IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 37774-C
37955-C
37962-A

April 16, 2012

Ms. Kim Schaffer, Director
Bickford Cottage of Clinton
1150 13th Avenue North
Clinton, IA 52732

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

Dear Ms. Schaffer:

I. Final Complaint/Incident Investigation Report – Bickford Cottage of Clinton, Clinton, IA

Enclosed is the **Final Complaint/Incident 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, Tenant Rights, Program Reporting to Department, Staffing, Tenant Documents and Service Plans. **Bickford Cottage of Clinton** ("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 April 3, 2012, has been reviewed and will constitute the final POC related to the on-site visit of February 14, 15, 16, 20, 21, 25 and 27, 2012.

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/Incident Investigation Report

Assisted Living Program:

Kim Schaffer, Director
Bickford Cottage of Clinton
1150 13th Ave. North
Clinton, Iowa 52732

Complaint/Incident Intake #:

37774-C
37955-C
37962-A

Date of Complaint/Incident Investigation:

February 14,15,16,20,21,25 and 27, 2012

Monitor(s):

Maribeth Freland RN
Joyce Kix RN

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:	32
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	37
TOTAL census of Assisted Living Program	37

Program History – There were no Regulatory Insufficiencies found during this certification period.

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

A. Policies and Procedures

Complaint/Incident Allegation: 37774-C: It was alleged staff members failed to document pertinent tenant information related to changes in condition in a timely manner and were directed to falsify the documentation at a later date by the program's administrative staff.

- Monitoring Observation: According to the program's policy, titled Documentation, all staff members were directed to document "care notes" on the Progress Notes form, dating the entry with the date and time of the entry and sign the entry with the writer's first initial, last name and position. The policy directed staff members to document any changes in a tenant's condition, changes in a tenant's behavior or any refusal of care in order to provide a record of information gathered about the tenant and to communicate these observations to other staff members.

  According to the program's policy, titled Significant Events, all significant events require documentation in a tenant's clinical record. The policy identified significant changes in a tenant's behavior or condition as a reason to document.

  According to the program's policy, titled Charting, all documentation should be completed at the time of occurrence and in chronological order.

  The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6, #7 and #8. The monitors identified no late entry documentation in Tenant #1, #6 and #7. The monitors identified late entries or addendums which were documented according to policy in the clinical records of Tenants #2, #3, #4 and #8.

The monitors noted the following in the clinical record of Tenant #5: Tenant #5, a 92 year old, was admitted on 5-4-11 with diagnoses of Coronary Artery Disease, Hypertension (HTN) and Atrial Fibrillation. According to Tenant #5's Mini Mental Status Exam (MMSE), dated 11-28-11, he/she answered only two questions partially correct, indicating no cognitive impairment.

Tenant #5's clinical record contained an entry, completed by Staff #1, certified medication aide (CMA) on 2-1-12 at 7:30 PM. The note indicated Tenant #5 had complained of experiencing symptoms of a stroke and was seeking knowledge on how to get to the hospital. Staff #1 documented her attempts at follow up to Tenant #5's concerns and his/her multiple refusals of the follow up.

During interview on 2-15-12, Staff #1 told the monitors she had inadvertently omitted documenting anything about Tenant #5's complaints on 2-1-12. Staff #1 indicated she told Staff #3, certified nurse aide (CNA), and Staff #4, CMA, of Tenant #5's complaints of stroke symptoms and requested they "keep an eye on him". Staff #3 and Staff #4 were working the same shift as Staff #1. Staff #3 and Staff #4 left work prior to Staff #1 on 2-1-12. Staff #1 indicated she did not contact the program's registered nurse to report Tenant #5's concerns and did not pass on information verbally or on the communication notes to the oncoming third shift staff.

Tenant #5 collapsed at the program during the morning of 2-2-12 and later died at the hospital. Upon receiving reports that Tenant #5 had complained of symptoms of stroke the previous evening, Staff #15, registered nurse (RN), called Staff #1 into the office. Staff #15 instructed Staff #1 to document Tenant #5's complaints from 2-1-12 and the CMA's follow up in Tenant #5's clinical record. Instead of adding the entry onto the current progress note being used by other staff and indicating the entry as a late entry, Staff #1 produced a new sheet and documented her findings. Staff #1 crossed through the remaining empty three lines at the bottom of the note and placed the new page behind the current page being used by other staff, which began on 2-2-12. Staff #1 did not mark the entry on the new page as being a late entry. Staff #1 reported completing this documentation on 2-3-12, two days after the date of occurrence and one day after Tenant #5's death.

The monitors interviewed Staff #2, #3, #6, #8, #11, #13, #14, all CNAs or CMAs. All seven staff members reported if they forgot to document an occurrence, they would complete a late entry in the clinical record. All indicated being instructed to document all information at the time of occurrence. All denied being told by administration to falsify documentation at any time. All indicated the program's usual procedure when a tenant change in condition is identified would be to immediately contact the RN to report the occurrence.

The program had policies directing staff members on what is required to be documented on, when it should be documented and why it should be documented timely. Staff members generally were knowledgeable of the policy requirements and direction. None of the staff members reported being told to falsify documentation. One staff member did not follow the program's policies; thereby, keeping other staff members and the registered nurse from having knowledge of significant changes in condition for Tenant #5.

Tenant #5 did not receive assessment from the RN or receive medical evaluation due to this lack of knowledge. According to reports from Tenant #5's family members, Tenant #5 had a massive stroke and subsequently died.

- Regulatory Insufficiency: A program's policies and procedures, must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. (IAC r. 481- 67.2)

B. Tenant Rights

Complaint/Incident Allegation: 37774-C: It was alleged a tenant suffered symptoms of a stroke, told a staff member and the staff member did not call the RN or assist the tenant in any way, resulting in the tenant's death. 37955-C: It was alleged a staff member held a tenant's head back and forced the tenant to take medications after the tenant verbally refused to take the medications. 37962-A: It was also alleged two staff members held a tenant's arms behind his/her back, forcing the tenant to take medications he/she did not want to take.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6, #7 and #8, finding no concerns related to tenant rights for Tenants #2, #3, #6, #7 and #8. The monitors reviewed documentation of investigations completed by the program administration and interviewed Staff #1, #2, #3, #4, #8, #9, #10, #11, #12, #13 and #15. The monitors also interviewed Tenant #8 and attempted to interview Tenants #1 and #4. The monitors identified the following concerns:

  Tenant #1, a 99 year old, was admitted on 8-13-08 with diagnoses of Dementia, Coronary Artery Disease, HTN and Diabetes and currently lived at the program. Tenant #1 scored 6 on the Global Deterioration Scale (GDS), dated 12-29-11, which indicated severe cognitive decline. The Nurse Review completed by Staff #15, RN, on 12-29-11, lacked documentation of any behavior concerns. The Nurse Review indicated Tenant #1 remained appropriate for the assisted living.

  According to the Service Plan, updated on 12-29-11, Tenant #1 occasionally would slap at staff members hands when trying to assist him/her. The Service Plan directed staff members to approach Tenant #1 head on, allowing him/her to visualize the staff member; speak loudly to allow him/her to hear staff member requests; and explain what they are trying to do to help Tenant #1 prior to touching him/her. The Service Plan did not document any special instructions related to medication administration.

  According to Tenant #1's Medication Administration Records (MARs), Tenant #1's physician approved crushing of his/her medications and placing the medications in pudding to allow easier swallowing. The MARs documented Tenant #1took Metoprolol XR, a blood pressure medication. Metoprolol could not be crushed, requiring staff members to place one and a half whole tablets into the pudding along with the crushed medications. Documentation on the MARs, dated November 2011 through February 2012, indicated Tenant #1 refused his/her medications on 11-19-11, 1-18-12 and 1-30-12.

During interview Staff #13, CNA, reported on 1-18-12 in the program dining room, she observed Staff #2, CMA, holding Tenant #1's head back in a hyper extended position, waited for Tenant #1 to open his/her mouth to say something, then forced a spoon full of medications into his/her mouth. Staff #13 reported Tenant #1 was slapping at Staff #2 and had been screaming "No, no. I don't want it- I told you I don't want it" prior to Staff #2 pushing Tenant #1's head back. Staff #13 reported she intervened, Staff #2 removed her hands from Tenant #1's head and he/she spit the pills back out.

During interview Staff #10, Assistant Cook, also reported on 1-18-12, she observed Staff #2 attempting to give medications to Tenant #1 in the dining room. Tenant #1 was swiping at Staff #2's hands and spit out the medications when placed in his/her mouth. Staff #2 then pushed Tenant #1's head back, "forcing him/her to take the medications". Staff #10 verified Staff #13 intervened.

During interview Staff #11, CMA, also reported on 1-18-12, she observed Staff #2 attempting to give medications to Tenant #1 in the dining room. Staff #11 reported Tenant #1 spit out some of his/her medications twice for Staff #2. On a third attempt, Staff #2 put the last whole pill in Tenant #1's mouth and held Tenant #1's head back while reaching for a glass of water. Staff #11 reported Tenant #1 was thrashing his/her head back and forth. Staff #11 verified Staff #13 intervened, Staff #2 removed her hands from Tenant #1's forehead and Tenant #1 spit out the pill.

During interview Staff #2, CMA, reported on 1-18-12 she found Tenant #1 sitting in the dining room alone. Staff #2 reported the program discouraged administration of medications in common areas of the building; however, she made the decision to give Tenant #1 his/her medications in the dining room as no other tenants were present. Staff #2 reported she crushed the medications she could and placed these medications and the Metoprolol into applesauce, which Staff #2 admitted was not usual for Tenant #1. The MARs direct placement of the crushed medications into pudding; however, Staff #2 reported she placed the medications into applesauce as Tenant #1 did not always close his/her mouth around the spoon. Pudding is thicker so it stayed on the spoon. Staff #2 believed applesauce would slide off the spoon easier.

Staff #2 reported she placed one spoonful of the applesauce mixture into Tenant #1's mouth. Tenant #1 swallowed the mixture, made a face and said "that doesn't taste good." Staff #2 attempted another spoonful of the applesauce mixture. Tenant #1 swallowed the bite but pushed Staff #2's hands away. Staff #2 reported she kept sitting with Tenant #1, giving bites of the applesauce mixture between Tenant #1's bites of oatmeal until only the two Metoprolol tablets remained. Tenant #1 kept spitting the whole tablets back out after attempting to give the pill another two or three times. Tenant #1 kept yelling and saying "it tastes bad". Staff #2 then reported she placed both pills in Tenant #1's mouth, placed three fingers on Tenant #1's forehead, pushed his/her head back to "keep him/her from spitting the pills out", reached for a glass of water and gave him/her a drink. At this time, Staff #13 yelled out "take your hands off of him/her". Staff #2 removed her hand from Tenant #1's forehead and he/she spit out the half pill. Staff #2 reported she spent approximately 15 uninterrupted minutes attempting to give Tenant #1 his/her medications on 1-18-12.

Staff #2 denied ever attempting to try the medications administration in the oatmeal or in pudding on 1-18-12. Staff #2 reported Staff #15, RN, had previously directed her to try to give a tenant who refused medications three attempts to give the medication, giving space in between attempts. Staff #2 stated "If a person is agitated, I give them a little more time. I have one hour before and one hour after the scheduled time to give the medication." Staff #2 acknowledged a tenant's right to refuse medications, indicating Staff #15 had directed to document the refusal on the MARs and notify the RN of the tenant's refusal.

Progress Notes, dated 1-19-12 and 1-20-12, documented Tenant #1 had a bruise on his/her left arm from the wrist to the thumb and 1st finger noted. The cause of the bruise was documented as unknown etiology.

The monitors attempted to interview Tenant #1; however, he/she was unable to relay accurate information due to advanced dementia. The monitors interviewed Staff #6, #8, #11 and #14, all CMA's, noting all reported receiving instruction from Staff #15, RN, to attempt to give each tenant medication three times, allowing time between each administration attempt, if a tenant refused medications. All reported knowledge that each tenant has the right to refuse medications and all reported being directed to document this refusal on the MARs and notify the RN to report the refusal.

On 2-27-12 at approximately 4:30 PM, the program emailed a summary of an internal investigation completed by the Corporate Divisional Director of Operations for Eastern Iowa and the Corporate Divisional RN. The internal investigation resulted in a need for further education to all staff regarding proper policy and procedure for medication administration and interactions with dementia tenants. Staff #2 and Staff #11 received counseling regarding this infraction and further training and education was initiated immediately.

Tenant #4, an 89 year old, was admitted on 8-8-11 with diagnoses of Alzheimer's Disease, Cardiomyopathy, Atrial Fibrillation, HTN and Congestive Heart Failure (CHF) and currently lived at the program. Tenant #4 scored 6 on the GDS, dated 2-14-12, which indicated severe cognitive decline. The Nurse Review, completed by Staff #15, RN, on 12-19-11, indicated Tenant #4 had experienced multiple behaviors in September, October and November 2011. The review indicated medication adjustments corrected these behaviors. On 12-16-11 through 12-18-11, Staff #1, CMA, documented Tenant #4 experienced multiple episodes of aggressive behavior. The Evaluations/Nurse Reviews completed by Staff #15, RN, on 1-25-12 and 2-14-12 lacked documentation of any behavior concerns. The Nurse Reviews indicated Tenant #4 remained appropriate for the assisted living.

According to the Service Plan, dated 8-5-11 and updated on 8-24-11, 9-26-11, 12-19-11, 1-25-12 and 2-14-12, revealed Tenant #4 can become agitated. The Service Plan directed staff members to allow Tenant #4 ample time to rest before reapproaching him/her following any refusal of activities of daily living (ADLs). On 12-19-11 the Service Plan documented direction to staff members to use humor and politeness with Tenant #4 when he/she became agitated. The Service Plan, dated 8-24-11 directed staff members to crush Tenant #4's medications. The Service Plan, dated 12-19-11, indicated extra assistance may sometimes be required during medication administration due to Tenant #4's cognitive status.

The Plan directed staff to attempt medication administration three times at various intervals to accomplish this task when Tenant #4 refused the medications.

According to Tenant #4's Medication Administration Records (MARs), Tenant #4 refused medications on only one occasion, 1-30-12, during the months of November 2011, December 2011, January 2012 and February 2012.

During interview with Staff #8, CMA, Staff #8 reported she could not remember the date of occurrence; however, believed the date was sometime in January 2012. Staff #8 reported Tenant #8 told her that he/she witnessed Staff #3 restraining Tenant #4's arms behind his/her back while Staff #1 forced Tenant #4 to take medications he/she had refused. Staff #8 reported she had no reason not to believe Tenant #8. The monitors interviewed Tenant #8, who related the same accounting of the above stated incident as previously accounted to Staff #8.

Tenant #8 completed a cognitive MMSE on 2/1/12, answering all questions correctly which indicated no cognitive impairment. Tenant #8 had the medical diagnosis of schizophrenia; however, Tenant #8's clinical record contained no documentation of behaviors, hallucinations or delusions. The monitors interviewed Staff #11, CMA, Staff #13, CMA, and Staff #15, RN. All three reported Tenant #8 could report accurate accountings of events and is not known to make false statements.

During interview Staff #3, CNA, reported sometime in January 2012 she witnessed Tenant #4 sitting in chairs by the medication room. Tenant #4 was tearful and accusing Staff #1, CMA, of "being mean to him/her". Staff #3 asked Tenant #4 to walk with her to the tenant's room. Tenant #4 complied with Staff #3's request, taking one of Staff #3's hands and both walked hand in hand down the hallway. As both neared the medication room, Staff #1 called to Tenant #4 that she had medications to give to him/her. Tenant #4 stopped and turned toward Staff #1, still holding hands with Staff #3. Upon seeing Staff #1, Tenant #4 reportedly became agitated. Staff #3 reached out and took Tenant #4's other hand into hers and began talking to Tenant #4 about taking his/her medications so he/she could go lay down. Tenant #4 verbally agreed to take the medications. Staff #1 put a spoonful of crushed medications in pudding into Tenant #4's mouth, he/she swished the mixture around in his/her mouth and then spit the mixture back at Staff #1. Staff #1 did not attempt to give the medications again and Staff #3 led Tenant #4 back to his/her room still holding hands. The monitors identified no concerns as staff did not physically restrain Tenant #4 and complied with his/her refusal of the medications after Tenant #4 spit the medications out.

Tenant #5's clinical record contained an entry, completed by Staff #1, CMA, on 2-1-12 at 7:30 PM. The note indicated Tenant #5 had complained of experiencing symptoms of a stroke and was seeking knowledge on how to get to the hospital. Staff #1 documented her attempts at follow up to Tenant #5's concerns and his/her multiple refusals of the follow up.

During interview, Staff #1 told the monitors she had inadvertently omitted documenting anything about Tenant #5's complaints on 2-1-12.

Staff #1 indicated she told Staff #3, certified nurse aide (CNA), and Staff #4, CMA, of Tenant #5's complaints of stroke symptoms and requested they "keep an eye on him". Staff #3 and Staff #4 were working the same shift as Staff #1. Staff #3 and Staff #4 left work prior to Staff #1 on 2-1-12. Staff #1 indicated she did not contact the program's registered nurse to report Tenant #5's concerns and did not pass on information verbally or on the communication notes to the oncoming third shift staff.

During interview, Staff #3 and Staff #4 reported around 8:00 PM on 2-1-12 Staff #1 told them Tenant #5 had reported he/she had experienced symptoms of a stroke. Staff #3 and #4 reported Tenant #5 was completely independent; therefore, neither usually saw him/her. Both denied seeing Tenant #5 after supper on the evening of 2-1-12. Both denied Staff #1 told them to keep an eye on Tenant #5. Staff #3 reported when Staff #1 told her about Tenant #5's report of not being able to move his leg and expressed a belief that he had experienced a stroke, Staff #3 told Staff #1 that is a sign of stroke and he/she should probably go to the hospital. Staff #1 reportedly stated "I told him I can't do anything for him." Staff #1 reportedly informed Staff #3, the tenant had taken his/her own vital signs; however, Staff #3 reported she told Staff #1 she needed to go do her own set of vital signs. Both Staff #3 and #4 left work around 11:00 PM and at that time; Staff #1 remained at the program.

The monitors interviewed Tenant #5's adult child. He/she reported Tenant #5 was very independent. He/she reportedly drove him/herself to and from doctor appointments if needed and also drove recreationally. Tenant #5 contacted his/her family on the evening of 2-1-12 at approximately 8:00 PM. Tenant #5 reported he/she was experiencing symptoms of a stroke and was concerned that he/she may need to go to the hospital. Tenant #5 requested the family member come to the program should the tenant need to leave as he/she had many valuables he/she did not wish to leave unattended. The family told Tenant #5 he/she should go to the hospital. Tenant #5 responded "I told them and they will know what to do." Tenant #5 indicated he/she was expecting a staff member to come to his/her apartment shortly. Staff #1 reported she checked on Tenant #5 in his/her apartment throughout the rest of the evening but did not contact the nurse related to the tenant's concerns.

The following morning, during breakfast, Tenant #5 collapsed and later died at the hospital.

During interview with Staff #15, RN, she reported she would have expected Staff #1 to contact her immediately when Tenant #5 expressed concerns of stroke symptoms. After the tenant died, the RN received a report that Tenant #5 had complained of symptoms of stroke the previous evening, Staff #15, called Staff #1 into the office. Staff #15 instructed Staff #1 to document Tenant #5's complaints from 2-1-12 and the CMA's follow up in Tenant #5's clinical record.

Staff #2 treated Tenant #1 without dignity and respect by forcefully requiring him/her to take medications after Tenant #1 both verbally and physically rejected the medication. Staff #1 did not respond appropriately to Tenant #5's report of stroke symptoms by not reporting his/her condition to the RN, who had medical knowledge to assess the tenant and refer for medical evaluation.

- Regulatory Insufficiency: All tenants have the right to be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481- 67.3(1))

- Regulatory Insufficiency: All tenants have the right to receive care, treatment and services which are adequate and appropriate. (IAC r. 481- 67.3(2))

During the course of the investigation, the monitors identified the following information:

C. Program Reporting to the Department

Complaint/Incident Allegation: 37955-C: It was alleged a staff member held a tenant's head back and forced the tenant to take medications after the tenant verbally refused to take the medications. 37962-A: It was alleged a staff member restrained a tenant's legs and hand, forcing the tenant to take medications after the tenant verbally refused to take the medications. 37962-A: It was also alleged a staff member spoke unkindly to a tenant and was witnessed pushing the tenant making the tenant stumble. 37962-A: It was also alleged two staff members held a tenant's arms behind his/her back, forcing the tenant to take medications he/she did not want to take.

- Monitoring Observation: During the complaint investigation, staff members reported one allegation of dependent adult abuse against Tenant #1, identifying Staff #2 as the alleged perpetrator, and multiple allegations of dependent adult abuse against Tenant #4, identifying Staff #1 and Staff #3 as the alleged perpetrators. The staff members reported all allegations were brought to the Director's attention either verbally or in writing.

  A staff member, who was a witness to an alleged occurrence of dependent adult abuse involving Tenant #1 on 1-18-12, named Staff #2, CMA, as the alleged perpetrator. The witness reported she addressed the issue directly with Staff #2, who responded in an agitated manner. The witness reported she told the Director the day following the occurrence of her allegations that Staff #2 continued to force Tenant #1 to take medications after the tenant refused the medications verbally and physically multiple times. Staff #2 allegedly forced Tenant #1's head back and forced the medications into his/her mouth. During interview, the Director reported she received verbal notification of the alleged dependent adult abuse involving Tenant #1. The Director reported she requested and obtained written statements from witnesses and involved staff members Staff #13 CNA, Staff #10, assistant cook, Staff #11, CMA, , Staff #2, CMA; however, she was unable to present any documentation of the written statements.

  During interview, the Director indicated she had completed an internal investigation, determining abuse had not occurred. The Director was unable to present any documentation of her internal investigation indicating she could not find the statements or her investigation documentation. The Director verified she did not separate the alleged perpetrator from the alleged victim and verified she did not report the allegations of dependent adult abuse to the Department of Inspections and Appeals.

Staff #13, Staff #11 and Staff #2 had saved a copy of their original written statements and all gave a copy of the statements to the monitors. Staff #10 reported she had not saved a copy of the statement; however, she verified she had given a written statement to the Director following the incident. Staff #2, the alleged perpetrator, reported she had received a verbal reprimand related to the incident, citing failure to follow program procedures by giving medications in the dining room, for not leaving Tenant #1 and retrying medication administration at a later time following his/her refusal of the medications and for "laying her hands" on Tenant #1. Staff #2's personnel file lacked any documentation of the verbal reprimand.

A staff member, who was a witness to an alleged occurrence of dependent adult abuse against Tenant #4, named Staff #1, CMA, as the alleged perpetrator. The witness reported she could not remember the date of occurrence; however, believed the date was sometime immediately prior to Christmas 2011 and alleged Staff #1 was witnessed restraining Tenant #4's legs and hands, forcing the tenant to take medications he/she had refused. The staff member reported she told the Director the day following the occurrence of her allegations and the Director told her she would look into it. The witness reportedly completed a written statement of the alleged occurrence and placed it in the Director's internal mailbox without keeping a copy of the written statement. The staff member reported she was later told that Staff #1 could not give medications to Tenant #4 without another staff member present. She reported this lasted "a couple of days."

During interview, the Director reported Staff #12, Marketing Director, verbally reported "someone told someone, who told someone, etc." that Staff #1, CMA, had restrained Tenant #4 while administering his/her medications. The Director reportedly told the Marketing Director that the actual witness needed to report the incident directly or fill out an incident report. The Director reported no one ever brought the incident to her attention verbally or in writing. The Director denied investigating this allegation and did not report the allegations to the Department of Inspections and Appeals. The Director reported Staff #1 was told she could not administer medications or care for Tenant #4 without another staff member present for a short time due to another reported incident other than this report.

A staff member, who was a witness to an alleged occurrence of dependent adult abuse against Tenant #4 on Saturday 12-17-11, named Staff #1, CMA, as the alleged perpetrator. The staff member alleged Staff #1 spoke unkindly to Tenant #4, calling him/her a profane name then placed both hands on Tenant #4's shoulders and pushed Tenant #4 causing him/her to stumble. Tenant #4 was allegedly upset, crying and stating "she is always mean to me and I'm afraid of her." Staff #1 allegedly began to argue with Tenant #4. The witness intervened upon observation of the pushing and when Staff #1 began arguing with Tenant #4. The witness reported she addressed the issue directly with Staff #1, who allegedly responded in an agitated manner.

The witness reported she telephoned the Director the evening of 12-17-11 to report the incident. On Monday 12-19-11, upon the Director's return to work, she questioned the Director about follow up to the incident and was instructed by the Director to fill out an incident report. The witness completed the incident report and gave to the Director the same day.

Approximately one week later, the witness reportedly asked the Director what had happened with the investigation. The Director told her that Staff #1 could not be around Tenant #4 without having another staff member present.

During interview, the Director verified she was contacted on 12-17-11 by the witness reporting the above stated allegation of dependent adult abuse and completed a written statement of her allegations on the following Monday 12-19-11 at the Director's request. The Director investigated the allegations and gave the monitors the documentation of her investigation. The Director reported she determined Staff #1 did not push Tenant #4 as she denied this and there were no other witnesses to this incident; therefore, the Director did not report the allegations to the Department of Inspections and Appeals. The Director reported she gave Staff #1 a verbal reprimand related to her inappropriate name calling of Tenant #4. Staff #1's personnel file lacked any documentation of this verbal reprimand. The Director verified she did not separate the alleged perpetrator from the alleged victim and verified she did not report the allegations of dependent adult abuse to the Department of Inspections and Appeals.

A staff member, who received a verbal report of alleged occurrence of dependent adult abuse against Tenant #4 from Tenant #8 , who named Staff #1, CMA, and Staff #3, CNA, as the alleged perpetrators. The witness reported she could not remember the date of occurrence; however, believed the date was sometime in January 2012. The witness reported Tenant #8 told her that he/she allegedly witnessed Staff #3 restraining Tenant #4's arms behind his/her back while Staff #1 forced Tenant #4 to take medications he/she had refused. The witness reported she told the Director immediately upon the Director's arrival at work the same day of Tenant #8's report of the allegation. The staff member reported she had no reason not to believe the tenant's allegations.

Tenant #8 completed a cognitive MMSE on 2/1/12, answering all questions correctly which indicated no cognitive impairment. Tenant #8 had the medical diagnosis of schizophrenia; however, Tenant #8's clinical record contained no documentation of behaviors, hallucinations or delusions. The monitors interviewed Staff #11,CMA, Staff #13, CMA, and Staff #15, RN. All three reported Tenant #8 could report accurate accountings of events and is not known to make false statements.

During interview, the Director reported the witness verbally reported Tenant #8 told her that Staff #1 and Staff #3 had restrained Tenant #4 while administering his/her medications. The Director reported she investigated this allegation determining Staff #1 and Staff #3's reports of the incident were similar in content and Tenant #8 was, in the Director's opinion, to be an unreliable source. The Director verified she did not separate the alleged perpetrators from the alleged victim and verified she did not report the allegations of dependent adult abuse to the Department of Inspections and Appeals. The Director reported she contacted the Corporate Divisional Director of Operations for Eastern Iowa about this allegation and a previous allegation involving Staff #1 and Tenant #4. The Director indicated a decision was made to keep Staff #1 from administering medications or providing care for Tenant #4 without another staff member present for a short time. The Director did not maintain any documentation of the above stated investigation and Staff #1's personnel file lacked any documentation of such discipline.

The Director did not remember how long Staff #1 had to have another staff member present and denied ever meeting with Staff #1 at a later date to lift this requirement.

The Director received four separate allegations of dependant adult abuse from staff members and one tenant, who multiple staff members report would be a reliable source of information. The Director investigated three of the allegations, chose not to investigate the fourth as the report had been "second hand" and the actual witness had not reported her concerns directly, although the actual witness told the monitors she had reported her concerns to the Director. The Director did not maintain any documentation of her internal investigation for three of the allegations. The Director executed verbal reprimands to Staff #1 and Staff #2 relating to the allegations without maintaining any documentation. The Director executed a requirement for Staff #1 to have another staff member present when caring for or administering medications to Tenant #4. The Director did not report any of the four allegations of dependent adult abuse to the Department of Inspections and Appeals.

- Regulatory Insufficiency: A staff member or employee of a facility or program who, in the course of employment, examines, attends, counsels, or treats a dependent adult in a facility or program and reasonably believes the dependent adult has suffered dependent adult abuse, shall report the suspected dependent adult abuse to the department. (IAC r. 235 E.2.2)

- Regulatory Insufficiency: If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. (IAC r. 235 E. 2.3(a))

D. Staffing

Complaint/Incident Allegation: 37774-C: It was alleged the program's delegating registered nurse sent delegation papers home with new staff members, having the staff members sign the forms and return the forms to the program. It was also alleged other aides mentored, trained and observed new staff members passing medications with no training or observation by the program's registered nurse.

- Monitoring Observation: Staff #4, CNA, had a hire date of 3-14-11. Staff #4's personnel files contained Nurse Delegation forms for delegation of Care Following Falls Involving Head Injuries, Care of Skin Tears, Brace Application and Removal, Portable Oxygen Tank Regulation, Catheter Care, Use of a Mechanical Lift, Care of Nose Bleeds and Application of Compression Stockings. All of the forms were signed by Staff #4 and Staff #15, RN. During interview, Staff #4 reported all of the above stated delegation forms were given to her for review with instructions to sign each document and return to Staff #15. Staff #4 reported Staff #15, did not complete any teaching or observation related to any of the above stated tasks. Staff #4 was mentored by Staff #9, activity director.

Staff #5, CNA, had a hire date of 1-17-12. Staff #5's personnel files contained Nurse Delegation forms for delegation of Care Following Falls Involving Head Injuries, Care of Skin Tears, Portable Oxygen Tank Regulation, Care of Nosebleeds and Application of Compression Stockings. All of the forms were dated 1-20-12 and signed by Staff #5 and Staff #15, RN. During interview, Staff #5 reported all of the above stated delegation forms were given to her on the first day of employment with instructions to sign each document and return to Staff #15, RN. Staff #5 reported Staff #15 did not complete any teaching or observation related to any of the above stated tasks. Staff #5 was mentored and observed by Staff #11, CMA. Staff #5 reported this was her first job as a CNA following completion of her training.

Staff #6, CMA, had a hire date of 11-28-11. Staff #6's personnel files contained Nurse Delegation forms for delegation of Aerosolized Medication Administration, Eye Drop Administration, Eye Ointment Administration, Administration of Oral Medications, Care Following Falls Involving Head Injuries, Care of Skin Tears, Cleaning of PEG Tube Site, Flushing a PEG Tube, Brace Application and Removal, Portable Oxygen Tank Regulation, Use of a Mechanical Lift, Care of Nosebleeds, Use of Glucoscan Machine, Blood Sugar Testing, and Application of Compression Stockings. All of the forms were dated as completed on 11-16-11 and signed by Staff #6 and Staff #15, RN. The dates were crossed through and replaced with 12-1-11. The personnel file also contained a Nurse Delegation form for medication administration, dated 12-1-11. During interview, Staff #6 reported she was handed completed delegation forms for the tasks as described above and told to sign and return to Staff #15, RN. Staff #6 reported she forgot to sign the forms, brought them to Staff #15 on 12-1-11 and was told to sign them on that date. Staff #6 reported Staff #15 did not complete any teaching or observation related to any of the above stated tasks. Staff #6 was mentored and observed by Staff #14, CMA, for one day while passing medications then was "thrown in to do meds" independently thereafter. Staff #6 reported feeling uncomfortable with completing medication administration independently after only one day of observation by her peer; however, she believed she had no choice in the matter.

Staff #7, CNA, had a hire date of 11-10-11. Staff #7's personnel files contained Nurse Delegation forms for delegation of Care Following Falls Involving Head Injuries, Care of Skin Tears, Brace Application and Removal, Portable Oxygen Tank Regulation and Application of Compression Stockings. Many of the above stated forms were dated with dates prior to Staff #7's hire date. The dates were crossed through and replaced with the date 11-12-11 and were signed by Staff #7 and Staff #15, RN. The personnel file also contained a Nurse Delegation form for the delegation of medication administration, dated 1-12-12. During interview, Staff #7 reported she and Staff #15 had done a one on one review of the medication delegation forms followed by Staff #15's observation of Staff #7's completion of medication administration for "a couple of tenants". All of the other forms Staff #7 was given for review were signed without observation by the RN of return demonstrations.

During interview, Staff #15, RN, reported all employees had taken the CNA classes; therefore, she does not complete any instruction related to delegation. Staff #15 reported giving the delegation forms to staff members to read then each new staff member is assigned to a peer for mentoring.

The RN reported she only observed medication administration. She stated "I don't watch any other tasks for each little thing." Staff #15 reported she completed competency clinicals for the certified medication assistant class for each employee who attended with the exception of Staff #6, who was currently taking classes to become a nurse. Staff #15 verified she did not observe Staff #6 administering medications until after Staff #6 was mentored by another CMA and administered medications independently during the mentoring session. Staff #15 reported she had observed all staff members at one time or another by looking into tenant rooms while staff members were providing care without each staff members knowledge; therefore, staff members would not be aware of the observation.

Per staff member interviews, the RN delegated multiple direct care tasks without performing any teaching or observation related to tasks being assigned to Staff #4, #5, #6 and #7 prior to the staff members performing these tasks while being observed by peer mentors. The RN delegated medication administration tasks without performing any teaching or observation of medication administration tasks for Staff #6 prior to her administering medications while being observed by a peer mentor.

- 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))

E. Evaluation

Complaint/Incident Allegation: 37774-C: It was alleged the program's registered nurse did not respond to reports of changes in tenant condition.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6, #7 and #8, finding no concerns related to the registered nurse's evaluation of reported concerns of significant change in condition. The monitors interviewed Staff #2, #3, #8, #11and #14, all direct care providers. All reported Staff #15, RN, timely responds to reports by staff of tenant significant changes in condition.

- Regulatory Insufficiency: None noted.

F. Criteria for Admission and Retention

Complaint/Incident Allegation: 37774-C: It was alleged the program retained multiple tenants who exceeded the assisted living level of care due to behavior issues.

- Monitoring Observation: The monitors interviewed Staff #3,#8, #13, #14, all direct care providers. All of the staff members reported no level of care concerns related to current tenants. The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6, #7 and #8 noting no level of care concerns.

  Tenant #3, an 89 year old, was admitted on 4-29-11 with diagnoses of Alzheimer's Disease, HTN and CHF and currently lived at the program. Tenant #3 scored 5 on the GDS, dated 11-21-11, which indicated moderately severe cognitive decline.

Tenant #3's clinical record included documentation of multiple episodes of Tenant #3's paranoia and fear of "men trying to kill" him/her. Tenant #3 did not ever show physical aggressiveness with staff members or other tenants. Family members of Tenant #3 reported he/she had experienced friends of his/her adult child who lived with the tenant torment him/her. The fears and paranoia expressed by Tenant #3 were not due to hallucinations or delusions, but due to past life experiences being relived emotionally.

Tenant #4 exhibited multiple behaviors of physical aggression against staff members and other tenants between 9-12-11 and 12-18-11. The program made multiple adjustments to Tenant #4's medication regime during this time, resulting in a decrease of the behaviors. Tenant #4 currently resided in the program with no behavior issues.

Tenant #6, an 81 year old, was admitted on 12-7-10 with diagnoses of HTN, Chronic Obstructive Pulmonary Disease (COPD), Osteoarthritis, Coronary Artery Disease and Depression and a discharge date of 1-30-12. Tenant #6 scored 4 on the GDS, dated 1-27-12, which indicated moderate cognitive decline. Tenant #6's clinical record indicated Tenant #6 became much more agitated during January 2012. He/she began having verbal altercations with his/her spouse, showing increased confusion, throwing medications on the floor and other behaviors out of the usual for him/her. Redirection worked effectively when used. The program made adjustments to Tenant #6's medication regime. At the end of the month, Tenant #6's family chose to move him/her to a long term care facility.

Tenant #7, an 87 year old, was admitted on 12-31-09 with diagnoses of Dementia, Atrial Fibrillation, Osteoarthritis, Diabetes, Coronary Artery Disease and history of a Stroke and a discharge date of 12-19-11. Tenant #7 scored a 3 on the GDS, dated 12-6-11, which indicated mild cognitive decline. Tenant #7's clinical record included documentation of him/her falling 11 times between 11-18-11 and 12-18-11. In late November 2011, Tenant #7 required hospitalization, returning to the program requiring the services of physical therapy. On 12-6-11, the program RN directed staff members to use a mechanical lift to transfer Tenant #7 due to safety reasons. On 12-15-11 the Director held a conference with Tenant #7 and his/her family members. The Director gave Tenant #7 a 30 day notice of discharge secondary to his/her inability to transfer with the assistance of one staff member. Tenant #7 required hospitalization for vomiting and diarrhea on 12-18-11. Tenant #7's family members chose to have him/her transferred to a long term care facility directly from the hospital. Tenant #7 did not return to the program.

While the program had past tenants who exceeded the level of care, the program appropriately discharged the tenants. The program had no current tenants exceeding level of care for an assisted living program.

- Regulatory Insufficiency: None noted.

During the course of the investigation, the monitors noted the following information:

G. Tenant Documents

- Monitoring Observation: The monitors noted the following documentation while reviewing tenant clinical records:

Tenant	Date	Behaviors identified in progress notes in clinical records.	Incident Report
Tenant #1	11-18-11	Increased confusion. Slapped and kicked staff member.	None completed.
Tenant #1	1-20-12	Bruising on L/hand from wrist to thumb and 1st finger- unknown etiology.	None completed.
Tenant #4	9-12-11	Spitting meds out- threatened to rip CMA's shirt- slapped staff member- threatened to kick another staff member.	None completed.
Tenant #4	9-26-11	Spitting meds out- hit CMA in ear with fist- hit CMA in arm- stated "like to beat you senseless".	None completed.
Tenant #4	10-31-11	Entered another tenant's room- staff members intervened- hitting, spitting, biting, kicking staff members. Swung at the other tenant.	None completed.
Tenant #4	11-19-11	In personal space of multiple other tenants- hit staff when redirection attempted.	None completed.
Tenant #4	12-16-11	Tried to sit in same chair already in use by another tenant- pushed other tenant with both hands.	None completed.
Tenant #4	12-16-11	Seen patting tenant of opposite sex buttocks- upset that tenant- that tenant verbalized plan to hit Tenant #4 with cane.	None completed.
Tenant #4	12-18-11	Belligerent- slapped staff member across face- kicked staff member.	None completed.
Tenant #4	12-18-11	Belligerent with another tenant- slapped other tenant twice- pulled staff member's hair, slapped, hit in jaw and kicked staff member when intervened.	None completed.
Tenant #4	12-18-11	Approached tenant of opposite sex- touched "inappropriately".	None completed.

Tenant #4	1-15-12	Made fist into hand and swung at staff member- slapped staff member- lay on bed kicking at staff member.	None completed.

Upon monitor requests for incident reports for Tenants #1 and #4, the Director reported having no incident reports for either during the months of September, October and November 2011. The Director gave the monitors all incident reports completed during December 2011, January 2012 and February 2012. The monitors found no incident reports documenting any of the above stated behaviors.

Staff members documented multiple behaviors with physical aggression against both staff members and other tenants by Tenant #1 and Tenant #4. None of the behaviors had been documented on an incident report.

- Regulatory Insufficiency: Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record.) (IAC r. 481- 69.25(1)o.)

H. Service Plans

Complaint/Incident Allegation: 37774-C: It was alleged the registered nurse told staff to separate two tenants from eating at the same time as other tenants due to behaviors and/or coughing and spitting issues.

- Monitoring Observation: Tenant #1's clinical record included a nurse review, completed by the program RN on 12-29-11. The review indicated Tenant #1 had been treated for pneumonia. Tenant #1 had increased sputum production and had been coughing uncontrollably. Tenant #1 had been upsetting his/her tablemates with the coughing and spitting of sputum and food onto the floor. The RN directed staff members to have Tenant #1 wait to come to the dining room for meals until the other tenants were finished with eating. This lasted for approximately three weeks. Tenant #1 currently eats with the others in the dining room for all meals. Tenant #1's service plan, updated last on 12-29-11, lacked direction to staff to have Tenant #1 wait until all other tenants were finished eating all meals.

  Tenant #2, an 86 year old, was admitted on 9-16-10 with diagnoses of Chronic Kidney Disease, COPD and HTN and died on 12-23-11 while hospitalized for pneumonia and sepsis. Tenant #2 scored a 3 on the GDS, dated 11-23-11, which indicated mild cognitive decline. According to the nurse review, completed 11-23-11, Tenant #2 had become disruptive at meals by yelling out inappropriate needs such as bowel movements. The program RN discussed this with Tenant #2 and his/her spouse. The RN suggested having Tenant #2 wait approximately ½ hour after the other tenants to allow those tenants to eat uninterrupted. Tenant #2 reluctantly agreed to this arrangement. Tenant #2's service plan, updated last on 11-23-11, lacked direction to staff to have Tenant #2 wait the ½ hour for his/her meals.

The program RN failed to accurately reflect the individualized meal plan on the service plan for both Tenants #1 and #2.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))