IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED

Complaint/Incident Intake #: 40635-C

November 15, 2012

Ms. Carla Popp, Director of Memory Care
Senior Star at Elmore Place ALPD
4504 Elmore Avenue
Davenport, IA 52807

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

Dear Ms. Popp:

I. Final Complaint/Incident Investigation Report – Senior Star at Elmore Place ALPD, 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, Tenant Documents, Service Plans and Structural Requirements. **Senior Star at Elmore Place ALPD** ("Program") is being assessed a $3,000 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 to

the State of Iowa in the amount of one thousand nine hundred and fifty dollars ($1950) 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 $3,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on October 30, 2012, has been reviewed and will constitute the final POC related to the on-site visit of September 19, 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: **Complaint/Incident Intake #:** 40635-C

Carla Popp, Director of Memory Care
Senior Star at Elmore Place ALPD
4504 Elmore Avenue
Davenport, IA 52807

Date of Complaint/Incident Investigation:

September 19, 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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	20
Total Population of Program at time of on-site	21
TOTAL census of Assisted Living Program	21

Program History – The program received Regulatory Insufficiencies in the area of Dementia Specific Education, Nurse Review, Service Plan, Evaluation, Criteria for Retention and Admission, Program Reporting, and Policies and Procedures 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: It was alleged there were inappropriate behaviors between tenants.

- Monitoring Observation: Eight tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7 and #8).

  Tenant #1, a 90 year old, was admitted on 2-21-12 and diagnoses include: Dementia, Cataract Removed Right Eye, Past History of Heart Attack and Angioplasty and Edema. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline.

  Tenant #2, an 85 year old, was admitted on 1-14-11 and diagnoses include: Hip Fracture, Lewy Body Dementia, Anxiety, Hypothyroidism and Osteoporosis. Tenant #2 was staged at a four on the GDS, which indicated moderate cognitive decline.

  According to Incident Report Forms and Incident Witness Statements on 9-14-12 at 3:15 p.m., Tenant #1 was standing beside Tenant #2 in the family room. Tenant #2, who was in a wheelchair, was facing toward the television. Tenant #1's pants were down around the ankles and Tenant #1's genitalia were exposed. Tenant #1's belt was unbuckled and pants were unzipped. Staff immediately pulled Tenant #1's pants up and asked Tenant #1 what Tenant #1 was doing. Tenant #1 said Tenant #1 was trying to have sex. Tenant #1 was immediately removed from the family room and taken to Tenant #1's apartment by staff. Tenant #2 was not visibly upset.

There were other tenants in the family room at that time. The Director and the Charge Nurse were notified. Tenant #1 and Tenant #2's family and physicians were notified.

The Charge Nurse said there was no physical contact and there was no harm to Tenant #2. She said there had been no subsequent reported incidents.

Tenant #1's service plan was updated on 9-17-12 and reflected Tenant #1 had shown sexual behaviors once towards a tenant on 9-14-12. Tenant #1 was to be redirected and shown to another area in the building. Tenant #1 was on 30 minute rounds for monitoring and was stationed on the other side of the building near tenants of the same gender. Tenant #1 responded easily to redirection and staff was to notify the Director of any incidents for further investigation and follow up.

Tenant #1's service plan was updated, Tenant #1 was put on 30 minute checks and incident reports were completed for Tenant #1 and Tenant #2 related to the incident.

Tenant #4, an 87 year old, was admitted on 8-13-12 and diagnoses include: Dementia and Bell's Palsy. Tenant #4 was staged at a four on the GDS, which indicated moderate cognitive decline.

Tenant #5, an 80 year old, was admitted on 3-14-12 and had a diagnosis of Alzheimer's Disease. Tenant #5 was staged at a six on the GDS, which indicated severe cognitive decline.

According to a Program investigation, on 8-22-12 at approximately 6:30 p.m. Staff #1 noticed Tenant #4 appeared to be "messing with" Tenant #5's shirt in the dining room. Tenant #5 was sleeping per staff reports. Staff #1 asked Tenant #4 what Tenant #4 was doing and Tenant #4 said "nothing." Staff #1 said all of Tenant #5's buttons on the shirt were unbuttoned except two. Staff #1 buttoned Tenant #5's shirt and asked Tenant #4 to go to the living room area. Tenant #5 was left sleeping in the chair of the dining room. Staff #2 said Staff #1 reported to her Tenant #4 was "unbuttoning" Tenant #5's shirt and Staff #2 later documented that in Tenant #4's record. Staff #2 made sure that Tenant #4 was in the other room and Tenant #5 was safe. An incident report was not completed because it did not appear they had enough information because no one directly observed what specifically happened. Tenant #5 had a history of unbuttoning Tenant #5's shirt on a regular basis. Tenant #5 also had a history of sleeping a lot during the day due to basically having days and nights confused. The rationale for not completing the incident report was that no one knew what happened and Tenant #4 might have been trying to button the shirt up or trying to close it for Tenant #5. Tenant #4 had no history of inappropriate behavior towards female tenants. Tenant #5 routinely tried to undress in and around the Program. There had been no further incidents of that type witnessed by any staff involving Tenant #4. Tenant #5 continued to unbutton Tenant #5's shirt on occasion and staff had been encouraging Tenant #5 to wear tee shirts rather than shirts with buttons. Staff had been made aware of the situation and had been instructed to inform administrative staff if there were any further occurrences.

Staff #1 indicated she was working and noticed Tenant #4 and Tenant #5 sitting next to each other and Tenant #5 appeared to be sleeping, while Tenant #4 was "messing with" Tenant #5's shirt. When she walked over to them, Tenant #5 had two buttons on the shirt buttoned and the rest was unbuttoned. Staff #1 asked what Tenant #4 was doing but Tenant #4 said nothing. She asked Tenant #4 to go into the living room with her and Tenant #4 agreed. She was not sure if Tenant #5's shirt was already unbuttoned or not.

The Director indicated there had been no subsequent incidents with Tenant #4 and Tenant #5.

An incident report was not completed because it did not appear they had enough information because no one directly observed what specifically happened between Tenant #4 and #5.

The Program's Accident/Incident Report policy indicated the Program would document events involving a tenant, staff or visitor. Written reports of any significant incident affecting the mental/physical condition/stability of any person would be maintained.

Review of tenant files, incident reports and interviews indicated there had been behaviors or incidents between tenants. Incident reports were completed as needed regarding the incident with Tenant #1 and Tenant #2. The Program provided an explanation as to why incident reports were not required related to the situation with Tenant #4 and Tenant #5.

- Regulatory Insufficiency: None noted.

B. Evaluation

Complaint/Incident Allegation: It was alleged evaluations were not completed appropriately.

- Monitoring Observation: Eight tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7 and #8).

  Tenant #2's file was reviewed. Nurse's Notes from 8-5-12 through 9-17-12, indicated Tenant #2 had increased anxiety, increased confusion noted with occasional hallucinations, Tenant #2 argued with staff, became angry, had a choking episode and had an episode of high anxiety with paranoia and hallucinations. On 8-25-12 Tenant #2 was found on rounds with legs hanging off bed and when attempted to reposition staff observed Tenant #2's arm was stuck in railing. Tenant #2 complained of pain all over Tenant #2's body. As needed Vicodin was given, Tenant #2 was repositioned and pillows were placed between Tenant #2 and the railing. Staff was educated on pillow placement for safety. Evaluations were not completed as needed.

Tenant #3, a 91 year old, was admitted on 8-30-12 and diagnoses include: Alzheimer's, Dementia, Hypertension, Benign Prostate Hypertrophy, Anxiety, Ataxia and Short Term Memory Loss. Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. A Mini Mental Status Examination (MMSE) was dated 8-17-12; however, was not signed by the person who completed the evaluation. Health and functional evaluations were completed; however, were not dated or signed by the person who completed the evaluations. The Charge Nurse indicated the Director completed the evaluations; however, the evaluations were not signed. A physician completed a Health History and Physical form dated 8-21-12. A GDS was completed on 8-30-12; however it was completed by the Charge Nurse, a licensed practical nurse (LPN). Functional and cognitive evaluations were not completed prior to taking occupancy.

Tenant #4's file was reviewed. Tenant #4 did not have cognitive, health and functional evaluations completed within 30 days of taking occupancy.

Tenant #5's file was reviewed. Nurse's Notes from 5-2-12 through 9-12-12 indicated Tenant #5 had continued anxiety, yelling and crying. On 6-3-12 Tenant #5 was extremely agitated, yelling and had swallowed non-toxic paint. On 6-13-12 Tenant #5 attempted to follow tenants of the opposite sex into the tenants' room. On 8-14-12 Tenant #5 was undressing in dining room and was resistant with staff attempting to redress. On 8-18-12 Tenant #5 had possible ingestion of hand sanitizer. Evaluations were not completed as needed.

Tenant #6, an 81 year old, was admitted on 1-27-12 and diagnoses include: Atrial Fibrillation, Huntington's Chorea and Dementia. Tenant #6 was staged at a four on the GDS, which indicated moderate cognitive decline. According to a fax sent to Tenant #6's physician dated 6-25-12, Tenant #6 became agitated with another tenant because the other tenant was in Tenant #6's way when entering the television room. Tenant #6 shoved a walker into the other tenant three times. Staff intervened and there was no injury noted to the other tenant. Nurse's Notes dated 7-16-12 indicated Tenant #6 had difficulty swallowing medications and Tenant #6 was able to take one at a time with pudding. Nurse's Notes dated 7-25-12 indicated Tenant #6 had a 17 pound weight loss post surgery, had poor appetite and Boost Plus 8 ounces three times daily was ordered. Tenant #6 also had loose stools with blood present. Tenant #6 was sent out to the emergency room (ER) for evaluation and was admitted for pain control, labs and Computed Tomography (CT). Tenant #6 returned on 7-27-12 and a nurse review was completed. According to a fax to Tenant #6's physician dated 9-6-12, Tenant #6 shoved the walker and chair into another tenant twice after supper. Staff intervened immediately and removed Tenant #6 from the dining room. Two staff assisted in removing Tenant #6 from the dining room and Tenant #6 attempted to hit staff. The fax indicated for some reason Tenant #6 did not like the other tenant. There were no injuries to the other tenant. The physician requested to avoid close contact between Tenant #6 and the other tenant. Evaluations were not completed as needed.

Tenant #8, an 86 year old, was admitted on 9-1-12 and diagnoses include: Cerebral Vascular Accident (some years ago), Myocardial Infarction and High Blood Pressure. Tenant #8 was staged at a six on the GDS, which indicated serve cognitive decline. The Resident Assessment was dated 9-3-12 and indicated the Charge Nurse, an LPN completed the assessment. The MMSE was dated 8-30-12; however, it was not signed by the person who completed the evaluation. The GDS was completed on 8-30-12 and 9-5-12; however, the evaluations were completed by the Charge Nurse, an LPN. Nurse's Notes from 9-1-12 to 9-16-12 indicated Tenant #8 hollered, took two staff for cares, had disruptive behaviors, was not weight bearing, was admitted to Hospice, had an open area on the coccyx, had monitoring of output and encouragement of fluids. Evaluations were not completed prior to taking occupancy or as needed.

Review of tenant files indicated evaluations were not completed appropriately including those prior to taking occupancy, within 30 days of taking occupancy and as needed.

- Regulatory Insufficiency: A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored objective screening tool. The evaluation shall be conducted by a health care professional or human service professional. (IAC r. 481-69.22(1))

- 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 change 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))

C. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged there was a tenant who required more than one staff for cares.

- Monitoring Observation: Eight tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7 and #8).

The Charge Nurse said Tenant #8 required a routine two person assist and the Program was in the process of applying for a waiver from the Department. The Director said one tenant, Tenant #8, was in question regarding level of care. She said a waiver was in process and they had been speaking with someone from the Department.

Tenant #8's file was reviewed. Nurse's Notes from 9-1-12 to 9-16-12 indicated Tenant #8 hollered, took two staff for cares, had disruptive behaviors, was not weight bearing, was admitted to Hospice, had an open area on the coccyx and had monitoring of output and encouragement of fluids. Tenant #8 was admitted to Hospice on 9-11-12 with a diagnosis of debility. The Program was in process of applying for a Request for Waiver of Administrative Rule (Health-Related).

Review of tenant files and interviews indicated none of the other tenants exceeded the appropriate level of care. The Program was in the process of applying for a waiver for Tenant #8. Regulatory insufficiencies were identified related to Tenant #8 regarding evaluations and service plan.

- Regulatory Insufficiency: None noted.

D. Tenant Documents

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

- Monitoring Observation: The table below represents physician ordered treatments not completed or not documented as completed. According to a fax to Tenant #6's physician dated 7-24-12, Tenant #6 had a 17 pound weight loss since 7-7-12 post surgery. Boost Plus, 8 fluid ounces three times daily was ordered and to continue to encourage regular meal intake. According to a fax to Tenant #7's physician Tenant #7 had a poor appetite and weight loss. Tenant #7 had an order for supplements with each meal. Medication Administration Records (MARs) reviewed indicated the following:

TENANT	TREATMENT	DATE/TIME	CHARTING ON MAR
Tenant #6	Boost Plus (Ensure) 8 ounces three times daily	8-1-12 at 5:00 p.m.	Circled on the front of the MAR; no explanation given on the back of the MAR
Tenant #6	Boost Plus (Ensure) 8 ounces three times daily	8-9-12 at 8:00 a.m.	Circled on the front of the MAR; no explanation given on the back of the MAR
Tenant #6	Boost Plus (Ensure) 8 ounces three times daily	8-16-12 at 5:00 p.m.	Circled on the front of the MAR; no explanation given on the back of the

			MAR
Tenant #6	Boost Plus (Ensure) 8 ounces three times daily	8-26-12 at 12:00 p.m.	Circled on the front of the MAR; no explanation given on the back of the MAR
Tenant #6	Boost Plus (Ensure) 8 ounces three times daily	8-30-12 at 5:00 p.m.	Circled on the front of the MAR; no explanation given on the back of the MAR
Tenant #7	Supplement with each meal. Ensure or whole milk	8-3-12 at 8:00 a.m.	Circled on the front of the MAR; no explanation given on the back of the MAR
Tenant #7	Supplement with each meal. Ensure or whole milk	8-8-12 at 12:00 p.m.	Circled on the front of the MAR; no explanation given on the back of the MAR
Tenant #7	Supplement with each meal. Ensure or whole milk	8-23-12 at 5:00 p.m.	Circled on the front of the MAR; no explanation given on the back of the MAR
Tenant #7	Supplement with each meal. Ensure or whole milk	8-29-12 at 8:00 a.m.	Circled on the front of the MAR; no explanation given on the back of the MAR

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception. (IAC r. 481-69.25(1)(i))

E. Service Plans

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

- Monitoring Observation: Eight tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6, #7 and #8).

  Tenant #2's file was reviewed. Nurse's Notes from 8-5-12 through 9-17-12, indicated Tenant #2 had increased anxiety, increased confusion noted with occasional hallucinations, Tenant #2 argued with staff, became angry, had a choking episode and had an episode of high anxiety with paranoia and hallucinations.

On 8-25-12 Tenant #2 was found on rounds with legs hanging off bed and when attempted to reposition staff observed Tenant #2's arm was stuck in railing. Tenant #2 complained of pain all over Tenant #2's body. As needed Vicodin was given, Tenant #2 was repositioned and pillows were placed between Tenant #2 and the railing. Staff was educated on pillow placement for safety. The service plan had an activation date of 3-14-12 and no signature page was found. The service plan had various handwritten updates including use wheelchair for all activity, assist of one for all dressing to conserve energy, soft foods, use light weight plastic glasses for drinking, use pillows in bed for positioning in safety, assist of one for all grooming, weekly weight related to taking Lasix, utilize as needed comfort medications per Hospice orders and assess for effectiveness, cleanse and treatment for skin tear on right elbow, high risk for skin tears on all extremities and needed hands on assistance for transfers. Most of the handwritten entries were without dates. The service plan was not updated as needed and did not reflect the needs of Tenant #2.

Tenant #3's file was reviewed. The preliminary service plan had an activation date of 8-30-12; however, was not signed by the Director or Tenant #3's legal representative until 9-6-12. The service plan was not signed prior to taking occupancy.

Tenant #4's file was reviewed. The initial service plan was signed by the legal representative on 8-14-12, one day after taking occupancy. The service plan was not signed by Tenant #4 or Tenant #4's legal representative prior to taking occupancy. A service plan was not developed within 30 days of taking occupancy.

Tenant #5's file was reviewed. Nurse's Notes from 5-2-12 through 9-12-12 indicated Tenant #5 had continued anxiety, yelling and crying. On 6-3-12 Tenant #5 was extremely agitated, yelling and had swallowed non-toxic paint. On 6-13-12 Tenant #5 attempted to follow tenants of the opposite sex into the tenants' room. On 8-14-12 Tenant #5 was undressing in dining room and was resistant with staff attempting to redress. On 8-18-12 Tenant #5 had possible ingestion of hand sanitizer. The service plan reflected staff to monitor for crying and communicate with physician if no relief. The service plan addressed Tenant #5 became anxious. The service plan did not address the behaviors related to undressing, wandering into apartments of tenants of the opposite sex and possible consumption of unsafe items including non toxic paint and hand sanitizer. The service plan was not updated as needed and did not reflect the needs of Tenant #5.

Tenant #6's file was reviewed. According to a fax sent to Tenant #6's physician dated 6-25-12, Tenant #6 became agitated with another tenant because the other tenant was in Tenant #6's way when entering the television room. Tenant #6 shoved a walker into the other tenant three times. Staff intervened and there was no injury noted to the other tenant. Nurse's Notes dated 7-16-12 indicated Tenant #6 had difficulty swallowing medications and Tenant #6 was able to take one at a time with pudding. Nurse's Notes dated 7-25-12 indicated Tenant #6 had a 17 pound weight loss post surgery, had poor appetite and Boost Plus 8 ounces three times daily was ordered. Tenant #6 also had loose stools with blood present. Tenant #6 was sent out to the ER for evaluation and was admitted for pain control, labs and CT. Tenant #6 returned on 7-27-12 and a nurse review was completed. According to a fax to Tenant #6's physician, Tenant #6 shoved the walker and chair into another tenant twice after supper.

Staff intervened immediately and removed Tenant #6 from the dining room. Two staff assisted in removing Tenant #6 from the dining room and Tenant #6 attempted to hit staff. The fax indicated Tenant #6 did not like the other tenant for some reason. There were no injuries to the other tenant. The physician requested to avoid close contact between Tenant #6 and the other tenant. The service plan reflected Tenant #6 became impatient and tried to push people out of the way with walker and staff was to redirect and had weight loss. The service plan did not reflect the physician's request to have no close contact between Tenant #6 and the other tenant. The service plan was not updated as needed and did not reflect the needs of Tenant #6.

Tenant #8's file was reviewed. The activation date of the service plan was 9-5-12. The service plan was signed by the Director and legal representative on 9-5-12. A service plan was not developed prior to taking occupancy. Nurse's Notes from 9-1-12 to 9-16-12 indicated Tenant #1 hollered, took two staff for cares, had disruptive behaviors, was not weight bearing, was admitted to Hospice, had an open area on the coccyx, had monitoring of output and encouragement of fluids. The service plan was not updated as needed and did not reflect the needs of Tenant #8.

Review of tenant files indicated service plans were not completed appropriately including those prior to taking occupancy, within 30 days of occupancy and as needed. The files reviewed indicated service plans did not reflect the needs of the tenants.

- Regulatory Insufficiency: Prior to the tenant signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3))

- 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))

F. Structural Requirements

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

- Monitoring Observation: According to an Incident Report Form dated 6-2-12 at 10:45 p.m., Tenant #5 drank a non toxic paint. Tenant #5 was given a glass of water to rinse Tenant #5's mouth. No adverse reaction was noted and vitals were within normal limits. The nurse on call, the physician and family were notified. Follow up indicated staff was to make sure all paint/coloring materials were put away out of tenant reach.

Nurse's Notes indicated Tenant #5 was found in the back of the dining room with a bottle of washable non toxic paint on Tenant #5's hand. Upon assessment Tenant #5 appeared to have paint on Tenant #5's mouth. Vitals were obtained and there was no adverse effect noted. Tenant #5 was monitored for any change in behavior or cognition and staff was to ensure all coloring materials were put away, out of tenant reach. Nurse's Notes from 6-3-12 through 6-5-12 indicated there was no adverse reaction noted from ingesting non toxic paint.

According to an Incident Report Form dated 8-18-12 at 8:30 p.m., Tenant #5 was found sitting in the front area holding a bottle of hand sanitizer. Staff was unsure if Tenant #5 had consumed any of the hand sanitizer. Vitals were obtained and the physician, family and Poison Control were notified. Nurse's Notes dated 8-18-12 indicated Tenant #5 was holding a large bottle of hand sanitizer with the cap off. Another tenant said Tenant #5 said Tenant #5 was thirsty so the other tenant gave Tenant #5 a bottle of water to drink. Staff was unsure if any of the sanitizer had been consumed. Poison control was contacted and stated the contents were 65% alcohol and Tenant #5 would become intoxicated if consumed. Staff was educated to remove any non-consumables from tenant reach. Nurse's Notes dated 8-18-12 at 10:00 p.m. indicated Tenant #5 was ambulating in hall per usual and there were no changes in behavior or cognition noted. Nurse's Notes dated 8-19-12 at 9:00 p.m. indicated no adverse reactions were noted or reported. Nurse's Notes dated 8-22-12 at 3:00 p.m. indicated the physician did not have any new orders, agreed to monitoring and remove objects from reach.

A tour of the Program on the day of the investigation revealed bath salts, lotions and a disposable razor were found in the south spa room. In the activity room paints, glue, crayons and beads were observed. In the north spa room a prescription shampoo, nail care products, hair products and one package of disposable razors were found.

The Potentially Hazardous Supplies policy indicated the Program would utilize and store potentially hazardous supplies in a manner designed to help reduce risk to tenants. It was strongly recommended that tenants and their responsible parties avoid storing any hazardous materials or supplies in the tenant's apartments. The Program would maintain only those supplies needed for maintaining the cleanliness, safety or maintenance of the physical plant and equipment. Supplies would be stored in areas limiting tenant access. Chemical supply and maintenance rooms would be kept locked at all times. All supplies would be labeled and stored according to manufacturers recommendations.

After the tour of the Program, the disposable razors were removed and the Program immediately arranged for tamper proof locks.

Review of tenant files, incident reports and a tour of the Program indicated tenants had access to items that were not safe in a dedicated dementia unit.

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