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: #27500-C
Incident Intake: #27507-I
Incident Intake: #27557-M

Ms. Patricia McNichols, Administrator
Bickford Cottage Assisted Living
3500 Lower West Branch Rd
Iowa City, IA 52245-4106

RE: I. Final Complaint and Incident Investigation Report – #27500-C, #27507-I and #27557-M
II. Civil Penalty
III. Hearings and Appeals
IV. Conclusion

Dear Ms. McNichols:

I. Final Complaint and Incident Investigation Report –Bickford Cottage Assisted Living, Iowa City, IA

Enclosed is the **Final Complaint and Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2009) and Iowa Administrative Code, chapters 481 – 67 and 69. The Final Report notes **Regulatory Insufficiencies,** in the areas of: Medications, Staffing, Dementia – Specific Education for Program Personnel and Record Checks. Bickford Cottage (Program) is being assessed a $1,000.00 civil penalty.

DIA is accepting the Plan of Correction (POC).

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 one thousand dollars ($650.00) 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 481 IAC 67.13, 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 $1,000.00 civil penalty. The final Plan of Correction (POC) submitted on March 23, 2010, has been reviewed and is accepted.

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 Incident and Complaint Investigation Report

Assisted Living Program:

Ms. Patricia McNichols, Administrator
Bickford Cottage Assisted Living
3500 Lower West Branch Rd
Iowa City, IA 52245-4106

Complaint Intake #: 27500-C
27507-I
27557-M

Date of Investigation:

February 16, 17 and 18, 2010

Monitor(s):

Hal L. Chase, RN BSN MPH

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. IAC r. 481-67.10(5). 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 481 IAC chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An incident and complaint investigation on-site visit was conducted at Bickford Cottage Assisted Living on February 16, 17 and 18, 2010. 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 a Dementia Specific Program by definition but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS):	7
Current number of tenants without cognitive disorder:	25
Total Population:	32

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

Program History – There have been substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Tenant Documents, Service Plans, Staffing and Other (not notifying DIA within 24 hours of an incident resulting in serious injury or death).

The October 6 and 7, 2009 Incident Investigation resulted in a civil penalty of $1,000.00 and a Regulatory Insufficiency in the area of Other (not notifying DIA within 24 hours of an incident resulting in serious injury or death).

The August 5 and 6, 2009 Complaint Investigation resulted in a civil penalty of $500.00 and Regulatory Insufficiencies in the areas of: Evaluation of Tenants, Tenant Documents, Service Plans, Staffing and Other (not notifying DIA within 24 hours of an incident resulting in serious injury or death).

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

A. Medications

Complaint Allegation #27500-C & 27507-I: It is alleged Tenant #1 was given Morphine Sulfate (MS) Contin immediate release (IR) 15 milliliters (ml) and MS Contin 90 mg extended release (ER) when the tenant had not been prescribed this medication.

Monitoring Observation: An incident report of 2-14-10 indicated a medication error occurred when Staff #1, registered nurse (RN), gave Tenant #2's MS Contin 15mg IR, MS Contin 60mg ER and MS Contin 30mg ER to Tenant #1 in error.

Tenant #1, 79 years old, was admitted on 5-25-09 and diagnoses included: Alzheimer's Disease, Parkinson's Disease, Anemia Not Otherwise Specified (NOS), Confusional Arousals and Edema Lower Extremities. The tenant was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. The tenant has a court appointed guardian. The service plan dated 12-31-09 indicated the program was to administer routine medications and treatments.

Tenant #2, 80 years old, was admitted on 8-5-07 and diagnoses included: Cerebral Palsy, Gastroesophageal Reflux Disease (GERD), Recurrent Urinary Tract Infection (UTI), History of Skin Breakdown, a Chronic History of Upper Respiratory Infections (URI) and Pneumonia. A mini mental status exam was completed on 2-1-10 and the tenant scored 30/30 which indicated normal cognition. An assessment completed on 2-1-10 indicated the tenant had difficulty getting words out and was difficult to understand. A service plan dated 2-1-10 indicated the program was to administer routine medications and treatments. MARs for 2-14-10 indicated the following medications were to be administered by Staff #1, Nurse, for Tenant #2, but were actually given to Tenant #1:

Tenant	Medication/Treatment	Dosage/Treatment
2	Morphine Sulfate IR Tablet	15mg tablet, three times daily.
2	Morphine Sulfate ER Tablet	30 mg tablet, every 8 hours, taken with a 60 mg. tablet.
2	Morphine Sulfate ER Tablet	60mg tablet, three times daily, taken with a 30 mg tablet.

Staff #1, RN, stated on 2-14-10 at 9:35 a.m. he removed Tenant #1's medication from the bubble pack package, placed each medication into a medication cup, initialed each medication on the MAR and took the medications into the tenant's apartment. Not seeing the tenant in his/her room, he took the medications back to the medication room, marked the cup with the tenant's initials and apartment number and placed the medication cup on top of the medication cart.

Staff #1, RN, stated he removed Tenant #2's medication from the bubble pack package, initialed each medication on the MAR and placed each medication into a medication cup. He then marked the medication cup with the tenant's initials and room number. He stated he placed Tenant #2's MS Contin 15mg IR, MS Contin 60mg ER and MS Contin 30mg ER into Tenant #1's medication cup, not realizing he had done so. He remembered seeing Tenant #1's bathroom door closed and decided to revisit the tenant. At 9:45 a.m.

he administered the medications placed in the medication cup marked with Tenant #1's initials and room number.

Staff #1, RN, stated at 9:50 a.m. he took Tenant #2's medications, which he had earlier placed in a medication cup marked with the tenant's initials and room number, and attempted to administer the medications to the tenant. Tenant #2 wanted to count the medications and counted seven pills. The tenant insisted there should be 10 pills. Tenant #2 stated he/she had to write out the word 'count' to make Staff #1 understand what he/she was saying. Staff #1 returned to the medication room and reviewed the tenant's MARs, bubble pack packaging and medication markings. He stated all of the medications were given correctly except for the MS Contin 15mg IR, MS Contin 60mg ER and MS Contin 30mg ER which had mistakenly been given to Tenant #1. He realized he had made a medication error and contacted Staff #4, who was a Certified Medication Aide. Staff #4 stated Staff #1, RN, told her he had given medications to the wrong tenant. She asked him who the tenant was and he indicated he did not know the tenant's name, but could take her to the tenant's room. He stated he had given Tenant #2's MS Contin 15mg IR, MS Contin 60mg ER and MS Contin 30mg ER to Tenant #1 at 9:00 a.m. Staff #1, RN, had earlier stated he had given Tenant #1, Tenant #2's medications, at 9:45 a.m. Staff #1, RN, stated he notified the Administrator of the medication error. The tenant was later transported by ambulance to a local hospital for emergency care.

Staff #1, RN, stated Staff #5, the on-call RN, directed him to give Tenant #2 MS Contin 15mg IR, MS Contin 60mg ER and MS Contin 30mg ER. He stated he administered these medications sometime around 10:30 a.m. The tenant's MAR was not corrected to indicate the 6:00 a.m. dose of MS Contin 15mg IR and 7:00 a.m dose of MS Contin 30mg ER and 60mg ER were given to a different tenant and not Tenant #2. Additionally, the MS Contin 15mg IR, MS Contin 60mg ER and MS Contin 30mg ER given at 10:30 a.m. were charted as refused at 11:00 a.m. despite Staff #1, RN, stating he had given all three MS Contin doses at 10:30 a.m.

Tenant #2's narcotic record dated 2-14-10, indicated four entries were made for MS Contin 15mg IR at 10:00 a.m, 11:00 a.m, 2:00 p.m. and 10:00 p.m. Three entries for MS Contin 30mg ER at 10:00 a.m. and 11:00 a.m. and 4:00 PM and three entries for MS Contin 60mg ER at 10:00 a.m and 11:00 a.m. and 4:00 PM. Each entry indicated the amount on hand and the time given. However, the first entry for all three medications indicated the documented time had been altered from the time originally written. Staff #1, RN, stated he had altered the time originally charted as given at 6:00 a.m. or 7:00 a.m. on 2-14-10 to a recorded time of 10:00 a.m. The second entry on the narcotic count sheet indicated the documented time was 11:00 a.m.

Program documents indicated the medication cart was to remain in the medication room. A tenant photo is placed in the front of each MAR to assist in the identification of each tenant. The program's medication administration practice guidelines indicated staff were to take each tenant's unit dose package with them when administering medications, remove the medication from the package, administer the medications and document in the MARs immediately after administration. In the event the tenant did not take the medication, staff were to document in the MAR by initialing in the appropriate time slot, circling their initials and documenting on the back of the MAR the specific information concerning the refusal, including an explanation in the communication log.

Staff #2, RN, stated she worked from 7:00 a.m. – 3:30 p.m. on 10-21-09 and provided orientation on how the program administered medications to tenants, to Staff #1, RN. She first explained the process of completing a shift change MAR audit. Staff #1, RN, started to audit the MARs for the shift. As he was auditing the MARs, Staff #2 obtained a task sheet and tenant list. On the tenant list she indicated which tenants had special treatments and which tenants kept their own medications in their apartments. When Staff #1 finished the MAR audits they both signed the audit documentation sheet. Staff #2 explained the program's policy of taking each tenant's medication bubble packs, MAR pages and/or treatment administration records and using a red tote to carry these items. She then showed him where the scheduled medications, PRN medications, and supplies were kept. She also showed him how to put the bubble packs back in the right order in the medication cart.

Staff #2, RN, stated she encouraged Staff #1, RN, to take his time and if he didn't have time to help the other staff when meals were served, he was to focus on administering medications and to help staff when he was finished. She explained the building layout, how to answer the phone and pagers. She pointed out the keys to the narcotic box and the tenant's lock boxes and explained where the narcotic box and the narcotic count sheets were located. They both proceeded to count narcotics and each signed off that the count had been completed. She gave him reports on the tenants, noting any recent changes or problems for the day. She wrote her phone number down and pointed out where the phone list was located in case he had any questions or needed to call the program RN. She stayed at the program until Staff #1, RN, stated he did not have any further questions.

Staff #3, RN, stated when an outside agency staff person was hired to administer medications, she would orient staff on the program's medication administration practice guidelines. A review of the MARs and Treatment Administration Records (TARs) were given. Staff were shown how medications were separated by apartment number and instructed the medication cart was not to be removed from the medication room. Staff were to use a red tote and to take each tenant's MARs and bubble packs with them when administering medications. Agency staff were oriented to the medication room, where treatment baskets were kept, where medication cups and keys to open the narcotic lock box was located and how to document narcotic administration. Staff were shown where medications needing refrigeration were stored and staff would be given a tour of the program. Before leaving for the day staff were shown where the communication book was kept and phone numbers in case they had any questions or needed to contact the program RN.

Staff #1, RN, stated he had worked at the program on two separate occasions. The first was 10-21-09 from 3:00 p.m. until 11:30 p.m. and again on 2-14-10 from 6:45 a.m. until 3:00 p.m. He was given instructions on medication administration practice prior to administering medications. He stated on 10-21-09 another RN stayed until supper and provided information that helped him in the administration of medications. Program records indicated supper began at 5:00 p.m. daily. The program RN stated she was present on 10-21-09 when Staff #1, RN, was oriented to the medication room, the MARs and TARs and was given a full report of tenants.

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

Monitoring Observation: During the on-site investigation, a monitor had reviewed the MARs for 2-1- 10 through 2-17-10. Medications were not documented as given to the following tenants.

Tenant	Medication	Date & time not documented as given.
2	Boost High Protein Liquid, one bottle, twice daily.	Initials written and circled for 10:00 a.m. without documentation giving specific information why the tenant did not receive this product.
2	Nursing Intervention, Check skin daily	2-14-10 @ 8:00 a.m.
2	Zinc Oxide Ointment, 20% Apply to right thigh skin tear, twice daily, until healed.	Initialed and circled as not given on 2-14-10 @ 8:00 a.m. without explanation
2	Nursing Intervention, Assist to the recliner to elevate legs, three times daily	Not documented as completed at 10:00 a.m. and 2:00 p.m.
3	Staff to straight catheterize four times daily.	Not documented as completed on 2-14-10 at 6:00 a.m. and 1:00 p.m.
3	Digoxin Tablet 0.5mg daily, hold if heart rate is less than 60 beats per minute (bpm).	Documented as given on 2-14-10 at 8:00 a.m. but heart rate was not taken prior to administration of medication.
4	Zinc Oxide, apply to perineum twice daily, after cleansing with pericare product every morning and evening.	Not documented as applied on 2-14-10 at 8:00a.m.
4	Johnson baby shampoo, wash eyelids twice daily.	Not documented as completed on 2-14-10 at 8:00 a.m.
5	Accu-check prior to scheduled dose of Humalog Insulin 5 units at 12:00 p.m. Hold if blood sugar is less than 150.	Documented as out of facility on 2-14-10 at 12:00 p.m. No documentation on MAR indicating accu-check and insulin was sent with the tenant.
5	Proctozone Cream HC, apply to hemorrhoids twice daily.	Not documented as applied on 2-14-10 at 8:00 a.m.
5	Vitamin A & D ointment, apply to rectal area daily.	Not documented as applied on 2-14-10 at 8:00 a.m.
6	Monitor daily blood pressure	Not documented as taken on 2-14-10 at 7:30 a.m.
6	Ace wrap on left foot/ankle daily, apply at 8:00 a.m. and remove at 8:00 p.m.	Time not documented as when the wrap was applied on 2-14-10 and 2-15-10.
7	Staff supervised medication administration (watching the tenant take his/her medications).	Not documented as supervised on 2-7-10 and 2-8-10 at 8:00 p.m. and on 2-14-10 at 8:00 a.m.
8	Norvasc 5mg tablet, once daily.	Not documented as given
8	Xanax 0.5 mg, one tablet by mouth, three times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m.	Documented on the narcotic count sheet as given on 2-14-10 at 12:00 p.m. and documented on the MAR at 2:00 p.m.
8	Darvocet 100mg/650mg, one tablet, three times daily.	Not documented, on the narcotic count sheet, as given on 2-14-10 at 8:00 a.m.

		and 12:00 p.m.
9	Staff supervised medication administration (watching the tenant take his/her medications).	Not documented as supervised on 2-14-10 at 8:00 a.m.
9	Clotrim/Beta Cream, apply twice daily to the foot after soaking.	Documented with initials circled on 2-14-10 without documentation giving specific information as to why the tenant did not receive this product.
10	Blood pressure monitoring daily at 8:00 a.m.	Not documented as completed on 2-14-10 at 8:00 a.m.
11	Encourage fluids between meals.	Not documented as completed on 2-14-10 at 2:00 p.m.

- Regulatory Insufficiency: When medications are administered traditionally by the program: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655—Chapter 6 governing nurse delegation. (IAC r.481-67.5(6))

B. Criteria for Exclusion of Tenants

Complaint Allegation #27500-C: It is alleged Tenant #1 has had a history of falls while living at the program and may need a higher level of care than an assisted living program can provide.

Monitoring Observation: Tenant #1's functional evaluation, completed on 12-31-09, indicated the tenant received physical therapy for strengthening and safety. The tenant completed physical therapy on 2-4-10, as the tenant reached maximum potential. The service plan dated 12-31-09 indicated the tenant has a 20 year history of falls related to a diagnosis of Parkinson's Disease. The service plan includes nursing interventions to provide stand by assistance for personal and health related cares, utilization of a walker, staff assistance of one to and from meals and activities of choice.

- Regulatory Insufficiency: None noted.

C. Staffing

Complaint Allegation#27500-C: It is alleged the program RN was surprised when staff at a local hospital called and indicated Tenant #1 was at their hospital and not the hospital emergency personnel were instructed to take the tenant.

Monitoring Observation: The tenant's file face sheet indicated the tenant's hospital preference was the hospital where emergency personnel had transported the tenant; however, the Administrator stated she contacted Tenant #1's physician and the physician requested the tenant be transported to a hospital where he had hospital privileges.

Complaint Allegation #27500-C: It is alleged the program did not notify Tenant #1's family of the details of the incident when the tenant received the wrong medication.

Monitoring Observation: The on-call RN stated she contacted Tenant # 1's guardian in regard to the incident and the tenant being transported to a hospital for treatment. Progress notes dated 2-14-10 indicated the tenant was sent by ambulance to a hospital for treatment and the family was notified of the incident by the on-call RN.

- Regulatory Insufficiency: None noted.

Complaint Allegation 27557-M: It is alleged Staff #1 administered Tenant #2's MS Contin 15mg IR, MS Contin 30mg SR and MS Contin 60mg to Tenant #1 and did not follow the training he/she received from Staff #2 on 10-21-2009.

Monitoring Observation: A program document indicated the medication cart was to remain in the medication room. The tenant's photo is placed in the front of each MARs to assist in the identification of each tenant. The program's medication administration practice guidelines indicated staff were to take each tenant's unit dose package with them when administering medications, remove the medication from the package, administer the medications and document in the MARs immediately after administration. In the event the tenant did not take the medication, staff were to document in the MAR by initialing in the appropriate time slot, circling their initials and documenting on the back of the MAR the specific information concerning the refusal with an explanation also written in the communication log.

Staff #2, RN, stated she worked from 7:00 a.m. – 3:30 p.m. on 10-21-09 and provided orientation to Staff #1, RN, on how the program administered medications to tenants. She first explained the process of completing a shift change MAR audit. Staff #1, RN, started to audit the MARs. As he was auditing the MARs, Staff #2 obtained a task sheet and tenant list and she indicated which tenants had special treatments and which tenants kept their own medications in their apartments. When Staff #1 finished the MAR audits they both signed the audit documentation sheet. She explained the program's policy of taking each tenant's medication bubble packs, MAR pages and/or TARs to the tenant's rooms and using a red tote to carry these items. She then showed him where the scheduled medications, as needed (prn) medications, and supplies were kept. She also showed him how to put the bubble packs back in the right order in the medication cart.

Staff #2, RN, stated she encouraged Staff #1, RN, to take his time and if he didn't have time to help other staff when meals were served he was to focus on administering medications and help staff when he was finished. She explained the building layout, how to answer the phone and pagers. She pointed out the keys to the narcotic box and the tenant's lock boxes. She explained where the narcotic box was located and the narcotic count sheets. They both proceeded to count narcotics and each signed off that the count had been completed. She gave him a report on the tenants, noting any recent changes or problems for the day. She wrote her phone number down and pointed out where the phone list was located in case he had any questions or needed to call the program RN. She stayed at the program until Staff #1, RN, stated he did not have any further questions.

Staff #3, RN, stated when an outside agency staff person was hired to administer medications, she would orient the staff on the program's medication administration practice guidelines. A review of the MARs and TARs were given and staff were shown how medications were separated by apartment number and instructed the medication cart was not to be removed from the medication room. Staff were to use a red tote and to take

each tenant's MARs and bubble packs with them when administering medications. Agency staff were oriented to the medication room, where treatment baskets were kept, where medication cups and keys to open the narcotic lock box was located and how to document narcotic administration. Staff were shown where medications needing refrigeration were stored and staff would be given a tour of the program. Before leaving for the day staff were shown where the communication book was kept and where the phone numbers were, in case they had any questions or needed to contact the program RN.

Staff #1, RN, stated he had worked at the program on two separate occasions. The first was 10-21-09 from 3:00 p.m. until 11:30 p.m. and again on 2-14-10 from 6:45 a.m. until 3:00 p.m. He was given instructions on medication administration practice prior to administering medications. He stated on 10-21-09 another RN stayed until supper and provided information that helped him in the administration of medications. Program records indicated supper began at 5:00 p.m. daily. The program RN stated she was present on 10-21-09 when Staff #1, RN, was oriented to the medication room, the MARs and TARs and was given a full report of tenants.

There is no written documentation that Staff #1 received training.

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

Monitoring Observation: Program documentation revealed staff who worked from 11:00 p.m. to 7 a.m. on 2-7-10 through 2-14-10 and on 2-16-10 through 2-19-10, were not trained to administer medications to tenants. The Administrator and program RN stated if a tenant needed, as needed (PRN), medications, staff were to call the program RN or on-call nurse and they would come into the program and administer the necessary medications.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r.481- 67.9(1))

- Regulatory Insufficiency: The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. (IAC r.481 – 69-29 (3))

D. Dementia-Specific Education for Program Personnel

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

Monitoring Observation: Staff #1's personnel file indicated he did not have eight hours of dementia-specific education and training within 30-days of employment. Staff #1 had worked at the program from 10-21-09 through 2-14-10.

- Regulatory Insufficiency: All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. (IAC r.481 – 69.30(1))

E. Record Checks

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

Monitoring Observation: Staff #1, RN, was hired as an agency nurse to administer medications to tenants residing at the program. On 10-21-09 and 2-14-10 Staff # 1 worked at the program and administered medications. The program did not ensure that a criminal background check was completed prior to Staff #1 working at the program.

- Regulatory Insufficiency: Pursuant to Iowa Code section 135C.33, a prospective employee of a program shall have a criminal history check, dependent adult abuse check, and child abuse check performed before the prospective employee begins work. If a prospective employee has a criminal history or an abuse history, the prospective employee shall not be employed by the program unless the department of human services has performed an evaluation and determined that the record does not warrant the employment prohibition. Proof of the pre-employment background check shall be maintained in the program's employee file. The program must meet all requirements of Iowa Code section 135C.33 and administrative rules adopted pursuant to Iowa Code section 135C.33. (IAC r. 481 – 67.9 (3))

Dated this 5th day of April, 2010.