IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 40045-I

October 18, 2012

Ms. Nichole Will, Director
Country Manor
900 W. 46th Street
Davenport, IA 52006

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

Dear Ms. Will:

I. Final Complaint/Incident Investigation Report – Country Manor, Davenport, 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: Evaluation, Criteria for Admission and Retention, Service Plans, Policies and Procedures, Staffing, Compliance with POC, and Structural Requirements.

Country Manor is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program's continued failure (or refusal) to comply with regulatory requirements within the prescribed time frame established has a direct relationship to the health, safety, or security of tenants. The program failed to follow policies and procedures as identified by the onsite completed on August 22 & 23, 2012.

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

ADMINISTRATION (515) 281-5457 FAX: (515) 242-6863
ADMINISTRATIVE HEARINGS (515) 281-6468 FAX: (515) 281-4477
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INVESTIGATIONS (515) 281-5714 FAX: (515) 242-6507
Telephone Number for the Hearing Impaired: (515) 242-6515

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 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 October 5, 2012, has been reviewed and will constitute the final POC related to the on-site visit of August 22 and 23, 2012.

The Request for Reconsideration regarding Policy and Procedure has been denied. Exits to the courtyard may not be required exits for egress according to the State Fire Marshal but are doors that lead to the outside and must be alarmed in dementia specific programs. The Request for Reconsideration regarding staffing has been denied due to staff failing to meet the tenants' needs: specifically, Tenant #1, a wandering tenant, who eloped from the program on two occasions. The Request for Reconsideration regarding compliance with POC has been denied. The program is required to continue to follow the plan of correction and prevent reoccurrence of regulatory insufficiencies as compliance with POC doesn't expire. The Request for Reconsideration regarding structural has been denied. Courtyard doors are exits that lead to the exterior of the building even though they are not classified as required exits for egress according to the State Fire Marshal. If locks are applied to a courtyard gate, all staff are required to have the ability to open the locks for the safety of the tenants.

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: **Complaint/Incident Intake #: 40045-I**

Nichole Will, Director
Country Manor
900 W. 46th Street
Davenport, IA 52006

Date of Complaint/Incident Investigation:

August 22 and 23, 2012

Monitor(s):

Hal Chase, RN BSN MPH
Lori Miner, RN BSN

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 Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	25
Total Population of Program at time of on-site	26
TOTAL census of Assisted Living Program	26

Program History – The program received regulatory insufficiencies in the areas of: Policy and Procedure, Medications, Food Service, Life Safety and Transportation during this certification period.

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

A. Evaluation

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1, a 73 year-old, was admitted on 6-20-12 and had diagnoses of: Manganese Toxicity Dementia, Hiatal Hernia, Gastroesophageal Reflux Disease (GERD), Arthritis, and Hypothyroidism. Tenant #1 scored 18 of 30 on the Mini Mental State Examination (MMSE), which indicated moderate cognitive impairment.

  Tenant #1, who had been living at home with a spouse, was admitted to the hospital on 6-18-12 for treatment of behavior, aggression and psychosis. The spouse reported Tenant #1 had become unruly in the evenings and was trying to go outside to feed the cows when cows were no longer present. A hospital history and physical preliminary report dated 6-19-12 indicated Tenant #1's spouse reported Tenant #1 wandered outside, was agitated and was looking for the cows. Tenant #1 was discharged from the hospital and admitted to the Program on 6-20-12.

  Functional, cognitive, and health evaluations were completed on 6-20-12, but did not reflect the known history of behavior, aggression and psychosis. An elopement risk assessment of 6-20-12 indicated a score of 10, which indicated elopement risk. A Global Deterioration Scale (GDS) done twice, both without a date of completion or signature, indicated Tenant #1 presented impairments in stage three, four and five, but no conclusion as to Tenant #1's GDS stage could be determined.

Tenant #1 eloped from the Program's courtyard on 6-21-12 and 7-23-12. A functional evaluation was completed on 6-21-12 following the elopement, but the evaluation did not reflect Tenant #1's elopement. Functional, cognitive and health evaluations were not completed within 30-days of admission and were not completed following the elopement of 7-23-12 when a change in condition existed.

Tenant #2, an 85 year old, was admitted on 3-25-04 and had diagnoses of: Hypercholesteremia, Alzheimer's Disease, Degenerative Joint Disease (DJD), Emphysema, Hypertension (HTN), Hyperlipidemia and Basal Cell Carcinoma. Nurse's notes of 8-20-12 indicated Tenant #2 received a black eye during the night by either rolling over and laying on Tenant #2's fist or by hitting the side rails on the bed. Tenant #2 was taken to the emergency room and returned with instructions to treat for a facial contusion. Functional, cognitive and health evaluations were not completed to reflect the injury to the eye and the use of bed side rails.

Tenant #3, a 79 year-old, was admitted on 7-19-12 and had diagnoses of: Picks Disease, Frontal Lobe Dementia, Hypotension, Chronic Obstructive pulmonary Disease, and Chronic Anemia. Tenant #3 was staged at five on the GDS which indicated moderately severe cognitive decline. Cognitive and health evaluations were not completed within 30 days of admission.

Tenant #4, a 97 year-old, was admitted on 8-22-12 and had diagnoses of: Dementia, Hypothyroidism, GERD, HTN, and Psoriasis. Tenant #4 scored 17 of 30 on the MMSE which indicated moderate cognitive impairment. Tenant #4 was admitted from a skilled care unit. Documentation from the skilled unit indicated Tenant #4 could only see shadows and needed set-up and supervision with meals. A dietitian documented Tenant #4 had shown weight loss and was on nutritional supplements. The Program health assessment indicated Tenant #4 preferred a bedtime snack. A medical history dated 4-11-12 revealed Tenant #4 frequently needed redirection from scratching psoriatic lesions on the skin. Functional, cognitive and health evaluations dated 8-22-12 were not completed to reflect limited vision, needed set-up and supervision with meals.

Tenant #5, a 90 year-old, was admitted on 1-21-11 and had diagnoses of: Macular Degeneration, HTN, Osteopenia, and Osteoporosis. Tenant #5 was staged at four on the GDS which indicated moderate cognitive decline. The Program indicated Tenant #5 wandered throughout the Program and the courtyard. Functional, cognitive and health evaluations completed on 3-23-12 and 6-18-12 did not reflect the known history of wandering, confusion and agitation.

Tenant #6, a 64 year-old, was admitted on 5-2-11and had diagnoses of: GERD, B 12 Deficiency, History of Melanoma, Scoliosis with Chronic Back Pain, recurrent Deep Vein Thrombosis. Tenant #6 was staged at five on the GDS which indicated moderately severe cognitive decline. A fax to the physician dated 6-26-12 indicated Tenant #6 was refusing all medication and verbalized wanting to die, and was noted to be depressed. A 90-day nurse review dated 7-5-12 indicated Tenant #6 had episodes of depression and would rather stay in bed and sleep. The program did not complete a functional, cognitive and health evaluation with a change in condition.

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

B. Criteria for Admission and Retention

Complaint/Incident Allegation: The Program reported Tenant #1 eloped on 7-23-12.

- Monitoring Observation: Tenant #1, who had been living at home with a spouse, was admitted to the hospital on 6-18-12 for treatment of behavior, aggression and psychosis. The spouse reported Tenant #1 had become unruly in the evenings and was trying to go outside to feed the cows, when cows were no longer present. A hospital history and physical preliminary report dated 6-19-12 indicated Tenant #1's spouse reported Tenant #1 wandered outside, was agitated and was looking for the cows. Tenant #1 was discharged from the hospital and admitted to the Program on 6-20-12. Functional, cognitive, and health evaluations were completed on 6-20-12. The Program also completed an elopement risk form. Tenant #1 received a score of 10 which indicated elopement risk.

  On 6-21-12, the day after admission, Tenant #1 eloped from the Program. According to Staff #1, she was sitting in the kitchen of Building A assisting tenants with an activity. Tenant #1 and another tenant were sitting outside in the courtyard. Staff #1 observed the tenants in the courtyard through the window. The Activity Director was reported to be in and out between buildings passing out root beer floats. The Activity Director asked Staff #1 as to the whereabouts of Tenant #1. The missing tenant procedure was initiated. Another tenant indicated Tenant #1 was going to jump the fence to get out. The police were called. Tenant #1 was found by the police at the corner of 53rd Street and Division, approximately one mile from the Program. Tenant #1 returned to the Program without injuries. Staff #1 stated Tenant #1 was gone 45 minutes. The Program reported the incident to the department on 6-21-12 and the incident was not investigated.

  According to the State Climatologist the weather conditions at the Davenport Airport on 6-21-12 at 2:00 p.m. were a temperature of 82 degrees with a heat index of 82 degrees. Wind was 14 miles per hour (mph) with gusts to 20 mph. The skies were partly cloudy with no rain. The weather conditions were similar the hour before and the hour after. Staff #1 reported Tenant #1 was dressed in a shirt, jeans, and cowboy boots.

  Upon Tenant #1's return to the Program, staff was assigned to be with Tenant #1, one-to one, and a sitter was hired. On 6-25-12, the physician ordered Seroquel 50 milligrams (mg) every hour as needed not to exceed 800 mg in 24 hours.

Nurses notes of 7-2-12 documented Tenant #1 had been taking Seroquel every two hours throughout the day. Tenant #1 was reported to be less anxious and more content. The Program was keeping Tenant #1 busy with activities. One-to-one supervision with a sitter was discontinued on 7-2-12, but staff members continued to observe Tenant #1.

According to the Program nurse, on 7-23-12, during the change of shift at approximately 3:00 p.m., Tenant #1 was observed by a staff member sitting on a couch in the living room in Building A. The staff member went to the medication room for change of shift counts. The staff member returned to the living room and Tenant #1 was gone. The nurse reported she believed the door to the courtyard was propped open so that fresh air would flow into the living room. The missing tenant procedure was begun and the police were notified. Tenant #1 was found a few blocks from the Program. Tenant #1 was gone from the Program approximately 20 minutes. Tenant #1 was returned to the Program, diaphoretic, but without injuries. Tenant #1 reported trying to go home to milk cows. Tenant #1 demonstrated to staff that he/she had gone over the fence in the courtyard by using the brick ledge on the side of the building at the corner to step up and go over the fence. Eight-foot fencing panels have been ordered for all corners of the building. A medic alert bracelet with Tenant #1's name and the address of the Program was ordered. Tenant #1 was seen by a physician on 7-24-12. Nurse's notes documented Tenant #1 could be drugged up or the Program would continue to work with Tenant #1 until Tenant #1stopped having the desire to leave.

According to the State Climatologist the weather conditions at the Davenport Airport on 7-23-12 at 3 p.m. were a temperature of 98 degrees with a heat index of 102 degrees. There was a west wind at 8 mph and the skies were clear. At 4 p.m. the temperature was 99 degrees with a heat index of 104 degrees.

The Program appropriately reported the elopements to the department.

Tenant #1 was admitted from home to hospital to the Program with a history of wandering. Tenant #1 eloped from the Program on 6-21-12, the day after admission. Tenant #1 was reported to have climbed the fence in the courtyard. After the first elopement, the Program instituted one-to-one observation, received an order for Seroquel, and began an intense activity program. Despite interventions, Tenant #1 eloped by climbing the fence on 7-23-12. The physician was reported to give options of sedation or working with Tenant #1 until the desire to leave was gone.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression. (IAC r. 481-69.23(1)(c)(1))

C. Service Plans

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1, who had been living at home with a spouse, was admitted to the hospital on 6-18-12 for treatment of behavior, aggression and psychosis. The spouse reported Tenant #1 had become unruly in the evenings and was trying to go outside to feed the cows, when cows were no longer present. A hospital history and physical preliminary report dated 6-19-12 indicated Tenant #1's spouse reported Tenant #1 wandered outside, was agitated and was looking for the cows. Tenant #1 was discharged from the hospital, and admitted to the Program on 6-20-12. Functional, cognitive, and health evaluations were completed on 6-20-12. The Program also completed an elopement risk form. Tenant #1 received a score of 10 which indicated elopement risk. The service plan dated 6-20-12 did not identify interventions related to elopement risk.

  The service plan was updated on 6-21-12 and 7-23-12 to reflect interventions when Tenant #1 had increased agitation but did not establish interventions related to elopement. Service plans of 6-21-12 and 7-23-12 were not supported by evaluations.

  Tenant #2 was reported to have a black eye on 8-20-12. According to nurse's notes Tenant #2 received the black eye during the night by either rolling over and laying on Tenant #2's fist or by hitting the side rails on the bed. Tenant #2 was taken to the emergency room and returned with instructions to follow following a facial contusion. The service plan was updated on 8-20-12 and indicated Tenant #2's eye was bruised, was seen in the hospital emergency room, but did not include interventions related to the use of bedrails the protection from further injury. The service plan of 8-20-12 was not supported by evaluations.

  Tenant #3 was admitted to the hospital on 7-18-12 for evaluation for program placement. Tenant #3 had been living at home but was confused and had wandering behavior. The family was no longer able to take care of Tenant #3 because of the wandering behavior. Tenant #3 was admitted to the Program on 7-19-12. On 7-27-12, nurse's notes described an incident in the courtyard with Tenant #3. Tenant #3 was standing against the building holding onto the fence. Tenant #3 swung at staff, and was unable to be redirected. Tenant #3 crawled behind the bushes along the fence. Tenant #3's family was called and upon arrival stated Tenant #3 did this from time to time, but family did not say anything for fear Tenant #3 would not be able to stay at the Program. Tenant #3 allowed staff members to assist Tenant #3 into a wheelchair as Tenant #3 was refusing to stand or walk. The service plan was not updated to include interventions for behavior or wandering.

  Tenant #4 was admitted from a skilled care unit. Documentation from the skilled unit indicated Tenant #4 could only see shadows and needed set-up and supervision with meals. A dietitian documented Tenant #4 had shown weight loss and was on nutritional supplements. The Program health assessment indicated Tenant #4 preferred a bedtime snack. A medical history dated 4-11-12 revealed Tenant #4 frequently needed redirection from scratching psoriatic lesions on the skin. The service plan did not identify interventions for limited vision, supplements or bedtime snacks, or scratching.

Tenant #5 was identified as someone who wanders. Nurse's notes dated 7-17-12 revealed Tenant #5 was more confused and agitated. The service plan dated 2-27-12 did not did not reflect interventions related to wandering, confusion and agitation.

Tenant #6, a 64 year-old, was admitted on 5-2-11and had diagnoses of: GERD, B 12 Deficiency, History of Melanoma, Scoliosis with Chronic Back Pain, recurrent Deep Vein Thrombosis. Tenant #6 was staged at five on the GDS which indicated moderately severe cognitive decline. A fax to the physician dated 6-26-12 indicated Tenant #6 was refusing all medication and verbalized wanting to die, and was noted to be depressed. A 90-day nurse review dated 7-5-12 indicated Tenant #6 had episodes of depression and would rather stay in bed and sleep. The service plan dated 10-31-11 was not updated to include interventions for depression, medication refusal, and a statement of wanting to die.

- 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 service 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)

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

D. Policies and Procedures

During the course of the investigation, the following was noted:

- Monitoring Observation: Country Manor was noted to be two, long rectangular buildings, each with two sides, A and B; C and D. The buildings sat parallel to each other. A fence approximately five feet high extended from each end of each building. Fencing was also run perpendicular to make a courtyard. The courtyard was approximately 100 feet wide by 300 feet long. There were two gates locked with a chain and padlock. The doors that went from the buildings to the courtyard had chimes that sounded when the doors were opened.

  A review of the Program's policy and procedure for alarmed doors indicated staff members would respond immediately to door alarm signals to exit doors. The Administrator referred to an exit door as those doors leaving the building and going to the outside. The courtyard doors were specifically identified in the policy as not being alarmed exit doors.

  Iowa Code 69.32(2) requires an operating alarm system be connected to each exit door in a dementia-specific assisted living program. The Program had alarms attached to the doors leading from the building to the courtyard. The Program's policy for alarmed exit doors did not meet the minimum standard when the policy did not identify doors to the courtyard as alarmed exit doors.

- 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. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)

E. Staffing

- Monitoring Observation: The Administrator reported staff members usually did not respond when doors to the courtyard chimed. Staff #1 reported doors to the courtyard have chimes and each chime is different. Staff #1 reported trying to look out windows when a chime sounded, but that she could not check the courtyard when she was assisting other tenants such as toileting. Staff #1 reported the courtyard was safe. Staff #2 reported the doors to the courtyard doors have chimes to notify staff the door has been opened but not all staff checks to see what tenant has gone into the courtyard. Staff #2 reported the courtyard was safe and tenants were allowed to wander in and out at will. The Activity Director stated when doors to the courtyard chimed staff don't always go to look and see the door or which tenant came in or went out. The Activity Director reported when doors leading outside, other than the courtyard, the doors were checked immediately. The Activity Director also reported tenants don't need staff assistance when outside in the courtyard.

  The Program was contained in two buildings. Each building had two sides-a total of four distinct areas, A, B, C, and D. The Program reported one staff member was assigned to each area for each shift. An additional "float" staff member was available on the day and evening shifts. The Program indicated there were 26 tenants and 10 of those tenants wandered throughout the Program.

  Tenant #1 eloped from the Program on two occasions. Both times, Tenant #1 left by climbing the fence. Tenant #1 was unattended in the courtyard.

  Staff members did not respond to alarms on the doors leading to the courtyard. Tenants were left unattended in the courtyard.

- 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))

- Regulatory Insufficiency: All staff shall be able to implement the accident, fire safety, and emergency procedures. (IAC r. 481-67.9(2))

F. Compliance with Plan of Correction

During the course of the investigation, the following was noted:

- Monitoring Observation: A monitoring visit was completed on March 6, 2012. The monitoring report documented three instances of a monitor exiting a door into the courtyard and no staff response. The Program was cited under Policies and Procedures. The Program submitted a plan of correction dated 4-2-12 indicated all personnel would be trained in response to alarmed exit door signaling.

During this monitoring visit staff identified the courtyard as a safe area and stated they did not always check the courtyard doors when they alarmed.

The Program did not demonstrate compliance with the plan of correction.

- Regulatory Insufficiency: Within 10 working days following receipt of the preliminary report, the program shall submit a plan of correction to the department. (a) The plan of correction shall include: elements detailing how the program will correct each regulatory insufficiency, what measures will be taken to ensure the problem does not recur, how the program plans to monitor performance to ensure compliance, and any other required information. (IAC r. 481-67.10(5)(a))

G. Structural Requirements

During the course of the investigation, the following was noted:

- Monitoring Observation: A tour of the courtyard was taken with the Administrator. There were two gates leaving the courtyard, both secured with a padlock. Key rings of the five staff members on duty were observed. Only one of the five members had a key to the courtyard gate. The Administrator was notified and padlock keys were placed on the key rings during the onsite visit.

- Regulatory Insufficiency: A program serving persons with cognitive impairment or dementia, whether in a general or dementia-specific setting, shall have the means to disable or remove the lock on an entrance door and shall disable or remove the lock if its presence presents a danger to the health and safety of the tenant. (IAC r. 481-69.35(1)(d))