IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

**DEMAND LETTER**
**CERTIFIED**
**Complaint Intake #: 44893-I**
**44964-I**
**44641-M**

October 1, 2013

Ms. Christina Bricker, Housing Director
Summit Pointe Senior Living Community
3505 English Glen Avenue
Marion, IA 52302

**RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - SUMMIT POINTE SENIOR LIVING COMMUNITY**
**II. Reduction of Civil Penalty**
**III. Appeals/Hearings**
**IV. Conclusion**

Dear Ms. Bricker:

**I. Final Complaint/Incident Investigation Report – Summit Pointe Senior Living Community, Marion, 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 **August 14, 15, 19, 20 & 21, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights.

**Summit Pointe Senior Living 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 a Regulatory Insufficiency in the area of Tenant Rights.

The determination of a **$500 civil penalty** is based upon repeated Regulatory Insufficiency in the area(s) of: Tenant Rights. As the enclosed Report details, a tenant was treated roughly by a staff person.

## 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 September 30, 2013, has

been reviewed and will constitute the final POC related to the on-site visit of August 14, 15, 19, 20 & 21, 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:**

Christina Bricker, Housing Director
Summit Pointe Senior Living Community
3505 English Glen Avenue
Marion, IA 52302

**Complaint/Incident Intake #:**

44893-I
44964-I
44641-M

**Date of Complaint/Incident Investigation:**

August 14, 15, 19, 20 & 21, 2013

**Monitor(s):**

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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

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

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

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

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

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

**Current Program Census**

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

| | |
|---|---|
| **General Population Program** | |
| Number of tenants without cognitive disorder: | 95 |
| Number of tenants with cognitive disorder: | 4 |
| Total Population of Program at time of on-site | 99 |
| | |
| **Dementia-Specific Program by Dedication** | |
| Number of tenants without cognitive disorder: | 11 |
| Number of tenants with cognitive disorder: | 1 |
| Total Population of Program at time of on-site | 12 |
| | |
| **TOTAL census of Assisted Living Program** | 111 |

**Program History** – During the Recertification and Complaint Investigation (40267-C) of October 2 and 3, 2012, the program received regulatory insufficiencies in the areas of: Food Service, Staffing, Tenant Rights, Program Reporting to the Department and Transportation.

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

**A. Tenant Rights**

Complaint/Incident Allegation #44893-I: The Program reported a nurse was rough with a tenant during a shower.

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 7-15-13 and diagnoses included: Congestive Heart Failure, Lung Neoplasm, Hyperlipidemia, Hyperkalemia and Hernia. Tenant #1 scored a one on the Global Deterioration Scale (GDS) which indicated no cognitive decline. The service plan indicated staff was to assist with Tenant #1's shower twice a week, help get in and out of the shower, assist with washing hard to reach areas and wash Tenant #1's hair.

  According to a Tenant Occurrence Report, on 8-7-13 at 10:30 a.m. Tenant #1 reported on 8-2-13 Tenant #1 was handled roughly during a shower. There were no apparent injuries and Tenant #1 denied any bruising or other marks from the experience. An assessment was completed by the Health Services Director (HSD) which confirmed Tenant #1's statement. An internal investigation was initiated.

  According to Service Notes dated 8-7-13 at 10:30 a.m., Tenant #1 informed the HSD that on 8-2-13 Tenant #1 received a shower from Nurse #1 and reported Nurse #1 was very rough despite Tenant #1 voicing Tenant #1 was hurting during the shower. Tenant #1 said Nurse #1's response was "I'm a nurse and I know what I'm doing."

Tenant #1 said after the experience Tenant #1 ached everywhere. Tenant #1 stated because of past surgeries, muscle and rib removal on the left side and contractures of the neck Tenant #1 needed to be handled just right or Tenant #1 may hurt for days. Tenant #1 denied bruising or any red areas from the shower. A physical assessment was completed and confirmed Tenant #1's statement. In particular Tenant #1 stated Nurse #1 was rough while washing left toe and scrubbed the scalp so hard Tenant #1 thought Tenant #1 was going to fall off the seat. Tenant #1 rated pain on 8-7-13 around a six or seven, normal baseline. After the shower the pain was close to a ten but a pain pill helped pain return to baseline. Tenant #1 stated Tenant #1 did not think Nurse #1 intentionally tried to hurt Tenant #1 but was in what seemed like a terrible rush and didn't know how she handled people.

According to a written statement dated 8-7-13, the Outreach Coordinator (OC) went to Tenant #1's apartment to discuss a billing concern with Tenant #1's spouse. When she arrived, the spouse was not present, but Tenant #1 and a family member were there. The family member asked if the HSD was there because there was a problem the family member wanted Tenant #1 to discuss with the HSD. The OC informed them that the HSD was not in the building but Nurse #1 was there and could help. The family member immediately said no, not Nurse #1, the family member needed the HSD. The OC asked if there was anything she could help with since the HSD was not in the building. The family member said Tenant #1 would tell her. Tenant #1 was hard to understand, so the OC listened to Tenant #1 tell the story several times and felt she understood what was being said. The family member also confirmed what the OC heard Tenant #1 say. Tenant #1 described a woman who was Nurse #1, who came in to give a shower. Nurse #1 was very rough and very gruff. Tenant #1 identified Nurse #1 by name. Tenant #1 said she told Nurse #1 during the shower that she was hurting Tenant #1. Nurse #1 told Tenant #1 she was a nurse and she had been doing this a long time. Tenant #1 reported crying afterward and still hurt from the rough treatment received during the shower. The OC told Tenant #1 and the family member how sorry she was and assured them tenants could request staff they liked or disliked to be a part of their cares when there were concerns. She stated feelings were important and she would like to follow up with the HSD and not to fear a rough shower again. The OC sent an email to the Housing Director and the HSD after her visit with Tenant #1.

According to the HSD, she received an email from the OC on 8-6-13 at 3:09 p.m. that indicated Tenant #1 was in tears as Nurse #1 was rough with Tenant #1. On 8-7-13 the HSD spoke to the Housing Director and went to see Tenant #1. She asked about the shower and Tenant #1 said Tenant #1 didn't want to get anyone in trouble and provided a statement. The HSD completed a physical assessment and did not find any bruising. Tenant #1 said Tenant #1 ached all over. The HSD typed up a statement and Tenant #1 signed it. The HSD spoke to Consultant #1 who interviewed Nurse #1 and had Nurse #1 write a statement.

According to the statement written by the HSD and signed by Tenant #1, Tenant #1 stated a shower was received on 8-2-13 from Nurse #1. Nurse #1 was rough with Tenant #1 despite the Tenant stating several times during the course of the shower that what Nurse #1 was doing was causing pain. In particular, Nurse #1 was rough while washing Tenant #1's left toe, which had a callus that bothered Tenant #1 and when Nurse #1 washed Tenant #1's hair. Tenant #1 thought Tenant #1 was going to

fall off the shower chair because Nurse #1 scrubbed so hard. Tenant #1 was not sure if Nurse #1 heard when Tenant #1 stated Tenant #1 was hurting. The only response Tenant #1 remembered Nurse #1 saying was "I know what I'm doing, I'm a nurse." Tenant #1 said after the shower every part of Tenant #1's body ached. Tenant #1 had never had anybody handle Tenant #1 with that kind of roughness. Because of all the surgeries Tenant #1 had, Tenant #1 had to be handled just right or Tenant #1 would hurt. Tenant #1 denied any bruising or marks on body from the shower described. The HSD completed an assessment and did not observe any bruising on the body. Tenant #1 requested Nurse #1 no longer assist with showers and had no other complaints. Tenant #1 stated she did not believe Nurse #1 intentionally tried to hurt Tenant #1 but it was more a result of Nurse #1 being in a rush. Tenant #1 thought maybe it was just Nurse #1's personality and Nurse #1 didn't realize how she handled people.

According to a written report by Consultant #1, on 8-6-13 around 7:30 p.m. she was contacted to investigate an alleged incident between Tenant #1 and Nurse #1. On 8-7-13 Consultant #1 interviewed Nurse #1 and asked her to describe the showers she had given to Tenant #1. Nurse #1 stated she had given two showers and did not have any problems that she was aware of. Consultant #1 asked Nurse #1 if Tenant #1 had told her on Friday during the shower that Tenant #1 was hurting. Nurse #1 replied, yes, Tenant #1 told me Tenant #1 was hurting when she was washing under the left armpit area and under left breast so she stopped washing but she had to rinse off and apply lotion. Consultant #1 asked Nurse #1 if she told Tenant #1 she was a nurse and knew what she was doing. Nurse #1 said she probably said that if Tenant #1 said that was what she said. Nurse #1 said if Tenant #1 said she was rough then she was rough. Nurse #1 stated she was aware of Tenant #1 being sensitive with cares and that she wrapped the wash cloth around her hand to prevent increased sensitivity.

Consultant #1 met with Tenant #1 and asked Tenant #1 to tell her about the showers. Tenant #1 said the two showers received from Nurse #1 were rough. Tenant #1 reported during the second shower Tenant #1 repeatedly told Nurse #1 she was hurting Tenant #1 but Nurse #1 didn't stop and Nurse #1 said, "I am a nurse and I know what I am doing." Tenant #1 reported during the shower Tenant #1 hurt all over but especially when Nurse #1 washed the left side and the sore left toe. Tenant #1 also reported when Nurse #1 washed the hair she scrubbed so hard Tenant #1 felt like Tenant #1 was going to fall off the seat. Tenant #1 reported Tenant #1 had never had anyone give a shower like that before and Nurse #1 was "hyper" and "rushing" and would not listen when told she was hurting Tenant #1. Tenant #1 denied any bruises or redness after the shower but did state was hurting for a while after the shower. Consultant #1 contacted Tenant #1's family member who said the family member didn't think Nurse #1 was intentionally trying to hurt Tenant #1 but Tenant #1 was upset and crying over the incident and had additional pain for a few days afterwards.

According to a written statement by Nurse #1, she had given Tenant #1 a bath before. Tenant #1 was hard to understand and had a method to bathing so Nurse #1 followed the instructions. For that bath Tenant #1's spouse was in the room as Tenant #1 took a shower in the spouse's bathroom. Nurse #1 got out the towels and moved the bath bench out and locked it. She put a towel on the seat, ran the water and once Tenant #1 was seated she unlocked the bench and put in over shower and locked it. She

handed Tenant #1 a washcloth to cover eyes and tested water on legs before getting wet. Nurse #1 washed the hair and back and rinsed and then traded the washcloth for a loofa which she soaped. Tenant #1 washed front and face with loofa while Nurse #1 washed the legs, feet and toes. Tenant #1 was very skin sensitive with touch. Nurse #1 rinsed and then wrung out washcloth and soap to wash the axilla and under breasts. Nurse #1 said Tenant #1 said "don't press so hard" on left axilla so she stopped. She rinsed the axilla and under breasts and made sure soap was removed. Tenant #1 stood while Nurse #1 washed the groin and rectum and rinsed both areas. The water was turned off and towel was over back and one towel handed to Tenant #1. Hair was dried with a third towel, bench was moved out and unlocked and back was dried. The axilla, groin, legs and feet were dried. Socks were applied. Lotion was applied to back and axilla and groin folds dried again to assure dryness. Underwear was pulled up when Tenant #1 stood up and Nurse #1 dried the front, back and perineal area. Robe was placed on Tenant #1 and walked back to room. Tenant #1 stood to dress in room, sat down in chair and Nurse #1 combed hair. Nurse #1 asked Tenant #1 if Tenant #1 needed anything else, Tenant #1 said "Thank you, No." Nurse #1 said goodbye to spouse seated in the living room.

According to the Housing Director, she received an email from the OC regarding Tenant #1. Tenant #1 was to receive a meal credit on the August billing statement so the OC went to the apartment to discuss the matter. While the OC was there Tenant #1 shared that Nurse #1 was rough with Tenant #1 in the shower. Nurse #1 no longer worked at the Program.

The Program completed an incident report and reported the incident to the Department.

Review of the Program's investigation, incident report, staff interviews and review of Tenant #1's file revealed Tenant #1 was not treated with consideration and respect.

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

Complaint/Incident Allegation #44964-I: The Program reported a staff was concerned about how another staff administered medications to a tenant.

- Monitoring Observation: Tenant #2, a 91 year old, was admitted on 7-1-11 and diagnoses included: Coronary Artery Disease, Atrial Fibrillation, Dementia, Sleep Apnea and Anemia. Tenant #2 was staged at a six on the GDS which indicated severe cognitive decline. Tenant #2 resided in a dementia unit and received hospice services. According to Tenant #2's service plan, dated 7-5-13, staff was to administer medications from medi-set daily. Medications would be stored in a locked medication room inside the medication cart and the nurse would set up medications weekly per physician orders as listed on the Medication Administration Record. Medications could be put in applesauce or yogurt to help with swallowing. Staff must stay and see that Tenant #2 got all the pills swallowed and had plenty of water to do so before leaving Tenant #2.

According to the HSD, Staff #2 wanted to talk to her on 8-14-13 sometime between 8:00 p.m. and 9:00 p.m. Staff #2 explained a situation that occurred between Staff #1 and Tenant #2. The HSD told Staff #2 to complete an Occurrence Report and she began an internal investigation on 8-15-13.

According to a Tenant Occurrence Report dated 8-14-13, an incident occurred on 8-13-13 at 9:45 p.m. Staff #1 asked Staff #2 to relieve her for a break around 9:40 p.m. Staff #2 went down to the dementia unit where Staff #1 was in Tenant #2's room. Staff #2 walked in and Tenant #2 was in a chair crooked, feet and head were not aligned in the chair. Staff #1 was putting pills into Tenant #2's mouth repeating, stop playing games with me and take these pills. Staff #1 put them in Tenant #2's mouth and put water up to the mouth. As Staff #1 tilted the cup, water spilled out the side of Tenant #2's mouth. Staff #1 took the cup away and Tenant #2 spit the pills down Tenant #2's shirt. Tenant #2 stated Tenant #2 couldn't swallow the pill. Staff #1 then took the pills and put them in Tenant #1's mouth again and put water up to mouth. The same thing happened, Tenant #2 spit them out and Staff #1 said, stop playing games with me like you have all night. Staff #1 told Tenant #2, you're talking these pills even if I stand here all night. Staff #1 then grabbed Tenant #2's legs and tried swinging them in front of the chair but they got caught on hers. She kicked the chair back in front of her and stepped back. She grabbed Tenant #2's legs with one arm and swung them forward. Tenant #2 stated, "Now that's enough." Staff #1 responded saying that no, Tenant #2 was enough and that Tenant #2 better take these pills. She wrapped her arm around his/her shoulder and pulled Tenant #2 up straight. Staff #1 then put the pills in Tenant #2's mouth again, put the water up, spilling some down Tenant #2's chin and Tenant #2 swallowed the pills. Staff #1 threw away the container for the pills and cup of water and put a new shirt on the chair and started pulling sheets down on the bed. Staff #2 told Staff #1 she could go and Staff #2 would take it from there. Staff #1 said thank you, I can't handle Tenant #2 anymore and left. Staff #2 changed Tenant #2's shirt and asked if Tenant #2 was okay and she was there to help. She got Tenant #2 comfortable in the chair with blankets, music and then left the room.

The HSD stated she assessed Tenant #2 and there were no injuries and Tenant #2 denied any pain. According to the Service Notes dated 8-15-13 at 5:15 p.m., Tenant #2 was currently at the supper table. Tenant #2 denied any pain and no bruises on legs, hands or red marks, only small, old scabbed area on right knee and scab on right hand, both from previous falls. Tenant #2 was moving all extremities without difficulty.

Consultant #2 met with Staff #2 on 8-15-13 at 2:00 p.m. specific to an incident Staff #2 witnessed on 8-13-13. Staff #2 indicated she attempted to notify the HSD on 8-13-13 but the HSD had already left for the day. Staff #2 was scheduled to work on 8-14-13 from 3:00 p.m. to 11:00 p.m. She notified the HSD on 8-14-13 around 8:00 p.m. or 9:00 p.m. The HSD asked Staff #2 to complete an incident report form. Staff #2 indicated she knew something was wrong and wanted to talk to the HSD about the protocol for passing pills because she felt something wasn't right.

On 8-13-13, Staff #2 indicated she went down to the dementia unit to relieve Staff #1 for break. She entered Tenant #2's room and observed Tenant #2 with legs over the left arm rest of the chair. Tenant #2 was leaning to the right with head partway off

the head rest with eyes closed. Tenant #2 held right arm up behind head most of the time. Staff #1 was standing by Tenant #2's legs leaning over Tenant #2's body. She had a cup of water in her left hand and the pills were in her right hand. Staff #1 was wearing gloves. Staff #2 indicated Staff #1 did not forcefully put the water up to Tenant #2's mouth on the first attempt. She didn't think water spilled out of Tenant #2's mouth, but the Tenant did spit out the pill onto shirt. Staff #1 picked up the pill from the shirt and put it back in mouth and attempted again. She put the cup up to mouth and water spilled out the side. Staff #2 indicated Staff #1 was stern, but didn't appear forceful. Staff #2 indicated she felt the tone of Staff #1's voice was threatening. Tenant #2 spit out the pill again. The only communication from Tenant #2 at this point was that Tenant #2 couldn't swallow the pill. Staff #2 indicated Staff #1 was not yelling or loud. Staff #1 was moderate loudness and stern. Staff #2 observed Staff #1 scoop legs that were hanging over arm of chair with her right arm. She tried to swing legs to the front side of the chair and hit her legs. The area she was working in was tight. Staff #1 dropped Tenant #2's legs. Staff #3 indicated the legs were not high above the armrest. Legs did not bounce and Tenant #2 did not make any sounds. Staff #1 scooped Tenant #2's legs with her right arm and she still had the glass of water in her left hand. Staff #1 swung the legs to the front of the chair and dropped Tenant #2's legs. Tenant #2 responded, "Now that's enough." Tenant #2's eyes were closed the entire time. Staff #2 observed Staff #1 move to the left side of Tenant #2 and slid her right arm behind shoulders. She then pulled Tenant #2 toward her. Staff #2 indicated Staff #1 appeared frustrated and the pull was stern. Tenant #2 did not say anything and Tenant #2's head did not move from side to side after being pulled. Staff #1 put the cup to mouth and that time water came out the side of mouth and down the chin. A lot of water came down Tenant #2's chin but Tenant #2 did not cough or say anything, eyes were still closed. The front of Tenant #2's shirt was wet. At that point Staff #2 offered to help and Staff #1 said she couldn't handle Tenant #2 anymore. Staff #2 changed the shirt and tried to get Tenant #2 up to go into the bed. Tenant #2 responded Tenant #2 was in bed. Staff #2 said you are in your recliner. She attempted again with the same response so she covered Tenant #2 with a blanket and turned on music. Staff #2 indicated Tenant #2 did not appear distressed or upset.

On 8-15-13 at approximately 3:00 p.m., Consultant #2, the HSD and Nurse #2 were present during an interview with Staff #1. Staff #1 stated she worked on 8-13-13 on the second shift and acknowledged passing medications to Tenant #2 on that evening, recalling medication administration times as afternoon and bedtime. Staff #1 said she more than likely went to Tenant #2's apartment to administer the medication and she remember Tenant #2 being extremely tired on that day and spit out pills when she tried to administer them. She stated Tenant #2 told her that Tenant #2 could not swallow the pills so Staff #1 helped Tenant #2 sit up straight. Staff #1 could not recall at first if Tenant #2 was in bed and she sat Tenant #2 up on the edge of the bed or if Tenant #2 was sitting in the recliner. She denied ever having seen Tenant #2 sitting in recliner with feet over the arm rest.

Staff #1 said she gave Tenant #2's pills one at a time. After putting the first pill in Tenant #2's mouth and providing water, the pill was swallowed without any problem. The second pill she put in Tenant #2's mouth, Tenant #2 tried to chew so she offered some water and Tenant #2 spit out the pill telling Staff #1 Tenant #2 could not swallow. That was when she helped Tenant #2 sit up straight. She remembered Tenant #2 was in bed while she was trying to administer medications when she

helped Tenant #2 sit up, Tenant #2 was leaning over on her. Staff #2 did not recall there being any furniture in her way or moving any chairs to give her more room. She did not recall ever picking up Tenant #2's legs to move or ever dropping the legs. Eventually Staff #1 said she did get all of Tenant #2's medications down. She said the large pill had disintegrated in the cup of water so she swished it around and gave the rest of the water to Tenant #2. Staff #1 denied Tenant #2 had any coughing spells while trying to get Tenant #2 to take medications but Tenant #2 did let the water dribble out of Tenant #2's mouth. She asked Tenant #2 if Tenant #2 had a sore throat in response to statement that Tenant #2 could not swallow but Tenant #2 denied any pain. Staff #1 said she remembered Staff #2 being in the apartment but she did not help with the medication administration. Staff #1 said she was not sure if she asked Staff #2 for help or if Staff #2 just came into Tenant #2's apartment, but Staff #2 did help Staff #1 turn Tenant #2 in bed to reposition alarm under Tenant #2. Staff #1 did not recall changing any of Tenant #2's clothes or linens because all the water spit out landed on her shoes and pants. Staff #1 denied feeling frustrated while tending to Tenant #2 on that evening. She said she did have to talk to Tenant #2 in a stern manner at times telling Tenant #2 she was there to keep Tenant #2 safe. Staff #1 said after Tenant #2 took all the medications, she helped Tenant #2 turn on left side with Staff #2's help, put the alarm under Tenant #2 and pulled up the sheet. According to Staff #1, Tenant #2 said Tenant #2 was fine.

According to the Service Notes dated 8-19-13 at 10:00 a.m., it was reported to the HSD that Tenant #2 could not swallow medication and refused medications on 8-17-13 and 8-18-13. Staff denied any coughing spells or choking and Tenant #2 ate all meals without any trouble. Medications were taken on 8-19-13 without any problem. A request for an order to crush medications was sent to the hospice physician. On 8-19-13 at 2:45 p.m. a signed order to crush medications as needed was received.

The service plan was updated on 8-19-13 to reflect Tenant #2 complained of increased difficulty swallowing pills the last couple of days. An order was received from hospice to crush medications as needed and put into applesauce or yogurt. Tenant #2 had not had any difficulty eating/swallowing food. Recently Tenant #2 had refused to take medications. The physician and hospice were made aware and fluids were encouraged. Staff was to observe Tenant #2 when eating and would see that Tenant #2 had plenty of water to take with pills. Appropriate medications would be crushed if needed.

A medication pass was observed on 8-19-13 at 11:05 a.m. Staff #3 opened the medi-set, put the pills in a medication cup, poured them into a plastic bag and crushed Tenant #2's medications. A container of yogurt was removed from the refrigerator in the medication room. A spoonful of yogurt was mixed with the pills in a medication cup and the yogurt was offered to Tenant #2. Tenant #2 swallowed three bites of medications and yogurt mixture in between drinks of water. All medications were consumed.

The HSD met with Staff #1 on 8-15-13 regarding the alleged incident with Tenant #2 and Staff #1 was suspended pending an investigation. Per the Suspension form, Staff #1 checked the box that indicated she disagreed for the following reasons: she would never hurt any tenant, staff or family member. The HSD stated she was not aware of

any issues between Staff #1 and Staff #2. The HSD stated this was Staff #2's first job as a Resident Assistant.

The Program completed an incident report and reported the incident to the Department.

Review of the Program's investigation, incident report, staff interviews and review of Tenant #2's file were completed. The monitors were not able to determine a preponderance of evidence to substantiate the allegation.

- Regulatory Insufficiency: None noted.

**B. Medications**

Complaint/Incident Allegation #44641-M: The Program reported an allegation of abuse. It was alleged there were suspicions a staff diverted tenant medications.

- Monitoring Observation: A mandatory dependent adult abuse investigation was initiated on 8-14-13. An alleged perpetrator and dependent adults were identified and the investigation was ongoing. Separation was provided between the alleged perpetrator and the tenants, the Department was notified and the Program completed an internal investigation.

- Regulatory Insufficiency: None noted.