IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED

Complaint Intake #: 43989-C

July 18, 2013

Ms. Mary Jo Pipkin, Administrator
Keystone Cedars Assisted Living
6325 Rockwell Drive NE
Cedar Rapids, IA 52402

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

Dear Ms. Pipkin:

I. Final Complaint/Incident Investigation Report – Keystone Cedars Assisted Living, Cedar Rapids, 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 **June 12 & 13, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Criteria for Admission and Retention, Evaluation, Service Plans, Tenant Rights and Nurse Review.

Keystone Cedars Assisted Living ("Program") is being assessed a **$1500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC 67.12(3)(a)(1)(2).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.12(3)(a)(1), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

The Program retained a tenant who exceeded criteria for retention. The tenant was physically and sexually abusive to staff and another tenant.

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 Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program had a repeated regulatory insufficiency in the area of Tenant Rights. The Program's continued failure (or refusal) to comply with regulatory requirements within the prescribed time frame established has a direct relationship in the health, safety, or security of tenants. The Program failed to protect a tenant from another tenant who was sexually abusive.

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 determination of a **$1500 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm; and for a repeated Regulatory Insufficiency in the area of Tenant Rights. As the enclosed Report details, the tenant was physically and sexually abusive to staff and another tenant.

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 **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of **nine hundred and seventy five dollars ($975)** 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 **$1500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a), (b) and 481 IAC 67.12(3)(a)(1), (2). The Plan of Correction (POC) submitted on July 16, 2013, has been reviewed and will constitute the final POC related to the on-site visit of June 12 & 13, 2013. The Request for Reconsideration has been reviewed and accepted in the area of Program Reporting to Department. The Final report is enclosed.

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, Rose Boccella, at 515/281-7039.

Sincerely,

Jim Friberg

Jim Friberg, Acting 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 #:** 43989-C

Mary Jo Pipkin, Administrator
Keystone Cedars Assisted Living
6325 Rockwell Drive N.E.
Cedar Rapids, IA 52402

Date of Complaint/Incident Investigation:

June 12 & 13, 2013

Monitor(s):

Hal L. Chase, RN BSN MPH

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:	63
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	64

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	12
Total Population of Program at time of on-site	14
TOTAL census of Assisted Living Program	78

Program History – The program received regulatory insufficiencies in the areas of: Policy and Procedure, Program Reporting to the Department and Life Safety during the July 30, 2012, Complaint Investigation (40022-C). The program received regulatory insufficiencies in the areas of Tenant Rights and Staffing during the March 5, 2013, Complaint Investigation (42535-C).

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

A. Criteria for Admission and Retention

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

- Monitoring Observation: Tenant #1, a 92 year old, was admitted on 9-20-09, and had diagnoses of: Dementia, Basal Cell Cancer with an Open Skin Wound, Osteoarthritis, Macular Degeneration, Dermatitis, Hard of Hearing (HOH) Gastro Esophageal Reflux Disease (GERD), Keratosis, History of Urinary Tract Infections (UTIs) and History of Pneumonia.

  A Global Deterioration Scale (GDS) was completed on 1-24-13, and staged Tenant #1 at five, which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit.

  A service plan of 1-24-13 established interventions related to verbal and physical aggressive behaviors. Interventions related to verbal aggression included redirection and to instruct the Tenant the behavior was not appropriate. Interventions related to physical aggression directed staff to remove themselves and tenants from the area, redirect Tenant #1 to stop hitting, allow space and re-approach at a safe distance and have different staff approach Tenant #1 when needed. If physical aggression continued staff was to notify the nurse.

Monthly assessment/sign off sheets, used to document cares given by staff, indicated the following: on 11-14-12 Tenant #1 punched staff in the chest, on 12-6-12 Tenant #1 tried to feel a staff's breast when assisting with cares and staff redirected and Tenant #1 rubbed staff's inner thigh and on 12-7-13 Tenant #1 rubbed a female staff's breasts and asked for a massage "down below." On 3-17-13 staff assisted Tenant #1 with cares and Tenant #1 grabbed staff's chest and "commented about getting an erection." On 4-30-13 Tenant #1 yelled in the dining room. Staff attempted to redirect and Tenant #1 grabbed and scratched a staff's arm when staff pulled away. On 5-6-13 Tenant #1 hit staff in the head. On 5-28-13 staff assisted Tenant #1 with changing his/her pants and Tenant #1 started to masturbate and asked staff for help. Later the same day, Tenant #1 punched staff when cares were given. On 6-5-13, Tenant #1 touched staff's "privates" and stated he/she was going to bite staff's breasts.

Staff Licensed Practical Nurse (LPN) 1 was interviewed and reported Tenant #1 was sexually inappropriate, touched staff sexually. Tenant #1's verbal, combative and sexually inappropriate behavior had worsened in the last month.

Staff #1 was interviewed and reported Tenant #1 was sexually and physically combative toward staff. Tenant #1's behavior was random, with most of the sexual and physical behavior happening when staff attempted to get Tenant #1 up in the morning.

Staff #2 was interviewed and reported Tenant #1 routinely refused cares four out of five days. Tenant #1 hit staff, touched female staff's breasts, vaginal area and buttocks. Tenant #1's behavior had gotten worse over the last two months. Tenant #1 was sexually inappropriate with Tenant #6. Tenant #1 would sit next to Tenant #6 and grab and touch Tenant #6's breasts. Staff would redirect Tenant #1 and would ask Tenant #1 to leave, but Tenant #1 often yelled, refused to leave and forced staff to remove Tenant #6 from the area.

Staff #2 reported Tenant #1 would unzip his/her trousers and masturbate under the table in the dining room when other tenants were present. Tenant #1 also masturbated in front of staff when they assisted with cares.

Staff #3 was interviewed and reported Tenant #1 was combative, hitting staff when cares were given and was sexually inappropriate toward staff by touching the vaginal area and breasts and often slapped staff's buttocks. Due to Tenant #1's behavior, two staff was needed when cares were given. Tenant #1 would masturbate in the commons area and in his/her apartment when staff assisted with cares. Tenant #1 was sexually inappropriate toward Tenant #6. Tenant #1 would rub Tenant #6's vaginal area and breasts. When seen together, staff would separate them, but Tenant #6 "gravitated" toward Tenant #1.

Staff #4 was interviewed and reported Tenant #1 was physically combative toward female staff. Tenant #1 slapped and hit female staff when assisting with cares. Tenant #1 was sexually inappropriate toward female staff. Tenant #1 would masturbate in front of female staff and continued to do so even when female staff asked Tenant #1 to stop.

Staff #4 reported Tenant #1 groped Tenant #6's breasts and vaginal area five or six times in the last five to six months. The last incident of sexual behavior occurred about one and half months ago. Staff #4 reported he had tried to redirect Tenant #1 when he/she exhibited behavior toward Tenant #6, but Tenant #1 refused to be redirected.

Staff #5 was interviewed and reported Tenant #1 often refused to shower and became physically and sexually inappropriate. Tenant #1 would hit staff when cares were attempted. Tenant #1 made sexual comments, grabbed staff's breasts and touched staff's vaginal area. Staff would enter Tenant #1's apartment to assist with cares, find Tenant #1 masturbating and Tenant #1 would continue to masturbate in front of staff. Tenant #1 masturbated in the common area and would often moan and call out Tenant #6's name. Tenant #1's combative and inappropriate sexual behavior had worsened over the last four to five months. Staff #5 reported Tenant #1's behavior to the nurse and the nurse directed staff to stand to one side when Tenant #1 attempted to touch staff inappropriately.

Staff #6 was interviewed and reported Tenant #1 was physically combative when staff assisted with cares. Tenant #1 became sexually inappropriate, touched staff's breasts, buttocks and vaginal area and staff were continually redirecting Tenant #1's behavior. Staff #6 reported Tenant #1 asked Tenant #6 to come to his/her apartment on at least two separate occasions. Staff #6 had seen Tenant #1 place his/her hand in Tenant #6's vaginal area and touch Tenant #6's breasts. Tenant #1 was not cooperative when redirected.

Tenant #6, a 96 year old, was admitted on 5-18-05 and had diagnoses of: Hypertension, Arthritis, Dementia, Agitation, History of UTIs, Confusion and Kidney Disease. A GDS was completed on 8-26-12 staged Tenant #6 at four, which indicated moderate cognitive decline. Tenant #6 resided in the dementia unit.

Tenant #6's service plan of 8-26-12 established interventions related to inappropriate sexual behaviors. The service plan indicated Tenant #6 may engage with male tenants inappropriately and staff was to redirect verbal or physical behavior. If staff were unable to redirect from an interaction Tenant #6 was involved in, staff were to remove Tenant #6 or a male tenant to stop the behavior.

Nurse's notes and monthly assessment/sign off sheets were reviewed and did not indicate any inappropriate interaction on the part of Tenant #6.

Tenant #1 was physically combative and sexually inappropriate toward a tenant and staff. Tenant #1 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))

B. Policies and Procedures

Complaint/Incident Allegation #43989-C: It was alleged the Program did not notify a tenant's Durable Power of Attorney (DPOA) when a tenant had fallen.

- Monitoring Observation: Six tenant files were reviewed. Tenant #5, an 83 year old, was admitted on 11-14-11 and had diagnoses of: Memory Loss, Osteoporosis, Macular Degeneration, GERD, HTN and Neuropathy.

  A GDS was completed on 6-3-13 and staged Tenant #5 at three, which indicated mild cognitive decline. Tenant #5 resided in the general population.

  A DPOA document was in Tenant #5's file; however, the DPOA authority existed only when Tenant #5's physician determined Tenant #5 was unable to make health care decisions. A review of Tenant #5's file did not include a physician's order activating the DPOA. Tenant #5's physician's office was contacted and reported a determination of Tenant #5's cognitive status had not been made. Tenant #5's physician scheduled a neuro-pscych evaluation on 8-20-13.

  Previous cognitive evaluations of 12-11-12, 5-15-13 and 5-28-13 had been completed. On 12-11-12 Tenant #5 scored 26 out of 30 on a Mini Mental Status Exam, which indicated normal cognitive function. On 5-15-13 Tenant #5 scored 20 out of 28, on a cognitive ability assessment which indicated Tenant #5 was at high risk for cognitive status. On 5-28-13, Tenant #5 scored 14 out of 28, which indicated high risk for cognitive impairment.

  Nurse's notes of 12-6-12 through 5-28-13 indicated no issues related to Tenant #5's cognitive status. Nurse's notes of 5-13-13 indicated staff notified the nurse Tenant #5 had fallen in the bathroom. Tenant #5 had reported he/she was going to the bathroom and fell head first onto the floor. Staff noted blood on the nose and the Tenant complained of pain to the lower extremities. Notes indicated Tenant #5's family was called and a message was left informing family Tenant #5 had fallen.

  An incident report was completed regarding the fall of 5-13-13. Instructions by the nurse directed staff to give Tylenol and place ice on Tenant #5's forehead and to check Tenant #5 every hour.

  A nurse review completed on 5-14-13, indicated during the second hour of one hour checks (on 5-13-13), Tenant #5 complained of pain. Tenant #5 was transported to a hospital emergency room (ER) by the Administrator. Tenant #5 returned to the Program later the same day.

  Hospital ER progress notes indicated Tenant #5 sustained a closed head injury and a contusion to the head and chest. Tenant #5 was in stable condition and discharged Discharge instructions included the use of an incentive spirometer ten times every hour while awake, Tylenol for pain and return to the hospital ER if pain worsened, blood in the urine, fever, cough, difficulty breathing or falls.

Tenant #5's physician had not determined Tenant #5 was unable to make personal and health care decisions. Nurse's notes indicated the Program notified Tenant #5's family of the fall on 5-13-13.

- Regulatory Insufficiency: None noted.

C. Dementia-Specific Education

Complaint/Incident Allegation #43989: It was alleged staff needed training managing tenants with dementia.

- Monitoring Observation: Eleven staff files reviewed indicated Staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11 had completed eight hours of dementia training within 30-days of employment and within the last twelve months of employment.

- Regulatory Insufficiency: None noted.

D. Evaluation

Complaint/Incident Allegation #43989-C: It was alleged an evaluation completed after a tenant had fallen was "questionable."

- Monitoring Observation: Six tenant files were reviewed. No issues were found with Tenants #1, #2, #3, #4 and #6 related to the allegation.

  Tenant #5's nurse's notes of 5-13-13 indicated Tenant #5 had reported he/she was going to the bathroom and fell head first onto the floor. Staff noted blood on the nose, a large knot on the forehead and Tenant #5 complained of pain to the lower extremities. Tenant #5's family was called and a message was left informing family Tenant #5 had fallen.

  An incident report was completed regarding the fall of 5-13-13. Instructions by the nurse directed staff to give Tylenol and place ice on Tenant #5's forehead and check the Tenant every hour.

  A nurse review completed on 5-14-13, indicated during the second hour of one hour checks (on 5-13-13), Tenant #5 complained of pain. Tenant #5 was transported to a hospital emergency room (ER) by the Administrator. Tenant #5 returned to the Program later the same day.

  Hospital ER progress notes indicated Tenant #5 sustained a closed head injury and a contusion to the head and chest. Tenant #5 was in stable condition and discharged. Discharge instructions included the use of an incentive spirometer ten times every hour while awake, Tylenol for pain and return to the hospital ER if pain worsened, blood in the urine, fever, cough, difficulty breathing or falls.

  Functional, cognitive and health evaluations completed on 5-15-13 indicated no change in health and functional status.

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

Monitoring Observation: Tenant #1's monthly assessment/sign off sheets, used to document cares given by staff to tenants, indicated the following: on 11-14-12 Tenant #1 punched staff in the chest, on 12-6-12 Tenant #1 tried to feel a staff's breast when assisting with cares and staff redirected and Tenant #1 rubbed staff's inner thigh, and on 12-7-13 Tenant #1 rubbed a female staff's breasts and asked for a massage "down below." On 3-17-13 staff assisted Tenant #1 with cares and Tenant #1 grabbed staff's chest and "commented about getting an erection." On 4-30-13 Tenant #1 yelled in the dining room. Staff attempted to redirect and Tenant #1 grabbed and scratched a staff's arm when staff pulled away. On 5-6-13 Tenant #1 hit staff in the head. On 5-28-13 staff assisted Tenant #1 with changing his/her pants and Tenant #1 started to masturbate and asked staff for help. Later the same day, Tenant #1 punched staff when cares were given. On 6-5-13, Tenant #1 touched staff's "privates" and stated he/she was going to bite staff's breasts.

Seven staff was interviewed and all reported Tenant #1 was sexually inappropriate and/or physically aggressive and combative.

Functional, cognitive and health evaluations were not completed with a change in status. Tenant #1 was sexually inappropriate toward Tenant #6 and staff and physically aggressive toward staff.

Tenant #2, a 92 year old, was admitted on 10-31-04 and had diagnoses of: Dementia, Hypothyroidism, History of a Head Injury and Vestibular Neurritis. Tenant #2 was admitted to hospice on 9-27-12 with an admitting diagnosis of Adult Failure to Thrive. A GDS was completed on 2-23-13 and staged Tenant #2 at seven, which indicated very severe cognitive decline. Tenant #2 resided in dementia unit. (The Program was granted a waiver for this tenant from March 12, through September 12, 2013.)

A functional evaluation was completed on 5-23-13, citing a change in condition related to increased assistance with mobility, eating, incontinence and a change in mental status. Health and cognitive evaluations were not completed.

Monthly assessment/sign off sheets of 1-20-13 through 6-12-13 indicated at least 17 incidents of physical aggression including: hitting, kicking, slapping, pinching and biting staff when cares were given and when medications were administered.

Staff LPN 1 reported Tenant #2 would become agitated at times and would hit, kick and bite when cares were given. At times, Tenant #2's behavior was predicated on staff's approach; however, Tenant #2's behavior was random and had worsened in the last couple of weeks.

Staff #1 through #6 reported Tenant #2 routinely hit, kicked, slapped, pinched and bit staff when cares were given. Staff #2 reported Tenant #2 had a Foley catheter and would attempt to pull it out. Staff #3 reported Tenant #2 threw cups and often swore at staff. Staff #4 reported Tenant #2 yelled and screamed and was combative toward other tenants. Staff #5 reported Tenant #2 would be in a good mood one minute and

the next minute would be combative. Tenant #2 had pulled out his/her catheter on more than one occasion.

A functional evaluation of 5-23-13 indicated a change in condition, but cognitive and health evaluations were not completed. Staff documentation of 1-20-13 through 6-12-13 indicated at least 17 incidents of physical aggression. Evaluations were not completed related to physical aggression.

Tenant #4, a 76 year old, was admitted on 4-2-07 and had diagnoses of: Bi-Polar Affective Disorder, HOH, Depression and Insomnia. A cognitive evaluation completed on 9-29-12 indicated Tenant #4 scored 29 out of 30, which indicated normal cognition. Tenant #4 had been court ordered to reside at the Program and resided in the general population.

Functional and health evaluations of 9-29-12 indicated Tenant #4 needed assistance with bathing. Monthly assessment/sign off sheets used to document cares given by staff to tenants indicated continuous refusal to shower from 3-22-13 through 5-23-13. Staff #1 and #5 reported Tenant #4 refused to shower in the past three weeks and had body odor. Evaluations were not completed with a change in condition.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human 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))

E. Service Plans

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

- Monitoring Observation: Tenant #1's monthly assessment/sign off sheets, used to document cares given by staff to tenants indicated the following: on 11-14-12 Tenant #1 punched staff in the chest, on 12-6-12 Tenant #1 tried to feel a staff's breast when assisting with cares and staff redirected and Tenant #1 rubbed staff's inner thigh and on 12-7-13 Tenant #1 rubbed a female staff's breasts and asked for a massage "down below." On 3-17-13 staff assisted Tenant #1 with cares and Tenant #1 grabbed staff's chest and "commented about getting an erection." On 4-30-13 Tenant #1 yelled in the dining room. Staff attempted to redirect and Tenant #1 grabbed and scratched a staff's arm when staff pulled away. On 5-6-13 Tenant #1 hit staff in the head. On 5-28-13 staff assisted Tenant #1 with changing his/her pants and Tenant #1 began to masturbate and asked staff for help. Later the same day, Tenant #1 punched staff when cares were given. On 6-5-13, Tenant #1 touched staff's "privates" and stated he/she was going to bite staff's breasts.

Seven staff were interviewed and all reported Tenant #1 was sexually inappropriate and/ physically aggressive and combative.

Tenant #1's service plan of 1-24-13 established interventions related to combative behavior toward staff, but the behavior continued despite these interventions. Tenant #1's service plan was not updated to establish additional or modified interventions related to the combative behavior. The service plan of 1-24-13 did not include interventions related to the sexual behavior exhibited toward Tenant #6.

Tenant #2's service plan of 2-22-13 was updated on 5-23-13 and established interventions related to increased assistance with mobility, eating, incontinence and a change in mental status, but the service plan was not based on health and cognitive evaluations.

Monthly assessment/sign off sheets of 1-20-13 through 6-12-13 indicated at least 17 incidents of physical aggression including: hitting, kicking, slapping, pinching and biting staff when cares were given and medications administered.

Staff LPN 1 reported Tenant #2 became agitated at times and would hit, kick and bite when cares were given. At times, Tenant #2's behavior was predicated on staff's approach; however, Tenant #2's behavior was random and had worsened in the last couple of weeks.

Staff #1 through #6 reported Tenant #2 routinely hit, kicked, slapped, pinched and bit staff when cares were given. Staff #2 reported Tenant #2 had a Foley catheter and would attempt to pull it out. Staff #3 reported Tenant #2 threw cups and often swore at staff. Staff #4 reported Tenant #2 yelled and screamed and was combative toward other tenants. Staff #5 reported Tenant #2 would be in a good mood one minute and the next minute would be combative. Tenant #2 had pulled out his/her catheter on more than one occasion.

The service plan of 2-22-13 did not establish interventions related to catheter care and combative behaviors toward staff.

Tenant #4's service plan of 9-29-12 indicated stand-by assistance with bathing and grooming and to monitor/observe completion of these tasks. Tenant #4's monthly assessment/sign off sheets used to document cares given by staff to tenants indicated continuous refusal to shower from 3-22-13 through 5-23-13. Staff #1 and #5 reported Tenant #4 had refused to shower in the past three weeks and had body odor.

Tenant #4's service plan did not include interventions related to Tenant #4's refusal to shower and groom.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluation conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1))

- Regulatory Insufficiency: 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))

F. Tenant Rights

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

- Monitoring Observation: Staff #2 was interviewed and reported Tenant #1 was sexually inappropriate with Tenant #6. Tenant #1 would sit next to Tenant #6 and grab and touch Tenant #6's breasts. Staff would redirect Tenant #1 and would ask Tenant #1 to leave, but Tenant #1 would often yell, refused to leave, forcing staff to remove Tenant #6 from the area.

  Staff #3 was interviewed and reported Tenant #1 would rub Tenant #6's vaginal area and breasts. When seen together, staff would separate them, but Tenant #6 "gravitated" toward Tenant #1.

  Staff #4 reported Tenant #1sexually groped Tenant #6's breasts and vaginal area five or six times in the last five to six months. The last incident of inappropriate sexual behavior occurred about one and half months ago. Staff #4 reported he has tried to redirect Tenant #1 when he/she exhibits this behavior toward Tenant #6, but Tenant #1 refused to be redirected.

  Staff #6 was interviewed and reported Tenant #1 has asked Tenant #6 to come to his/her apartment on at least two separate occasions. Staff #6 has seen Tenant #1 place his/her hand in Tenant #6's vaginal area and touch Tenant #6's breasts. Tenant #1 was not cooperative when redirected.

  Tenant #6's rights were violated.

- Regulatory Insufficiency: All tenants have the following rights. 1. To be treated with consideration, respect and full recognition of personal dignity and autonomy. 4. To be free from mental and physical abuse. (IAC r. 481-67.3 (1)(4))

G. Nurse Review

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

- Monitoring Observation: Tenant #1's monthly assessment/sign off sheets, used to document cares given by staff to tenants indicated the following: on 11-14-12 Tenant #1 punched staff in the chest, on 12-6-12 Tenant #1 tried to feel a staff's breast when assisting with cares and staff redirected and Tenant #1 rubbed staff's inner thigh and on 12-7-13 Tenant #1 rubbed a female staff's breasts and asked for a massage "down below."

On 3-17-13 staff assisted Tenant #1 with cares and Tenant #1 grabbed staff's chest and "commented about getting an erection." On 4-30-13 Tenant #1 yelled in the dining room. Staff attempted to redirect and Tenant #1 grabbed and scratched a staff's arm when staff pulled away. On 5-6-13 Tenant #1 hit staff in the head. On 5-28-13 staff assisted Tenant #1 with changing his/her pants and Tenant #1 started to masturbate and asked staff for help. Later the same day Tenant #1 punched staff when cares were given. On 6-5-13, Tenant #1 touched staff's "privates" and stated he/she was going to bite staff's breasts.

Seven staff were interviewed and all reported Tenant #1 was sexually inappropriate and/or combative.

Ninety-day nurse reviews were completed on 1-21-13 and 4-22-13; however, they did not include combative and sexual behavior exhibited by Tenant #1 toward staff and Tenant #6.

Tenant #2's Monthly assessment/sign off sheets of 1-20-13 through 6-12-13 indicated at least 17 incidents of physical aggression; hitting, kicking, slapping, pinching and biting staff when cares were given and when medications were administered.

Staff LPN 1 reported Tenant #2 became agitated at times and would hit, kick and bite when cares were given. At times, Tenant #2's behavior was predicated on staff's approach; however, Tenant #2's behavior was random and had worsened in the last couple of weeks.

Staff #1 through #6 reported Tenant #2 routinely hit, kicked, slapped, pinched and bit staff when cares were given. Staff #2 reported Tenant #2 had a Foley catheter and would attempt to pull it out. Staff #3 reported Tenant #2 threw cups and often swore at staff. Staff #4 reported Tenant #2 yelled and screamed and was combative toward other tenants. Staff #5 reported Tenant #2 would be in a good mood one minute and the next minute would be combative. Tenant #2 had pulled out his/her catheter on more than one occasion.

Tenant #2's 90-day nurse reviews of 2-22-13 and 5-23-13 did not include Tenant #2 physical aggression toward staff and tenants and did not include Tenant #2's attempts to pull out his/her catheter.

Tenant #4's nurse review of 3-31-13 did not include Tenant #4's refusal to shower and groom. Monthly assessment/sign off sheets used to document cares given by staff to tenants indicated continuous refusal to shower from 3-22-13 through 5-23-13. Staff #1 and #5 reported Tenant #4 refused to shower in the past three weeks and had body odor.

Tenant #6's 90-day nurse review of 5-23-13 did not include sexual behavior exhibited by Tenant #1 toward staff and Tenant #6. Staff #2 through #6 reported Tenant #1 had been sexually inappropriate toward Tenant #6 on multiple occasions. The Program did not complete an accurate review of Tenant #6's behaviors during the previous three months.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: to monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r.481-69.27(1))

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r.481-69.27(3)