IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

**DEMAND LETTER**
**CERTIFIED**
**Complaint Intake #: 39758-I**

August 20, 2012

Ms. Alison Kapustka, Director
Windsor Manor Nevada
1642 South G Avenue
Nevada, IA 50201

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

Dear Ms. Kapustka:

**I. Final Complaint/Incident Investigation Report – Windsor Manor Nevada, Nevada, 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: Criteria for Exclusion of Tenants, Evaluation, Service Plan and Policies and Procedures.

**Windsor Manor Nevada** ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Program failed to comply with regulatory requirements. The non-compliance resulted in imminent danger or a substantial probability of resultant death or physical harm to a tenant. Program retained two tenants despite patterns of behavior which placed staff and tenants at risk for injury.

**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 to the State of Iowa 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.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on August 14, 2012, has been reviewed and will constitute the final POC related to the on-site visit of July 9 & 10, 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, 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 Complaint/Incident Investigation Report

**Assisted Living Program:**

Alison Kapustka, Director
Windsor Manor Nevada
1642 South G Ave.
Nevada, Iowa 50201

**Complaint/Incident Intake #:**

39758-I

**Date of Complaint/Incident Investigation:**

July 9 and 10, 2012

**Monitor(s):**

Maribeth Freland 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.

| General Population Program | |
|---|---|
| Number of tenants without cognitive disorder: | 26 |
| Number of tenants with cognitive disorder: | 2 |
| Total Population of Program at time of on-site | 28 |

| Dementia-Specific Program by Dedication | |
|---|---|
| Number of tenants without cognitive disorder: | 0 |
| Number of tenants with cognitive disorder: | 8 |
| Total Population of Program at time of on-site | 8 |
| **TOTAL census of Assisted Living Program** | 36 |

**Program History** – The certification visit of September 11, 2011 resulted in a regulatory insufficiency in the following area: Record Checks.

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

**A. Criteria for Admission and Retention**

Complaint/Incident Allegation: The program reported one tenant exhibited aggressive physical and sexual behaviors against staff members and was wandering into other tenant rooms disturbing personal belongings.

- Monitoring Observation: The monitor reviewed the program's incident reports from the previous three months, noting two tenants, Tenant #1 and Tenant #2 exhibited aggressive physical and/or sexual aggressiveness. The monitor interviewed multiple staff members, who identified Tenant #1 and Tenant #2 as being physically and/or sexually aggressive in the previous three months.

  Tenant #1, an 80 year old, was admitted to the program on 5-12-12 with diagnoses of: Coronary Artery Disease; Advanced Dementia; Hypertension (HTN); Atrial Fibrillation; Venous Insufficiency; Venous Stasis Dermatitis; Psychosis and Agitation. Tenant #1 resided in the program's secured memory care unit. Tenant #1 scored a 5 on the Global Deterioration Scale (GDS) completed on 5-9-12, 6-8-12, 6-28-12 and 7-2-12, indicating moderately severe cognitive decline.

  Prior to moving to the program on 5-13-12, Tenant #1 resided at another local dementia-specific assisted living program. As the assisted living program was dementia-specific by definition, the program had all exit doors located within the building secured. All exit doors were locked, requiring a code to be input to release

the door locks. Each door had a 15 second emergency egress bar that would emit an audible alarm when being pushed but would release the locks after 15 seconds. Each door had a Wander Guard system which sounded whenever a tenant wearing a Wander Guard device was in close proximity to the door when opened. Tenant #1 wore a Wander Guard device due to exit seeking behavior.

While residing at the other assisted living program, Tenant #1 frequently wandered into other tenant apartments disturbing personal belongings, made sexually inappropriate comments to staff members and female tenants on multiple occasions, exhibited inappropriate sexual touching of multiple staff members, exhibited inappropriate sexual touching of multiple female tenants, eloped from the program multiple times and became physically aggressive with a staff member while trying to redirect Tenant #1 back into the program on 4-1-12. The other assisted living program gave Tenant #1's legal representative an involuntary 30-day notice to discharge from the program on 4-12-12 citing behavioral reasons for the discharge. Tenant #1's legal representative contacted Windsor Manor Nevada seeking admission for Tenant #1 after receiving the involuntary discharge from the previous assisted living program.

The program's (Windsor Manor Nevada) Health Care Coordinator went to the previous assisted living program to conduct a pre-admission evaluation on 4-16-12. The Health Care Coordinator reported she completed a health, functional and cognitive assessment of Tenant #1 on 4-16-12 and reviewed three months of progress notes found in Tenant #1's clinical record and looked at the most current physician order sheet found in Tenant #1's clinical record. The progress notes included documentation of Tenant #1's wandering, "psychotic behaviors", previous sexual behaviors and one elopement attempt, which documented Tenant #1's aggressive physical behavior when a staff member attempted to redirect Tenant #1 back into the building. The Physician's Order Sheet, dated 3-27-12, included the diagnoses of psychosis and agitation.

The Health Care Coordinator returned to the previous assisted living program to conduct another pre-admission evaluation of Tenant #1's health, functional and cognitive status on 5-9-12, noting no changes on the evaluations. Tenant #1's clinical record now contained documentation of another elopement attempt on 5-5-12, during which Tenant #1 again became physically aggressive when staff members attempted to redirect Tenant #1 back into the building. Tenant #1 was discharged from the previous assisted living program on 5-12-12 and admitted to Windsor Manor Nevada on 5-12-12.

Tenant #1 moved into the program's secured memory care unit. The unit had one locked exit door that required a code to be entered to release the door lock, one locked exit door that had a 15 second emergency egress bar that would sound audibly when pushed for 15 seconds then release the lock and a padlocked gate which exited out of the enclosed courtyard outside of the unit.

Incident reports and progress notes documented the following:

a. On 5-16-12 Tenant #1 was "very aggressive" with Staff #1, universal worker (UW) causing Staff #1 to fear being hit by Tenant #1. Throughout the night,

Tenant #1 wandered into other tenant rooms disturbing personal belongings and repeatedly attempted to exit the memory care unit via the emergency door. Staff #1 notified the Health Care Coordinator to report Tenant #1's behaviors. The Health Care Coordinator gave suggestions to redirect and instructed Staff #1 to give an anti-anxiety medication ordered as needed for agitation.

b. On 5-21-12 during the early morning hours. Tenant #1 grabbed Staff #2, UW, from behind and threw her onto his/her bed face down. Tenant #1 attempted to pull Staff #2's pants down but was unsuccessful as the pants were tied around Staff #2's waist. Tenant #1 was making sexual comments during this encounter. Staff #2 was able to get away from Tenant #1 and was attempting to call for help on her mobile two-way radio when Tenant #1 again grabbed her and threw her up against Tenant #1's dresser. Staff #2 was again able to get away from Tenant #1 and successfully summoned assistance from staff members working in the general population area. Tenant #1 smiled and laughed through the entire incident. Staff #2 reported she did not call the Health Care Coordinator that night but filled out a communication report leaving the report on the Health Care Coordinator's desk. Staff #2 reported she completed an incident report in the afternoon of 5-21-12 after being instructed to do so by the Health Care Coordinator. The Health Care Coordinator contacted Tenant #1's legal representative and Tenant #1's physician on 5-22-12 to report Tenant #1's behavior. Law enforcement was not summoned.

c. On 5-26-12, Tenant #1 pushed a chair around the common area of the memory care unit. Tenant #1 pushed the chair repeatedly into other tenants. Staff attempted to intervene by stepping between the chair and other tenants. Tenant #1 responded by grabbing staff members in anger. When staff members attempted to remove the chair from Tenant #1's grasp, Tenant #1 pulled and pushed on the chair in an attempt to get the staff member to release the chair. Tenant #1 fell onto the floor during this interaction getting a skin tear to his/her elbow and a large bruise to the abdomen. Tenant #1 let go of the chair, stood up and grabbed a table and attempted to push the table around. Staff members held onto the other side of the table to prevent Tenant #1 from pushing the table. Tenant #1 grabbed, pushed and threatened staff members. Staff #3, UW, physically restrained Tenant #1 to prevent staff member and tenant injury. Law enforcement was sought and Tenant #1 was transported to the emergency room for medical evaluation of his/her behaviors. Staff #3 contacted the Health Care Coordinator via telephone to report Tenant #1's behaviors immediately and attempted to contact Tenant #1's legal representative multiple times with no answer.

The program allowed Tenant #1 to remain living at the program despite Tenant #1's pattern of behaviors which placed staff members and other tenants at risk for injury.

d. On 6-30-12, Tenant #1 was wandering into other tenant rooms. When Staff #4, UW, attempted to redirect Tenant #1, Tenant #1 punched Staff #4 in the jaw. Staff #4 did not contact the Health Care Coordinator. Staff #4 asked Staff #5, UW, to give Tenant #1 an anti-anxiety medication ordered as needed for agitation. Staff #4 completed an incident report and left the report on the Health Care Coordinator's desk. The Health Care Coordinator did not find the incident report until 7-2-12, at which time Tenant #1 was transported to the emergency room for medical evaluation of his/her behaviors. Tenant #1 was allowed to return to the

program with one-on-one supervision 24 hours daily. After conferencing with administration and Tenant #1's legal representative, Tenant #1's legal representative voluntarily agreed to find alternative placement for Tenant #1. Tenant #1 remained at the program with planned discharge from the program to a long term care facility on 7-12-12.

During interview, Staff #1 reported Tenant #1 frequently wandered into other tenant rooms disturbing personal belongings. On one occasion, Tenant #1 entered Tenant #3's room in the night, shaking Tenant #3 and awakening him/her.

During interview, Staff #2 reported Tenant #1 slept through the night for a few days then Tenant #1 began waking up during the night. Tenant #1 would pace and act in an agitated manner at times.

During interview, Staff #3 reported Tenant #1 was "quiet" for a couple of days. Then Tenant #1 began acting "hypersexual" and with physical aggression against staff members. Staff #3 reported Tenant #1 put his/her arms around Staff #3 and began rubbing his/her genitals against Staff #3 on the second or third night following admission to the program. Staff #3 reported Tenant #1 was frequently sexually suggestive in comments.

Written documentation and staff member interview indicated Tenant #1 was admitted to the program despite previous behaviors at another assisted living program which resulted in an involuntary discharge due to level of care issues. Within four days of admission, Tenant #1 began exhibiting similar behaviors while residing at Windsor Manor Nevada. Tenant #1 exhibited frequent wandering into other tenants' rooms disturbing personal belongings, exhibited sexual inappropriateness with staff members, attempted to elope from the memory care unit and became physically aggressive with staff members while residing at the program. The program retained Tenant #1 despite Tenant #1's patterns of behavior suggesting he/she no longer met the assisted living level of care.

Tenant #2, an 80 year old, was admitted to the program on 8-1-11 with the diagnosis of Dementia. Tenant #2 began hallucinating and exit-seeking following admission to the program, resulting in Tenant #2 moving into the program's secured memory care unit on 2-6-12. Tenant #2 scored a 4 on the GDS completed on 3-29-12, indicating moderate cognitive decline.

During interview, Staff #1, UW, reported Tenant #2 had hallucinations, exhibited frequent exit seeking behaviors and exhibited physical aggressiveness with staff members.

During interview, Staff #3, UW, reported Tenant #2 experienced hallucinations such as saw people lying on the floor dying and believed he/she had babies who were missing. Tenant #2 frequently exhibited exit-seeking behaviors which required a staff member calling 911 when unable to redirect Tenant #2. Tenant #2 once called 911 during one of his/her hallucinations, requiring staff members to keep phones out of Tenant #2's reach.

During interview, Staff #4, UW, reported Tenant #2's hallucinations and behaviors became progressively worse after moving to the memory care unit. Staff #4 reported Tenant #2 was "aggressive all the time", frequently agitated, pulled staff members' hair, grabbed staff members' wrists in anger and experienced exit seeking behaviors frequently. Tenant #2 would stand by the exit doors in the unit and cry "because no one would let her out."

During interview, Staff #6, UW, reported Tenant #2 frequently wandered the halls of the memory care unit "looking for kids." Tenant #2 was frequently agitated and angry- standing by the exit doors with arms crossed. Staff #6 reported Tenant #2 exhibited exit-seeking behavior and on one occasion Tenant #2 pulled her hair and twisted her wrist when she attempted to redirect Tenant#2 during an exit seeking incident.

Incident reports and progress notes documented the following:

a. On 12-6-11, Tenant #2 was noted to display increased dementia and exhibited paranoia at night.

b. On 2-5-12, Tenant #2 was noted to have an increase in wandering in the hallways, looking for babies and his/her "mom" and knocking on other tenant apartment doors to ask for help in locating mom and babies.

c. On 2-6-12, Tenant #2 was exit-seeking and agitated with staff member interference with leaving the building. Tenant #2 was moved into the secured memory care unit at this time.

d. On 2-24-12, Tenant #2 reported seeing dead people in his/her room. The Health Care Coordinator contacted Tenant #2's physician and obtained an order to initiate Seroquel, an anti-anxiety medication at bedtime.

e. On 3-8-12, Tenant #2 was looking for a baby that was missing.

f. On 3-31-12, Tenant #2 was taken to the front courtyard by staff members. Tenant #2 ran from staff members and tried to go around the building. Tenant #2 became agitated and refused to return into the building. Law enforcement was summoned to assist with Tenant #2's return to the building.

g. On 4-7-12, Tenant #2 was upset with staff members for not allowing him/her outside of the memory care unit. Tenant #2 repeatedly kicked the mechanical room door in anger for five continuous minutes. Tenant #2 picked up a set of keys and attempted to break the glass window exiting out of the unit unsuccessfully. Tenant #2 opened up the emergency door to exit but was redirected. Tenant #2 continued to be angry, yelling at staff members and once again attempted to leave the unit via the emergency exit. Law enforcement was summoned and Tenant #2 was taken to the emergency department for medical evaluation of his/her behaviors.

h. On 4-15-12, Tenant #2 grabbed Staff #4's hair, pulling hair from her head.

i. On 4-16-12, Tenant #2 was attempting to exit the unit via the emergency door. Staff #1, #3 and #4 responded to redirect Tenant #2 from leaving the unit. Tenant #2 grabbed Staff #1's wrists and refused to let go. After disengaging Tenant #2's hold on Staff #1, Tenant #2 picked up a glass coffee cup and repeatedly hit it against a window in an attempt to break the window for exit. Tenant #2 then picked up a chair and swung the chair across the room directed at Staff #4. Law enforcement was summoned and Tenant #2 was taken to the emergency department for medical evaluation of his/her behaviors. Following medical evaluation, Tenant #2 was placed in a long-term care facility directly from the hospital without ever returning to the assisted living program.

Tenant #2 began exhibiting hallucinations and paranoid behaviors not usually associated with dementia and exit-seeking behaviors. The program moved Tenant #2 into the secured memory care unit on 2-6-12. Documentation and staff member interview indicate Tenant #2's hallucinations escalated after moving to the unit. Tenant #2 became more agitated, becoming physically aggressive with staff members, attempted multiple times to elope from the memory care unit and exhibited labile emotions while living in the unit. Law enforcement was summoned on three separate occasions between 3-31-12 and 4-16-12. The program retained Tenant #2 for 6 weeks in the unit while Tenant #2 exhibited a pattern of behaviors which placed staff members and Tenant #2 at risk for injury.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: a. Is bed-bound; or b. Requires routine, two-person assistance with standing, transfer or evacuation; or c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk; or d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or e. Is under the age of 18; or f. Requires more than part-time intermittent health related care; or g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or h. Is medically unstable; or i. Requires maximal assistance with activities of daily living. (IAC r. 481-69.23(1))

During the course of the investigation, the monitor identified the following:

**B. Evaluation**

- Monitoring Observation: Tenant #1 moved into the program's secured memory care unit on 5-9-12.

  On 5-16-12 Tenant #1 was "very aggressive" with Staff #1, universal worker (UW) causing Staff #1 to fear being hit by Tenant #1. Throughout the night, Tenant #1 wandered into other tenant rooms disturbing personal belongings and repeatedly attempted to exit the memory care unit via the emergency door.

  On 5-21-12 during the early morning hours, Tenant #1 grabbed Staff #2, UW, from behind and threw her onto his/her bed face down. Tenant #1 attempted to pull

Staff #2's pants down but was unsuccessful as the pants were tied around Staff #2's waist. Tenant #1 was making sexual comments during this encounter. Staff #2 was able to get away from Tenant #1 and was attempting to call for help on her mobile two-way radio when Tenant #1 again grabbed her and threw her up against Tenant #1's dresser. Staff #2 was again able to get away from Tenant #1 and successfully summoned assistance from staff members working in the general population area. Tenant #1 smiled and laughed through the entire incident.

On 5-26-12, Tenant #1 pushed a chair around the common area of the memory care unit. Tenant #1 pushed the chair repeatedly into other tenants. Staff attempted to intervene by stepping between the chair and other tenants. Tenant #1 responded by grabbing staff members in anger. When staff members attempted to remove the chair from Tenant #1's grasp, Tenant #1 pulled and pushed on the chair in an attempt to get the staff member to release the chair. Tenant #1 fell onto the floor during this interaction getting a skin tear to his/her elbow and a large bruise to the abdomen. Tenant #1 let go of the chair, stood up and grabbed a table and attempted to push the table around. Staff members held onto the other side of the table to prevent Tenant #1 from pushing the table. Tenant #1 grabbed, pushed and threatened staff members. Staff #3, UW, physically restrained Tenant #1 to prevent staff member and tenant injury. Law enforcement was sought and Tenant #1 was transported to the emergency room for medical evaluation of his/her behaviors.

The Health Care Coordinator completed a 30-day evaluation of Tenant #1's health, functional and cognitive status on 6-8-12, noting none of Tenant #1's behaviors as described above.

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

**C. Service Plans**

- Monitoring Observation: Tenant #1 moved into the program's secured memory care unit on 5-9-12.

  On 5-16-12 Tenant #1 was "very aggressive" with Staff #1, universal worker (UW) causing Staff #1 to fear being hit by Tenant #1. Throughout the night, Tenant #1 wandered into other tenant rooms disturbing personal belongings and repeatedly attempted to exit the memory care unit via the emergency door.

  On 5-21-12 during the early morning hours, Tenant #1 grabbed Staff #2, UW, from behind and threw her onto his/her bed face down. Tenant #1 attempted to pull Staff #2's pants down but was unsuccessful as the pants were tied around Staff #2's waist.

Tenant #1 was making sexual comments during this encounter. Staff #2 was able to get away from Tenant #1 and was attempting to call for help on her mobile two-way radio when Tenant #1 again grabbed her and threw her up against Tenant #1's dresser. Staff #2 was again able to get away from Tenant #1 and successfully summoned assistance from staff members working in the general population area. Tenant #1 smiled and laughed through the entire incident.

On 5-26-12, Tenant #1 pushed a chair around the common area of the memory care unit. Tenant #1 pushed the chair repeatedly into other tenants. Staff attempted to intervene by stepping between the chair and other tenants. Tenant #1 responded by grabbing staff members in anger. When staff members attempted to remove the chair from Tenant #1's grasp, Tenant #1 pulled and pushed on the chair in an attempt to get the staff member to release the chair. Tenant #1 fell onto the floor during this interaction getting a skin tear to his/her elbow and a large bruise to the abdomen. Tenant #1 let go of the chair, stood up and grabbed a table and attempted to push the table around. Staff members held onto the other side of the table to prevent Tenant #1 from pushing the table. Tenant #1 grabbed, pushed and threatened staff members. Staff #3, UW, physically restrained Tenant #1 to prevent staff member and tenant injury. Law enforcement was sought and Tenant #1 was transported to the emergency room for medical evaluation of his/her behaviors.

The Health Care Coordinator updated Tenant #1's service plan on 6-8-12, without addressing Tenant #1's behaviors as described above and without giving direction to staff members on how to deal with Tenant #1's behaviors as they occur.

- 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))

**D. Policies and Procedures**

- Monitoring Observation: The program's policy, titled Personal Care Services and revised on 12-14-09, directed staff members to immediately notify the Nurse/Manager if a tenant became ill, fell, exhibited abnormal behavior or in the event of any unusual occurrence.

  On 5-21-12 during the early morning hours, Tenant #1 grabbed Staff #2, UW, from behind and threw her onto his/her bed face down. Tenant #1 attempted to pull Staff #2's pants down but was unsuccessful as the pants were tied around Staff #2's waist. Tenant #1 was making sexual comments during this encounter. Staff #2 was able to get away from Tenant #1 and was attempting to call for help on her mobile two-way radio when Tenant #1 again grabbed her and threw her up against Tenant #1's dresser. Staff #2 was again able to get away from Tenant #1 and successfully summoned assistance from staff members working in the general population area. Tenant #1 smiled and laughed through the entire incident. Staff #2 reported she did not call the Health Care Coordinator that night but filled out a communication report

leaving the report on the Health Care Coordinator's desk. Staff #2 reported she completed an incident report in the afternoon of 5-21-12 after being instructed to by the Health Care Coordinator. The Health Care Coordinator contacted Tenant #1's legal representative and Tenant #1's physician on 5-22-12 to report Tenant #1's behavior. Law enforcement was not summoned.

On 6-30-12, Tenant #1 was wondering into other tenant rooms. When Staff #4, UW, attempted to redirect Tenant #1, Tenant #1 punched Staff #4 in the jaw. Staff #4 did not contact the Health Care Coordinator. Staff #4 asked Staff #5, UW, to give Tenant #1 an anti-anxiety medication ordered as needed for agitation. Staff #4 completed an incident report and left the report on the Health Care Coordinator's desk. The Health Care Coordinator did not find the incident report until 7-2-12, at which time Tenant #1 was transported to the emergency room for medical evaluation of his/her behaviors.

- 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 the program. (IAC r. 481-67.2)