IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 41696-CR
42594-C
42618-C

May 13, 2013

Ms. Cheryl Rogan, Administrator
Oak Park Place Assisted Living
1381 Oak Park Place
Dubuque, IA 52002

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - OAK PARK PLACE ASSISTED LIVING
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Rogan:

I. Final Complaint/Incident Investigation Report – Oak Park Place Assisted Living, Dubuque, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued 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, following an investigation by DIA on **March 12 - 14, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Criteria for Admission and Retention, Evaluation, Service Plan, Medications and Compliance with Plan of Correction.

Oak Park Place Assisted Living ("Program") 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).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.12(3)(a)(2), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of: Criteria for Admission and Retention, Evaluation, Service Plan, Medications and Compliance with Plan of Correction.

The determination of a **$1,000 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Criteria for Admission and Retention, Evaluation, Service Plan, Medications and Compliance with Plan of Correction. As the enclosed Report details, the Program failed to discharge tenants that exceeded retention criteria, failed to appropriately evaluate tenants and failed to individualize and update service plans.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service 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 and fifty dollars ($650)** within 30 days after the notice or service of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written 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 the notice or service of this demand letter.

IV. Conclusion

The Program 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 Plan of Correction (POC) submitted on April 29, 2013, has been reviewed and will constitute the final POC related to the on-site visit of March 12 - 14, 2013.

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 notice or service 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 #: 41696-C – Revisit
42594-C
42618-C

Cheryl Rogan, Administrator
Oak Park Place Assisted Living
1381 Oak Park Place
Dubuque, IA 52002

Date of Complaint/Incident Investigation:

March 12-14, 2013

Monitor(s):

Hal L. Chase, RN BSN MPH
James Berkley, RN BS

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:	39
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	42

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	63

Program History – The program received regulatory insufficiencies in the areas of Criteria for Admission and Retention of Tenants, Policy and Procedures, Evaluations and Service Plans during this certification period.

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

A. Policies and Procedures

During the onsite complaint investigation 41696-C of 12-18 & 19, 2012, the Program received a regulatory insufficiency for not completing incident reports for Tenant's #4 and #7.

- Monitoring Observation: Tenant #4 no longer resides at the Program.

  Tenant #7, an 80 year old, was admitted on 6-21-12 and had diagnoses of: Atrial Fibrillation, Hypertension (HTN), High Cholesterol, History of Polio, History or Urinary Tract Infections, Depression and Stress Incontinence. Tenant #7 scored 31 out 31 on the Mini Mental Status Questionnaire. Tenant #7 resided in the general population.

  Program records indicated incidents reported had been completed for falls of 1-8-13 and 1-11-13. However, nurse's notes of 2-9-13 indicated staff found Tenant #7 on the floor.

Tenant #7 reported he/she fell out of the wheelchair while reaching for something. Staff reported Tenant #7 displayed confusion. An incident report had not been completed when Tenant #7 had fallen out of the wheel-chair.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in rule (69.23) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.

B. Criteria for Admission and Retention

Complaint/Incident Allegation #42618-C: It was alleged a tenant exceeded criteria for admission and retention.

- Monitoring Observation: Tenant's #3, #4 and #6 no longer reside at the Program. Thirteen tenant files were reviewed. No issues were found related to admission and retention criteria for Tenant's #5, #7, #8, #11, #12 and #13.

  Tenant #2, an 82, year old, was admitted on 10-3-09 and had diagnoses of: Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Dementia, HTN, Hyperlipidemia, Atrial Valve Prolapse and history of Pneumonia.
  A GDS was completed on 12-21-12 and staged Tenant #2 at six, which indicated severe cognitive decline. Tenant #2 resided in the dementia unit.

  Nurse's notes of 6-7-12 indicated Tenant #2 was moved from the general population to the dementia unit due to increased confusion. On 6-3-12 the nurse noted Tenant #2 had shortness of breath and was admitted to the hospital for Pneumonia. Tenant #2 returned on 6-6-12 with antibiotic therapy (ATB) for an additional five days. On 6-14-12, Tenant #2 had increased incontinence episodes. Tenant #2's service plan was updated to include staff assistance with toileting.

  Nurse's notes of 11-8-12 indicated increased agitation and becoming verbally abusive toward staff and tenants. Functional, cognitive and health evaluations were completed and the service plan was updated to include increased assistance with ADLs, but continued to be independent with ambulation.

  Nurse's notes of 12-21-12 indicated Tenant #2 had increased agitation when at the beauty salon; elbowing and striking out at staff when redirected. A service plan was updated 12-21-12 and included interventions related to increased verbal agitation.

  An incident report of 1-4-13 indicated Tenant #2 was found on the floor when staff entered his/her apartment. No injury was noted. An incident report of 1-21-13 indicated staff witnessed Tenant #2 getting up from a sitting position, ambulated down a hallway, turned and tripped over his/her feet. Tenant #2 sustained a two-inch hematoma on the left upper forearm and complained of left ankle pain when staff assisted Tenant #2 to a standing position. A nurse completed vital signs and notified family and Tenant #2's physician.

Tenant #2 was transported to a hospital emergency room and was subsequently admitted with a diagnosis of a Left Hip Fracture. Tenant #2 did not return to the Program. Tenant #2 did not exceed criteria for admission and retention.

Tenant #9, a 79 year old, was admitted on 9-23-11 and had diagnoses of: Anemia, Bradycardia, Coronary Artery Disease (CAD), Lewy Body Dementia, Hyponatremia, Hypercholestremia, Hypothyroidism and a History of Urinary Tract Infections (UTIs). Tenant #9 was admitted to hospice on 1-24-13 with a diagnosis of Acute Cerebro Vascular Accident (CVA). A GDS was completed on 1-23-13 and staged at five, which indicated moderate cognitive decline. Tenant #9 resided in the dementia unit.

Nurse's notes of 8-17-12 indicated chair/bed alarm had been used by the Program to alert staff when Tenant #9 attempted to leave his/her chair or bed. Nurse's notes of the same entry indicated Tenant #9's spouse would turn off the alarm and escort Tenant #9 when ambulating. Signs were taped to all alarm devices, doors and walls reminding Tenant #9's spouse not to turn off alarms.

Nurse's notes of 8-30-12 through 12-3-12 indicated at least eight incidents where Tenant #9's spouse alerted staff Tenant #9 had fallen. Staff determined Tenant #9's spouse had turned off the alarm(s) and assisted Tenant #9 with ambulation and transfer.
On 11-30-12 Tenant #9 was evaluated by hospital emergency room personnel for increased lethargy and decreased responsiveness. Tenant #9 returned the same day with ATB therapy.

Nurse's notes of 12-10-12 through 12-23-12 indicated at least four additional incidents of staff finding Tenant #9 on the floor. An incident of 12-12-12 resulted in a head laceration, emergency room evaluation and treatment. On 12-26-12 Tenant #9 was transported to a hospital emergency room for evaluation due to an "unresponsive episode." Tenant #9 was admitted for observation and later transferred to skilled nursing facility for treatment.

Tenant #9's service plan was updated on 1-21-13 to reflect a hospice admission and was updated again on 2-8-13 to include: assist of one staff and intermittently two staff; with the use of a gait belt, with ambulation and transfer and required "total assist" with all other cares.

Staff #9 LPN, Staff #14 and #5 indicated Tenant #9 needed routine two staff assist with transfer and ambulation. Staff #9 LPN reported Tenant #9 was not reliable in bearing weight with transfer and was non-responsive at times and was unable to participate with ADLs. Tenant #9's nonresponsive episodes had increased in number and severity.

Staff #14 reported Tenant #9 was a routine two staff assist with transfer and ambulation seven to eight out of ten times. Tenant #9 has had a stroke in December, 2012 and his/her ability to assist with ADLs had declined.

Staff #15 reported Tenant #9 was a routine two staff assist with transfer and ambulation seven out of ten times. Tenant #9 could not consistently bear weight and

it wasn't safe to transfer with one staff. Nine out of ten times Tenant #9 would be totally dependent on staff to initiate and complete cares.

A hospice nurse was interviewed by a monitor and reported Tenant #9 was a routine two-person transfer at all times; as it was not safe to transfer with one staff due to Orthostatic Hypotension. Tenant #9 exceeded retention and admission criteria as Tenant #9 was a routine two-staff assist with transfer and ambulation.

Tenant #10, a 100 year old, was admitted on 4-14-07 and had diagnoses of: Osteoporosis, Scoliosis, Overactive Bladder, Irritable Bowel Disorder, Salivary Gland Infection and a history of Trans Ischemic Attacks. A GDS was completed on 12-26-12 and staged Tenant #10 at seven, which indicated very severe cognitive decline. Tenant #10 resided in the dementia unit. Tenant #10 was admitted to hospice on 12-26-12 with admitting diagnosis of Unspecified Dysphagia.

A service plan of 1-14-13 indicated Tenant #10 needed assistance with ADLs; including one staff and intermittently two staff assist with transfer. Tenant 10 used a wheelchair for mobility.

Staff #10, #12, #13, #14 and #15 reported Tenant #10 was a routine two-person assist with all transfers. Staff #10, #11, #12, #13, #14 and #15 reported Tenant #10 was a maximal assist with ADLs; including eating, bathing, grooming, dressing, transfer and toileting.

The hospice nurse was interviewed and reported Tenant #10 was a routine two-staff assist with all transfers as it was not safe to transfer with on-staff assist. Tenant #10 was a maximal assist with ADLs; including, eating, bathing, grooming, dressing, transfer and toileting.

Tenant #10 exceeded retention and admission criteria as Tenant #10 was routine for two-staff assistance with transfer and required maximal assistance with ADLs.

- 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. Evaluation

During the onsite complaint investigation 41696-C of 12-18 & 19, 2012, the Program received a regulatory insufficiency for not completing functional, cognitive and health evaluations with a significant change in health status for Tenant's #3, #4, #7 and #8.

Monitoring Observation: Tenant's #3 and #4 no longer reside at the Program.

Tenant #7's nurse's notes of 1-2-13 indicated Tenant #7 had increased confusion. Tenant #7 was seen by a physician on 1-3-13 for a urology consult and prescribed ATB therapy twice daily for seven days and then daily for 30-days. Nurse's notes of 1-12-13 indicated staff found Tenant #7 on the floor and was confused. A urinalysis (UA) was obtained and on 2-12-13 and results were negative. Nurse's notes of 3-11-13 indicated Tenant #7 wasn't feeling well and was seen by his/her physician. Tenant #7 was prescribed ATB therapy for seven days.

Tenant #7's functional, cognitive and health evaluations were completed on 3-9-13 and addressed the need for assistance with ADLs not addressed in the previous evaluation of 8-1-12. However, the evaluations of 3-9-13 did not address the chronic UTI's and increased confusion as documented in nurse's notes as cited previously.

Tenant #8, a 77 year old, was admitted on 9-26-12 and had diagnoses of: Dementia, HTN, Dyslipidemia, Bells Palsy and Anemia. A GDS completed on 11-20-12 staged Tenant #8 at six, which indicated severe cognitive decline. Tenant #8 resided in the dementia unit. Functional, cognitive and health evaluations were not updated to reflect accurate information and representation of Tenant #8's identified needs.

- 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 services 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))

D. Service Plans

During the onsite complaint investigation 41696-C of 12-18 & 19, 2012, the Program received a regulatory insufficiencies for not establishing interventions related to behaviors, assistance of ADLs, exacerbation of current illness and when a tenant has Dementia and is unable to plan his/her own activities for Tenant's #1, #2, #3, #4, #5, #7 and #8.

- Monitoring Observation: Tenant #3 and #4 no longer reside at the Program.

  Tenant #1's service plan was updated on 12-20-12 and included interventions related to aggressive behaviors. Staff was to use music therapy, "give space," and give an anti-psychotic as needed with Tenant #1 demonstrated aggressive behavior.

  Tenant #2's service plan was updated on 12-21-12 and included interventions related to activities based on Tenant #2's abilities and personal interests.

Tenant #5, a 67 year old, was admitted on 9-26-12 and had diagnoses of: Alzheimer's Disease, Hypertension (HTN) and Hypothyroidism. A GDS was completed on 1-23-12 and staged Tenant #5 at six, which indicated severe cognitive decline. Tenant #5 resided in the dementia unit. Tenant #5's service plan was updated on 1-23-12 and included interventions related to activities based on Tenant #2's abilities and personal interests.

Tenant #7's file indicated a service plan was updated on 3-9-13 and included interventions related to assistance with ambulation and transfer. However, Tenant #7's nurse's notes of 1-2-13 indicated Tenant #7 had increased confusion. Tenant #7 was seen by a physician on 1-3-13 for a urology consult and prescribed ATB therapy twice daily for seven days and then daily for 30-days. Nurse's notes of 1-12-13 indicated staff found Tenant #7 on the floor and was confused. A UA was obtained and on 2-12-13 and results were negative. Nurse's notes of 3-11-13 indicated Tenant #7 wasn't feeling well and was seen by his/her physician. Tenant #7 was prescribed ATB therapy for seven days.

Tenant #7's service plan was updated on 3-9-13, but the service plan did not include interventions related to chronic UTIs and confusion.

Tenant #8's service plan of 11-20-12 was not updated to reflect interventions related to activities based on Tenant #8's abilities and personal interests.

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

- Monitoring Observation: Tenant #9's service plan was updated on 1-21-13 to reflect a hospice admission and was further updated on 2-8-13 to include: assist of one staff and intermittently two staff; with the use of a gait belt, with ambulation and transfer and required "total assist" with all other cares.

  Nurse's notes of 8-17-12 indicated chair/bed alarm had been used by the Program to alert staff when Tenant #9 attempted to leave his/her chair or bed. Nurse's notes of the same entry indicated Tenant #9's spouse would turn off the alarm and escort Tenant #9 when ambulating. Signs were taped to all alarm devices, doors and walls reminding Tenant #9's spouse not to turn off alarms.

  Nurse's notes of 8-30-12 through 12-3-12 indicated at least eight incidents where Tenant #9's spouse alerted staff Tenant #9 had fallen. Staff determined Tenant #9's spouse had turned off the alarm(s) and assisted Tenant #9 with ambulation and transfer. On 11-30-12 Tenant #9 was evaluated by hospital emergency room personnel for increased lethargy and decreased responsiveness. Tenant #9 returned the same day with ATB therapy.

  Nurse's notes of 12-10-12 and 12-12-12 indicated two additional incidents of staff finding Tenant #9 on the floor after Tenant #9's spouse attempted to assist Tenant #9 with transfer. The incident of 12-12-12 resulted in a head laceration, emergency room evaluation and treatment.

Nurse's notes of 12-19-12 through 12-24-12 indicated two additional falls on 12-13-12 and 12-23-12. On 12-26-12 Tenant #9 was transported to a hospital emergency room for evaluation due to an "unresponsive episode." Tenant #9 was admitted for observation and later transferred to skilled nursing facility for treatment.

Staff #9 LPN, Staff #14 and #5 indicated Tenant #9 needed routine two staff assist with transfer and ambulation. Staff #9 LPN reported Tenant #9 was not reliable in bearing weight. Tenant #9 would be non-responsive at times and was unable to assist with transfer, ambulation and most cares. The non-responsible episodes have increased in number and severity.

Staff #14 reported Tenant #9 was routine two staff assist with ambulation and transfer seven to eight out of ten times. Tenant #9 has had a stroke in December, 2012 and had declined in his/her ability to assist with ADLs.

Staff #15 reported Tenant #9 was a routine two staff assist with ambulation and transfer seven out of ten times. Tenant #9 cannot consistently bear weight and it wasn't safe to transfer with one staff. Tenant #9 has had a decline in his/her ability to participate in ADLs. Nine out of ten times Tenant #9 would be totally dependent on staff to initiate and complete cares.

A hospice nurse was interviewed by a monitor and reported Tenant #9 was a routine two-person transfer at all times; as it was not safe to transfer with one staff due to Orthostatic Hypotension.

Tenant #9's service plan did not include interventions related to falls, the use of and disarming of the chair/bed alarm. The hospice nurse reported two staff was needed at all times with transfer and ambulation. However, the service plan indicated Tenant #9 was a one and intermittent two-staff assist with transfer and ambulation when it was unsafe to have one staff transfer and ambulate Tenant #9. The service plan was not representative of Tenant #9's indentified needs.

Tenant #11, a 67 year old, was admitted on 5-29-12 and had diagnoses of: Hyposmolality, Schizoaffective Disorder, Bi-Polar Disorder, Alcohol Dependence, HTN, Atrial Fibrillation, Esophageal Reflux Disease and a History of Trans Ischemic Attacks. A GDS completed on 10-16-12 staged Tenant #11 at four, which indicated moderate cognitive impairment. Tenant #11 resided in the dementia unit.

Tenant #11's service plan of 10-16-12 established interventions directing staff to monitor and redirect if Tenant #11 attempted to give away or trade personal items, take things apart or is behaving in an unacceptable manner, becomes agitated or uncooperative. Tenant #11 was not be in other tenant's apartments and was not to touch tenants or staff or do anything unsafe. Staff was to observe and report any obsessive verbal or physical threats of behavior. Staff was to do frequent safety checks for exit seeking behavior.

Nurse's notes of 10-8-12 indicated on 10-6-12 Tenant #11 was agitated because he/she was late getting to a music presentation. Tenant #11 was redirected to his/her apartment. Tenant #11 stayed in his/her room but got up during the night and paced the floor. On 10-7-12 Tenant #11 continued to be upset and physically threatened

staff with his/her cane. The Program called local police and Tenant #11 was escorted to a hospital emergency department for evaluation and was later admitted.

Nurse's notes of 10-17-12 indicated Tenant #11 returned to the Program on 10-16-12. Tenant #11 reported he/she had a chemical imbalance and felt he/she was not himself/herself and had no desire to be verbal or physically aggressive with anyone.

An incident report of 1-27-13 indicated Tenant #13 leaned up against Tenant #11who was sitting in the dining room. Tenant #11 leaned against Tenant #13 and told Tenant #13 "come to my room later." Staff told Tenant #11 female tenants were not allowed in his/her apartment. Tenant #11 exploded out of his/her chair and began waving his/her arms while holding a coffee mug in each hand. Another tenant walked passed and was struck in the nose by one of the mugs Tenant #11 was holding.

An incident report of 3-5-13 indicated staff was toileting a tenant after supper and noted Tenant #11 and Tenant #13 were watching television. When staff returned both Tenant #11 and Tenant #13 were no longer watching television. Staff went to Tenant #13's apartment and found Tenant #13 lying on the bed, with Tenant #11 standing over Tenant #13. Tenant #11 had his/her hands on both sides of Tenant #13. Staff told Tenant #11, he/she wasn't to be in anyone's apartment.
Tenant #11 jumped up and stated he/she was "only covering .... up," as Tenant #13 was cold. Staff directed Tenant #11 to his/her apartment. The Program did not establish behavioral interventions following the incidents of 1-27-13 and 3-5-13.

Tenant #13, an 82 year old was admitted on 12-10-12 and had diagnoses of History of Multi-Infarct Dementia, History of Stroke, Aortic Valve Replacement, Congestive Heart Failure, History of UTI's and Colon Cancer. A GDS was completed on 2-1-13 and staged Tenant #13 at five, which indicated moderately severe cognitive decline. Tenant #13 resided in the dementia unit.

A service plan of 2-23-13 indicated Tenant #13 needed assistance with ADLs; including grooming, bathing, peri-care as needed and medication administration. The service plan included interventions related to Tenant #13's belief other male tenants were his/her spouse or his/her son. Tenant #13 would attempt to be physically close to male tenants; wanting to hold hands, hug and sit on their laps. Staff was to redirect Tenant #13 when he/she became agitated or had inappropriate behavior, including aggression and sexual tendencies. Staff was to give antipsychotics when redirection wasn't successful.

Incident reports of 1-6-13 and 1-19-13 indicated two events where Tenant #13 followed Tenant #11 around the unit and attempted go into Tenant #11's apartment. Nurse's notes of 1-7-13 indicated on 12-27-12 and 1-6-13, Tenant #13 had entered other tenant's apartments. When redirected by staff Tenant #13 was verbally aggressive and threatened to hit staff.

Nurse's notes of 1-11-13 indicated staff had reported Tenant #13 was observed sitting on a tenant's lap kissing him/her. Staff was directed to keep Tenant #13 in sight at all times.

Nurse's notes of 1-22-13 indicated on 1-19-13 Tenant #13 was exit seeking. On 1-20-13 Tenant #13 had wandered into another tenant's apartment and became agitated and punched a staff member when asked to leave the apartment. Tenant #13 was evaluated by a psychiatrist related to aggressive behavior and prescribed Lorazepam .5mg three times daily.

An incident report of 1-27-13 indicated Tenant #13 leaned up against Tenant #11who was sitting in the dining room. Tenant #11 leaned against Tenant #13 and told Tenant #13 "come to my room later." Nurse's notes of 2-8-13 indicated on 2-4-13 Tenant #13 was found in another tenant's apartment and refused to leave, raised his/her hand, as if to hit staff, didn't and left the apartment.

An incident report of 3-5-13 indicated staff was toileting a tenant after supper and noted Tenant #11 and Tenant #13 were watching television. When staff returned both Tenant #11 and Tenant #13 were no watching television. Staff went to Tenant #13's apartment and found Tenant #13 lying on the bed with Tenant #11 standing over Tenant #13. Tenant #11 had his/her hands on both sides of Tenant #13.

The Program did not establish behavioral interventions related to wandering into other tenant's apartments, exit seeking and incidents of 1-27-13 and 3-5-13.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30days 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: (a) The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

E. Medications

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

- Monitoring Observation: A review of Medication Administration Records (MARs) for 3-1-13 through 3-12-13 indicated the following medication errors.

Tenants	Medication and Dosage	Medication error
Tenant #1	Namenda 10mg one tablet daily	Not recorded as given on 3-11-13 at 8:00 a.m.
Tenant #1	Risperidone 0.5mg – one tablet daily	Not recorded as given on 3-2-13 & 3-3-13 at 8:00 a.m.
Tenant #9	Ibuprofen 200mg tablet – two tablets at bedtime	Recorded as refused 3-1-13 – 3-11-13
Tenant #10	Acetaminophen 325mg – two tablets four times daily	Not recorded as given on 3-5-13
Tenant #15	Baza Antifungal 2% crème	Not recorded as applied on 3-10-13
Tenant #17	Aricept 23mg – one tablet daily	Not recorded as given on 3-3-13
Tenant #17	Detrol Tablet – one tablet daily	Not recorded as given on 3-3-13

Tenant #17	Celebrex 100mg – one tablet twice daily	Not recorded as given on 3-3-13 at 8:00 a.m.
Tenant #17	Namenda 10mg – one tablet twice daily	Not recorded as given on 3-3-13 at 8:00 a.m.
Tenant #17	Polyethylene Glycol – Mix 17 grams in 8 ounces of water	Not recorded as given on 3-3-13
Tenant #18	Novolog 70/30 – Inject 20 units subcutaneous in the morning	Not recorded as given on 3-3-13 and 3-9-13
Tenant #18	Novolog 70/30 – Inject 5 units subcutaneous in the evening	Not recorded as given on 3-8-13

- Regulatory Insufficiency: When medications are administered traditionally by the program (a) the administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655—Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

F. Transportation

Complaint/Incident Allegation #42594-C: It was alleged the Program used a passenger vehicle that was unsafe. The passenger door wouldn't stay open when tenants attempted to enter the vehicle.

- Monitoring Observation: The program reported two vehicles were used to transport tenants. Visual inspection was completed and no issues were found with the Program's bus. Upon inspection of the passenger car revealed when the front passenger door was open the door wouldn't stay open to allow a tenant to enter; causing a safety hazard. Staff # 16 acknowledged the passenger door could be a safety hazard.

  While a deviation from the requirements of the rules was found, it did not meet the standard set forth in rule 69.33 (1) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.

G. Compliance with Plan of Correction

During the course of the revisit, the following information was obtained.

- Monitoring Observation: Tenant #1 was given a 30-day notice of discharge. During the onsite investigation Tenant #1 continued to reside at the Program. The Program did not notify the department Tenant #1 had not been discharged.

Tenant #7's evaluations and service plan were updated on 3-9-13 and not as indicated the plan of correction of 2-2-13.

Tenant #8's evaluations and service plan were not updated as indicated in the plan of correction of 2-2-13.

- 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))