IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Demand Letter
Certified

April 5, 2010

Complaint Intake: #25767-C

Kent Walton, Administrator
Promise House
1320 Litchfield Drive
Hiawatha, IA 52233-2343

RE: I. Final Complaint Investigation Report – #25767-C
II. Civil Penalty
III. Hearings and Appeals
IV. Conclusion

Dear Mr. Walton:

I. Final Complaint Investigation Report –Promise House, Hiawatha, IA

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2009) and Iowa Administrative Code, chapter 321 – 25. The Final Report notes **Regulatory Insufficiencies,** in the areas of: Evaluation of Tenants, Service Plans, Staffing, Dementia - Specific Education, Structural Requirements and Other (not reporting to DIA within 24 hours). Promise House (Program) is being assessed a $3,500.00 civil penalty.

DIA is accepting the Plan of Correction (POC). The Request for Reconsideration is being denied as evaluations were not completed as needed. Nurse's notes are not the assessment form approved for the evaluation of tenants.

You are unable to ask for a request of reconsideration for a fine; however, you can request an appeal of the fine and that is explained in section III. Hearings and Appeals.

II. Civil Penalty

If, within thirty (30) days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 231C.14. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send written

notice to the Certification Coordinator and remit the penalty assessed by check or money order in the amount of two thousand two hundred seventy-five dollars ($2,275.00) within 30 business days after the receipt of this demand letter. **Please be sure to identify the program and its location on the check or money order.**

III. Hearings/Appeals

The Program may appeal the DIA decision in accordance to 321 IAC 26.4, within 30 days of notice, by submitting a request for appeal 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.

IV. Conclusion

The Program is being assessed a $3,500.00 civil penalty. The final Plan of Correction (POC) submitted on March 26, 2010, has been reviewed and is accepted. The Request for Reconsideration has been denied as explained in section one.

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 in regard to this letter and report, please contact your Certification Coordinator, Chris Nothaft, at 515-281-4116.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #: 25767-C**

Kent Walton, Administrator
Promise House
1320 Litchfield Drive
Hiawatha, IA 52233-2343

Date of Investigation:

December 28, 29 & 30, 2009

Monitor(s):

Stephanie Cummins, MA

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 visit was conducted at Promise House on December 28, 29 and 30, 2009. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	20
Total Census of ALP:	20

***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 Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Service Plans, Nurse Review, Staffing and Structural Requirements.

The August 25, 2009 complaint visit resulted in a Regulatory Insufficiency in the area of Medications.

The May 27, 2008 recertification visit resulted in the areas of: Evaluation of Tenants, Service Plans, Nurse Review, Staffing and Structural Requirements.

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

Complaint Allegation: It was alleged a tenant was designated a two person lift and was in a lounge chair day and night in the common area, due to a health condition. It was alleged a tenant had a high bed, fell out and was put back into bed despite having a hip fracture. The same tenant fell out of bed frequently and at times it took two people to transfer the tenant. It was alleged a tenant had problems with his/her leg, could not go to the bathroom independently, was incontinent all the time and could not reposition himself/herself in bed. It was alleged a tenant had a skin tear and Sensicare had to be placed on it. It was alleged a tenant was resistant to dressing, at times required two people to transfer and was incontinent, requiring bed changes. It was alleged a tenant fell out of bed and at times it took two people to transfer.

Monitoring Observation: Nine tenant files were reviewed.

Tenant #1, 81 years old, was admitted on 1-8-09 and diagnoses include: Dementia, Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), Glaucoma, Benign Prostate Hypertrophy (BPH) and Gastroesophageal Reflux Disease (GERD). The tenant was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The tenant died on 11-11-09. According to Nurse's Notes dated 10-26-09 through 11-11-09 and faxes to the tenant's physician, the tenant had decreased mobility and became a two person transfer. Staff repositioned the tenant, provided oral cares, changed the tenant's protective garment and oral medications were discontinued. Evaluations were not completed as needed. The nurse and Staff #1 and #2 stated the tenant did not have any issues with his/her skin or with ulcers. The nurse indicated there were concerns in regard to the tenant and safety; therefore, the tenant spent most the day in the common area. The tenant napped and staff checked on the tenant in the afternoon. The tenant slept in the common area in the recliner and family declined another room that became available. The tenant was toileted either in his/her private restroom or the public restroom. The nurse stated none of the tenant's personal cares were completed in the common area. The nurse stated this situation lasted approximately three to four weeks until a room opened up close to the common area. She stated cleaning in the common area was done hurriedly and staff were expected to be respectful of when the tenant was resting. Evaluations were not completed as needed.

Tenant #2, 88 years old, was admitted 1-8-08 and diagnoses include: Alzheimer's Disease, Renal Insufficiency, HTN, Scoliosis, High Cholesterol and Recovering Alcoholic. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. The tenant was discharged from the program on 12-8-09. According to Nurse's Notes dated 11-20-09 through 12-7-09 and faxes to the tenant's physician, the tenant took two people to transfer at times, was not weight bearing at times, refused to ambulate at times, yelled out and required increased assistance with eating. The tenant's service plan indicated staff were to assist with toileting routinely. The service plan addressed interventions if the tenant was resistive. Evaluations were not completed as needed.

Tenant #3, 82 years old, was admitted on 4-18-09 and diagnoses include: Alzheimer's Disease, Depression, HTN, Osteoporosis, Allergic Rhinitis and Glaucoma. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. According to

Nurse's Notes dated 9-21-09, the nurse received a call from staff that Tenant #3 had put on his/her call light and was found sitting on his/her left hip with his/her knees bent to the side. The notes indicated the tenant only complained of ankle pain initially, range of motion (ROM) was completed and the tenant complained of no other pain except for the left ankle. Staff assisted the tenant to bed and the tenant then complained of left hip pain. An ambulance was called at 2:15 a.m. The ambulance arrived and splinted left leg to right leg and the tenant complained of significant pain. The tenant had a left hip fracture and surgery. Notes indicated the tenant went to a care center and returned to the program on 10-13-09. Evaluations were completed on 10-12-09. Notes dated 10-9-09 indicated the tenant's bed needed to be lowered before the tenant returned and Occupational Therapy (OT) recommended the bed be no higher than 18-20 inches from the floor to the top of the mattress. According to Occurrence Reports, the tenant was found on the ground on three occasions and staff lowered him/her to the ground one time between 10-7-09 and 12-26-09. Nurse's notes and faxes to the tenant's physician in November and December of 2009 indicated the tenant was having left knee pain. The service plan was updated on 11-09 and indicated the tenant needed one or two people to assist him/her from a sitting position. Evaluations were not completed as needed.

Tenant #4, 86 years old, was admitted on 4-8-09 and diagnoses include: Chronic Dementia, Chronic Right Eye Blindness, Depression, GERD, HTN and Osteoporosis. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. According to a fax dated 10-28-09 to the tenant's physician, the tenant had decreased transfer ability, decreased ability to communicate and poor intake. Hospice Services were initiated on 10-29-09 with the tenant's diagnosis of End Stage Alzheimer's. Evaluations were not completed as needed.

Tenant #5, 72 years old, was admitted on 12-8-08 and diagnoses include: Dementia with Agitation, Orthostatic Hypotension, Gout, Back Pain, Spondylitis, Compression Fracture, Prostate Cancer (two years ago) with Radiation. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. The tenant had an order for Sensicare as needed. A review of the tenant's file indicated the tenant had been evaluated for knee pain on 6-12-09 and the doctor ordered Ibuprofen, 400 mg, by mouth every morning and increased the Tylenol to 1000 mg, by mouth twice daily. Sensicare was not used in October or November 2009. The tenant's service plan stated the tenant received routine toileting and staff provided peri-care, monitored the tenant's skin for any breakdown and reported to the nurse. Staff indicated Tenant #5 participated in his/her toileting cares, did not have any skin tears and could reposition himself/herself in the bed. The staff did not identify any concerns with the tenant's bed and providing cares. Evaluations were completed appropriately.

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

Tenant #6, 75 years old, was admitted on 6-29-09 with a diagnosis of Breast Cancer, Right Mastectomy (1999). The tenant was staged at a six on the GDS, which indicated severe cognitive decline. According to Nurse's Notes dated 10-12-09 through 11-30-09 and faxes to the tenant's physician, the tenant had loose stools, elopement attempts, aggressive physical behavior towards staff and removed his/her clothing in the common area. Evaluations were not completed as needed.

Tenant #9, 76 years old, was admitted on 10-14-09 and diagnoses include: Alzheimer's Disease, Hyperlipidemia, HTN, Hypothyroidism, Depression, Constipation, Macular Degeneration, Eczema, Dermatitis, Osteoarthritis, History of Cerebrovascular Accident (CVA) with exacerbation of Alzheimer's. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. According to Nurse's Notes dated 11-13-09 through 12-28-09 and faxes from the physician, the tenant had attempted elopements, aggressive physical behaviors towards staff, swearing towards tenants and staff and inappropriate comments and gestures towards staff. Evaluations were not completed as needed.

- Regulatory Insufficiency: The program did not evaluate each tenant's functional, cognitive and health related status as needed to determine the tenant's continued eligibility for the program and to determine any modification to services needed. (321 IAC r. 25.23(2))

B. 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.

Complaint Allegation: It was alleged the program retained tenants that exceeded the appropriate level of care including tenants that required routine two person transfers and had incontinence.

Monitoring Observation: Staff #1, #2, #3, #5, #6 and #8 were interviewed. Staff interviews, the review of nine tenant files, monitor observations and an interview with the nurse indicated none of the current tenants exceeded the appropriate level of care.

- Regulatory Insufficiency: None noted.

C. Service Plan – Program has an individualized service plan developed and updated for each tenant as required.

Monitoring Observation: Nine tenant files were reviewed.

Tenant #1's file was reviewed. According to Nurse's Notes dated 10-26-09 through 11-11-09 and faxes to the tenant's physician, the tenant had decreased mobility and became a two person transfer. Staff repositioned the tenant, provided oral cares, changed the tenant's protective garment and oral medications were discontinued. The tenant's service plan was not updated to reflect all of the changes. Some changes were noted on the service plan; however, these changes were not based on evaluations and signatures were not obtained. The nurse and Staff #1 and #2 stated the tenant did not have any issues with his/her skin or with ulcers. The nurse indicated there were concerns in regard to the tenant and safety; therefore, the tenant spent most of the day in the common area. The tenant napped and staff checked on the tenant in the afternoon. The tenant slept in the common area in the recliner and family declined another room that became available. The tenant was toileted either in his/her private restroom or the public restroom. The nurse stated none of the tenant's personal cares were completed in the common area. The nurse stated this situation lasted approximately three to four weeks until a room opened up close to the common area. She stated cleaning in the common area was done hurriedly and staff were expected to be respectful when the tenant was resting. The

service plan was not updated as needed and did not reflect the tenant sleeping and spending time in the common area due to safety concerns.

Tenant #2's file was reviewed. According to Nurse's Notes dated 11-20-09 through 12-7-09 and faxes to the tenant's physician, the tenant took two people to transfer at times, was not weight bearing at times, refused to ambulate at times, yelled out and required increased assistance with eating. The tenant's service plan indicated staff were to assist with toileting routinely. The service plan addressed interventions if the tenant was resistive. The tenant's service plan was not updated to reflect all of the changes. Some changes were noted on the service plan; however, these changes were not based on evaluations and signatures were not obtained.

Tenant #3's file was reviewed. According to Nurse's Notes dated 9-21-09, the nurse received a call from staff that Tenant #3 had put on his/her call light and was found sitting on his/her left hip with his/her knees bent to the side. The notes indicated the tenant only complained of ankle pain initially, ROM was completed and the tenant complained of no other pain except for the left ankle. Staff assisted the tenant to bed and the tenant then complained of left hip pain. An ambulance was called at 2:15 a.m. The ambulance arrived and splinted left leg to right leg and the tenant complained of significant pain. The tenant had a left hip fracture and surgery. Notes indicated the tenant went to a care center and returned to the program on 10-13-09. Evaluations were completed on 10-12-09. Notes dated 10-9-09 indicated the tenant's bed needed to be lowered before the tenant returned and OT recommended the bed be no higher than 18-20 inches from the floor to the top of the mattress. According to Occurrence Reports the tenant was found on the ground on three occasions and staff lowered him/her to the ground one time between 10-7-09 and 12-26-09. Nurse's notes and faxes to the tenant's physician in November and December of 2009 indicated the tenant was having left knee pain. The service plan was updated on 11-09 and indicated the tenant needed one or two people to assist him/her from a sitting position. The service plan was not based on evaluations and signatures were not obtained to reflect the changes.

Tenant #4's file was reviewed. According to a fax dated 10-28-09 and sent to the tenant's physician, the tenant had decreased transfer ability, decreased ability to communicate and poor intake. Hospice Services were initiated on 10-29-09 with the tenant's diagnosis of End Stage Alzheimer's. The service plan was updated on 10-28-09 to reflect Hospice services; however, evaluations were not completed and signatures were not obtained to reflect the changes. The tenant's service plan was not updated as need and did not reflect the needs of the tenant.

Tenant #5's file was reviewed. The tenant had an order for Sensicare as needed. A review of the tenant's file indicated the tenant had been evaluated for knee pain on 6-12-09 and the doctor ordered Ibuprofen, 400 mg, by mouth every morning and increased the Tylenol to 1000 mg, by mouth twice daily. Sensicare was not used in October or November 2009. The tenant's service plan stated the tenant received routine toileting and staff provided peri-care, monitored the tenant's skin for any breakdown and reported to the nurse. Staff indicated Tenant #5 participated in his/her toileting cares, did not have any skin tears and could reposition himself/herself in the bed. The staff did not identify any concerns with the tenant's bed and providing cares. The service plan was updated appropriately.

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

Tenant #6's file was reviewed. According to Nurse's Notes dated 11-13-09 through 12-28-09 and faxes from the physician, the tenant had attempted elopements, aggressive physical behaviors towards staff, swearing towards tenants and staff and inappropriate comments and gestures towards staff. The tenant's service plan was not updated as needed and did not reflect the needs of the tenant.

Tenant #9's file was reviewed. According to Nurse's Notes and faxes to the tenant's physician, between 11-13-09 and 12-28-09 the tenant had attempted elopements, aggressive physical behaviors towards staff, swearing towards tenants and staff and inappropriate comments and gestures towards staff. The tenant's service plan was not updated as needed and did not reflect the needs of the tenant.

- Regulatory Insufficiency: The program did not develop a service plan for each tenant based on the evaluations conducted in accordance with 25.23(2) and 25.23(3) and designed to meet the specific service needs of the individual tenant. (321 IAC r. 25. 28(1))

- Regulatory Insufficiency: The program did not update the tenant's service plan when a tenant needs personal care or health-related care as needed, 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. (321 IAC r. 25.28(3))

D. 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.

Complaint Allegation: It was alleged a tenant had a swollen leg, was in pain and could not ambulate without assistance. It was alleged the tenant did not receive a pain medication because the medication count was off. It was alleged the medication room was accessible to everyone as the keys were not kept secure. It was alleged narcotics were counted inappropriately. It was alleged narcotics were administered to tenants in pudding and they were spoon fed.

Monitoring Observation: According to a statement from the nurse, the program did not have any medication errors from September 2009 through 12-28-09. The Narcotic Policy stated PRN narcotics were kept locked in the narcotic box in the medication room. They were administered per physician orders and accounted for at the change of each shift. Narcotics were counted at the change of shift by the staff reporting on duty and the staff reporting off duty. They recorded that the count was correct. Narcotic Count Sheets were obtained and the sheets documented staff consistently signed off narcotics with two staff at shift change. The nurse and Staff #1 and #2 were interviewed and indicated narcotics were counted at shift change with two staff. The monitor observed an on duty and off duty staff counting narcotics at shift change. A medication pass was observed and appropriate medication protocol was observed. Staff #1, #2 and the nurse indicated

tenants received pain medication as ordered and as needed. The nurse stated there were no issues with tenants not receiving medications because counts were not reconciled. The nurse provided a list tenants that received crushed medications and the list included: Tenant #3, #4 and #6 and all of the tenants had a physician's order for crushed medications. Staff #2 stated that on third shift staff that did not pass medications also had a key to the medication room.

Tenant #7, 96 years old, was admitted on 6-23-09 and diagnoses include: Colon Resection, Right Upper Arm Deep Vein Thrombosis (DVT), Coronary Artery Disease (CAD), Diabetes Mellitus II, Hyperlipidemia, Renal Insufficiency, Hiatal Hernia, HTN, Peripheral Edema and a History of Respiratory Distress. The tenant was staged at a five to six on the GDS, which indicated moderately severe to severe cognitive impairment. On 9-15-09, the tenant was admitted to the hospital with DVT to the leg and returned to the program on 9-21-09. Nurse's notes dated 9-11-09 and 9-15-09 indicated the tenant did not complain of pain. The Medication Administration Records (MARs) indicated the tenant received Vicodin, 5/500, twice daily and the MARs showed the tenant received the medication consistently. The tenant also had an order for Vicodin, 5/500, one tablet by mouth every four hours, as needed. This was used twice in September once on 9-5-09 and once on 9-13-09 for back pain.

- Regulatory Insufficiency: None noted.

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.

Complaint Allegation: It was alleged people were hired to cook regardless of their cooking ability. It was alleged the nurse purchased food from the store. It was alleged the tenants had cold cereal served every morning and at times fruit was not available.

Monitoring Observation: The nurse had a ServSafe certificate that was current. The nurse purchased some food items at local stores but stated the majority of the food came from Martin Brothers. The menus were approved by Martin Brothers and the Registered Dietician (RD) from the care center. Breakfast was observed on 12-29-09 and 12-30-09 and a variety of items were served including both hot and cold items. The occupancy agreement was reviewed and the agreement indicated three meals would be provided. Staff #1 and the nurse indicated breakfast included both hot and cold items and fruit was available. They stated the fruit was either fresh or canned and it was always available. Staff #3 stated there were no issues with food being available and stated canned or fresh fruit was available. The nurse stated none of tenants had experienced weight loss related to the meals . The nurse stated generally hot meals were served.

- Regulatory Insufficiency: None noted.

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.

Complaint Allegation: It was alleged the building was left unattended.

Monitoring Observation: Staff #1, #2 and #3 were interviewed and reported the building was never left unattended. The nurse was interviewed and indicated the building was not left unattended. A review of the schedule indicated four caregivers were scheduled on first and second shifts and two caregivers on third shift. According to a policy, staff cannot leave the facility during working hours unless they have prior approval from the Director.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged supplies were not available, including linens, to appropriately clean up tenants.

Monitoring Observation: Staff #1, #2 and #3 were interviewed. The staff stated supplies were available, including linens. The nurse stated supplies were available.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged there was no dress code for staff and they wear shorts and no shoes. It was alleged staff cannot be distinguished from visitors.

Monitoring Observation: Staff #1, #2 and #3 were interviewed. Staff indicated staff did not work bare foot. The monitor observed staff did not have bare feet. The nurse indicated staff did not work bare foot. An employee dress code policy was obtained and indicated staff were required to dress appropriately at all times and clothing is expected to be neat and clean. Footwear must be rubber soled. Shorts and name tags were not addressed on the dress code and grooming policy.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged staff worked on puzzles while on duty.

Monitoring Observation: Staff #1, #2 and #3 were interviewed. Staff indicated they did not work on puzzles while on duty. The nurse stated she would not allow staff to work on puzzles while on duty.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged staff were asked to provide extensive cleaning duties in addition to tenant cares.

Monitoring Observation: Staff #1, #2 and #3 were interviewed. These staff worked first, second and third shifts. They did not identify any issues with providing tenant cares and completing cleaning tasks as assigned. The nurse stated there were no issues with providing tenant cares and completing cleaning task as assigned and she stated tenant cares came first.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged a waiver was signed allowing tenants to have a private bed. It was alleged tenant cares could not be appropriately completed due to tenants having private beds and not hospital beds.

Monitoring Observation: Staff #1, #2 and #3 were interviewed. The staff did not have issues or concerns with providing appropriate care to tenants with private beds. The nurse stated the rooms accommodate a twin or double bed and a hospital bed is the tenant's choice. She stressed safety in the rooms. The nurse stated Tenant #3's bed was too high and now the bed was lowered as a recommendation from OT.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged there was MRSA in the building and no MRSA warnings were posted except in the nurse's notes. It was alleged staff did not wear shoes.

Monitoring Observation: Tenant #8, 100 years old, was admitted on 1-27-09 and diagnoses include: Dementia, Constipation, Head Wounds and History of Left Thigh Wounds. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. The nurse stated staff were informed Tenant #8 had MRSA. The tenant had orders for an antibiotic on 8-31-09. Nurse's Notes indicated on 9-10-09, the antibiotic was completed and improvement to the scalp was noted. Universal precautions were carried out, the tenant's nails were kept clean and his/her hats were removed. According to the nurse, no other tenants or staff were affected and the area on the tenant's head was resolved quickly.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged staff reported to work when they were sick.

Monitoring Observation: The nurse was interviewed and stated staff did not come to work when they were sick and they were encouraged to stay at home when sick. She stated the program provided sick days for staff.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged there were not sufficient staff to evacuate tenants in case of a fire.

Monitoring Observation: Fire drills for the past year were reviewed and the nurse indicated that the tenants were not evacuated as part of the drills.

- Regulatory Insufficiency: The program did not consistently conduct emergency egress and relocation drills not less than six times per year on a bimonthly basis, with not less than two drills conducted during the night when tenants are sleeping. (231C.4) (321 IAC r. 25.40(1)e)

Complaint Allegation: It was alleged that staff trained to administer medications and narcotics were not scheduled to count narcotics.

Monitoring Observation: Staff #1, #2, #4, #5, #6 and #7's medication administration training documents were reviewed and staff did not have any documented training from the current nurse regarding medication administration, blood sugars or activities of daily living (ADLs). The nurse indicated training had occurred; however, it was not documented. Staff #3 did not administer medications; however, she did provide assistance with ADLs and did not have documented training regarding ADLs. The program employed certified and uncertified staff.

- Regulatory Insufficiency: The program did not provide sufficient trained staff available at all times to fully meet tenant's identified needs. (321 IAC r. 25.33(1))

G. 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.

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

Monitoring Observation: Staff #2 and #4 did not have six hours of dementia training annually. The last documented dementia training was in February of 2008.

- Regulatory Insufficiency: The program did not provide all personnel employed or contracted with a dementia-specific program a minimum of two hours of dementia-specific continuing education annually. Direct-contact personnel receive a minimum of six hours of dementia-specific education annually. (321 IAC r. 25.34(3)).

H. 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.

Complaint Allegation: It was alleged there were not enough activities offered and tenants did not participate in some of the activities that were offered. It was alleged the tenants sit and watch the staff work on arts and crafts.

Monitoring Observation: An activity calendar dated December, 2009 was provided to the monitor. The monitor observed activities taking place and tenants during the on-site. Interviews with Staff #1, #2 and #3 and the nurse indicated there were sufficient activities.

- Regulatory Insufficiency: None noted.

I. 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.

Complaint Allegation: It was alleged a janitorial closet (which contained cleaning chemicals) was unlocked and a tenant had gotten into the closet defecated.

Monitoring Observation: Staff #1, #2 and #3 were interviewed. Staff and the nurse indicated none of the tenants had gotten into the cleaning closets and the chemicals were locked. Tenant #6's file was reviewed and the nurse's notes did not indicate the tenant

had gotten into the cleaning closets. Occurrence Reports were reviewed and there was not a report regarding a tenant who had gotten into a cleaning closet.

Three tours of the building were conducted by the monitor. On the first tour, the monitor observed janitorial closets were locked and the sprinkler closet was unlocked; however, it did not contain any chemicals. The monitor observed dishwasher detergent and Isopropyl Alcohol in unlocked cabinets. The detergent was locked immediately after it was discovered and the Isopropyl Alcohol was removed. On the second tour, the monitor observed the janitorial closets and sprinkler closets were locked. The monitor also observed aftershave and craft glue in an unlocked drawer. The aftershave and craft glue were given to staff to secure. On the third tour, the monitor observed janitorial and sprinkler closets and all chemicals were locked.

- Regulatory Insufficiency: The program did not provide buildings and grounds that are well-maintained, clean, safe and sanitary. (321 IAC r. 25.40(1)(b))

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

Complaint Allegation: It was alleged a tenant wandered and used other tenants' restrooms.

Monitoring Observation: Staff #1, #2 and #3 were interviewed. Staff indicated Tenant #6 wandered around the building and sometimes wandered into other tenants' apartments. Staff indicated there had been no outcomes related to the wandering into others apartments. The nurse stated Tenant #6 wandered into other tenants' apartments and staff redirected the tenant. She stated some tenants locked their doors and there had been no outcomes related to the wandering and if belongings were taken, they were returned. The nurse stated Tenant #6 had gone to the bathroom in other tenants' apartments and it was nothing purposeful; however, a part of the tenant's dementia. The nurse in the past two months had not observed any issues with Tenant #6 going to the bathroom in other tenants' apartments.

- Regulatory Insufficiency: None noted.

Complaint Allegation: It was alleged a razor and nail clippers were used on multiple tenants.

Monitoring Observation: The nurse indicated if razors or clippers were used on tenants, they were cleaned with alcohol between uses. Staff #8 stated razors and clippers were cleaned with alcohol between uses, if used with different tenants.

- Regulatory Insufficiency: None noted.

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

Monitoring Observation: According to Nurse's Notes, dated 9-21-09, the nurse received a call from staff that Tenant #3 had put on his/her call light and they found the tenant sitting on his/her left hip with his/her knees bent to the side. The notes indicated the tenant only complained of ankle pain, ROM checks were completed and the tenant

complained of no other pain except for the left ankle. Staff assisted the tenant to bed and the tenant complained of left hip pain. An ambulance was called at 2:15 a.m. The tenant had a left hip fracture that required surgery. The program did not report the substantial injury to the Department.

- Regulatory Insufficiency: The program did not report to the Department within 24 hours, by the most expeditious means available, an accident causing substantial injury or death. (321 IAC r. 26.10(2))

Dated this 5th day of April, 2010.