IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 38919-C
38931-C
38935-C

June 4, 2012

Ms. Jill Boss, RN Director
Maggie's House Assisted Living
107 E. 2nd Street
DeWitt, IA 52742

RE: Final Complaint/Incident Investigation Report – Maggie's House Assisted Living, DeWitt, IA

Dear Ms. Boss:

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.

DIA has reviewed both your Plan of Correction (POC) and Request for Reconsideration in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC.

Based on the information provided, DIA accepts your Request for Reconsideration as it relates to the Service Plan for Tenant #7.

If you have any questions, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau
Enclosure

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

Assisted Living Program:

Jill Boss, RN Director
Maggie's House Assisted Living
107 E. 2nd Street
De Witt, IA 52742

Complaint/Incident Intake #: 38919-C
38931-C
38935-C

Date of Complaint/Incident Investigation:

May 2 & 3, 2012

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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.

General Population Program	
Number of tenants without cognitive disorder:	19
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	20
TOTAL census of Assisted Living Program	20

Program History – The program received regulatory insufficiencies in the areas of Service Plan, Criteria for Exclusion of Tenants and Reporting Requirements during this certification period.

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

A. Medications

Complaint/Incident Allegation #38931-C; #38935-C: It was alleged medications were not administered in the prescribed timeframes.

- Monitoring Observation: Two medication passes were observed during the investigation. Medications were administered from a medication planner previously set up by the RN Director. Medications were administered within one hour before and one hour after the prescribed time. Appropriate hand washing technique was observed. Staff ensured tenants consumed the medications and documentation was completed on the Medication Administration Records.

  Seven tenant interviews were held. The tenants stated medications were administered on time.

  The RN Director said there had been no reports by tenants or family members regarding medications not administered in the appropriate timeframe. The RN Director did not report any issues or concerns with medications being administered outside of the prescribed timeframe.

  Review of nine tenant files (Tenants #1, #2, #3, #4, #5, #6, #7, #8 and #9) indicated medications were administered by the Program and no issues of medications administered outside the prescribed timeframe were identified.

Medication error reports from 3-1-12 to 4-14-12 were reviewed. There were 13 total medication error reports and the errors included: 9 errors when staff did not document medications that were administered, 1 error when a weight was not recorded and 3 errors when medications were not given. None of the instances where medications were not given had an outcome, according to the reports.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation #38919-C; #38931-C: It was alleged several staff had resigned which left few staff.

- Monitoring Observation: The RN Director provided a written statement regarding staff. She indicated since 4-24-12 she had received resignations from three floor staff and one kitchen staff. She had hired and was in the process of training one full time second shift floor staff/caregiver. She had also hired a part time kitchen staff and she would be training that week. Interviews for the other open positions were ongoing and job offers were anticipated to be made soon. She indicated the hours worked by two staff who had resigned would be split into three positions, allowing for more staff. Until all open positions were filled, extra hours were offered to current staff and overtime had been approved. The RN Director indicated if any of the hours were not covered by current trained staff then the Owner, Activity/Operations Director or the RN Director would cover the hours. The building would be fully staffed and the tenants would receive the cares they needed and deserved, according to the RN Director. She wanted to make the transition as smooth as possible for the tenants and wanted to maintain current and new staff.

  According to the staff list provided by the Program, Staff #4, a universal worker was hired 4-27-12. Staff #4 had a Competency Checklist, which indicated nurse delegated training on Activities of Daily Living (ADLs), medication administration and treatments.

  Staff #1 said recently four people quit, the RN Director had hired three people and was working to get needs met. Staff #2 said the current schedule reflected enough staff to meet the needs of the tenants and they were hiring and training new staff to replace the staff that quit. Staff #3 said they were hiring and trying to get the hours covered.

  At the time of the investigation the nursing schedule showed full staffing capacity through 5-7-12. The schedule identified open shifts that staff could volunteer to pick up.

  Seven tenant interviews were held. The tenants said there was enough staff to meet their needs and they received all the cares expected. Tenants said staff responded promptly when they called for assistance.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #38931-C: It was alleged the Director did not respond when paged.

- Monitoring Observation: Staff #1 said she called the RN Director at various times and she always answered. She was available when called and responded to after hour calls. Staff #2 said the RN Director was available when called and responded to after hour calls every time when called. Staff #3 said the RN Director was available when called and responded to after hour calls.

  The RN Director said she responded when called and responded to calls after hours. She said there had been no complaints and she had responded to every call.

  The Nurse Coordinator (RN Director) job description indicated, he/she would take calls 24 hours a day and provide consultation to direct staff in emergency situations.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #38931-C: It was alleged there was one staff overnight and staff called 911 for assistance if a tenant fell.

- Monitoring Observation: Staff #1 said they assessed the situation, called 911 if needed, stayed with the tenant and if it was not an emergency situation they called another staff member. She said if a tenant fell and had pain, staff called 911. Staff #1 said probably one more staff member was needed on third to cover when there were two tenants' needs occurring simultaneously. Staff #2 said sometimes an extra person was needed on third shift. Staff #1 and Staff #2 did not work on the third shift. Staff #3 worked third shifts and said she knew of staff who had called 911 to come and help; although she had not done so. She said there was enough staff on third shift and she could also call another staff member who lived in town. Staff #3 said there was enough staff to meet the needs of the tenants.

  The RN Director said there had been no complaints about staffing on third shift. She said if a tenant had fallen and staff needed assistance, staff could call the Activity/Operations Director, otherwise staff could call 911. She said there had been one instance when 911 was called to get a tenant off the floor and she was not aware of any other instances since she had been there.

  Seven tenant interviews were held. The tenants said there was enough staff to meet their needs and they received all the cares expected. Tenants said staff responded promptly when they called for assistance.

  The Program's Staffing Policy indicated trained staff would be available at all times with staff awake while on duty during 24 hours per day to fully meet tenants identified needs.

- Regulatory Insufficiency: None noted.

C. Criteria for Admission and Retention

Complaint/Incident Allegation #38919-C; #38931-C; #38935-C: It was alleged tenants were high level of care for various reasons including frequent falls and some falls with pain, hospitalizations, seizures, inability to ambulate, dependence for all cares, incontinence and amount of time staff spent on tenant cares.

- Monitoring Observation: Nine tenant files were reviewed including one discharged tenant file.

  Tenant #2, a 93 year old, was admitted on 6-2-08 and diagnoses include: Congestive Heart Failure (CHF), Edema, Osteoporosis, Osteoarthritis and Dry Eyes. A Nurse Review dated 3-15-12 indicated Tenant #2 had increased generalized weakness and complained of left knee pain. An order was received for Physical Therapy (PT) to evaluate and treat. Tenant #2 required intermittent transfer assist to two. There was a discussion with family if PT determined they felt he/she could not be rehabilitated within 21 days they would have to start a 30 day discharge notice. A Nurse Review dated 3-19-12 indicated Tenant #2 had greatly improved and the need for assist of two had decreased. According to a Nurse Review dated 4-5-12, PT was discharged and the goals were met. According to a Nurse Review dated 4-27-12, Tenant #2 got dizzy and fell on 4-18-12. At the time of the fall there was no apparent injury and he/she was able to do range of motion. On 4-19-12 Tenant #2 reported his/her left hip hurt and Tenant #2 was taken to the Emergency Room (ER). Tenant #2 was admitted for dehydration, low blood pressure and pain. Tenant #2 had a hairline fracture in the right foot and required a walking shoe or boot. Tenant #2 received PT/Occupational Therapy (OT). According to a Nurse Review dated 5-2-12, PT was started on 5-1-12 for gait training, lower extremity strengthening and transfers, two to three times per week. Tenant #2 walked 30 feet with his/her walker and minimal assist. The Nurse Review indicated Tenant #2 moved very slowly, needed prompts to keep on track and staff would be patient with him/her. Staff was to encourage and offer fluids in between meals. The service plan dated 5-2-12 indicated Tenant #2 received assistance with bathing, hygiene and grooming, dressing, transferring and mobility, continence and medications. The service plan indicated Tenant #2 participated in various aspects of his/her cares and was not dependent for all cares. Tenant #2 required staff assistance with ADLs; however, did not receive maximal assistance with ADLs and did not exceed the level of care.

  Tenant #3, a 91 year old, was admitted on 9-21-09 and diagnoses include: Urinary Tract Infection (UTI), Colon Cancer, Subdural Hematoma, Pacemaker-Tachycardia, Corneal Transplants, Vertigo, Anemia, Arthritis and Insomnia. Tenant #3 was found on the floor on 3-3-12, twice on 3-21-12, 4-22-12 and on 4-26-12. The Incident/Unusual Occurrence Report dated 4-26-12 indicated at 12:00 a.m. staff did a bed check, opened the door and Tenant #3 was sitting on the floor by the kitchen. Tenant #3 said he/she had been sitting there for about 30 minutes, called for help and didn't get an answer. Tenant #3 was going to bed and mentioned that he/she hurt his/her finger. First aid was given, there were carpet burns to the forehead and nose, and a cold compress was applied. Tenant #3 refused ice for the finger and said his/her neck was a little sore. According to Resident Medical Follow Up, Tenant #3 was diagnosed with a Neck Sprain and x-rays were pending.

New orders included ice three times a day for three to seven days and APAP/Hydrocodone 5/325 0.5-1 tablet every four hours for pain. Nurse's Notes dated 4-27-12 indicated a cervical x-ray showed no fracture, just arthritis. Tenant #3 reported he/she did not really have pain, more like mild to moderate stiffness. Nurse's Notes dated 5-1-12 indicated Tenant #3 denied pain and reported neck stiffness much improved. The service plan dated 4-13-12 reflected Tenant #3 had a history of falls, had a non-slip protective covering on the bed, had a lift chair in the apartment and was able to manage per self. The service plan identified Tenant #3 also had an Ankle Foot Orthosis (AFO) brace on the right lower leg/foot and he/she used a wheeled walker. The service plan indicated Tenant #3 took himself/herself to the toilet and staff helped with perineal care. Tenant #3 was usually continent during the day and was incontinent at night. Tenant #3 used a commode at night and staff emptied the commode. The service plan indicated Tenant #3 had bowel problems in the past. Tenant #3 had falls; however none of the incident reports that were reviewed indicated Tenant #3 had a significant injury. Tenant #3 was incontinent at times; however, he/she did not have unmanageable incontinence and did not exceed the level of care.

Tenant #4, a 76 year old, was admitted on 5-18-11 and diagnoses include: Fractured Left Humerous Status Post Fall, History of Osteoarthritis, Kyphosis, Diabetes, Hypertension (HTN), High Cholesterol, Mild Cerebral Vascular Accident (CVA) and Cellulitis. The service plan dated 4-13-12 indicated Tenant #4 received assistance with bathing, grooming and hygiene, dressing transfers and mobility, continence and medication administration. The service plan indicated Tenant #4 participated in various aspects of his/her cares and was not dependent for all cares. Tenant #4 required staff assistance with ADLs; however, did not receive maximal assistance with ADLs and did not exceed the level of care.

Tenant #5, a 90 year old, was admitted on 2-22-11 and diagnoses include: CVA (2000), Anxiety, CHF, Appendectomy, Left Knee Surgery and Carotid Surgery. Tenant #5 was discharged on 4-7-12. A Nurse Review dated 3-19-12 indicated Tenant #5 was admitted to PT/OT with visits scheduled two to three times per week for three weeks. Tenant #5 had decreased endurance and he/she was to wear oxygen when ambulating. The edema was worse on the left leg which was 4+ and right leg was 3-4+. The left leg oozed a little bit of clear watery-like drainage. Physician orders were received to discontinue Amlodipine and start Zaroxolyn daily in the morning with Lasix. Tenant #5 walked part way to meals and ambulated independently in the apartment. A Nurse Review on 3-26-12 indicated Tenant #5 continued to have problems with fluid retention and bilateral lower leg edema. There was occasional weeping of fluid in the lower legs. Daily weights were ordered and were to be report weekly. Tenant #5 was short of breath with exertion and did not like to wear the oxygen as ordered. Tenant #5 fatigued easily, used a wheelchair to meals and ambulated in the apartment. The Nurse's Notes dated 4-4-12 indicated Tenant#5 had periods of increased confusion, felt very weak and was discharged from the home health nurse. An order was received for blood work and a Urinary Analysis (UA). Nurse's Notes dated 4-6-12 indicated Tenant #5 was very fatigued and had very poor endurance. The UA came back and appeared within normal limits. Lungs sounds were diminished and pedal edema was greater than 4+ on the left and 3+ to 4+ on the right. Tenant #5 had five falls since 3-31-12, according to the Nurse's Notes.

On 4-7-12 Tenant #5 was more confused, pocketing food and was not like himself/herself. Tenant #5 was taken to the ER and was admitted.

Tenant #5 went to the ER and returned the same day on 2-27-12 and on 3-16-12. Tenant #5 was not admitted for either of these ER visits. Tenant #5 went to the hospital on 3-8-12, was admitted and returned to the Program on 3-13-12. Tenant #5 was sent to the hospital on 4-7-12 and did not return to the Program. Tenant #5 did not have three or more significant hospitalizations in the past three months. Tenant #5's file reflected issues with edema, falls and breathing difficulties and interventions related to the concerns. Those interventions included PT/OT, a home health nurse, updates to the doctor with changes in status and medication and treatment orders. Tenant #5 was not medically unstable and did not exceed level of care. Tenant #5 was discharged on 4-7-12.

Tenant #6, an 88 year old, was admitted on 3-27-11 and diagnoses include: HTN, Dementia and Enlarged Heart. Tenant #6 was staged at a three on the Global Deterioration Scale (GDS), which indicated a mild cognitive decline. According to a Nurse Review dated 4-4-12, Tenant #6 had some increased incontinence and difficulty getting to the toilet on time. Staff had cleaned the bathroom floor and rugs. Tenant #6 had periods of increased confusion and tearfulness and had vomited once after lunch. The RN Director suspected a possible UTI and sent a fax to the doctor regarding the situation. An order for a UA was obtained, collected and sent to the lab. A result showed an abnormality and a new order was received for an antibiotic (ATB) to be given twice a day for seven days. Staff would prompt Tenant #6 to toilet before meals, at bedtime and encourage extra water and cranberry juice. Tenant #6 continued to ambulate with a walker. He/she walked frequently around the building and did go outdoors. Tenant #6 attended many of the activities and was very social. According to Tenant #6's service plan dated 4-4-12, Tenant #6 was independent in toileting, had urinary frequency and urgency and had a UTI. Staff was to monitor the bathroom floor and mop as needed. Staff was to encourage extra water and cranberry juice. Tenant #6 was independent in transferring and mobility and used a wheeled walker. According to the Nurse's Notes on 4-12-12 the signs and symptoms of the UTI were resolved and the ATB was completed. Staff was to continue to encourage fluids. Tenant #6 did not have unmanageable incontinence and did not exceed level of care.

Tenant #7, an 85 year old, was admitted on 12-16-11 and diagnoses include: History of Left Humerus Fracture and History of Right Shoulder Fracture. According to an Incident/Unusual Occurrence Report dated 4-5-12 at 8:00 p.m., Tenant #7 was talking to a staff member who was in Tenant #7's apartment but not within sight. The staff member heard a noise and looked around the corner and found Tenant #7 lying on the floor. Tenant #7 appeared confused while talking to the RN Director, did not realize he/she had fallen and did not realize he/she was lying on the floor while waiting for an ambulance. Tenant #7 was transported to the ER and was diagnosed with a UTI.

According to Nurse's Notes dated 4-6-12, Tenant #7 reported bruising on left lateral hip and reported discomfort. Tenant #7 continued to have a frequent harsh cough. Nurse's Notes on 4-12-12 indicated Tenant #7 continued to have a frequent, productive cough and complained of fatigue. On 4-13-12, an x-ray of the left hip and pelvis were negative for fracture.

On 4-15-12, Tenant #7 did not feel any better, continued to have a frequent, productive cough and reported the left hip had a shooting pain every time he/she coughed. On 4-16-12, Tenant #7 was transported to the hospital, admitted and diagnosed with Pneumonia. On 4-20-12, a third x-ray revealed a fractured tailbone in the sacral area. Tenant #7's service plans dated 3-8-12, 4-25-12 and 4-30-12 indicated he/she was independent in transfers and mobility and used a wheeled walker.

According to the Nurse's Notes on 4-27-12, a staff member reported she was in another tenant's room and heard someone yell out. She immediately started a room check and entered Tenant #7's apartment to find him/her breathing funny, fast and abnormal and foaming at the mouth and making a gurgling noise. Tenant #7's eyes were rolled back and he/she was not responding. The staff member called 911 for assistance. Tenant #7 was admitted to the hospital for observation and lab results indicated low Potassium. Tenant #7 returned to the Program on 4-30-12. According to a Nurse Review dated 4-30-12, Tenant #7 was admitted to the hospital on 4-27-12 with an episode of unresponsiveness. Labs indicated a low Potassium level. Tenant #7 was started on a Potassium supplement and would be seeing a neurologist to rule out seizure activity. Tenant #7 ambulated independently with a walker and had PT/OT as ordered by the doctor. According to the service plan dated 4-30-12, Tenant #7 was independent in transfers and mobility and used a wheeled walker. Tenant #7 did not exceed level of care.

Tenant #9, an 87 year old, was admitted on 7-22-10 and diagnoses include: Alzheimer's Disease, Heart Disease-Atrial Fibrillation, Breast Cancer with Left Mastectomy and Right Lumpectomy. Tenant #9 was staged at a six on the GDS, which indicated severe cognitive decline. According to the service plan dated 2-23-12, Tenant #9 ambulated to and from the dining room, toilet and bedroom with a wheeled walker. Staff was to walk with Tenant #9 and pulled the wheel chair behind. Tenant #9 could make it the whole way to the apartment. Tenant #9 was incontinent of bladder and was toileted every a.m., p.m., before meals, after meals and as needed. Protective undergarments were worn and a commode was in the bedroom and used in the morning. Staff was to complete perineal care after each incontinent episode. Staff encouraged and used hand over hand to get Tenant #9 started with eating. Sometimes staff fed him/her. Tenant #9 required staff assistance with ADLs; however, did not receive maximal assistance with ADLs and did not exceed level of care.

Staff #1, #3 and the RN Director identified Tenant #2 required significant cares and time of staff. Staff #2 identified Tenant #4 required significant cares and time of staff. Staff #3 said cares were completed for others and there were issues with the time spent. The RN Director said there had been no tenant or family complaints and she did not feel Tenant #2's care needs took away from others. The RN Director indicated Tenant #2's shower took approximately 45 minutes per day. Staff #1 said Tenant #2's whirlpool took 50 minutes and a shower took 15-45 minutes dependent on mood. Staff #2 said Tenant #2 had a sponge bath that took a minimum of 45 minutes and a shower took 1 hour. Staff #1, #3 and the RN Director did not identify any tenants who required a routine two-person assist, had unmanageable incontinence, were medically unstable or required maximal assistance with ADLs.

Review of tenant files, monitor observations, tenant interviews, staff interviews and the RN Director interview did not reveal any tenants that exceeded the level of care.

- Regulatory Insufficiency: None noted.

D. Service Plans

Complaint/Incident Allegation #38931-C: It was alleged a tenant required a brace and had not received the brace.

- Monitoring Observation: Nine tenant files were reviewed.

  Tenant #3's file was reviewed. Nurse's Notes dated 4-13-12 indicated PT/OT was completely done with visits and Tenant #3 had an AFO brace. Nurse's Notes dated 4-13-12 indicated the brace was taken to the orthotic company to make modifications. The service plan reflected the AFO brace on the right lower leg/foot. Tenant #3 was observed at the time of the investigation and had a brace on the right foot. The brace was received and was used.

  Tenant #8, a 71 year old, was admitted on 2-24-12 and diagnoses include: Nephrectomy 12-2-11, Lung Metastasis, Anemia, Coronary Artery Disease, Chronic Kidney Disease and CVA Right Sided Hemi Paresis. Tenant #8 received a prescription from his/her doctor on 4-13-12 for an AFO brace. The orthotic staff came that day to measure Tenant #8 for an AFO brace for the right ankle/foot drop. On 5-2-12, the RN Director called the orthotic company to check on the status of the brace for the right ankle/foot drop. The representative reported the company was in the process of fabricating the AFO brace at an out of town location and hoped it would be ready the next week. A brace was needed and was ordered.

- Regulatory Insufficiency: None noted.

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

- Monitoring Observation: Nine tenant files were reviewed.

  Tenant #3's file was reviewed. Nurse's Notes dated 4-13-12 indicated PT/OT was completely done with visits and Tenant #3 had an AFO brace. The service plan dated 4-13-12 indicated Tenant #3 was to start PT. The service plan did not reflect the discontinuation of the PT services. The service plan was not individualized to identify the needs and preferences for assistance

  The service plan indicated Tenant #3 took himself/herself to the toilet and staff helped with perineal care. Tenant #3 was usually continent during the day and was incontinent at night. Tenant #3 used a commode at night and staff emptied the commode. Staff #1 said staff had to strip Tenant #3's bed on a daily basis due to urinary incontinence. Staff #2 said staff changed Tenant #3's bed if wet. Staff #3 said Tenant #3 was incontinent of urine every day and was pretty wet in the morning.

The service plan indicated Tenant #3 had incontinence at night; however, the service plan did not reflect the need for bed changes due to urinary incontinence. The service plan was not individualized to identify the needs and preferences for assistance.

Tenant #5's file was reviewed. The service plan indicated the doctor ordered PT/OT and Tenant #5 had home health. The homecare nurse would discharge him/her from skilled visits on 4-4-12. The service plan did not indicate any specifics for the services to be provided by PT/OT and home health. The service plan was not individualized to identify the needs and preferences for assistance.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

E. Structural Requirements

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

- Monitoring Observation: According to the tenant list provided by the Program, there were 20 tenant apartments. Of the 20 tenant apartments, 19 apartments were occupied at the time of the investigation. It was observed the apartments did not have locks on the entrance doors. The private dwelling units did not have single-action, lockable entrance doors.

- Regulatory Insufficiency: Programs shall have private dwelling units with a single-action, lockable entrance door. (IAC r. 481-69.35(1)(c))