation: Program records indicate dining services staff received food service training on 3-26-08. The Food Services Director stated direct care staff had not received orientation on sanitation and safe food handling. Interviews held with Staff #4, #9, and #11 stated they had not received training on sanitation and safe food handling. A review of employee files for Staff #1, #2, #3, #4, #5, #6, #7, and #8 indicated staff had not received training on sanitation and safe food handling. The program did not provide training as stated in their POC of 2-12-08.

- Regulatory Insufficiency: The program did not consistently ensure that personnel who are employed by or contracting with the program and who are responsible for preparing or serving food, or both preparing and serving food, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (25.32 (5))

F. 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]

The program received two regulatory insufficiencies on 10-25-07 related to not consistently providing sufficiently trained staff at all times to fully meet the tenant's identified needs and not consistently providing mandatory dependent adult abuse training for all staff.

- Monitoring Observation: File review for Staff #1, #3 and #4 indicate staff had demonstrated medication administration back to the Registered Nurse (RN). Review of Staff #2's file did not indicate this staff person demonstrated medication administration back to the RN. The program did not provide training as stated in their POC of 2-12-08.

File review for Staff #1, #2, #3, #4, #5, #6, #7, #8 indicate none of the staff had documented dependent adult abuse training. The program did not provide training as stated in their POC of 2-12-08.

- Regulatory Insufficiency: The program did not consistently provide sufficiently trained staff at all times to fully meet the tenant's identified needs. (25.23(1))

- Regulatory Insufficiency: The program did not consistently provide mandatory dependent adult abuse training for all staff. (235.16 (5)(b))

G. Managed Risk Statement – Program has a managed risk statement which includes the tenant's or legal representative's signed acknowledgement of the shared responsibility for identifying and meeting needs and the process for managing risk and upholding tenant autonomy when tenant decision making may result in poor outcomes for the tenant or others. [321 IAC 25.36]

The program received a regulatory insufficiency on 10-25-07 related to not consistently initiating a managed risk agreement when tenant decision making may result in poor outcomes for the tenant and others.

- Monitoring Observation: Program records indicate managed risk agreements were initiated for tenants who did not participate in fire drills but were later discontinued as tenants are now participating in fire drills.

- Regulatory Insufficiency: None noted.

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

The program received a regulatory insufficiency on 10-25-07 related to not consistently conducting fire drills.

- Monitoring Observation: Program records indicate fire drills were conducted monthly during the day, evening and night beginning 1-23-08 through 7-27-08 for both the general population and the dementia unit.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: The program's POC, submitted on 2-12-08 related to the Recertification Monitoring Evaluation Report of 10-24 & 25-2008, which indicated the program planned to make corrections in the following areas: Evaluation of Tenant, Tenant Documents, Service Plans, Nurse Review, Food Service, Staffing, Managed Risk Statements and Life Safety. These corrections were not fully implemented.

- Regulatory Insufficiency: The program did not fully implement the Plan of Correction submitted on 2-12-08. (26.2((6)a))

Dated this 15th day of August 2008.