IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED

Complaint Intake #:

34794-CR
34822-CR
34948-CR

January 12, 2012

Ms. Kara Bernsee, Administrator
Silvercrest at Woodlands Creek Assisted Living
12605 Woodlands Parkway
Clive, IA 50325

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

Dear Ms. Bernsee:

I. Final Revisit Complaint Investigation Report – Silvercrest at Woodlands Creek Assisted Living, Clive, IA

Enclosed is the **Final Revisit 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: Policies and Procedures, Medications, Criteria for Admission and Retention and Structural Requirements. **Silvercrest at Woodlands Creek Assisted Living** ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The fine has been received.

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 **Rose Boccella** and remit the civil penalty assessed by check or money order in the amount of six hundred fifty dollars ($650) 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 $1,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on January 10, 2012, has been reviewed and will constitute the final POC related to the on-site visit of November 29-30, December 1-2 and 4-5, 2011.

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, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Revisit Complaint Investigation Report

Assisted Living Program:

Kara Bernsee, Administrator
Silvercrest at Woodlands Creek Assisted Living
12605 Woodlands Parkway
Clive, IA 50325

Complaint Intake #: 34794-CR
34822-CR
34948-CR

Date of Complaint Investigation:

November 29-30, December 1-2, and 4-5, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH
Lori Miner, RN BSN
Ann Martin, RN
Rose Boccella, MA

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a

Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	45
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	53

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	3
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	12
TOTAL census of Assisted Living Program	65

Program History – The program received regulatory insufficiencies in the areas of: Tenant Documents, Service Plan, Medications, Nurse Review, Staffing, Policies and Procedures, Life Safety and Structural during the Complaint and Incident Investigation of July 2011.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Policies and Procedures

Complaint/Incident Allegation #34948-C: During the onsite complaint investigation of 7-19-21 & 25-29, 2011, the Program received a regulatory insufficiency for not following the policies and procedures established by the Program related to staff being trained on universal precautions, housekeeping isolation precautions, and the cleaning a decontamination of spills, or splashes of blood or body fluids.

- Monitoring Observation: Staff #21 was no longer employed by the Program. Staff #12 and #22 had documentation of training on 8-25-11 on universal precautions, infection control, and cleaning/decontamination of spills of blood/body fluids. Two new housekeeping employees, Staff #28 hired 10-17-11 and Staff #29 hired 10-24-11, also had documentation of completion of the training.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: An incident report of 8-24-11 was completed by the Program Nurse on 8-24-11 at 8:00 a.m. and indicated Tenant #11 was in Tenant #21's apartment nude with the other tenant. Tenant #11 reported feeling safe, but had no recall of the incident. Clinical notes of 8-25-11 indicated on 8-24-11, at 5:15 a.m., staff had assisted Tenant #11 with a shower. At 5:45 a.m. Tenant #11 was assisted back to the Tenant's apartment. At 6:10 a.m., staff found Tenant#11 in Tenant #21's apartment, lying in bed with no clothes on. Staff assisted Tenant #11 with getting dressed and helped Tenant back to his/her apartment. Staff #15 was in charge of the program the morning of 8-24-11. The staff member in charge did not prepare and sign an incident report and did not include statements from staff who witnessed the event.

- Regulatory Insufficiency: The program's policies and procedures of incident reports, at a minimum, shall include the following...(c) the person in charge at the time of the incident shall prepare and sign the report and (d) the incident report shall include statements from individuals, if any, who witnessed the incident. (IAC r.481-67.2(1)(c)(d))

B. Medications

During the course of the onsite complaint investigation of 7-19-21 & 25-29, 2011, the Program received a regulatory insufficiency for not following an appropriate standard for the administration of medications to tenants, including Tenants #2, #3 and #21.

- Monitoring Observation: Tenant #2 & #3 no longer reside at the program. Staff #23 stated in an interview that she had received training from a registered nurse on medication administration. Staff #16, who was new to medication administration, also revealed she had received training on medication administration. Both staff indicated the Program Nurse had observed them during a medication pass. Training records for Staff #16 and #23 contained documentation of medication administration training.

  Staff #23 was observed during a medication pass. She was observed checking the medication against the Medication Administration Record (MAR) prior to administering the medication. Documentation was completed after administration of the medications. On 11-29-11 and 12-2-11 Staff #23 was noted to check a blood sugar on Tenant #21 prior to lunch. Sliding scale insulin was given appropriately. MAR's were reviewed for five tenants for the months of October and November 2011. Medications were documented as given.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: Staff #30, a Certified Medication Aide, (CMA) was hired 11-7-11. She stated she had received training from a registered nurse on medication administration. Training records contained documentation of medication administration training. Staff #30 was observed during a medication pass on 12-1-11

shortly after 11:00 a.m. with Tenant #24. The Tenant's service plan indicated the Tenant required assistance with the application of support hose.
Tenant # 24 was observed sitting in a chair with feet on the floor. A family member stated the Tenant did not have support hose on, and observed the Tenant's legs to have some swelling. The family member stated he/she visited three times a week and, one-third of the times, support hose were not on the Tenant. The monitor observed that support hose were not on, yet the electronic MAR, signed by Staff #30, indicated support hose had been applied on 12-1-11. The Corporate Nurse indicated that when staff members placed their initials on the electronic MAR, it was not possible to determine the time of day that the initials were signed. Staff #30 was observed applying the support hose. Staff #30 stated she thought the support hose had already been applied because the Tenant wore regular socks over the support hose. After applying the support hose, regular socks were not applied.

On 12-1-11 Staff #30 was observed passing medications to Tenant # 25. The service plan revealed the Program administered medications. During the medication pass, Staff #30 was observed leaving pills in a cup on a table in the Tenant's apartment. The cup contained Renvela and Calcium Acetate, both used to reduce phosphorus in the body. Staff #30 indicated the Tenant would take the pills with him/her to lunch to take with the meal. Staff #30 did not document the pills as given, but stated she would check later and document after the pills were taken. At 12:15 p.m. Tenant # 25 was observed entering the dining room with pills in a pill cup. The pill cup was placed on the table. The Tenant was noted to sit with Tenant # 26 who was staged at four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. Tenant # 26 had diagnoses of Dementia and Glaucoma. Staff did not observe the Tenant taking medications as ordered.

- 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))

C. Criteria for Admission and Retention

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

- Monitoring Observation: Tenant #11, a 92 year-old, was admitted on 4-27-10 and had diagnoses of Dementia and Venous Stasis. A cognitive evaluation was completed on 11-29-11 and staged Tenant #11 at five on the GDS, which indicated moderately severe cognitive decline. Tenant #11 resided in the dementia unit. The service plan of 8-29-11, indicated Tenant #11 needed assistance with activities of daily living (ADLs), including bathing, grooming, dressing, and toileting. The Program administered medications. Tenant #11 was oriented to person but not oriented to place.

  An incident report of 8-24-11, (which the Program Nurse believed to have occurred on 8-24-11, but actually occurred between 8:00 a.m. and 9:00 a.m. on 8-23-11) was reviewed. Staff #7, reported she was walking the hall and tried Tenant #21's door

and noted the door was locked. She went to the dining room to access her keys, returned and entered Tenant #21's apartment door and called Tenant #21's name. Instead of hearing Tenant #21's voice, she heard a female's voice. She opened the bedroom door and saw Tenant #11 putting on a shirt and Tenant #21 sitting in his/her chair nude. She asked Tenant #11 to come with her and told Tenant #21 to get dressed. She took Tenant #11 back to his/her apartment and gave him/her a shower.

A second incident report of 8-24-11, completed by the Program Nurse, indicated Tenant #11 was nude in Tenant #21's apartment, and with Tenant #21. Tenant #11 reported feeling safe but had no recall of anything that happened. Clinical notes of 8-25-11 indicated on 8-24-11, staff assisted Tenant #11 with a shower at 5:15 a.m. At 5:45 a.m. staff accompanied Tenant #11 back to his/her apartment and left. At 6:10 a.m., staff found Tenant #11 in Tenant #21's apartment, lying in bed with no clothes on. Staff assisted Tenant #11 with dressing and returned the Tenant back to his/her apartment.

Tenant #11's physician was notified and agreed with the nurse to have Tenant #11 seen at a hospital emergency room for a pelvic examination. Hospital emergency room notes of 8-24-11 indicated Tenant #11 arrived at 4:45 p.m. and was seen by an emergency room physician at 5:05 p.m. Tenant #11 reported he/she did not remember what had happened. The Tenant was treated for Sexually Transmitted Disease (STD) exposure. Hospital emergency records indicated Tenant #11 would not allow the attending physician to complete a physical examination other than a speculum examination. Tenant #11 was treated for Vaginitis and was administered two antibiotics.

Tenant #21, an 89 year-old, was admitted on 4-23-10 and had diagnoses of: Cerebro Vascular Accident (CVA), Dementia, Diabetes Mellitus and Coronary Artery Disease (CAD). A cognitive evaluation was completed on 8-24-11 and indicated Tenant #21 scored 0/4, which indicated low risk/normal cognition. Tenant #21 resided in the dementia unit until 8-24-11 at 6:05 p.m., when Tenant #21 was moved to the general population, (which is dementia-specific by definition). The service plan of 11-10-11 indicated Tenant #21 needed assistance with activities of daily living (ADLs), including; bathing, grooming and dressing. The Program administered medications to Tenant #21. The service plan of 11-10-11 established interventions for staff to monitor for sexual behaviors/inappropriate behaviors and report. Staff members were to tell Tenant #21 these comments and actions were inappropriate. If Tenant #21 continued to make comments or actions, staff was to make sure Tenant #21 was safe and leave his/her room. Staff was to return and finish with cares as needed after 10 to 15 minutes. If Tenant #21 was again inappropriate, staff was to again make sure he/she was safe and remind him/her it was inappropriate and leave. This intervention was established on 7-6-11 and continued with each subsequent updated service plan, including the most recent service plan of 11-10-11.

Incident of 8-23-11 and 8-24-11 indicated Tenant #21 and Tenant #11 were alone in the Tenant #21's apartment. In both incidents Tenant #21 was nude and Tenant #11 was nude or partially clothed. The incident of 8-24-11 led to Tenant #11 being seen at a local hospital emergency room for examination for possible sexual intercourse, possible exposure to an STD and treatment of Vaginitis.

Clinical notes of 8-26-11 indicated the Tenant #21 "at times would be nude in the hallway and has asked other female tenants to accompany" him/her.

Staff #7 was interviewed and confirmed the events as reported in the incident report of 8-23-11. She reported staff had "issues," with Tenant #21 as he/she wanted Tenant #11 to go back to his/her room. She stated other staff members, including the Program Nurse, Operations Manager, Staff #2, Staff #3, and Staff #16 knew Tenant #21 was trying to get Tenant #11 into his/her room.

Staff #16 was interviewed and reported she worked the week of 8-22-11, but was unsure which days she worked that week. Program records indicated she worked 8-22-11 from 7:09 a.m. until 9:16 p.m., 8-23-11 from 7:08 a.m. until 3:18 p.m. and 8-24-11 from 7:00 a.m. until 9:49 p.m. She reported one of the days when she came to work, overnight staff reported finding Tenant #11 in the Tenant#21's apartment. She reported she believed overnight staff reported Tenant #11 and the Tenant #21 had been lying in bed together. That same morning at breakfast, she noticed the Tenant #21 was "constantly staring at" Tenant #11. Staff knew of the incident that happened earlier between them and both "were being watched closely." After lunch Tenant #21 finished eating and walked to the end of the hall where he/she could still see Tenant #11. She stated "it was like he/she was trying to get ... attention." She noticed Tenant #11 got up from the dining room table and walked with Tenant #21 to his/her apartment. Staff attempted to redirect Tenant #11 by asking him/her to go with staff. Tenant #21 immediately got upset and told staff to "mind their business and get a man to take care of them." Tenant #11 was confused at this point and told staff he/she was fine going with Tenant #21. She stated on 8-23-11 or 8-24-11 a door alarm was placed on the Tenant #21's door because of the Tenant's behavior. The next day staff found Tenant #21 and Tenant #11 together again.

Staff #35, in a written statement of 8-31-11, reported she went into Tenant #21's apartment, as he/she had asked for something cold to drink. She went and got him/her a "pop" out of the refrigerator. When she came back Tenant #21 was uncovered and had no clothes on. She gave Tenant #21 his/her pop and went to shut off the pager. Tenant #21 was touching his/her genital area and asked the staff member if she wanted to "touch it."

On 8-24-11, Tenant #21's physician was notified of Tenant #21's increased libido and inviting and coaxing other tenants to his/her apartment. Tenant #21 was having inappropriate behavior in the common areas. On 9-12-11, Tenant #21's primary care clinic was notified Tenant #21 was making inappropriate sexual advances toward other tenants and the Program would like suggestions. A physician assistant recommended redirection, behavior modification and to re-admit Tenant #21 to the dementia unit if Tenant #21's cognition declined.

Staff #23, in a written statement of 10-16-11, reported she went to assist Tenant #21 with a shower. Tenant #21 asked her to shower with him/her. She left and returned a short time later to assist Tenant #21 with placing TED hose on. Tenant #21 exposed his/her genitalia, touching himself/herself and asked her to help. On 10-17-11 she arrived at Tenant #21's apartment and found Tenant #21 naked by the sink, touching his/her genitalia and asked her to help him/her. Staff #23 asked a male staff to come into the Tenant's apartment and the Tenant pulled up his/her pants.

Staff #36 LPN, in a written statement of 10-23-11, reported she went to Tenant #21's apartment to complete an accu-check and found the Tenant in the shower. She thought Tenant #21 was taking a bath and stepped out. She checked on Tenant #21 later and found the Tenant spraying water on his/her genitalia. Tenant #21 stated he/she was "trying to get rid of my staff "and "why don't you help me it will be better."

Twenty-four hour staff report sheets of 11-21-11 reported Tenant #21 was "very inappropriate this a.m. Sexual comments." A similar report sheet for 11-24-11 reported Tenant #21 was "verbally aggressive toward staff during shower." Despite the Program's attempts to establish interventions related to Tenant #21's behavior toward staff and tenants, the Tenant continues to be verbally and physically sexually inappropriate.

Staff #4 was interviewed. When asked if there were tenants who were sexually inappropriate she responded Tenant #21 masturbates and "won't stop." Staff #4 indicated the Tenant would be in the lobby in front of other tenants. She stated the Tenant masturbates in the lobby early in the morning one- to two-times per week. Staff #4 stated she had reported the behavior to the Program Nurse and the Operations Manager, and had documented incidents on the 24-hour report.

Staff #6 was interviewed on 11/30/11. When asked if there were tenants who were sexually inappropriate she responded Tenant #21 was inappropriate with Tenant #11. Staff #6 indicated Tenant #21 called her "stupid" and occasionally "cusses." This occurred as recently as one week ago. She noted "last week", referring to one week ago from the date of this interview, Tenant #21was sitting in the lobby with hands in pants "playing" with himself/herself, (referring to the Tenant's genitalia), but his/her genitalia was not exposed. Other tenants were present during this time. Staff #6 stated Tenant #21 would turn on the call light and when staff responded, Tenant #21 was "playing" with himself/herself.

Staff #16 was interviewed. When asked if there were tenants who were sexually inappropriate she responded Tenant #21 masturbated when a staff member was in the room. She indicated Tenant #21 would not masturbate when more than one staff member was in the room.

Staff #23 was interviewed on 11/29/11. When asked if there were tenants who were sexually inappropriate she responded Tenant #21 masturbated and asked staff members to help "finish." She indicated the Tenant masturbated in the lobby sometimes, most recently seen three weeks ago. This behavior was noted in the lobby in the mornings. She indicated Tenant #21 masturbated in his/her apartment. Two staff members would go into the room at one time to limit what Tenant #21 would ask staff members to do. Tenant #21 was observed masturbating "last week", referring to one week ago from the date of this interview. She stated she had reported the issue to the Program Nurse "about one month ago" from the date of this interview.

Staff #30 was interviewed. When asked if there were tenants who were sexually inappropriate she responded Tenant # 21 masturbated "wherever and whenever."

When the Tenant was asked to stop, he/she would not. Staff #30 revealed that Tenant #21 masturbated in public places.

Staff #32 was interviewed. When asked if there were tenants who were sexually inappropriate she responded Tenant #21. She stated Tenant #21 would call staff in to watch him/her masturbate, and was last observed 11-27-11. She described Tenant #21 as masturbating "all the time" and indicated two staff go into the room at one time to limit his/her activity.

Staff #33 was interviewed. When asked if there were tenants who were sexually inappropriate she responded Tenant #21 liked to put his/her hands down his/her pants in public and tells "dirty jokes" to staff.

Tenant #21's service plan of 8-29-11 had established interventions continued from 7-6-11 related to sexual and inappropriate behaviors. Clinical nursing notes, incident reports involving inappropriate sexual behavior toward another tenant and staff interviews recounting Tenant #21's masturbation in the presences of staff and fondling himself/herself in public. Despite the program's efforts to establish interventions related to this behavior, Tenant #21 was chronically sexually aggressive and displayed behavior that placed Tenant #11 at risk.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who… (1), despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression. (2), displays behavior that places another tenant at risk. (IAC r.481-69.23(1)(2))

D. Staffing

Complaint/Incident Allegation #34794-C: During the onsite complaint investigation of 7-19-21 & 25-29, 2011, the Program received a regulatory insufficiency for not administering medications within the Program's policy of one-hour before and one hour after the scheduled times.

- Monitoring Observation: Staff #3 and #13 were no longer with the program. The Program indicated Staff #2 no longer passes medications and was out of the building on leave during this onsite visit. Interviews with Staff # 15, 16, and 23 revealed that medications were being passed per program policy of one-hour before and one-hour after scheduled times. Medication passes were observed on 11-29-11 and 12-1-11. Medications were passed on time.

  Staff training records were reviewed. Staff #15 received medication training on 9-29-11. Staff # 16 received medication training on 9-19-11 and Staff #23 received medication training on 9-20-11. Staff #30, was given medication training on 11-17-11. All training was documented by a registered nurse.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #34794-C and 34948-C: During the onsite complaint investigation of 7-19-21 & 25-29, 2011, the Program received a regulatory insufficiency for not responding to tenants' calls for assistance in a timely manner.

- Monitoring Observation: Call light records were reviewed for four dates in November 2011 selected at random. Call light response times were reviewed for the 24-hour periods of November 1, 12, 21, and 24, 2011. The majority of the calls were answered in less than 15 minutes. One call on November 12 took just under 19 minutes to answer.

  Staff #13 was no longer employed at the program. Staff training records were reviewed. Staff #2, #4, #6, #15, #17, #18, and #20 had documentation of training on call lights. The training file for Staff #19 lacked documentation of call light training. The Program Nurse stated training had not been completed for Staff #19.

  Staff training records were reviewed for three new employees (#30, 31, 32). All were employed in the nursing department. Staff training files for these employees included documentation of training on call lights.

  A tenant meeting was held with 26 tenants. Tenants reported staff would respond to call lights in a timely manner; within 15 minutes of being called. Tenants reported there were recent instances of staff arriving at the tenant's apartment, ask what their need was, and if not an emergency, staff would reset the pager and tell tenants they would return later.

  Two private tenant interviews were conducted. One tenant reported staff members responded to call lights, but when the Tenant requested privacy in the restroom, staff left and never came back. Another tenant stated staff responded to call lights in five to ten minutes.

  Staff # 4, #23, and #31 reported during interview when a call light was answered the tenant would be asked if the request for assistance was an emergency. If it was not an emergency, the call light was turned off, staff left to attend to the next call, and returned later.

- Regulatory Insufficiency: None noted.

During the course of the onsite complaint investigation of 7-19-21 & 25-29, 2011, the Program received a regulatory insufficiency for not having sufficiently trained staff available at all times to fully meet tenants' needs.

- Monitoring Observation: Training records for Staff #2, #4, #15, #6, #17, #18, #20 and #23 were reviewed. Each contained documentation of nurse-delegation training on activities of daily living. Four staff members interviewed (4, 6, 16, 23) revealed that nurse delegation had been completed and a registered nurse had observed cares being done. Training records for three new staff members also contained documentation of nurse delegation training within 30 days of employment. Two new staff members (#30, 32) were interviewed and stated they had been delegated.

- Regulatory Insufficiency: None noted.

E. Tenant Documents

Complaint Allegation #34822-C: During the onsite complaint investigation of 7-19-21 & 25-29, 2011, the Program received a regulatory insufficiency for not having accurate documentation of the completion of routine personal or health-related cares on task sheets for Tenant's #2, #3, #7, #8, #9, #12 and #15.

- Monitoring Observation: Tenant's #2, #3, #8 and #12 no longer resided at the Program. A review of Tenant #7's and Tenant #15's file indicated task sheets were completed as needed.

- Regulatory Insufficiency: None noted.

F. Service Plans

Complaint/Incident Allegation #34948-C: During the onsite complaint investigation of 7-19-21 & 25-29, 2011and during the course of the investigation, the Program received a regulatory insufficiency for not establishing interventions related to tenant's identified needs and preferences for assistance for tenant's #3, #7, #8, #11 and #12.

- Monitoring Observation: Tenants #3, #8 and #12 no longer resided at the Program. Tenant #7's and #11's file were reviewed and indicated service plans were updated as needed and with a change in condition.

- Regulatory Insufficiency: None noted.

G. Nurse Review

During the course of the onsite complaint investigation of 7-19-21 & 25-29, 2011, the Program received a regulatory insufficiency for not assessing and documenting the health status of tenant's #3, #7 and #12.

- Monitoring Observation: Tenant #3 and #12 no longer resided at the Program. Tenant #7's file and five additional tenant files were reviewed and each indicated nurse reviews were completed as needed.

- Regulatory Insufficiency: None noted.

H. Life Safety

Complaint/Incident Allegation #34794-C: During the onsite complaint investigation of 7-19-21 & 25-29, 2011, the Program received a regulatory insufficiency for not having an operating alarms system to each exit door in the dementia-specific setting.

- Monitoring Observation: During the onsite, monitors observed the dementia doors were operating appropriately. The Program provided documentation of persons given a key to the alarm system. Documentation of training to those persons was also

provided. Five staff members interviewed (4, 6, 23, 31, 32) stated there had been no problems with the door alarms. A review Program documentation indicated the dementia unit entrance/exit doors were checked monthly by maintenance personnel.

- Regulatory Insufficiency: None noted.

I. Structural Requirements

During the course of the onsite complaint investigation of 7-19-21 & 25-29, 2011, the program received a regulatory insufficiency for not having the building safe for tenants. A monitor observed a bottle of bleach was sitting on a chair in the dining room of the dementia program. Staff reported the bleach bottle had been left out by mistake.

- Monitoring Observation: Staff #16 had documentation of training on chemicals and other potential hazards to tenants. Five staff members interviewed (#6, 5, 23, 31, 32) indicated there had been no chemicals or other hazards within easy access for tenants.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: On 11-30-11, a monitor toured the dementia unit and found a liquid container attached to a mop sitting adjacent to the housekeeping cart in the hallway. Program records indicated the liquid container contained a cleaning chemical which was corrosive to the skin and eyes and may be harmful if swallowed. The housekeeping cart and mop were left unattended. A toaster oven was plugged into an electric outlet in the dining room and a bread toaster was sitting on top of the refrigerator.

- Regulatory Insufficiency: The building and grounds shall be well-maintained, clean, safe and sanitary. (IAC r.481-69.35(1)(b))