IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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KIM REYNOLDS
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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 44318-I
44425-I

August 13, 2013

Ms. Annette Grochala, Executive Director
Vintage Hills Retirement Community
604 E. Hillcrest Drive
Indianola, IA 50125

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - VINTAGE HILLS RETIREMENT COMMUNITY
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Grochala:

I. Final Complaint/Incident Investigation Report – Vintage Hills Retirement Community, Indianola, 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 **July 16 & 17, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Service Plans and Managed Risk Agreements.

Vintage Hills Retirement Community ("Program") is being assessed a **$500 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 Service Plans.

The determination of a **$500 civil penalty** is based upon repeated Regulatory Insufficiency in the area(s) of: Service Plans. As the enclosed Report details, the Program failed to update Service Plans when tenants had a significant change in condition.

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 **three hundred twenty five dollars ($325)** 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 **$500 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 August 7, 2013, has been reviewed and will constitute the final POC related to the on-site visit of July 16 & 17, 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, 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:

Annette Grochala, Executive Director
Vintage Hills Retirement Community
604 E. Hillcrest Drive
Indianola, IA 50125

Complaint/Incident Intake #: 44318-I
44425-I

Date of Complaint/Incident Investigation:

July 16th and 17th, 2013

Monitor(s):

Lori Miner, RN BSN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: *In preparing this report, the following information was considered:*

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	28
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	32

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	8
Total Population of Program at time of on-site	8
TOTAL census of Assisted Living Program	40

Program History – The program received regulatory insufficiencies during the Oct. 2012 Recertification on-site in the areas of: Evaluation, Service Plan, Food Service, Dementia Specific Education and Structural.

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

A. Staffing

Complaint/Incident Allegation: The program reported a tenant left the memory care unit and the staff was not aware the tenant got outside. (#44425-I)

- Monitoring Observation: Tenant #1, an 82 year-old, was admitted on 10-1 12 and had diagnoses of: Alzheimer's, Diabetes Type II, Hypertension (HTN), Hyperlipidemia, Gastroesophageal Reflux Disease, and Arthritis. On 1-22-13, Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderate dementia. Tenant #1 resided in memory care.

  On 7-4-13 at approximately 7:15 p.m., the staff of the memory care unit was taking tenants outside to the secured courtyard for a Fourth of July party. Tenant #4, a tenant in the general population of the building, was visiting the spouse Tenant #2, who resided in the memory care unit. A dog owned by Tenant #4 exited the courtyard by going under the fence. Staff #2 was in the courtyard with tenants. Staff #1 left the memory care unit, entered the general population, and spoke with another tenant who was near an exit door. The tenant stated the dog had run by, and was headed in the direction of the secured courtyard. At the same time, Tenant #4 was exiting the memory care unit. Tenant #4 reported seeing Tenant #1 behind him/her but did not think Tenant #1 could reach the door before it locked. Tenant #4 stated

he/she was worried about the dog and did not stay at the locked door to make sure it locked.

Staff #1 returned to the memory care unit and went to locate Tenant #1 to take him/her outside to the secured courtyard. Staff #1 was unable to locate Tenant #1 after doing a search of the memory care unit. Staff #1 contacted the team leader in the building. Staff #1 reported she and the team leader searched the building, and then searched the grounds. Tenant #1 was found approximately 81 steps from the exit door located in the assisted living dining room. Tenant #1 was found behind the building off the sidewalk in a grassy area. Tenant #1 was found with an abrasion on the forehead and a one centimeter laceration on the nose. Staff #1 thought the cut on the nose was from glasses worn by Tenant #1. Tenant #1 was escorted back inside the memory care unit and the wounds treated. Staff #1 reported Tenant #1 was found with a cap, shirt, pants, and shoes on.

The physician was notified via fax dated 7-5-13 of the fall outside and the abrasion and laceration.

An incident report was completed which indicated Tenant #1 was gone from the building at least 15 minutes. Staff #1 stated it may have been as long as 25 minutes. Tenant #1's temperature was documented as 98.2 degrees Fahrenheit. The Registered Nurse (RN) was notified.

According to the State Climatologist, the weather conditions at the Des Moines Airport, the closest reporting station, the condition on July 4, 2013 at 6:54 p.m. was a temperature of 83 degrees, a heat index of 82 degrees, winds from the south at 10 miles per hour, with partly cloudy skies.

Staff #1 stated the secured doors were working at the time of the incident. Interviews with Staff #3 and #4 indicated the door alarms in the memory care unit were functional and had not been deactivated.

Staff #1, #3, and #4 stated Tenant #1 had a history of exit seeking. Staff #1, #3, and #4 stated redirection with activities usually worked to distract Tenant #1 from exit seeking. If redirection failed, medication was available. The service plan for Tenant #1, current at the time of the elopement and dated 4-15-13 indicated Tenant #1 had exit seeking behaviors and identified redirection and activities to use for redirection. The service plan indicated medication was a last resort.

Staff #1, #3, and #4 stated since the elopement, 15 minute checks had been started. The program provided documentation of the completion of the checks. The program also placed signs on the exit doors asking persons entering and exiting the program to observe for tenants in the area and notify staff if tenants were near the exit doors. The signs were observed to be on the exit doors, inside and out.

Staff #3 and #4 stated there were two staff members scheduled for the day and evening shifts and one person scheduled for nights in both the memory care and general population. A review of the scheduled for June and July 2013 indicated this to be generally true. The program also provided documentation of staff education on the new staffing procedure when tenants are outside as well as inside. One staff is to

remain in the building when tenants are inside as well as outside. General population staff is to be contacted when issues arise outside of memory care.

The program reported the incident to the Department appropriately. The program followed its elopement policy.

- Regulatory Insufficiency: None noted.

B. Tenant Rights

Complaint/Incident Allegation: The program reported a cognitively impaired tenant alleged someone did something to him. The program submitted the information as an allegation of sexual abuse. (#44318-I)

- Monitoring Observation: Tenant #2, an 89 year-old was admitted to the general population of the program on 10-9-12. Tenant #2 resided at the program with a spouse, Tenant #4. In an interview with the RN, she stated Tenant #2 was suddenly admitted to the memory care unit on 6-20-13 as Tenant #4 could not calm Tenant #2 and Tenant #4 could no longer care for Tenant #2. Tenant #2 had diagnoses of: Dementia, Heart Disease, HTN, Hyperlipidemia, Glaucoma, and History of Prostate Cancer. Tenant #2 was reported to have a history of paranoia and hallucinations. On 6-20-13 Tenant #2 was staged at five on the GDS which indicated moderately severe cognitive decline.

  On 6-21-13, Staff #3 reported she cared for Tenant #2 during the day shift. Staff #3 reported Tenant #2 was independent with toileting and would indicate the need to toilet. Staff members were generally not in the bathroom when Tenant #2 was toileting self to allow privacy. The Assistant Director of Nursing (ADON) reported he had been in training under the RN. On the day after admission to memory care, the ADON reported Staff #3 was getting ready to shower Tenant #2. The RN completed an assessment of Tenant #2's skin, and noted a reddened area on the coccyx. Tenant #2 was reported to be bent forward toward the toilet. The ADON reported he was standing by the door. The ADON was unable to observe the genital region, but did not observe any blood from his position in the doorway. The RN reported she was not looking for blood but was not aware of any bleeding. Staff #3 reported after the RN, she assisted Tenant #2 with a shower. Staff #3 reported she washed the back and Tenant #2 washed the genitals. Staff #3 did not recall seeing blood during the shower. The Medication Administration Record documented the application of a dressing to the coccyx area on 6-21-13. Staff #3 stated Tenant #2 reported no concerns to her during the day shift of 6-21-13. Staff #3 reported Tenant #2's spouse, Tenant #4, was with Tenant #2 on 6-21-13.

  Staff #1 worked the evening shift on 6-21-13. Staff #1 stated Tenant #4 reported to her that Tenant #2 stated a little girl and little boy were in the apartment, and the girl and boy had to do something because Tenant #2 was "peeing too much" according to the little boy. Staff #1 called the RN who reported Tenant #2 had not had any procedures done. The RN thought Tenant #2 was referring to the application of the dressing to the coccyx when referring to a procedure. According to Staff #1, Tenant #4 referred to Tenant #2 as "crazy" for saying those things. According to Staff #1,

Tenant #2 kept bringing up the situation with the little boy and girl, referring to a procedure, all night long.

Between 7:00 – 8:00 p.m., Tenant #4 was assisting Tenant #2 in getting ready for bed. Upon removing outer garments, Tenant #4 noticed Tenant #2 had blood present on the front of the underwear. Staff #1 was notified. Staff #1 reported an apple-sized bright red spot on the front of the underwear. Tenant #2 was not complaining of pain, nor pain with urination. Staff #1 observed a blood clot from the head of the penis. Staff #1 observed grooming razors in Tenant #2's bathroom. Tenant #2 denied using the razors.

Staff #1 contacted the RN. Concern was voiced about the spouse, Tenant #4, safely driving to Des Moines after dark. The local urgent care clinic was reported to be closed. Staff #1 attempted to call a relative of Tenant #2's to take Tenant #2 to a medical facility to be seen. The relative was not able to be contacted.

According to the RN, staff reported to her Tenant #2's vital signs were normal. The RN instructed staff to push fluids and for Tenant #2 to be seen at a medical facility the next day. The RN stated she gave staff instructions to watch for a fever, increased bleeding, or any other changes. The RN thought the blood was coming from the urine. Tenant #2 had no previous episodes of bleeding.

Staff #7 who worked the overnight shift beginning at 10 p.m. on 6-21-13 indicated she received report from Staff #1 that Tenant #2 had experienced bleeding during the evening shift. Staff #7 recalled seeing blood on a wash cloth. Staff #7 reported no further instances of bleeding from Tenant #2.

On 6-22-13, Tenant #4 took Tenant #2 to a clinic in town. The clinic record indicated while there was blood in the urine, there was no evidence of a urinary infection. Dried blood was present on the penis, but the meatus was normal in appearance. Tenant #2 was noted to be on Coumadin, a blood thinner, but anticoagulation was within normal limits and no changes were made to the dosage of Coumadin. The clinic record documented Tenant #4 did not want to pursue an investigation as to the cause of the bleeding.

During the time at the in-town clinic, Tenant #2 reported to clinic staff that a bath had been done the night before by a male attendant, and reported a male and female had done a procedure on the penis to cause it to bleed. Tenant #2 also reported to clinic staff that after the bath, blood ran down the leg. The clinic record documented the Department of Human Services (DHS) Elder Abuse Hotline was called, and the clinic was waiting for a call from a case worker. Tenant #2 returned to the program. In an interview with Tenant #4, the bleeding was caused by the Coumadin which thinned the blood.

The Executive Director stated the program did not suspect abuse, but upon learning the clinic was reporting the incident to DHS to evaluate for abuse, the program self-reported the incident to the Department on 6-22-13 and conducted an internal investigation. The program was unable to identify a perpetrator.

The program identified five male staff members: Maintenance, Marketing Director, ADON, Director of Dining Services, and Cook. All were interviewed and all denied inappropriate contact with any tenant.

Maintenance was interviewed and stated he was in the memory care unit one- to two times a day to do checks. Maintenance stated he is usually there during breakfast and the tenants were in the common area eating. Maintenance stated he usually did not do work in a tenant's apartment when the tenant was present, so as to not disturb the tenant. In an emergency, Maintenance reported he took another staff member with him to enter a tenant's apartment with the tenant present. Maintenance reported he had not ever seen any inappropriate actions by anyone and had not seen anything of concern. Maintenance reported he had never observed any sexual behavior while working in the memory care unit.

During the onsite visit, a new construction project, an addition, was noted on the grounds. Maintenance stated construction workers were never in the memory care unit unless he escorted them.

On 7-16-13 at approximately 12:10 p.m. a tour of the memory care unit was taken. Maintenance was observed in a tenant's apartment with the door open. The tenant was not in the apartment.

The Marketing Director was interviewed and stated he coordinated events in the common areas of the building and out in the community. The Marketing Director toured the building with prospective tenants, and stated he gave notice of several hours to the memory care unit when a tour was anticipated. The Marketing Director stated he followed up with tenants after they moved in, usually in the dining room or other common area. The Marketing Director reported he had never seen or heard of any inappropriate behavior occurring within the program.

The ADON was interviewed and stated he had been in Tenant #2's apartment, standing in the doorway observing the RN perform a skin assessment the day after Tenant #2 was admitted to memory care. Staff #3 was also present. The ADON stated he was in orientation, working about one day a week, and has not been alone with a tenant. The ADON reported he had not observed any inappropriate care, had not observed any tenants in the memory care unit expressing themselves sexually, and had not observed any staff member inappropriately touching tenants.

The Director of Dining Services stated he plated and delivered food to the memory care unit. He also responded when door alarms sounded in the memory care unit and reset the alarm as the door to the kitchen was near the memory care unit. The food was delivered on a cart, and The Director of Dining Services left the cart on the unit. Sometimes he visited with tenants if the tenants come up to him. The Director of Dining Services also went to the memory care unit for a dining event such as a birthday party. The Director of Dining Services stated he had never been in a tenant's apartment. He was not aware of anyone touching a tenant inappropriately and was not aware of any persons in the unit who should not be there.

The Cook stated he took food to the memory care unit and had short visits speaking to the tenants. The Cook stated the visits occurred in the dining room of the memory

care unit with other staff members present. The Cook reported he had never been alone with a tenant in an apartment. The Cook reported he had not seen or heard anyone being inappropriate with any tenant.

According to the program, there are no men employed as direct care workers at this time.

Staff #1, a direct care staff member who usually worked in the memory care unit, was interviewed and stated she had not observed anything inappropriate in the memory care unit. There were no visitors exhibiting unusual behavior, none of the tenants in the memory care unit expressed themselves sexually and Tenant #2 had not been observed masturbating.

Staff #3, a direct care staff member who usually worked in the memory care unit, was interviewed and stated she had no concerns about visitors or other staff members including male staff. Staff #3 stated there were no other tenants in the unit who expressed themselves sexually and was not aware of Tenant #2 masturbating. Staff #3 stated there were no other tenants who experienced bleeding from the genital area.

Staff #4, a direct care staff member who usually worked in the memory care unit, was interviewed and stated she had no concerns about other staff members or visitors interacting with the tenants. Staff #4 stated there were no tenants in memory care who expressed themselves sexually and had not observed Tenant #2 masturbating.

The program provided documentation that a former employee who was male, Staff #5, and Staff #6 were counseled about being in the building when off-duty. It was reported Staff #5 would come to the building when he was off-duty and visit with Staff #6 who was on-duty. The counseling was completed in March. Staff #5 resigned in May 2013.

Staff #6 was interviewed. According the June staffing schedule, Staff #6 was scheduled to work the overnight shift on 6-20 and 6-21 in the general population. Staff #6 stated she covered in the memory care unit for 40 to 50 minutes during every shift worked so the staff member assigned to memory care could get supplies, do laundry and take a break. Staff #6 thought she worked 6-20 and 6-21-13, the overnight shifts. Staff #6 stated she had not observed anything of concern, and had not observed tenants expressing themselves sexually. Staff #6 stated Tenant #2's apartment in memory care was near the nurse's station and Tenant #2 would awaken and come to the door of the apartment when she entered the unit. Staff #6 stated she never observed any blood on Tenant #2. Staff #6 stated Staff #5 had not been at the program since May, and had not been at the program on the night shift since he left employment in May.

Staff #7 was interviewed. According to the June staffing schedule, Staff #7 was scheduled to work the overnight shift on 6-20 and 6-21 in the memory care unit. Staff #7 stated she was usually gone from the memory care unit for about 10 minutes to get supplies and then returns. The staff member from the general population covered the unit in Staff #7's absence. Staff #7 stated Staff #5 quit in May and was last at the program in May except to drop Staff #6 off for work. Staff #7 did not think Staff #5 was at the program on 6-20 or 6-21. Staff #7 stated she had no concerns

about any current or former staff member. Staff #7 stated no one in the memory care unit wandered at night, and no one was in Tenant #2's apartment. Staff #7 has not observed any unusual behavior and has not observed any tenants engaged in sexual activity. Staff #7 has not observed Tenant #2 masturbating.

The RN was interviewed and stated Tenant #2 had a history of prostate cancer, paranoid behavior and hallucinations. The RN stated Tenant #2 has had no further bleeding since the episode of 6-21-13. The RN stated she had no concerns about any staff member being inappropriate with a tenant. There have been no complaints from other tenants in regards to inappropriate sexual activity. No other tenants exhibit sexual behavior. Tenant #2 has not been observed exhibiting sexual behavior.

On 7-17-13 an attempt was made to interview Tenant #2, who was sitting alone at a table in the common area of the memory care unit. Tenant #2 stated he had trouble with his memory. Tenant #2 was not able to complete a thought. Tenant #2 was unable to provide any information surrounding the bleeding episode.

Tenant #4, the spouse of Tenant #2, was interviewed. Tenant #4 stated Tenant #2 has had no further episodes of bleeding, and believed the bleeding occurred because of the medication Coumadin. Tenant #4 had no concerns about the staff at the program or the care Tenant #2 received.

During the onsite visit, the monitor was in the memory care unit several times. No episodes of inappropriate actions were observed.

In summary, on 6-21-13 Tenant #2 stated a procedure had been performed by a boy and a girl which resulted in bleeding from the penis. Tenant #2 was seen at a local clinic and at the request of the spouse; an investigation into the cause of the bleeding was not completed. The spouse attributed the bleeding to Tenant #2's use of Coumadin. Tenant #2 also had a history of prostate cancer. None of the staff interviewed have witnessed any inappropriate behavior on the part of other staff, visitors, or other tenants. Tenant #2 has not been observed exhibiting sexual behavior. Tenant #2 has had no episodes of bleeding since. Tenant #4, spouse of Tenant #2 was satisfied with the care Tenant #2 has received and has no concerns about the care received.

- Regulatory Insufficiency: None noted.

C. Service Plans

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

Monitoring Observation: Tenant #1 eloped from the program on 7-4-13. The service plan for Tenant #1, current at the time of the elopement and dated 4-15-13 indicated Tenant #1 had exit seeking behaviors and identified redirection and activities to use for redirection. The service plan indicated medication was a last resort. The service plan also indicated Tenant #1 signed a negotiated risk agreement on 6-13-13 due to falls. The negotiated risk agreement indicated Tenant #1 should have glasses on,

proper foot wear, rest when tired, use a walker or wheelchair for mobility, and have lights on to reduce the risk of falls.

On 7-12-13, the service plan for Tenant #1 was updated. A cognitive evaluation was completed on 1-22-13, but was not completed with the service plan update. The service plan was not based on a cognitive evaluation.

The service plan dated 7-12-13 did not identify Tenant #1 exhibited exit seeking behaviors, interventions for exit seeking including checks every 15 minutes, or interventions to reduce the risk of falls. The service plan did not meet the identified needs of Tenant #1.

On 6-21-13 the RN completed a skin assessment and an open area was noted on the buttock of Tenant #2. Staff members applied a dressing to the area every three days. The service plan did not identify interventions for open areas of the skin or observations staff members were to report to the RN.

Staff #6 and #7 were interviewed. Staff #7 stated Tenant #2 was a Vietnam veteran and Tenant #2 lived in those memories. Staff #7 stated Tenant #2 grabbed a glass jar and threatened Staff #6 and #7, thinking the staff members worked for the enemy. Staff #7 stated the incident continued for an hour. Staff #6 recalled the incident occurred in July 2013. Staff #6 reported Tenant #2 carried a jar and tried to hit the staff with it. Tenant #2 was reported to state he/she would kill if he/she had to, believing staff members were the enemy. Staff #6 reported the incident continued for about two hours and then Tenant #2 "snapped out of it."

A fax to the physician indicated on 7-5-12 staff reported Tenant #2 was exhibiting paranoid behaviors. The fax also indicated Tenant #2 believed it was war time and Tenant #2 would kill staff members if they came closer. Seroquel was ordered to be given daily at bedtime.

The service plan dated 6-20-13 was not updated with interventions for staff to use when Tenant #2 exhibited paranoid and threatening behavior. The service plan did not meet the identified needs of Tenant #2.

Tenant #3, an 88 year-old was admitted on 1-14-13 and had diagnoses of: History of Left Hip Fracture, Alzheimer's Disease, Anemia, Anxiety, Osteoarthritis, HTN, and Osteoporosis. Tenant #3 was staged at six on the GDS, dated 1-7-13, which indicated severe cognitive decline. Tenant #3 resided in the memory care unit.

The current service plan was dated 5-6-13. A cognitive evaluation was not completed at that time. The service plan was not based on a cognitive evaluation.

On 1-15-13 a negotiated risk agreement was completed that indicated Tenant #3 had a history of falls related to anxiety when needing to toilet. The risk agreement indicated a toileting schedule and regular visual checks was an alternative.

The service plan for Tenant #3 indicated Tenant #3 required assistance with toileting, but did not identify a toileting schedule or regular visual checks. The service plan identified Tenant #3 as being incontinent and using absorbent undergarments. Tenant

#3 was noted to have a history of redness in the coccygeal area and directed staff to take Tenant #3 out of the wheelchair as tolerated, but did not identify specific interventions for the prevention and identification of skin breakdown.

The service plan did not meet the identified needs of Tenant #3.

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

D. Other – Managed Risk Agreements

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

- Monitoring Observation: Tenant #1 was staged at five on the GDS which indicated moderate dementia. On 6-13-13 Tenant #1 and the legal representative signed a negotiated risk agreement related to a history of falls. The clinical record contained documentation dated 12-27-12 from a physician which stated Tenant #1 was not capable of making decisions. Tenant #1 was not able to participate in the negotiated risk process.

  Tenant #3 was staged at six on the GDS which indicated severe cognitive decline. On 1-15-13 Tenant #3 and the legal representative signed a negotiated risk agreement related to a history of falls. The clinical record contained documentation dated 1-29-13 from a health care provider which stated Tenant #3 was not capable of providing for necessities to provide for health, safety or general welfare. Tenant #3 was not able to participate in the negotiated risk process.

- Regulatory Insufficiency: The program shall have a managed risk policy. The managed risk policy shall be provided to the tenant along with the occupancy agreement. The managed risk policy shall include the following: A consensus-based process to address specific risk situations. Program staff and the tenant shall participate in the process. The result of the consensus-based process may be a managed risk consensus agreement. The managed risk consensus agreement shall include the signature of the tenant and the signatures of all others who participated in the process. The managed risk consensus agreement shall be included in the tenant's file. (IAC r. 481-69.31(2))