IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint/Incident Intake #: 41964-I-R1
42847-I
43072-I

May 29, 2013

Ms. Cathy Hughes, Executive Director
Senior Star at Elmore Place Memory Care
4504 Elmore Avenue
Davenport, IA 52807

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL RECERTIFICATION MONITORING EVALUATION, COMPLAINT/INCIDENT INVESTIGATION AND INVESTIGATION REVISIT REPORT
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Standard Certification
V. Conclusion

Dear Ms. Hughes:

I. Final Recertification Monitoring Evaluation, Complaint/Incident Investigation And Investigation Revisit Report

Enclosed is the **Final Recertification Monitoring Evaluation, Complaint/Incident Investigation And Investigation Revisit Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapter 481—67 and 481—69 following an investigation by DIA on April 2 - 4, 2013. The Report notes the Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plans, Criteria for Admission and Retention, Medications, Food Service, Dementia Specific Education and Compliance with Plan of Correction.

Senior Star at Elmore Place Memory Care is being assessed a **$5,000 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 $5000.

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 and Dementia Specific Education.

The determination of a **$5,000 civil penalty** is based upon repeated regulatory insufficiencies in the areas of: Criteria for Admission and Retention, Evaluation, Service Plan and Dementia Specific Education. As the enclosed Report details, the Program failed to discharge two tenants who exceeded level of care, the Program failed to conduct evaluations and update service plans when tenants had a significant change in condition and the Program failed to train staff within 30 days of employment.

II. Reduction of Civil Penalty

If, within thirty (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 penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant in accordance with IAC 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 cover letter to the attention of **Jim Berkley** and remit the penalty assessed by check or money order to the State of Iowa in the amount of **three thousand two hundred and fifty dollars ($3,250)** 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 30 days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to IAC chapter 481—10. If the Program appeals, the civil penalty will be suspended, pending the appeal process. If the Program does not appeal, the fine is due within 30 days of notice.

IV. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0292** with effective dates of **April 17, 2013** through **April 16, 2015**.

V. Conclusion

The Program is being assessed a **$5,000 civil penalty** pursuant to Iowa Code section 231C.14 (1)(b) and 481 IAC 67.12(3)(a)(1). The POC submitted on May 14, 2013, has been reviewed and will constitute the final POC related to the on-site visit of April 2 - 4, 2013.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal or request a hearing on 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 report, please contact your Program Coordinator, Jim Berkley, at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Recertification Monitoring Evaluation & Complaint/Incident Investigation Report and Incident Investigation Revisit Report

Assisted Living Program:

Ms. Cathy Hughes, Executive Director
Senior Star at Elmore Place Memory Care
4504 Elmore Avenue
Davenport, IA 52807

Complaint/Incident Intake #: 41964-I –R1
42847-I
43072-I

Date of Complaint/Incident Investigation:

April 2 - 4, 2013

Monitor(s):

Hal L. Chase, RN BSN MPH
Rose Boccella, MA

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:	16
Total Population of Program at time of on-site	17
TOTAL census of Assisted Living Program	17

Tenant/Family Satisfaction Results – A monitor interviewed two tenants and a family member privately. One tenant reported he/she would rather be home than reside at the Program. Another tenant reported he/she liked living at the Program and would recommend the Program to anyone. Tenants and family reported housekeeping services were completed to their satisfaction and the building was clean, safe and sanitary. Nursing services were available when needed and staff responded within five to 10 minutes of being called. Staff was respectful, gave good service and knew what needed to be done. The food was described as wonderful to excellent and a variety of meats, vegetable and deserts were offered. Tenants and family reported the Program offered activities throughout the day. One tenant reported he/she made his/her own decisions related to health and personal cares and each reported they and their family member felt safe living at the Program.

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

A. Evaluation

During the onsite complaint investigation #41964-I of 12-26 and 27, 2012, the Program received a regulatory insufficiency for not completing functional, cognitive and health evaluations within 30-days of admission for Tenant's #1 and #2 and for not completing evaluations with a change in condition for Tenant's #4 and #5. The Program's POC indicated Tenant's #1, #2 and #5 no longer resided at the Program. Tenant #4's evaluations were to be completed on 1-30-13.

- Monitoring Observation: Tenant #1 was discharged on 1-28-13. Tenant #2 was discharged on 1-25-13. Tenant #3 was discharged on 2-12-13. Tenant #5 was discharged on 2-1-13. Tenant #4's file was reviewed and indicated functional, cognitive and health evaluation were completed on 1-30-13. Evaluations were updated on 2-19-13 due to a change in condition.

Complaint/Incident Allegation #43072-I: The Program reported Tenant #6 fell 1-13-13 while ambulating without his/her walker. Tenant #6 received continuous oxygen and

while ambulating, reached the end of the oxygen tubing and fell backwards hitting his/her head on the floor.

- Monitoring Observation: Tenant #6, a 94 year old, was admitted on 5-21-11 and had diagnoses of: Early Dementia, Moderate Aortic Stenosis, Hypertension and Hyperlipidemia. A Global Deterioration Scale (GDS) was completed on 3-15-13 and staged Tenant #6 at five, which indicated moderately severe cognitive decline.

  Program records indicated Tenant #6 sustained three falls on 3-13-13, 3-18-13 and 3-22-13. The incident of 3-13-13 indicated staff was walking down the hall and saw Tenant #6 walking without his/her walker. Staff #6, a Licensed Practical Nurse (LPN) reported Tenant #6 ambulated in the commons area and the oxygen tubing became tight and pulled Tenant #6 backwards, causing Tenant #6 to fall on his/her right side. Tenant #6 was transported to a local hospital emergency room for evaluation and was admitted for a Subdural Hematoma.

  Tenant #6 returned from a hospitalization to the Program on 3-15-13. Tenant #6 had been admitted to hospice care during his/her hospitalization, but those services were suspended until another hospice evaluation could be done one week later. Nurse's notes 3-15-13 indicated Tenant #6 was wearing a Wander-guard device. Nurse's notes of 3-16-13 indicated Tenant #6 was experiencing increased confusion and had difficulty eating without staff assistance. Nurse's notes of 3-16-13 indicated Tenant #6 was using a wheelchair for mobility.

  An incident of 3-18-13 indicated staff walked into Tenant #6's apartment and found him/her on the floor. Staff noted the chair alarm was not plugged into the electrical outlet all the way. An incident of 3-22-13 indicated Tenant #6 was ambulating, attempted to sit and missed the chair, resulting in a fall. Tenant #6 sustained a hematoma and swelling (location not identified). Staff was directed to provide increased monitoring as Tenant #6 was fall risk.

  Tenant #6 was admitted to hospice on 3-30-13 with an admitting terminal diagnosis of Subdural Hematoma and secondary diagnoses of Congestive Heart Failure (CHF) Hypertension (HITN) and Dementia. Additionally, the hospice plan care plan indicated Tenant #6 had Altered Neurological and Respiratory status and needed assistance with ambulation, transfer and bathing. A hospice fall risk assessment of 3-30-13 indicated Tenant #6 was a "max assist" of two staff with transfers. Tenant #6 did not ambulate, using a wheelchair for mobility, with staff propelling Tenant #6. The hospice nurse was interviewed and stated two staff members were needed at all times with transfer, as it was not safe to transfer using one staff. Tenant #6 was inconsistent with weight bearing.

  Staff #6 LPN and Staff #8 reported Tenant #6 was a routine two staff assist as it wasn't safe to transfer Tenant #6 with one staff. A monitor made four observations over the course of two days of staff transferring Tenant #6. Tenant #6 was unstable and was inconsistent with bearing weight requiring the assistance of two staff for a safe transfer.

The hospice nurse and hospice home health aide were interviewed and stated two staff members were needed at all times with transfer, as it was not safe to transfer using one staff. Tenant #6 was inconsistent with weight bearing.

Functional, cognitive and health evaluations of 3-15-13 indicated Tenant #6 was a one to two staff assist with transfers. Evaluations were not completed with a significant change as evidenced by the need for routine two-staff assist with transfers, an admission to hospice with hospice services and Altered Neurological and Respiratory status.

Complaint/Incident Allegation #42847-I: On 2-16-13 staff heard a "thump" from a room monitor, investigated and found Tenant #8 on the floor on his/her side. Tenant #8 was bleeding from the head and knee. Tenant #8 was transported to a hospital emergency room where he/she was evaluated and admitted with "broken ribs."

- Monitoring Observation: Tenant #8, an 87 year old, was admitted on 7-15-12 and had diagnoses of: Debility, History of Cerebro Vascular Accident (CVA), Aphasia, Place of Pacemaker and Cognitive Impairment. A GDS was completed on 1-31-13 and staged Tenant #8 at five, which indicated moderately severe cognitive impairment.

  Incident reports and nurse's notes of 12-10-13 through 2-16-13 indicated Tenant #8 sustained at least 12 falls during this period. The incident of 2-16-13 resulted in an injury and required an evaluation by hospital emergency room personnel. Tenant #8 was hospitalized for fractured ribs.

  Functional, cognitive and health evaluations of 1-31-13 indicated Tenant #8 was a fall risk and his/her walker was to be placed in front of him/her when sitting to help as a reminder to use when ambulating. Staff was to use a gait belt when providing stand by assistance with ambulation.

  Nurse's notes of 2-6-13 through 2-15-13 indicated Tenant #8 had "a lot of difficulty" moving his/her right leg and required two staff to assist with transfer and ambulation. Nurse's notes of 2-12-13 indicated Tenant #8 wasn't able, at times, to move his/her right leg. Nurse's notes of 2-14-13 indicated two staff was needed to assist with ambulation and transfer. Nurse's notes of 2-15-13 indicated Tenant #8 would attempt to get up without assistance and two staff members were needed to assist with transfer.

  Evaluations were not completed with a significant change in status. Incident reports and nurse's notes indicated Tenant #8 needed two staff to assist with transfer and ambulation.

- 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 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))

B. Service Plans

During the onsite complaint investigation #41964-I of 12-26 and 27, 2012, the Program received a regulatory insufficiency for: not having evaluations completed to support service plans, service plans not completed within 30-days of admission and as needed with a change in condition and for not having service plans individualized to meet tenants identified needs and preferences for Tenants #1, #2, #3, #4 and #5. The Program's POC indicated Tenants #1, #2, #3 and #5 no longer resided at the Program. Tenant #4's service plan was to be updated by 1-30-13.

- Monitoring Observation: Tenant #4's service plan was updated on 1-30-13 and established interventions related to exit seeking behaviors, resistance with activities of daily living (ADLs), continuous use of a wrist splint, wound care, admission to hospice and activities based on Tenant #4's ability and personal interests.

During the course of this incident revisit #41964-I, incidents #428447-I & 43072-I and recertification, the following information was obtained:

- Monitoring Observation: Tenant #6's service plan of 1-16-13 indicated Tenant #6 was a fall risk and established interventions, including standby assist with the use of a walker and assist with portable oxygen with transfer and ambulation. A bed alarm was to be used at night and for naps. Chair monitoring, described by Staff #6 LPN, required staff to keep Tenant #6 in eye sight at all times.

  Program records indicated Tenant #6 sustained three falls on 3-13-13, 3-18-13 and 3-22-13. The incident of 3-13-13 resulted in a hospital emergency room for evaluation and admission for a Subdural Hematoma.

  Tenant #6 returned to the Program on 3-15-13 and was admitted to hospice care during his/her hospitalization. A notation was added on 3-16-13, which indicated hospice care would not be initiated and Tenant #6 would be "assessed" in one week. Nurse's notes 3-15-13 indicated Tenant #6 was wearing a Wander-guard device. A service plan was updated on 3-15-13 indicated continuation of interventions established in the service plan of 1-16-13 and added the use of a chair alarm.

  Nurse's notes of 3-16-13 indicated Tenant #6 was experiencing increased confusion and had difficulty eating without staff assistance. Nurse's notes of 3-16-13 indicated Tenant #6 was using a wheelchair for mobility.

  An incident of 3-18-13 indicated staff walked into Tenant #6's apartment and found him/her on the floor. Staff noted the chair alarm was not plugged into the electrical outlet all the way. An incident of 3-22-13 indicated Tenant #6 was ambulating, attempted to sit and missed the chair, resulting in a fall. Tenant #6 sustained a hematoma and swelling (location not identified). Staff was directed to provide increased monitoring as Tenant #6 was fall risk.

Tenant #6 was admitted to hospice on 3-30-13 with an admitting terminal diagnosis of Subdural Hematoma and secondary diagnoses of: CHF, HTN and Dementia. Additionally, the hospice plan care plan indicated Tenant #6 had Altered Neurological and Respiratory status and needed assistance with ambulation, transfer and bathing. A hospice fall risk assessment of 3-30-13 indicated Tenant #6 was a "max assist" of two staff with transfers. Tenant #6 did not ambulate, using a wheelchair for mobility, with staff propelling Tenant #6.

Staff #6 LPN and Staff #8 reported Tenant #6 was a routine two staff assist; citing it wasn't safe to transfer Tenant #6 without two staff. A monitor made four observations over the course of two days of transfers of Tenant #6. Two staff was needed to transfer Tenant #6, as Tenant #6 was unstable and inconsistent with bearing weight.

The hospice nurse and hospice home health aide were interviewed and stated two staff was needed at all times with transfer, as it was not safe to transfer using one staff. Tenant #6 was inconsistent with weight bearing.

Tenant #6's service plan of 3-15-13 was not updated with a significant change as evidenced by the need for routine two-staff assist with transfers and admission to hospice with Altered Neurological and Respiratory status and hospice care. The service plan did not include services provided by hospice.

Tenant #8's incident reports and nurse's notes of 12-10-13 through 2-16-13 indicated at least 12 falls during this period. The incident of 2-16-13 resulted in an injury and required an evaluation by hospital emergency room personnel. Tenant #8 was hospitalized for fractured ribs.

A service plan of 1-31-13 indicated Tenant #8 was a fall risk and his/her walker was placed in front of him/her when sitting to help as a reminder to use when ambulating. Staff was use a gait belt when providing stand by assistance with ambulation.

Nurse's notes of 2-6-13 through 2-15-13 indicated Tenant #8 had "a lot of difficulty moving his/her right leg and required two-staff to assist with transfer and ambulation. Nurse's notes of 2-12-13 indicated Tenant #8 wasn't able, at times, to move his/her right leg. On 2-14-13 indicated two staff was needed to assist with ambulation and transfer. On 2-15-13 Tenant #8 continued to get up without assistance and two staff was needed to assist with transfer.

The service plan of 1-31-13 was not updated to reflect a significant change in Tenant #8's ability to ambulate and transfer without the assistance of two staff.

- 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))

C. Criteria for Admission and Retention

During the onsite complaint investigation #41964-I of 12-26 and 27, 2012, the Program received a regulatory insufficiency for Tenant #1, Tenant #2 and Tenant #3 who exceeded admission and retention criteria. The Program submitted a Plan of Correction (POC) on 2-5-2013, which indicated Tenant #1, Tenant #2 and Tenant #3 no longer resided at the Program.

- Monitoring Observation: Tenant #1, #2 and #3 no longer resided at the Program.

During the course of this incident revisit #41964-I, investigation of incidents #428447-I & 43072-I and recertification, the following information was obtained:

- Monitoring Observation: Tenant #6's nurse's notes of 3-20-13 indicated Tenant #6 was "highly agitated," pulled a door off of a cabinet, was combative toward staff, was confused and complained of back pain. Nurse's notes of the same date, but separate entry indicated Tenant #6's family member was notified of his/her decline and the need for one to two staff assist with transfers and toileting.

  Nurse's notes of 3-21-13 indicated Tenant #2 required two staff to assist with transfer and to remind Tenant #6 to leave his/her oxygen nasal canula on. An incident report of 3-22-13 indicated Tenant #6 was ambulating and was using a walker, approached a chair and attempted to sit down, missed the chair and fell. The incident report indicted staff was to "increase monitoring" related to safety of Tenant #6's transfer and ambulation.

  A hospice evaluation was completed on 3-30-13 and Tenant #6 was admitted to hospice. The hospice plan care plan of the same date indicated Tenant #6 had Altered Neurological and Respiratory status and needed assistance with ambulation, transfer and bathing. A hospice fall risk assessment of 3-30-13 indicated Tenant #6 was a "max assist" of two staff with transfers. Tenant #6 did not ambulate; using a wheelchair for mobility, with staff propelling Tenant #6.

  Staff #6 LPN and Staff #8 reported Tenant #6 was a routine two staff assist, citing it wasn't safe to transfer Tenant #6 without two staff. A monitor made four observations over the course of two days of transfers of Tenant #6. Two staff was needed to transfer Tenant #6, as Tenant #6 was unstable and inconsistent with bearing weight.

The hospice nurse and hospice home health aide were interviewed and stated two staff was needed at all times with transfer, as it was not safe to transfer using one staff. Tenant #6 was inconsistent with weight bearing.

Tenant #6 exceeded admission and retention criteria.

Tenant #7, a 75 year old, was admitted on 11-22-11 and had diagnoses of: Dementia and Urinary Urgency. A GDS was completed on 7-3-12 and staged Tenant #7 at six, which indicated severe cognitive decline.
Nurse's notes of 11-25-12 indicated Tenant #7 continued to randomly urinate in front of other tenant's apartment doors. Tenant #7 was not cooperative when staff attempted to toilet; becoming increasingly combative when evening cares were given. Tenant #7 was going into other tenant's apartments and would become combative when staff attempted to redirect. Nurse's notes of 1-5-13 indicated Tenant #7 was walking by another tenant and grabbed and squeezed his/her wrist. Two staff members were required to loosen Tenant #7's grip. Staff was directed to intervene when Tenant #7 approached other male tenants.

Nurse's notes of 3-14-13 indicated Tenant #7's physician was notified that Tenant #7 was having increased "behaviors" and was hitting and pinching staff when cares were given. Nurse's notes of 3-18-13 indicated Tenant #7 had been aggressive and combative when staff assisted with cares. Tenant #7 was hitting, kicking, head butting and required two to three staff to assist when cares were given. Tenant #7 randomly urinates in front of other tenant's apartment doors, on furniture and in corners of the hallways.

Nurse's notes of 3-23-12 indicated Tenant #7 was incontinent during the night and had urinated all over the bathroom floor. Staff assisted Tenant #7 with incontinent care and Tenant #7 became combative and attempted to hit staff. Nurse's notes of 3-24-13 indicated Tenant #7 was combative, hitting and cursing at staff when attempting to redirect Tenant #7 out of another tenant's apartment.

Nurse's notes of 3-26-13 indicated Tenant #7 was combative, punching and kicking staff when staff attempted to remove clothing to take a shower. Nurse's notes of 3-29-13 indicated Tenant #7 was swearing and attempting to hit staff when staff assisted with evening cares. Nurse's notes of 3-31-13 indicated Tenant #7 was "bothering other" tenants while they were eating. Staff attempted to redirect Tenant #7 and "came at nurse quickly" with his/her "arm swinging."

Staff #4, #7 LPN and #8 were interviewed and reported Tenant #7 was physically aggressive and combative, swinging, punching, kicking and head butting when personal cares were given. Staff #6, LPN, reported Tenant #7 wanders throughout the Program, was resistant to cares and has attempted to hit at staff, but hadn't made contact. Staff #7, LPN, reported Tenant #7 was verbally abusive and would swing at staff. Tenant #7 was more combative and urinates indiscriminately in front of other tenant's apartment. Tenant #7's behavior is random and how you approach Tenant #7 didn't make any difference. Staff #8 reported two to three staff was needed when personal cares are given. One staff will hold Tenant #7's hands while two other staff assisted with cares.

Tenant #7 exceeded admission and retention criteria.

- 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))

D. Medications

During the onsite complaint investigation #41964-I of 12-26 and 27, 2012, the Program received a regulatory insufficiency for not administering medications in accordance with requirements in 655-Chapter 6 governing nurse delegation for Tenant's #2, #3, #4, #12 and #13. The Program's POC indicated medication administration records (MARs) would be reviewed weekly by a registered nurse (RN), Licensed Practical Nurse (LPN) or designee to ensure appropriate documentation. All staff who administered medication would review medication administration documentation requirements by 2-15-13.

- Monitoring Observation: Tenants #4, #12 and #13's MARs for 3-1-13 through 4-3-13 indicated medications administered were charted appropriately. A review of staff files indicated staff received nurse delegated training and returned demonstration on medication administration.

During the course of this incident revisit #41964-I, investigation of incidents #428447-I & 43072-I and recertification, the following information was obtained:

- Monitoring Observation: On 4-4-13 a monitor observed Staff #6 LPN administer medications to Tenants #7 and #9. Staff #6 LPN did not wash or sanitize her hands prior to or after administering medications to these tenants.

- 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))

E. Staffing

During the onsite complaint investigation #41964-I of 12-26 and 27, 2012, the Program received a regulatory insufficiency for not having a sufficient number of trained staff at all times to fully meet tenants' identified needs. Tenants #1, #2, #3, #7, #8, #9 and #10 had a history of wandering throughout the Program. Tenant #1 had removed his/her Wander-guard security anklet without staff's knowledge and eloped from the Program. Program documentation indicated a policy and procedure had been developed to check the placement of a Wander-guard on tenants. Tenants #1, #2 and #3 no longer resided at the Program.

A review of program documentation of 3-21-13 through 4-2-13 indicated staff checked placement of the Wander-guard devices on Tenants #7, #8, #9, #10 and #11 at the beginning of each of three shifts.

- Regulatory Insufficiency: None noted.

F. Nurse Review

During the onsite complaint investigation #41964-I of 12-26 and 27, 2012, the Program received a regulatory insufficiency for not completing a 90-day nurse review for Tenant's #1, #2, #3, #4 and #5. The Program's POC indicated Tenant #1, #2, #3 and #5 no longer resided at the Program. The 90-day nurse review for Tenant #4 was to be completed by 1-30-13.

- Monitoring Observation: A review of Tenant #4's file indicated evaluations and medication review was completed on 2-19-13, which negated the need to complete a 90-day nurse review.

- Regulatory Insufficiency: None noted.

G. Life Safety

During the onsite complaint investigation #41964-I of 12-26 and 27, 2012, the Program received a regulatory insufficiency for not having written procedures regarding alarm systems and appropriate staff response when a tenant(s) are at risk of elopement or exhibits wandering behavior. The Program's POC indicated a policy and procedure for safety checks, routine monitoring of exterior door alarms and Wander-guards would be completed by 2-28-13.

- Monitoring Observation: Program records indicated the Program developed and implemented a policy and procedure for safety checks, routine monitoring of exit door alarms and Wander-guard placement on tenants. Program documentation of checks completed by staff was reviewed beginning 4-1-13 through 4-4-13.

- Regulatory Insufficiency: None noted.

H. Structural Requirements

During the onsite complaint investigation #41964-I of 12-26 and 27, 2012, the Program received a regulatory insufficiency for not having building and grounds well maintained, clean, safe and sanitary. On 12-26-12 and 12-27-12, a shower room was left open and cabinet doors with two bottles of Clorox bleach were accessible to tenants. A hallway door leading to the kitchen was left ajar and not closed. The dining room center island cabinet, with child proof locks was damaged and accessible to tenants. The Program's POC indicated corrective action was to be completed by 2-28-13.

Monitoring Observation: During the investigation a monitor checked daily on all shower room doors and hallway doors leading into the kitchen and found each to be securely locked. The dining room center island cabinets had key locks and were securely locked.

- Regulatory Insufficiency: None noted.

I. Food Service

During the course of this incident revisit #41964-I, incidents #428447-I & 43072-I and recertification, the following information was obtained:

- Monitoring Observation: Staff #6 LPN, #9 and #12 provided assistance with meals including; serving and occasionally plating of food at meal time for tenants. A review of personnel files indicated staff did not have annual food safety and sanitation training.

- Regulatory Insufficiency: Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food preparation. (IAC r. 481-69.28)(5))

J. Dementia-Specific Education

During the course of this incident revisit #41964-I, incidents #428447-I & 43072-I and recertification, the following information was obtained:

- Monitoring Observation: A review of personnel files indicated Staff #11, a custodian was hired on 7-9-12 had not completed eight hours of dementia training within 30-days of employment. Staff #10, a housekeeper, was hired on 2-11-13 had not completed eight hours of dementia training within 30-days of employment. Staff #12, a Certified Nursing Assistant, was hired on 2-19-13 had not completed eight hours of dementia training within 30-days of employment.

- Regulatory Insufficiency: All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. (IAC r.481-69.30(1))

K. Compliance with Plan of Correction

During the onsite complaint investigation #41964-I of 12-26 and 27, 2012, the Program submitted a POC on 2-5-13.

- Monitoring Observation: The Program's POC indicated the Program would ensure all prospective and current tenants are assessed by an RN for history of and/or signs and symptoms of danger to self or others or is physically aggressive or abusive, or

displays unmanageable verbal abuse or aggression would be immediately put on a plan for discharge from the Program. Tenant's #6 and #7 were cited for exceeding admission and retention criteria as each had demonstrated verbal and physical aggression toward staff and tenants.

The Program's POC indicated the Program would complete evaluations with a significant change and update service plans to meet identified needs and preferences for assistance. Tenant's #6 and #8 had a significant change in personal and health care. The Program did not complete evaluations with a significant change and did not update the service plan to reflect identified needs.

The Program's POC indicated staff was to receive an additional eight hours of dementia care training on 1-23-13 and 1-24-13, which included managing difficult behaviors. Program documentation obtained during the onsite indicated staff that provided direct care to tenants had not completed eight hour of dementia training and managing difficult behaviors on 1-23 & 24, 2013.

- 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))