IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 32401-C

April 6, 2011

Ms. Sue Hyde, Administrator
Keelson Harbour Assisted Living
2810 Aurora Avenue
Spirit Lake, IA 51360

RE: I. Final Complaint Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Hyde:

I. Final Complaint Investigation Report – Keelson Harbour Assisted Living, Spirit Lake, IA

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69. The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Criteria for Exclusion of Tenant, Service Plans and Medications. **Keelson Harbour Assisted Living** ("Program") is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

II. Civil Penalty

If, within 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 civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Jim Berkley** and remit the civil penalty assessed by check or money order in the amount of three hundred twenty five dollars ($325) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on March 25, 2011, has been reviewed and will constitute the final POC related to the on-site visit of February 9 & 10, 2011. The Request for Reconsideration has been denied due to program not providing a compelling reason to retain the tenant.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal 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 enclosed Report, please contact your Program Coordinator, Jim Berkley, 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 #: 32401-C**

Sue Hyde, Administrator
Keelson Harbour Assisted Living
2810 Aurora Avenue
Spirit Lake, IA 51360

Date of Investigation:

February 9 & 10, 2011

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:

A complaint investigation on-site visit was conducted at Keelson Harbour Assisted Living on February 9 & 10, 2011. In preparing this report, the following information was considered:

Current Program Census:

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

Current number of tenants without cognitive disorder:	39
Current number of tenants with cognitive disorder:	9
Total Population of GPP:	48

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

Total Population of DSP:	23
Total Census of ALP:	71

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

Program History – There were substantiated Regulatory Insufficiencies in the areas of: Food Service, Staffing, Dementia Specific Education and Life Safety during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

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

A. Evaluation of Tenant

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

- Monitoring Observation: Eight tenant files were reviewed. Tenant #2, an 85 year old, was admitted on 1-19-11 and had diagnoses of: Dyslipidemia, Dementia and Prostate Cancer. A cognitive evaluation was completed on 12-20-10 and staged the tenant at three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. The tenant lived in the general population portion of the program. Functional and health evaluations were completed on 12-20-10.

  Staff communication records of 1-19-11, indicated the tenant was wandering outside at 12:00 a.m. The tenant was dressed and looking for coffee. The tenant was wearing "very light clothes." On 1-21-11, the tenant left the program around 7:00 a.m. Family had arrived at the program to have breakfast with the tenant. The tenant could not be found. Family notified police and filed a complaint in order to locate the tenant's car. The tenant returned later in the day. Staff communication records revealed staff wrote to keep on eye on the tenant. At 6:30 p.m., another tenant's family member "carelessly" let the tenant get into the entryway on the dementia unit and staff tried to get the tenant back into the program. Staff were called to assist staff in getting the tenant back inside the program. On 1-31-11 the tenant was wandering the halls until 1:00 a.m., looking for his/her wallet and trying to open doors as he/she walked around the program. On 2-9-11, the tenant was transferred from the general population to the dementia unit due to increased confusion.

  The Administrator stated the tenant's dementia was "a lot worse" and the tenant had wandered throughout the program since his/her admission and was unable to find his/her apartment. Staff #4 stated the tenant wandered throughout the building and couldn't find his/her apartment. The tenant had moved in one month earlier and his/her dementia was getting worse. The tenant had left one day in his/her car, but family came to have breakfast with the tenant, but the tenant had left earlier that morning. On 2-1-11 the program nurse told staff to redirect the tenant to his/her room when he/she was seen wandering. Staff #6 stated the tenant had been seen outside at times and staff were told to bring the tenant back into the program. Staff #7 stated the tenant was wandering inside and outside of the program shortly after being admitted to the general population. The tenant was confused as to where his/her apartment was located.

  The program did not complete evaluations with a change in condition as evidence by the tenant's wandering as early as 1-31-11 and did not complete evaluations prior to moving the tenant to the dementia unit.

  Tenant #3, a 75 year old, was admitted on 11-1-07 and had diagnoses of: Hypertension (HTN), Memory Loss and a History of Alcohol Abuse. A cognitive evaluation was completed on 1-27-11 and scored two out of ten on the Mental Status Questionnaire (MSQ), which indicated no or minimal cognitive impairment. The tenant lived in the general population program. Progress notes of 8-25-10 through 12-18-10 revealed the tenant had fallen at least five times and staff had smelled alcohol on the tenant's breath. The tenant's fall of 12-18-10 required hospital emergency room for treatment for a head laceration, which required staple placement.

Functional, cognitive and health evaluations completed on 1-27-11, did not evaluate the tenant's recent history of falls and possible associated alcohol use. The program did not complete evaluations with a significant change to determine any changes in services were needed.

Tenant #4, a 73 year old, was admitted on 4-12-10 and had diagnoses of: Dementia, Alcoholism, and Cancer with Radical Neck Dissection, Closed Head Injury, Depressive Disorder, Diabetes Mellitus II, Dysphagia and Gastro Esophageal Reflux Disease (GERD). A cognitive evaluation was completed on 2-4-11and staged the tenant at five on the GDS, which indicated moderately severe cognitive decline. The tenant lived in the dementia unit of the program. Program documentation revealed the tenant had been court ordered to live at the program, as the tenant was "seriously mentally impaired and in need of continued outpatient treatment."

Progress notes of 1-3-11 revealed the tenant slapped the program nurse across the face. The nurse approached the tenant again threatened to slap the program nurse's face if she didn't stop talking. The tenant went into the memory care coordinator's office and became verbally inappropriate. Notes of 1-19-11 revealed the tenant was belligerent and was not cooperative with activities of daily living (ADLs).

The Administrator stated the tenant "gets a little naughty." The tenant makes inappropriate verbal statements and has grabbed at female staff's breasts. Staff #1 and Staff #2 stated the tenant would "grab" female staff's breasts and pinched their bottoms. This behavior has been ongoing since admission. Staff #2 stated the tenant has put his/her arm around a female tenant and rubs his/her back. She stated the tenant threw her on the bed and climbed on top of her. She stated she was afraid to go into the tenant's apartment by herself. Staff #3 stated the tenant was verbally abusive, calling staff "bitches." Staff #4 stated the tenant has asked her to take off her pants and had been verbally abusive. Staff #5 stated she hasn't been touched inappropriately, but has seen the tenant touch female staff's breasts. The tenant has asked staff to sleep with him/her and spend the night together. Staff #6 stated the tenant has a history of sexual aggression. The tenant has touched female staff's breasts but hasn't seen this behavior for the last couple of months. Staff #7 stated the tenant has made sexual comments and would ask staff to lay with him/her on the bed. The tenant has tried to kiss staff and staff reported the tenant has touched their breasts and bottoms. She stated this behavior hasn't happened in the last three to four weeks. The tenant continued to be verbally abusive toward staff.

Functional, cognitive and health evaluations completed on 2-4-11, did not evaluate the tenant's verbal and sexual abuse and determine any changes in services were needed.

Tenant #5, a 93 year old, was admitted on 10-7-08 and had diagnoses of: Dementia, Arthropathy, Back Pain, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), HTN, Hyperlipidemia, Osteoporosis, Spinal Stenosis, Urinary Incontinence and Urinary Tract Infection. A cognitive evaluation was completed on 12-7-10 and staged the tenant at five on the GDS, which indicated moderately severe cognitive decline. The tenant lived in the dementia unit. An incident report of 10-3-10 revealed the tenant was yelling at another tenant. Staff intervened and the tenant slapped staff across the face and bit the staff person's

finger. Staff #2 stated the tenant had been verbally abusive, calling staff "bitches." The tenant threatened staff with a knife, has slapped staff twice and bit a staff person's hand. The tenant's behavior has been constant for over a year. This past summer the tenant slapped another tenant. The program nurse told staff the tenant's behavior was part of the disease process. Staff #5 stated the tenant was verbally and physically abusive. The tenant's behavior was intermittent, but continued to be a problem. The tenant swears at staff and uses profanity. The tenant would strike out with an open hand and closed fist. The tenant has scratched staff and has purposely run into staff with a walker. She reported the tenant has been physically abusive greater than five times in the last three months.

Staff #6 stated the tenant was physically abusive and scratched staff when they assisted with ADLs. The tenant would push a walker into staff and would try and hit staff with his/her hand. She stated the tenant hasn't been physically aggressive for the past couple of months. Staff #7 stated the tenant was "resistant" when assisted with ADLs and when medications were administered. The tenant was verbally abusive and attempted to strike out at staff, but hasn't made contact so far.

The program completed functional, cognitive and health evaluations on 10-7-10, but the evaluations did not reflect the cognitive status related to the physical and verbal abuse, the tenant's continued eligibility and changes to needed services.

Tenant #8, an 82 year old, was admitted on 8-2-10 and had diagnoses of: Lung Cancer, CHF, COPD, CVA and HTN. A cognitive evaluation was completed on 9-2-10 and staged the tenant at five, which indicated moderately severe cognitive decline. The tenant lived in the dementia unit. . Functional, cognitive and health evaluations were completed on 7-16-10 and within 30-days of admission on 9-2-10. The tenant was admitted to hospice on 7-15-10 with an admitting diagnosis of Malignant Neoplasm of the Bronchial/Lung. Hospice completed at least seven updates in the plan of care between 8-18-10 and 11-24-10 and each reflected a decline in the tenant's abilities related to ADLs, including recent falls, increased weakness, poor appetite, increased weight loss, increased incontinence, increased confusion, increased time in bed and the use of bed side rails.

Progress notes of 8-28-10 revealed the tenant had slipped off the edge of bed and landed on the floor. Progress notes of 9-17-10 revealed the tenant had fallen and sustained a skin tear. Progress notes of 10-12-11 revealed the tenant rolled out of bed onto the floor, below the side rails. Between 9-1-10 through 11-24-10, hospice completed at least five updates to the plan of care, due to increased weakness, increased incontinence, increased confusion, weight loss, increased time in bed and the use of bed side rails. Progress notes of 11-17-10 revealed a medical waiver request was made to the Department, as the tenant became increasingly weaker and required routine two staff assistance with ambulation and transfer. Notes of the same date indicated the tenant remained in bed much of the time, had poor nutritional intake and was incontinent of bladder and bowel. The tenant transferred to a skilled nursing facility on 12-8-10.

Staff #1 and Staff #2 stated the tenant needed total care with all ADLs. Staff #2 stated hospice bathed the tenant and staff would assist. Bed rails were used on both sides of the bed. The program nurse told staff bed rails were to be up when the tenant

was in bed and the bed had to be down to the ground. Staff would turn the tenant every two hours and give nutritional supplements three times daily as the tenant would not have an appetite. Staff #3 stated she had recently started working at the program and knew the tenant received hospice care. She stated staff spent a lot of time caring for the tenant. Staff #5 stated the tenant had a gradual decline in his/her health and functional status. The tenant went from being up for meals to becoming bed bound. The tenant initially was independent with eating but declined to where staff were bringing food and feeding the tenant. If the tenant was sleeping, staff would try and wake the tenant and give nutritional supplements.

The hospice nurse stated the last two months the tenant resided at the program; the tenant was dependent with ADLs, including assistance with eating. She stated hospice and program staff were attentive to the tenant's needs and provided the cares needed. She had no concerns regarding the cares given.

The program did not complete evaluations with a change in status to determine if any changes in services were needed.

- Regulatory Insufficiency A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. (IAC r. 481-69.22(1))

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Criteria for Exclusion of Tenants

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

- Monitoring Observation: Tenant #4's progress notes of 1-3-11 revealed the tenant slapped the program nurse across the face. The nurse approached the tenant again threatened to slap the program nurse's face if she didn't stop talking. The tenant went into the memory care coordinator's office and became verbally inappropriate. Notes of 1-19-11 revealed the tenant was belligerent and was not cooperative with ADLs.

The Administrator stated the tenant "gets a little naughty." The tenant makes inappropriate verbal statements and has grabbed at female staff's breasts. Staff #1 and Staff #2 stated the tenant would "grab" female staff's breasts and pinched their bottoms. This behavior has been ongoing since admission. Staff #2 stated the tenant has put his/her arm around a female tenant and rubs his/her back. She stated the tenant threw her on the bed and climbed on top of her. She stated she was afraid to go into the tenant's apartment by herself. Staff #3 stated the tenant was verbally abusive, calling staff "bitches." Staff #4 stated the tenant has asked her to take off her pants and had been verbally abusive.

Staff #5 stated she hasn't been touched inappropriately, but has seen the tenant touch female staff's breasts. The tenant has asked staff to sleep with him/her and spend the night together. Staff #6 stated the tenant has a history of sexual aggression. The tenant has touched female staff's breasts but hasn't seen this behavior for the last couple of months. Staff #7 stated the tenant has made sexual comments and would ask staff to lay with him/her on the bed. The tenant tried to kiss staff and staff reported the tenant has touched their breasts and bottoms. She stated this behavior hasn't happened in the last three to four weeks. The tenant continued to be verbally abusive toward staff. The tenant exceeds retention criteria.

Tenant #5's service plan of 10-7-10 revealed the tenant was physically abusive or disruptive and uses physical violence and destroys property. The tenant was verbally abusive, threatens or uses foul language and displays outbursts of anger toward staff.

An incident report of 10-3-10 revealed the tenant was yelling at another tenant. Staff intervened and the tenant slapped staff across the face and bit the staff person's finger. Staff #2 stated the tenant had been verbally abusive, calling staff "bitches." The tenant threatened staff with a knife, has slapped staff twice and bit a staff person's hand. The tenant's behavior has been constant for over a year. This past summer the tenant slapped another tenant. The program nurse told staff the tenant's behavior was part of the disease process. Staff #5 stated the tenant was verbally and physically abusive. The tenant's behavior was intermittent, but continued to be a problem. The tenant swore at staff and used profanity. The tenant would strike out with an open hand and closed fist. The tenant has scratched staff and has purposely run into staff with a walker. She reported the tenant has been physically abusive greater than five times in the last three months.

Staff #6 stated the tenant was physically abusive and scratched staff when they assisted with ADLs. The tenant would push a walker into staff and would try and hit staff with his/her hand. She stated the tenant hasn't been physically aggressive for the past couple of months. Staff #7 stated the tenant was "resistant" when assisted with ADLs and when medications were administered. The tenant was verbally abusive and attempted to strike out at staff, but hasn't made contact so far. The tenant exceeds retention criteria.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who, despite intervention chronically elopes, was sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression. (IAC r. 481-69.23(1)(c)(1))

C. Service Plan

Complaint Allegation: It was alleged a tenant was "very goofy" during a conversation with family. The tenant was "just very weird" and was "almost like drunk." Staff reported night staff had been waking the tenant almost every hour to put oxygen tubing on the tenant, causing the tenant to be sleep deprived for three days. Staff reported the tenant's physician had ordered oxygen for the tenant 24 hours daily. It was alleged staff fed a tenant when the tenant was lying flat in bed. It was alleged the tenant had fallen out of bed twice. The program made no effort to stop this from happening or address how this could be happening. Family purchased bed rails, but the tenant fell out a second time and the bed rails were never locked into position. It was alleged staff fed a tenant when the tenant was lying flat in bed.

- Monitoring Observation: Tenant #8 was admitted to hospice on 7-15-10. An initial hospice care plan of 7-15-10 through 12-8-10 revealed the tenant was to use two liters per minute of oxygen, as needed (prn) and established interventions related to changes in mental status, anxiety, edema, fluid retention, swelling and changes in respiratory status. Hospice completed at least seven updates in the plan of care between 8-18-10 and 11-24-10 and each reflected a decline in the tenant's abilities related to ADLs, including recent falls, increased weakness, poor appetite, increased weight loss, increased incontinence, increased confusion, increased time in bed and the use of bed side rails.

  An initial service plan of 7-16-10 revealed the tenant was independent with most ADLs, including being independent with mobility, could transfer without assistance and was occasionally incontinent of bowel. The tenant needed help with oxygen equipment at 1.5 liters per minute to 2.0 liters per minute, but did not establish what type of delivery system, frequency of use and did not identify interventions identified above, on the hospice care plan.

  Progress notes of 8-28-10 revealed the tenant had slipped off the edge of bed and landed on the floor. Progress notes of 9-17-10 revealed the tenant had fallen and sustained a skin tear. Progress notes of 10-12-11 revealed the tenant rolled out of bed onto the floor, below the side rails. Between 9-1-10 through 11-24-10, hospice completed at least five updates to the plan of care, due to increased weakness, increased incontinence, increased confusion, weight loss, increased time in bed and the use of bed side rails. Progress notes of 11-17-10 revealed a medical waiver request was made to the Department, as the tenant became increasingly weaker and required routine two staff assistance with ambulation and transfer. Notes of the same date indicated the tenant remained in bed much of the time, had poor nutritional intake and was incontinent of bladder and bowel. The tenant transferred to a skilled nursing facility on 12-8-10.

  Staff #1 and Staff #2 stated the tenant needed total care with all ADLs. Staff #2 stated hospice bathed the tenant and staff would assist. Bed rails were used on both sides of the bed. The program nurse told staff bed rails were to be up when the tenant was in bed and the bed had to be down to the ground. Staff would turn the tenant every two hours and give nutritional supplements three times daily as the tenant would not have an appetite. Staff #3 stated she had recently started working at the program and knew the tenant received hospice care. She stated staff spent a lot of

time caring for the tenant. Staff #5 stated the tenant had a gradual decline in his/her health and functional status. The tenant went from being up for meals to becoming bed bound. The tenant initially was independent with eating but declined to where staff were bringing food and feeding the tenant. If the tenant was sleeping, staff would try and wake the tenant and give nutritional supplements.

The hospice nurse stated the last two months the tenant resided at the program; the tenant was dependent with ADLs, including assistance with eating. She stated hospice and program staff were attentive to the tenant's needs and provided the cares needed. She had no concerns regarding the cares given.

The service plan of 7-16-10 did not identify hospice care and care needs established from the hospice care plan of 7-15-10. The service plan was not updated within 30-days of admission. The service plan was not updated to reflect care needs as described in the updated hospice care plans of 8-18-10 through 11-24-10. The tenant's cognitive status revealed the tenant was unable to plan his/her own activities. The service plan did not establish identified needs, including activities based upon the tenant's abilities and personal interests

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

- Monitoring Observation: Tenant #1, a 79 year old, was admitted on 4-5-10 and had a diagnosis of Dementia. A cognitive evaluation was completed on 11-3-10, which indicated the tenant was staged at five on the GDS, which indicated moderately severe cognitive decline. An initial service plan of 4-2-10 revealed the tenant was independent with ambulation, was at risk of falling and for elopement. Progress notes of 8-20-10 through 1-29-11 revealed the tenant had fallen at least five times and sustained injuries with each fall. The last fall on 1-29-11, the tenant was sent to a hospital emergency room and was treated for facial lacerations which required sutures. Staff #1, #2, #3 and #5 indicated the tenant has a history of falls and often forgot to use his/her walker. Staff #6 stated the tenant had a history of falls because the tenant forgot to take his/her walker. Staff was to remind the tenant to use his/her walker. Staff #7 stated the tenant had a history of falls and staff was to remind the tenant when he/she wasn't using the walker. Staff was to walk with the tenant and retrieve the walker.

  The service plan did not establish interventions related to falls and the use of a walker. The tenant's cognitive status revealed the tenant was unable to plan his/her own activities. The service plan did not establish identified needs, including activities based upon the tenant's abilities and personal interests.

  Tenant #2's service plan of 12-20-10 revealed no behaviors which required intervention. The tenant was disoriented daily but did not wander. Staff communication records of 1-19-11, indicated the tenant was wandering outside at 12:00 a.m. The tenant was dressed and looking for coffee. The tenant was wearing "very light clothes." On 1-21-11, the tenant left the program around 7:00 a.m. Family had arrived at the program to have breakfast with the tenant. The tenant could not be found. Family notified police and filed a complaint in order to locate the tenant's car. The tenant returned later in the day. Staff communication records revealed staff wrote "Please keep eyes on ..." At 6:30 p.m., another tenant's family

member "carelessly" let the tenant get into the entryway on the dementia unit and staff tried to get the tenant back into the program. Staff was called to assist in getting the tenant back inside the program. On 1-31-11 the tenant was wandering the halls until 1:00 a.m., looking for his/her wallet and trying to open doors as he/she walked around the program. On 2-9-11, the tenant was transferred from the general population to the dementia unit due to increased confusion.

The Administrator stated the tenant's dementia was "a lot worse" and the tenant had wandered throughout the program since his/her admission and was unable to find his/her apartment. Staff #4 stated the tenant wandered throughout the building and couldn't find his/her apartment. The tenant had moved in one month earlier and his/her dementia was getting worse. The tenant had left one day in his/her car, but family came to have breakfast with the tenant, but the tenant had left earlier that morning. On 2-1-11 the program nurse told staff to redirect the tenant to his/her room when he/she was seen wandering. Staff #6 stated the tenant had been seen outside at times and staff was told to bring the tenant back into the program. Staff #7 stated the tenant was wandering inside and outside of the program shortly after being admitted to the general population. The tenant was confused as to where his/her apartment was located.

The service plan was not updated with a change in condition evidenced by the tenant's increased confusion, inability to find his/her apartment and wandering in and outside of the apartment. The service plan did not establish interventions for staff to implement related to the above listed behavior. The tenant's cognitive status revealed the tenant was unable to plan his/her own activities. The service plan did not establish identified needs, including activities based upon the tenant's abilities and personal interests. An initial service plan was not completed prior to the tenant moving to the dementia care unit.

Tenant #3's service plan of 10-27-10 revealed the tenant was independent with ambulation and was not at risk for falls. The service plan revealed the tenant had a history of alcohol abuse and was at risk for falls. Progress notes of 8-25-10, 11-15-10, 12-8-10, and 12-9-10 revealed the tenant had fallen and staff smelled alcohol on the tenant's breath. On 12-18-10 the tenant had fallen, sustained a head laceration, and was sent to a hospital emergency room for staple placement. Staff #4 stated the tenant has a history of alcohol use and has smelled alcohol when the tenant has fallen. The program nurse stated the tenant has fallen and staff has smelled alcohol on his/her breath, but couldn't tell if the tenant was intoxicated. The program did not establish interventions for staff to implement related to falls sustained between 8-25-10 through 12-28-10 and did not establish interventions related to the tenant's use of alcohol.

Tenant #4's progress notes of 1-3-11 revealed the tenant slapped the program nurse across the face. The nurse approached the tenant again threatened to slap the program nurse's face if she didn't stop talking. The tenant went into the memory care coordinator's office and became verbally inappropriate. Notes of 1-19-11 revealed the tenant was belligerent and was not cooperative with ADLs.

The Administrator stated the tenant "gets a little naughty." The tenant makes inappropriate verbal statements and has grabbed at female staff's breasts.

Staff #1 and Staff #2 stated the tenant would "grab" female staff's breasts and pinched their bottoms. This behavior has been ongoing since admission. Staff #2 stated the tenant t has put his/her arm around a female tenant and rubs his/her back. She stated the tenant threw her on the bed and climbed on top of her. She stated she was afraid to go into the tenant's apartment by herself. Staff #3 stated the tenant was verbally abusive, calling staff "bitches." Staff #4 stated the tenant has asked her to take off her pants and had been verbally abusive. Staff #5 stated she hasn't been touched inappropriately, but has seen the tenant touch female staff's breasts. The tenant has asked staff to sleep with him/her and spend the night together. Staff #6 stated the tenant has a history of sexual aggression. The tenant has touched female staff's breasts but hasn't seen this behavior for the last couple of months. Staff #7 stated the tenant has made sexual comments and would ask staff to lay with him/her on the bed. The tenant has tried to kiss staff and staff reported the tenant has touched their breasts and bottoms. She stated this behavior hasn't happened in the last three to four weeks. The tenant continued to be verbally abusive toward staff.

The tenant's service plan of 3-29-10 did not establish interventions related to the tenant's sexually inappropriate behavior and verbal abuse toward staff and tenants as described above. The tenant's cognitive status revealed the tenant was unable to plan his/her own activities. The service plan did not establish identified needs, including activities based upon the tenant's abilities and personal interests.

Tenant #5's service plan of 10-7-10 revealed the tenant was physically abusive or disruptive and uses physical violence and destroys property. The tenant was verbally abusive, threatens or uses foul language and displays outbursts of anger toward staff.

An incident report of 10-3-10 revealed the tenant was yelling at another tenant. Staff intervened and the tenant slapped staff across the face and bit the staff person's finger. Staff #2 stated the tenant had been verbally abusive, calling staff "bitches." The tenant threatened staff with a knife, has slapped staff twice and bit a staff person's hand. The tenant's behavior has been constant for over a year. This past summer the tenant slapped another tenant. The program nurse told staff the tenant's behavior was part of the disease process. Staff #5 stated the tenant was verbally and physically abusive. The tenant's behavior was intermittent, but continued to be a problem. The tenant swears at staff and uses profanity. The tenant would strike out with an open hand and closed fist. The tenant has scratched staff and has purposely run into staff with a walker. She reported the tenant has been physically abusive greater than five times in the last three months.

Staff #6 stated the tenant was physically abusive and scratched staff when they assisted with ADLs. The tenant would push a walker into staff and would try and hit staff with his/her hand. She stated the tenant hasn't been physically aggressive for the past couple of months. Staff #7 stated the tenant was "resistant" when assisted with ADLs and when medications were administered. The tenant was verbally abusive and attempted to strike out at staff, but hasn't made contact so far.

The tenant's service plan of 10-7-10 did not establish interventions related to the tenant's physical and verbal abuse toward staff and tenants as described above. The tenant's cognitive status revealed the tenant was unable to plan his/her own activities.

The service plan did not establish identified needs, including activities based upon the tenant's abilities and personal interests.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance, the service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy and for tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. (IAC r. 481-69.26(4)(a,c,d))

D. Medications

Complaint Allegation: It was alleged a tenant did not receive 5:00 p.m. medications on time as there was no staff available to administer medications to tenants. It was alleged a tenant was given Ativan for being combative when the tenant wasn't combative. It was alleged an order was given to discontinue a tenant's pain medication on 11-24-10, but the tenant continued to receive the medication.

- Monitoring Observation: Program records revealed on 9-13-10, dementia unit staff contacted the program nurse and reported there wasn't anyone to administer medications to tenants. The program nurse spoke to a staff person in the general population program and asked if she would administer medications to tenants in the dementia unit. The program nurse arrived at the program at 6:15 p.m. and noted most of the 5:00 p.m. medications had been administered to tenants residing in the dementia unit. The program did not administer medications within an applied standard of medication administration.

  Tenant #8's medication administration records (MARs) for October, 2010, revealed, on 10-8-10, the tenant was prescribed Darvocet N100 tablets – one to two tablets prn every four to six hours as needed for pain. Darvocet was administered on 10-8-10, 10-9-10, 11-23-10, 11-24-10 and 11-25-10. Hospice records indicated Darvocet was discontinued by the physician on 11-26-10 and replaced with Roxanol 0.25ml – 0.5mg every hour prn at the family's request.

  On 11-4-10 hospice requested and was given a physician's order for Lorazepam (Ativan) 0.5mg – 1.0 mg tablet prn every four to six hours for anxiety. On 11-26-10 Ativan dosage and frequency was changed to 0 .25mg – 0.5mg tablet prn every six hours for anxiety. MARs for November and December 2010 revealed Ativan was given on 11-26-10, 11-29-10 and 12-1-10. MARs indicated Ativan was given for anxiety and not for being combative.

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

- Monitoring Observation: Tenant #8's narcotic count sheet of 11-29-10, recorded 16 tablets of Darvocet N100 tablets remained. The tenant was discharged from the program on 12-8-10. During a review of the tenant's MARs and narcotic count sheets, it was discovered five tablets of Darvocet N100 were missing. The program nurse reported the tenant's medications were placed in a white Tupperware container upon the tenant's discharge and placed in a locked cabinet in the nurse's office.

- 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)(a))

E. Staffing

Complaint Allegation: It was alleged a staff person was verbally inappropriate toward tenants on two occasions.

- Monitoring Observation: Program documentation revealed a staff person was verbally abrasive and physically pulling on Tenant #8's arm. The program nurse spoke to the staff person regarding the incident. Staff denied any behavior that was inappropriate or any physical touch by her. The staff person was reassigned and was not allowed to provide direct tenant care. No other incidents of staff being inappropriate to tenants were found.

  Staff #1, #3, #4, #5, #6 and #7 stated they had not witnessed or heard of any staff being verbally or physically inappropriate toward tenants. Staff #2 stated she had heard a family member of a tenant had complained a staff person had had been rude to a tenant, but did not cite any examples. She stated she had not heard of any other complaint about staff being verbally or physically inappropriate to tenants.

- Regulatory Insufficiency: None noted.

F. Other

Complaint Allegation: It was alleged a tenant's family was told by the Administrator and program nurse, they did not want to hear of anymore complaints and if so they would evict the tenant from the program immediately.

- Monitoring Observation: The Administrator stated she remembered having a conversation with Tenant #8's family regarding a family member upsetting other tenant's family members. She stated she told Tenant #8's family if they were not comfortable with the care given then they should look for other placement. She stated she did not threaten to evict any tenant. Staff #1, #2, #3, #4, #5 and #6 stated they had not heard of any tenant threatened with eviction. Staff #7, the memory care unit manager stated Tenant #8's family had concerns the program wasn't doing everything they could to care for the tenant.

She stated she told family if they felt the program wasn't meeting the tenant's needs they were welcomed to look for another place. Family was never threatened with eviction.

- Regulatory Insufficiency: None noted.

Dated this 5th day of April, 2011.