IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 45320-C
45462-C

January 14, 2014

Ms. Emily Lightbody, Divisional Director of Operations
Bickford Cottage Marion
1100 Linden Drive
Marion, IA 52302

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION & RECERTIFICATION MONITORING EVALUATION REPORT - BICKFORD COTTAGE MARION
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Lightbody:

I. Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report – Bickford Cottage Marion, Marion, IA

Enclosed is the **Final Complaint/Incident Investigation & Recertification Monitoring Evaluation 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 **October 1, 2 and 3, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Policies and Procedures, Evaluation, Tenant Documents, Service Plans, Food Service, Dementia Specific Education, Record Checks and Other.

Bickford Cottage Marion ("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 Insufficiencies in the area(s) of: Service Plans. As the enclosed Report details, the Program failed to develop service plans based on evaluations and 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 November 26, 2013, has been reviewed and will constitute the final POC related to the on-site visit of October 1, 2 and 3, 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 and Recertification Monitoring Evaluation Report

Assisted Living Program: **Complaint/Incident Intake #:** 45320-C
45462-C

Emily Lightbody, Divisional Director of Operations
Bickford Cottage Marion
1100 Linden Drive
Marion, IA 52302

Date of Complaint/Incident Investigation & Monitoring Visit:

October 1, 2 and 3, 2013

Monitor(s):

Stephanie Cummins, MA

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

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

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

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

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

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

Current Program Census

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

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	23
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	29

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	6
TOTAL census of Assisted Living Program	35

Tenant/Family Satisfaction Results – A community meeting with 12 tenants was held. When asked what they liked about living the Program, the response was the people. Housekeeping services were completed to their satisfaction and the apartments and common areas were clean. The building and grounds were safe, clean and sanitary and there was a quick response from maintenance staff. There were no improvements provided regarding housekeeping, laundry or maintenance. Nursing services were available and they received the services expected when the occupancy agreement was signed. Staff was described as helpful and good and the tenants received the services requested. Staff normally responded right away when tenants called for assistance; however, one tenant said the wait was 10 minutes the previous night. The majority of tenants said staff was trained; however, one tenant said staff needed more training on medications. They liked the food and said it was really good. There was variety of foods; however, there was too much pasta served. The cold foods were served cold and the hot foods were served hot, with the exception the vegetables could be warmer. There were enough activities offered and they received a calendar of activities. They enjoyed Bingo, music, volleyball, exercises and accordion players. Tenants could decline to attend activities. They felt safe, were satisfied living at the Program and would recommend it to others.

Program History – During the course of the Recertification visit and Complaint/Incident investigation conducted on October 1, 2 and 3, 2013, the Program received regulatory insufficiencies in the areas of: Policies and Procedures, Evaluation, Tenant Documents, Service Plan, Food Service, Dementia-Specific Education, Record Checks and Other.

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

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

A. Policies and Procedures

- Monitoring Observation: According to the Program's Incident and Accident Report policy, tenant, staff or visitor incidents or accidents were to be reported and documented immediately after they occurred. Incidents or accidents included but were not limited to: medication errors, staff or visitor injuries and tenant falls or injuries. All incidents and accidents were to be reported to the Director or registered nurse (RN) Coordinator. Incidents or accidents should be documented on the incident report form immediately following the occurrence. The person in charge at the time of the incident or accident shall prepare and sign the report. The incident report should include statements from all witnesses, if any. Any incident needed to be documented in tenant Progress Notes but not to refer to the incident report in the Progress Notes. Vital signs should be taken and documented on each incident report.

  Tenant #2, an 82 year old, was admitted on 7-8-13 and diagnoses included: Dementia and Behavioral Problems. Tenant #2 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit. Tenant #2 moved from the general population to the dementia unit on 9-19-13.

  Tenant #7, a 99 year old was admitted on 2-4-11 and diagnoses included: Dementia and Fever/Chills.

  According to an incident report dated 8-15-13 at 12:50 p.m., staff was clearing tables and heard some yelling. Staff saw Tenant #7 yelling at Tenant #2. While walking towards them staff saw Tenant #7 slap Tenant #2's lower arm area. Staff walked Tenant #2 to the dining room where they talked, had a drink and a cupcake. Tenant #7 was escorted away. There were two incident reports dated 8-15-13 at 12:50 p.m. regarding the incident between Tenant #2 and Tenant #7. Both incident reports listed both Tenant #2 and Tenant #7.

  There was documentation of the incident in Progress Notes for Tenant #2; however, there was no documentation of the incident in Tenant #7's Progress Notes as indicated in the policy. Vital signs were not recorded on the incident reports as indicated in the policy.

  Tenant #4, a 74 year old, was admitted on 8-26-13 and diagnoses included: Dementia, Hypertension (HTN), Attention Deficit Disorder, Hyperlipidemia, Cerebral Vascular Accident, Sleep Apnea and Depression. Tenant #4 scored a 17/30 on the Mini Mental Status Examination (MMSE) and 24-30 was indicated as "normal."

  Tenant #5, a 75 year old, was admitted on 5-17-12 and had a diagnosis of: Alzheimer's Disease. Tenant #5 was staged at a five on the GDS, which indicated moderately severe cognitive decline.

  According to an incident report, on 9-14-13 at 9:00 p.m. staff walked into the room to assist Tenant #4 with putting on a Continuous Positive Airway Pressure (CPAP) machine. When staff walked in Tenant #4 was laying fully nude on bed and Tenant

#5 was sitting on the edge of the bed, clothed with head bent down towards the groin of Tenant #4 and hand was on Tenant #4's genitalia. When Tenant #4 saw staff Tenant #4 told Tenant #5 staff was there. Staff asked Tenant #5 to stop and come with staff. Tenant #5 was escorted out of the room. Tenant #4 said he/she did not have sexual intercourse with Tenant #5.

There was no documentation in Progress Notes regarding the incident between Tenant #4 and Tenant #5 as indicated in the policy. Vital signs were not completed on the incident reports as indicated in the policy.

According to a Nurse Delegation Training-Acknowledgment of Participation form, staff understood that he/she was to contact the RN for medical emergencies as indicated by the RN.

Tenant #6 an 86 year old, was admitted on 5-9-13 and diagnoses included: Alzheimer's Disease, Diabetes Mellitus and Congestive Heart Failure. Tenant #6 was staged at a three on the GDS, which indicated mild cognitive decline. Tenant #6 was discharged on 9-12-13.

According to an incident report dated 9-11-13 at 12:45 a.m. Tenant #6 was found sitting inside the apartment doorway. Legs were out in front of Tenant #6. Tenant #6 was alert and denied hitting head. The RN was notified, vitals were taken and Active Range of Motion (AROM) was done with no complaints of pain. No bruising or redness was found. The doctor and family were notified. Vital signs were taken and were as follows: blood pressure 138/80, temperature 97.6, pulse 70 and respirations 20.

According to an incident report dated 9-11-13 at 10:10 p.m. while doing rounds staff entered Tenant #6's apartment and found Tenant #6 lying on the floor. Tenant #6 denied hitting head and moved lower extremity upon command. Vital signs were taken and were as follows: blood pressure 182/100, temperature 98.3, pulse 72 and respirations 24. The doctor and family were notified. According to the incident report, on 9-12-13 at 6:00 a.m. staff reported Tenant #6 had increased confusion. Night shift staff reported Tenant #6 had large emesis at approximately 2:00 a.m. on 9-12-13. Tenant #6's family was notified and said the family would transport to the hospital. Tenant #6 was too weak and Emergency Medical Services (EMS) was notified and transported to the hospital via ambulance.

Progress Notes dated 9-12-13 at 2:15 a.m. indicated Tenant #6 had a large emesis, was very lethargic and mumbling. Vital signs were as follows: blood pressure 200/122, pulse 70, respirations 20 and temperature 98.5. Progress Notes dated 9-12-13 at 6:00 a.m. indicated Tenant #6 was still very weak and not able to understand speech. There was no more emesis. Vital signs were as follows: blood pressure 148/82 and temperature 99.3. Progress notes dated 9-12-13 indicated Tenant #6's family was notified of fall and elevated blood pressure and confusion. The family was going to transport to hospital; however, upon the family arrival Tenant #6 was very lethargic and was unable to bear weight. EMS was called and Tenant #6 was transported to the hospital. According to Progress Notes dated 9-13-13, Tenant #6 was admitted to the hospital with a diagnosis of Pneumonia and received intravenous (IV) antibiotics. Progress Notes dated 9-16-13 at 1:00 p.m. indicated Tenant #6

would most likely go to skilled care for rehabilitation post hospitalization. Progress Notes dated 9-16-13 at 4:00 p.m. indicated Tenant #6 was diagnosed with a brain bleed and would be placed on in house hospice. Progress Notes dated 10-1-13 indicated a call was received from Tenant #6's family and Tenant #6 expired on 9-28-13.

The RN said vomiting after a fall was a change of condition and she would have expected to be notified. She was notified at 6:00 a.m.

Staff did not notify the RN when Tenant #6 had an emesis, elevated blood pressure, was lethargic and mumbling. Tenant #6 had fallen on 9-11-13 at 10:10 p.m. The RN was not notified per the Nurse Delegation Training-Acknowledgment of Participation form.

Review of tenant files, incident reports and Program policies indicated the incident report policy was not followed and staff did not notify the RN as needed.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2))

B. Evaluation

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7).

  Tenant #2's file was reviewed. Progress Notes indicated the following: On 7-9-13 Tenant #2 became tearful and wondered where Tenant #2's people were. On 7-10-13 it was documented Tenant #2 was up and wandered twice during the night. On 7-10-13 Tenant #2 became tearful when family brought Tenant #2 back from an appointment. On 7-21-13 Tenant #2 was found sitting the courtyard next to the bird bath and had scrapes on the right side of the back from the bird bath. On 7-29-13 Tenant #2 entered another tenant's apartment. A tenant ambulating in the hall stated that was not Tenant #2's apartment. Tenant #2 came towards the other tenant. The other tenant was standing in the hall with a visitor. The visitor put an arm out to protect the other tenant and Tenant #2 poked the visitor. Tenant #2 was escorted away from the situation by staff and at that time Tenant #2 hit the visitor on the buttocks. Tenant #2 was given one to one attention and redirections to an appropriate activity. On 8-15-13 staff was cleaning up tables and heard some yelling. Staff saw another tenant yelling at Tenant #2. While staff walked towards them staff saw the other tenant slap Tenant #2's lower arm area. Staff walked Tenant #2 to the dining room where they talked, had a drink and a cupcake. On 9-12-13 Tenant #2 was standing behind the couch while attempting to pull the cushion off and fell back onto the floor. On 9-13-13 Tenant #2 was walking around, anxious at times and bothering other tenants at times. On 9-18-13 it was noted Tenant #2 had experienced occasional diarrhea and occasional "sun downing" behaviors occurring two to four times per week at approximately 3:00 p.m. to 7:00 p.m. Tenant #2 became agitated,

had increased wandering and at times was uncooperative with direct cares. On 9-25-13 Tenant #2 was in another tenant's apartment, staff attempted to redirect to correct apartment and asked Tenant #2 if Tenant #2 was looking for a restroom. While walking back to Tenant #2's apartment Tenant #2 stated "I wanna die, I just want to die, I wanna die, I want to get out of here" and then began crying out Tenant #2's spouse's name. On 9-25-13 Tenant #2 entered another tenant's apartment while staff was helping the other tenant in the restroom and defecated on the carpet near the nightstand. On 10-1-13 Tenant #2 ambulated to the north exit door and pulled the fire alarm. All tenants were evacuated safely. Tenant #2 was easily distracted and redirected with music.

According to Staff Communication Log records, on 9-28-13 (day staff) Tenant #2 had a large bowel movement (BM) on the shower floor. On 9-29-13 (afternoon staff) Tenant #2 was into everything and screaming at the top of lungs for no reason. On 10-1-13 (day staff) Tenant #2 defecated on the floor of another tenant's apartment. On 10-1-13 (afternoon staff) Tenant #2 pulled the fire alarm. On 10-2-13 (afternoon staff) Tenant #2 was very upset before supper, agitated throwing items, said "I want to kill myself" and wanted to go home. Tenant #2 was very tired after supper.

A functional evaluation and service plan was completed when Tenant #2 moved to the dementia unit on 9-19-13. Health and cognitive evaluations were not completed at that time. Tenant #2 displayed wandering behavior, toileted in places other than the restroom, made comments about wanting to die or harm self and had "sun downing" behaviors occurring two to four times per week. Evaluations were not completed as needed.

Tenant #4's file was reviewed. Tenant #4's occupancy agreement was signed on 8-23-13. The cognitive evaluation was completed on 8-26-13 at 11:00 a.m., the health evaluation was completed on 8-26-13 at 3:30 p.m., the functional evaluation was completed on 8-26-13 at 6:15 p.m. and the service plan was completed on 8-26-13 at 6:22 p.m. According to Progress Notes dated 8-26-13 at 3:00 p.m. Tenant #4 arrived and was oriented to the apartment. The occupancy agreement was signed before the cognitive, health and functional evaluations were completed. There were no evaluations completed within 30 days of occupancy.

According to an incident report, on 9-14-13 at 9:00 p.m. staff walked into the room to assist Tenant #4 with putting on a CPAP machine. When staff walked in Tenant #4 was laying fully nude on bed and Tenant #5 was sitting on the edge of the bed, clothed with head bent down towards the groin of Tenant #4 and hand was on Tenant #4's genitalia. When Tenant #4 saw staff Tenant #4 told Tenant #5 staff was there. Staff asked Tenant #5 to stop and come with staff. Tenant #5 was escorted out of the room. Tenant #4 said Tenant #4 did not have sexual intercourse with Tenant #5.

Evaluations were not completed after the incident between Tenant #4 and Tenant #5. Evaluations were not completed prior to signing the occupancy agreement, within 30 days or as needed.

Tenant #5's file was reviewed. According to an incident report, on 9-14-13 at 9:00 p.m. staff walked into the room to assist Tenant #4 with putting on a CPAP machine. When staff walked in Tenant #4 was laying fully nude on bed and Tenant #5 was

sitting on the edge of the bed, clothed with head bent down towards the groin of Tenant #4 and hand was on Tenant #4's genitalia. When Tenant #4 saw staff Tenant #4 told Tenant #5 staff was there. Staff asked Tenant #5 to stop and come with staff. Tenant #5 was escorted out of the room. Tenant #4 said Tenant #4 did not have sexual intercourse with Tenant #5.

Evaluations were not completed related to the incident that occurred between Tenant #4 and Tenant #5. Evaluations were not completed as needed.

Tenant #6's file was reviewed. According to incident reports, Tenant #6 fell or was found on the floor 13 times from 7-4-13 to 9-11-13 and 10 of those incidents occurred from 8-8-13 to 9-11-13. According to incident reports Tenant #6 had two falls on 9-11-13.

According to an incident report dated 9-11-13 at 12:45 a.m. Tenant #6 was found sitting inside the apartment doorway. Legs were out in front of Tenant #6. Tenant #6 was alert and denied hitting head. The RN was notified, vitals were taken and AROM was done with no complaints of pain. No bruising or redness was found. The doctor and family were notified. Vital signs were taken and were as follows: blood pressure 138/80, temperature 97.6, pulse 70 and respirations 20.

According to an incident report dated 9-11-13 at 10:10 p.m. while doing rounds staff entered Tenant #6's apartment and found Tenant #6 lying on the floor. Tenant #6 denied hitting head and moved lower extremity upon command. Vital signs were taken and were as follows: blood pressure 182/100, temperature 98.3, pulse 72 and respirations 24. The doctor and family were notified. According to the incident report, on 9-12-13 at 6:00 a.m. staff reported Tenant #6 had increased confusion. Night shift staff reported Tenant #6 had large emesis at approximately 2:00 a.m. on 9-12-13. Tenant #6's family was notified and said the family would transport to the hospital. Tenant #6 was too weak and EMS was notified and transported to the hospital via ambulance.

Progress Notes dated 9-12-13 at 2:15 a.m. indicated Tenant #6 had a large emesis, was very lethargic and mumbling. Vital signs were as follows: blood pressure 200/122, pulse 70, respirations 20 and temperature 98.5. Progress Notes dated 9-12-13 at 6:00 a.m. indicated Tenant #6 was still very weak and not able to understand speech. There was no more emesis. Vital signs were as follows: blood pressure 148/82 and temperature 99.3. Progress notes dated 9-12-13 indicated Tenant #6's family was notified of fall and elevated blood pressure and confusion. The family was going to transport to hospital; however, upon the family arrival Tenant #6 was very lethargic, was unable to bear weight. EMS was called and Tenant #6 was transported to the hospital. According to Progress Notes dated 9-13-13, Tenant #6 was admitted to the hospital with a diagnosis of Pneumonia and received IV antibiotics. Progress Notes dated 9-16-13 at 1:00 p.m. indicated Tenant #6 would most likely go to skilled care for rehabilitation post hospitalization. Progress Notes dated 9-16-13 at 4:00 p.m. indicated Tenant #6 was diagnosed with a brain bleed and would be placed on in house hospice. Progress Notes dated 10-1-13 indicated a call was received from Tenant #6's family and Tenant #6 expired on 9-28-13.

Evaluations were last completed on 6-6-13 and were not completed as needed when Tenant #6 had falls.

Review of tenant files indicated evaluations were not completed prior to taking occupancy, within 30 days and as needed.

- Regulatory Insufficiency: A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. (IAC r. 481-69.22(1))

- 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 service 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))

C. Criteria for Admission and Retention

- Complaint/Incident Allegation #45320-C; #45462-C: It was alleged a tenant wandered into other tenant apartments. It was alleged a tenant urinated and defecated in inappropriate places.

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7). Staff interviews and review of tenant files indicated Tenant #2 had wandered into other tenant apartments and had urinated and defecated in inappropriate places.

  Tenant #2's file was reviewed. The Physician's Resident Admission form indicated Brief Summary of Status: Advanced Dementia. Tenant #2 scored a 3/30 on the MMSE on 7-3-13. Tenant #2 moved from the general population to the dementia unit on 9-19-13.

  Tenant #2's file was reviewed. Progress Notes indicated the following: On 7-9-13 Tenant #2 became tearful and wondered where Tenant #2's people were. On 7-10-13 it was documented Tenant #2 was up and wandered twice during the night. On 7-10-13 Tenant #2 became tearful when family brought Tenant #2 back from an appointment. On 7-21-13 Tenant #2 was found sitting the courtyard next to the bird

bath and had scrapes on the right side of the back from the bird bath. On 7-29-13 Tenant #2 entered another tenant's apartment. A tenant ambulating in the hall stated that was not Tenant #2's apartment. Tenant #2 came towards the other tenant. The other tenant was standing in the hall with a visitor. The visitor put an arm out to protect the other tenant and Tenant #2 poked the visitor. Tenant #2 was escorted away from the situation by staff and at that time Tenant #2 hit the visitor on the buttocks. Tenant #2 was given one to one attention and redirections to an appropriate activity. On 8-15-13 staff was cleaning up tables and heard some yelling. Staff saw another tenant yelling at Tenant #2. While staff walked towards them staff saw the other tenant slap Tenant #2's lower arm area. Staff walked Tenant #2 to the dining room where they talked, had a drink and a cupcake. On 9-12-13 Tenant #2 was standing behind the couch while attempting to pull the cushion off the couch Tenant #2 fell back onto the floor. On 9-13-13 Tenant #2 was walking around, anxious at times and bothering other tenants at times. On 9-18-13 it was noted Tenant #2 had experienced occasional diarrhea and Imodium AD one by mouth three times daily as needed was ordered. Tenant #2 had occasional "sun downing" behaviors occurring two to four times per week at approximately 3:00 p.m. to 7:00 p.m. Tenant #2 became agitated, had increased wandering and at times was uncooperative with direct cares. Progress Notes dated 9-18-13 indicated the doctor preferred not to order anything per family request as they stated Tenant #2 had experienced adverse reactions. On 9-25-13 Tenant #2 was in another tenant's apartment, staff attempted to redirect to correct apartment and asked Tenant #2 if Tenant #2 was looking for a restroom. While walking back to Tenant #2's apartment Tenant #2 stated "I wanna die, I just want to die, I wanna die, I want to get out of here" and then began crying out Tenant #2's spouse's name. On 9-25-13 Tenant #2 entered another tenant's apartment while staff was helping the other tenant in the restroom and defecated on the carpet near the nightstand. On 10-1-13 Tenant #2 ambulated to the north exit door and pulled the fire alarm. All tenants were evacuated safely. Tenant #2 was easily distracted and redirected with music.

According to Staff Communication Log records, on 9-28-13 (day staff) Tenant #2 had a large BM on the shower floor. On 9-29-13 (afternoon staff) Tenant #2 was into everything and screaming at the top of lungs for no reason. On 10-1-13 (day staff) Tenant #2 defecated on the floor of another tenant's apartment. On 10-1-13 (afternoon staff) Tenant #2 pulled the fire alarm. On 10-2-13 (afternoon staff) Tenant #2 was very upset before supper, agitated, throwing items, stated "I want to kill myself" and wanted to go home. Tenant #2 was very tired after supper.

Staff #1 said when Tenant #2 was in the general population Tenant #2 was going into other tenant apartments quite a bit. Tenant #2 was lost in the general population. Tenant #2 was still going into other tenant apartments but it had improved. She heard there were a couple of tenants upset that Tenant #2 was in their apartment and general unhappiness with Tenant #2 out there (general population). As an intervention staff provided one to one activity, walked with Tenant #2, listened to music and the interventions were effective. Tenant #2 urinated and defected in inappropriate places and there were several instances. It had improved since Tenant #2 moved to the dementia unit. There had been one time where Tenant #2 defecated in another tenant's apartment in the dementia unit. Tenant #2 was on a toileting program.

Staff #2 said Tenant #2 had wandered quite a bit in the general population and was lost. In the dementia unit Tenant #2 wandered but it was cut down a little. Staff redirected Tenant #2 to the birds and walks in the enclosed courtyard. Tenant #2 had urinated and defected in inappropriate places in the general population. She was not aware of any issues since Tenant #2 moved to the dementia unit. Staff kept an eye on Tenant #2 and took Tenant #2 to the bathroom.

Staff #3 said Tenant #2 was verbally aggressive, cursing and screaming at the top of Tenant #2's lungs. Tenant #2 had outbursts daily, mostly towards staff. Staff #3 wanted to get another tenant up and was trying to get Tenant #2 to leave the other tenant alone. Tenant #2 punched Staff #3 in the stomach. Tenant #2 wandered in both the general population and dementia unit. Tenant #2 wandered into other tenant apartments and would lay on other tenants' beds. Tenant #2 was easily redirected and staff took Tenant #2 to Tenant #2's apartment. In the general population Tenant #2 defecated and urinated in the time clock room and defecated in other tenant apartments. Tenant #2 also defecated in a tenant's apartment in the dementia unit. Tenant #2 urinated and defecated in Tenant #2's shower. Tenant #2 was toileted every hour and maintenance cleaned the carpets.

Staff #10 said Tenant #2 used to wander in the general population before moving to the dementia unit. Tenant #2 was easily redirected. Tenant #2 had a few instances of urinating or defecating in inappropriate places prior to moving to the dementia unit. Tenant #2 was toileted frequently. Staff #10 had not worked with Tenant #2 since Tenant #2 had moved to the dementia unit.

The RN said Tenant #2 wandered quite often while in the general population. In the dementia unit there were fewer apartments and Tenant #2 would occasionally wander. Tenant #2's behavior had improved. Tenant #2 was safer in the dementia unit and Tenant #2 enjoyed art and music. Tenant #2 toileting in other tenant apartments had subsided since the move to the dementia unit.

Tenant #2's service plan reflected Tenant #2 would attempt to enter the wrong apartment and staff was to speak to Tenant #2 and show Tenant #2 the apartment. Tenant #2 would at times attempt to toilet in a place that was not a restroom. Although Staff provides frequent toileting, Tenant #2 did not exceed criteria for retention.

- Regulatory Insufficiency: None noted.

D. Tenant Documents

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7).

  According to the Program's Incident and Accident Report policy, tenant, staff or visitor incidents or accidents were to be reported and documented immediately after they occurred. Incidents or accidents included but were not limited to: medication errors, staff or visitor injuries and tenant falls or injuries. All incidents and accidents

were to be reported to the Director or RN Coordinator. Incidents or accidents should be documented on the incident report form immediately following the occurrence. The person in charge at the time of the incident or accident shall prepare and sign the report. The incident report should include statements from all witnesses, if any. Any incident needed to be documented in tenant Progress Notes but not to refer to the incident report in the Progress Notes. Vital signs should be taken and documented on each incident report.

Tenant #1, a 77 year old, was admitted on 4-18-13 and diagnoses included: Traumatic Brain Injury, HTN, Influenza, Deep Venous Thrombosis, Dementia, Gastro Esophageal Reflux Disease and Chronic Pain. Progress Notes dated 8-31-13 indicated Tenant #1 was sent to the hospital (psych) by spouse by ambulance at 4:00 p.m. The RN indicated Tenant #1 had inappropriate sexual behaviors towards private caregivers. Tenant #1 was hospitalized from 8-31-13 to 9-23-13. Progress Notes dated 9-23-13 indicated Tenant #1 was admitted to the hospital with inappropriate sexual behavior, groping and verbally inappropriate sexual statements especially to caregivers. High dose Depakote treatment was attempted that resulted in Hyperammonemia and was doing better with Zyprexa. An incident report was not completed regarding incidents of Tenant #1's behavior.

Tenant #3, a 74 year old, was admitted on 6-3-10 and diagnoses included: Bipolar, Osteoarthritis, Hypothyroidism and Chest Pain. Tenant #3 was staged at a four on the GDS, which indicated moderate cognitive decline.

According to Progress Notes dated 7-29-13, Tenant #3's hair needed to be combed, Tenant #3 was anxious and talking about visitors arriving tomorrow. Tenant #3 asked when Tenant #3's mind would settle down. Tenant #3 did not recall events or statements of 7-28-13 made to a licensed practical nurse (LPN) "What do I have to do break a window et slash my wrist." There was no entry in the Progress Notes or incident report found regarding the events/statement on 7-28-13. Progress Notes dated 7-30-13 indicated Tenant #3 was very anxious, tearful and stated "Why am I so full of hatred, all this poison building up inside of me, what am I going to do?" A whirlpool bath was encouraged for relaxation. Staff was with Tenant #3 in the whirlpool and Tenant #3 stated "want to stab myself in the heart, God needs to just take me." All sharp objects were removed from the apartment. Calls were placed to doctors and one of the doctors recommended hospitalization. Family was made aware and family transported Tenant #3 to an emergency room (ER) for evaluation. On 8-9-13 a call was placed to staff at the hospital as it was reported Program staff received a phone call from Tenant #3, who stated "all I want is to just die." Tenant #3 returned to the Program on 8-9-13. Incident reports were not completed related to the incidents of Tenant #3's suicidal ideations.

Review of tenant files and incident reports indicated incident reports were not completed.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: Incidents reports involving the tenant, including but not limited to those related to medication errors, accidents falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record). (IAC r. 481-69.25(1)(o))

E. Service Plans

- Monitoring Observation: Seven tenant files were reviewed (Tenants #1, #2, #3, #4, #5, #6 and #7).

  Tenant #1's file was reviewed. According to a Physician Visits note dated 10-1-13, the reason for the visit was fatigue and edema (lower legs) and the summary indicated Tenant #1 had 2 to 3 + edema (pitting) lower legs. Anti-embolism hose were discontinued and physical therapy (PT), evaluate and treat was ordered. The service plan did not reflect the discontinuation of the anti-embolism hose and order for PT. The service plan did not reflect the needs of Tenant #1.

  Tenant #2's file was reviewed. Tenant #2 moved in on 7-8-13. The service plan was completed on 7-9-13, after Tenant #2 took occupancy.

  Progress Notes indicated the following: On 7-9-13 Tenant #2 became tearful and wondered where Tenant #2's people were. On 7-10-13 it was documented Tenant #2 was up and wandered twice during the night. On 7-10-13 Tenant #2 became tearful when family brought Tenant #2 back from an appointment. On 7-21-13 Tenant #2 was found sitting the courtyard next to the bird bath and had scrapes on the right side of the back from the bird bath. On 7-29-13 Tenant #2 entered another tenant's apartment. A tenant ambulating in the hall stated that was not Tenant #2's apartment. Tenant #2 came towards the other tenant. The other tenant was standing in the hall with a visitor. The visitor put an arm out to protect the other tenant and Tenant #2 poked the visitor. Tenant #2 was escorted away from the situation by staff and at that time Tenant #2 hit the visitor on the buttocks. Tenant #2 was given one to one attention and redirections to an appropriate activity. On 8-15-13 staff was cleaning up tables and heard some yelling. Staff saw another tenant yelling at Tenant #2. While staff walked towards them staff saw the other tenant slap Tenant #2's lower arm area. Staff walked Tenant #2 to the dining room where they talked, had a drink and a cupcake. On 9-12-13 Tenant #2 was standing behind the couch while attempting to pull the cushion off the couch Tenant #2 fell back onto the floor. On 9-13-13 Tenant #2 was walking around, anxious at times and bothering other tenants at times. On 9-18-13 it was noted Tenant #2 had experienced occasional diarrhea and occasional "sun downing" behaviors occurring two to four times per week at approximately 3:00 p.m. to 7:00 p.m. Tenant #2 became agitated, had increased wandering and at times was uncooperative with direct cares. On 9-25-13 Tenant #2 was in another tenant's apartment, staff attempted to redirect to correct apartment and asked Tenant #2 if Tenant #2 was looking for a restroom. While walking back to Tenant #2's apartment Tenant #2 stated "I wanna die, I just want to die, I wanna die, I want to get out of here" and then began crying out Tenant #2's spouse's name. On 9-25-13 Tenant #2 entered another tenant's apartment while staff was helping the other tenant in the restroom and defecated on the carpet near the nightstand. On 10-1-13 Tenant #2 ambulated to the north exit door and pulled the fire alarm. All tenants were evacuated safely. Tenant #2 was easily distracted and redirected with music.

  According to Staff Communication Log records, on 9-28-13 (day staff) Tenant #2 had a large BM on the shower floor. On 9-29-13 (afternoon staff) Tenant #2 was into everything and screaming at the top of lungs for no reason. On 10-1-13 (day staff)

Tenant #2 defecated on the floor of another tenant's apartment. On 10-1-13 (afternoon staff) Tenant #2 pulled the fire alarm. On 10-2-13 (afternoon staff) Tenant #2 was very upset before supper, agitated throwing items, said "I want to kill myself" and wanted to go home. Tenant #2 was very tired after supper.

A functional evaluation and service plan was completed when Tenant #2 moved to the dementia unit. Health and cognitive evaluations were not completed at that time. Tenant #2 displayed wandering behavior, toileted in places other than the restroom, made comments about wanting to die or harm self and had "sun downing" behaviors occurring two to four times per week. The service plan dated 9-19-13 was not based on cognitive and health evaluations.

The service plan developed on 9-19-13 indicated Tenant #2 would attempt to enter the wrong apartment and staff would speak to Tenant #2 and show Tenant #2 the correct apartment. Tenant #2 would at times attempt to toilet in a place that was not a restroom and staff was to provide frequent toileting. The service plan did not address the verbal behavior and comments regarding wanting to harm self and interventions related to that behavior.

The service plan was not developed prior to signing the occupancy agreement, was not based on evaluations and did not reflect the identified needs of Tenant #2.

Tenant #3's file was reviewed. According to Progress Notes dated 7-29-13, Tenant #3's hair needed to be combed, Tenant #3 was anxious and talking about visitors arriving tomorrow. Tenant #3 asked when Tenant #3's mind would settle down. Tenant #3 did not recall events or statements of 7-28-13 made to a LPN "What do I have to do break a window et slash my wrist." There was no entry in the Progress Notes or incident report found regarding the events/statement on 7-28-13. Progress Notes dated 7-30-13 indicated Tenant #3 was very anxious, tearful and stated "Why am I so full of hatred, all this poison building up inside of me, what am I going to do?" A whirlpool bath was encouraged for relaxation. Staff was with Tenant #3 in the whirlpool and Tenant #3 stated "want to stab myself in the heart, God needs to just take me." All sharp objects were removed from the apartment. Calls were placed to doctors and one of the doctors recommended hospitalization. Family was made aware and family transported Tenant #3 to an ER for evaluation. On 8-9-13 a call was placed to staff at the hospital as it was reported Program staff received a phone call from Tenant #3, who stated "all I want is to just die." Tenant #3 returned to the Program on 8-9-13. Evaluations were completed on 8-9-13 and the service plan was completed on 8-9-13. The service plan did not reflect the suicidal ideations and interventions related to the behavior. The service plan did not reflect the identified needs of Tenant #3.

Tenant #4's file was reviewed. Tenant #4's occupancy agreement was signed on 8-23-13. The cognitive evaluation was completed on 8-26-13 at 11:00 a.m., the health evaluation was completed on 8-26-13 at 3:30 p.m., the functional evaluation was completed on 8-26-13 at 6:15 p.m. and the service plan was completed on 8-26-13 at 6:22 p.m. According to Progress Notes dated 8-26-13 at 3:00 p.m. Tenant #4 arrived and was oriented to the apartment. The occupancy agreement was signed and Tenant #4 was oriented to the apartment before the service plan was developed. A service plan was not developed within 30 days of taking occupancy.

According to an incident report, on 9-14-13 at 9:00 p.m. staff walked into the room to assist Tenant #4 with putting on a CPAP machine. When staff walked in Tenant #4 was laying fully nude on bed and Tenant #5 was sitting on the edge of the bed, clothed with head bent down towards the groin of Tenant #4 and hand was on Tenant #4's genitalia. When Tenant #4 saw staff Tenant #4 told Tenant #5 staff was there. Staff asked Tenant #5 to stop and come with staff. Tenant #5 was escorted out of the room. Tenant #4 said Tenant #4 did not have sexual intercourse with Tenant #5. The service plan was not updated as needed after the incident between Tenant #4 and Tenant #5 and did not reflect interventions related to the behavior.

Staff Communication Log documents indicated on 9-28-13 Tenant #4 turned on all water faucets in rooms. The documents indicated on 9-29-13 Tenant #4 was very busy, into everything and turned on the water again. The service plan did not reflect the behavior and interventions related to the behavior.

The service plan was not developed prior to taking occupancy, within 30 days, as needed and did not reflect the identified needs of Tenant #4.

Tenant #5's file was reviewed. According to an incident report, on 9-14-13 at 9:00 p.m. staff walked into the room to assist Tenant #4 with putting on a CPAP machine. When staff walked in Tenant #4 was laying fully nude on bed and Tenant #5 was sitting on the edge of the bed, clothed with head bent down towards the groin of Tenant #4 and hand was on Tenant #4's genitalia. When Tenant #4 saw staff Tenant #4 told Tenant #5 staff was there. Staff asked Tenant #5 to stop and come with staff. Tenant #5 was escorted out of the room. Tenant #4 said Tenant #4 did not have sexual intercourse with Tenant #5. The service plan was not updated as needed after the incident between Tenant #4 and Tenant #5 and did not reflect interventions related to the behavior.

According to Staff Communication Log documents, on 9-29-13 (night staff) a BM ball was removed from the refrigerator and the room had an odor. On 9-30-13 (day staff) Tenant #5 had a shower at 6:30 a.m. and was incontinent of BM and soiled night clothes. The service plan reflected staff would provide Tenant #5 with assistance with toileting including reminders throughout the day to use the restroom and assistance with changing incontinence undergarments. Staff would provide assistance as needed. The service plan did not reflect the identified needs of Tenant #5 regarding toileting.

The service plan was not updated as needed and did not reflect the identified needs of Tenant #5.

Tenant #6's file was reviewed. According to incident reports, Tenant #6 fell or was found on the floor 13 times from 7-4-13 to 9-11-13 and 10 of those incidents occurred from 8-8-13 to 9-11-13. According to incident reports Tenant #6 had two falls on 9-11-13.

According to an incident report dated 9-11-13 at 12:45 a.m. Tenant #6 was found sitting inside the apartment doorway. Legs were out in front of Tenant #6. Tenant #6 was alert and denied hitting head. The RN was notified, vitals were taken and

AROM was done with no complaints of pain. No bruising or redness was found. The doctor and family were notified. Vital signs were taken and were as follows: blood pressure 138/80, temperature 97.6, pulse 70 and respirations 20.

According to an incident report dated 9-11-13 at 10:10 p.m. while doing rounds staff entered Tenant #6's apartment and found Tenant #6 lying on the floor. Tenant #6 denied hitting head and moved lower extremity upon command. Vital signs were taken and were as follows: blood pressure 182/100, temperature 98.3, pulse 72 and respirations 24. The doctor and family were notified. According to the incident report, on 9-12-13 at 6:00 a.m. staff reported Tenant #6 had increased confusion. Night shift staff reported Tenant #6 had large emesis at approximately 2:00 a.m. on 9-12-13. Tenant #6's family was notified and said the family would transport to the hospital. Tenant #6 was too weak and EMS was notified and transported to the hospital via ambulance.

Progress Notes dated 9-12-13 at 2:15 a.m. indicated Tenant #6 had a large emesis, was very lethargic and mumbling. Vital signs were as follows: blood pressure 200/122, pulse 70, respirations 20 and temperature 98.5. Progress Notes dated 9-12-13 at 6:00 a.m. indicated Tenant #6 was still very weak and not able to understand speech. There was no more emesis. Vital signs were as follows: blood pressure 148/82 and temperature 99.3. Progress notes dated 9-12-13 indicated Tenant #6's family was notified of fall and elevated blood pressure and confusion. The family was going to transport to hospital; however, upon the family arrival Tenant #6 was very lethargic and was unable to bear weight. EMS was called and Tenant #6 was transported to the hospital. According to Progress Notes dated 9-13-13, Tenant #6 was admitted to the hospital with a diagnosis of Pneumonia and received IV antibiotics. Progress Notes dated 9-16-13 at 1:00 p.m. indicated Tenant #6 would most likely go to skilled care for rehabilitation post hospitalization. Progress Notes dated 9-16-13 at 4:00 p.m. indicated Tenant #6 was diagnosed with a brain bleed and would be placed on in house hospice. Progress Notes dated 10-1-13 indicated a call was received from Tenant #6's family and Tenant #6 expired on 9-28-13.

Tenant #6's service was developed on 6-6-13 and was updated on 7-15-13 and reflected PT was discontinued. The service plan reflected Tenant #6 used a walker for ambulation and staff provided escorts to and from activities and meals until Tenant #6 was acclimated to surroundings. The service plan was not updated as needed with Tenant #6's falls and interventions related to the falls. The service plan was not updated as needed and did not reflect the identified needs of Tenant #6.

Review of tenant files indicated service plans were not developed prior to signing the occupancy agreement, within 30 days and as needed. Service plans were not based on evaluations and did not reflect the identified needs of tenants.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in the accordance with subrules 69.22(1) and 69.22(2) and shall be designated 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: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

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

F. Food Service

- Monitoring Observation: Seven staff files were reviewed (Staff #2, #4, #5, #6, #7, #8 and #9).

  Staff #2 was hired on 3-18-09 and was a CMA. Staff #2's most recent food safety training was on 10-14-11. Staff #2 did not have an annual in-service training on food protection.

  Staff #4 was hired on 9-17-13 and was a CMA. Staff #4 did not have an orientation on sanitation and safe food handling prior to handling food.

  Staff #5 was hired on 9-16-13 and was a CNA. Staff #5 did not have an orientation on sanitation and safe food handling prior to handling food.

  Staff #6 was hired on 5-14-13 and was a CNA. Staff #6 did not have an orientation on sanitation and safe food handling prior to handling food.

  Staff #7 was hired on 7-23-13 and was a CMA. Staff #7 did not have an orientation on sanitation and safe food handling prior to handling food.

  Staff #8 was hired on 6-6-13 and was a CNA. Staff #8 did not have an orientation on sanitation and safe food handling prior to handling food.

  Staff #9 was hired on 6-5-13 and was a CNA. Staff #9 did not have an orientation on sanitation and safe food handling prior to handling food.

  Review of staff files indicated Staff #4, #5, #6, #7, #8 and #9 did not have an orientation on sanitation and safe food handling prior to handling food and Staff #2 did not have an in-service on food protection annually.

- Regulatory Insufficiency: Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food

preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (IAC r. 481-69.28(5))

G. Dementia-Specific Education

- Monitoring Observation: Seven staff files were reviewed (Staff #2, #4, #5, #6, #7, #8 and #9).

  The Program consisted of a general population that was dementia specific by definition and a dementia unit that was dementia specific by dedication.

  Staff #2 was hired on 3-18-09 and was a CMA. Staff #2 had 10 hours of dementia training completed on 6-26-12. Staff #2 did not have eight hours of dementia-specific training completed annually.

  Staff #6 was hired on 5-14-13 and was a CNA. Staff #6 had 10 hours of dementia training completed on 8-21-13; however, it was not completed within 30 days of employment.

  Staff #7 was hired on 7-23-13 and was a CMA. Dementia training was not found for Staff #7. Eight hours of dementia-specific training was not completed within 30 days of employment.

  Staff #8 was hired on 6-6-13 and was a CNA. Dementia training was not found for Staff #8. Eight hours of dementia-specific training was not completed within 30 days of employment.

  Staff #9 was hired on 6-5-13 and was a CNA. Dementia training was not found for Staff #9. Eight hours of dementia-specific training was not completed within 30 days of employment.

  Review of staff files indicated Staff #6, #7, #8 and #9 did not have eight hours of dementia-specific training completed within 30 days of employment. Staff #2 did not have dementia-specific training completed annually. Staff did not dementia-specific training within 30 days of employment and annually.

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

- Regulatory Insufficiency: All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. (IAC r. 481-69.30(3))

H. Record Checks

- Monitoring Observation: Seven staff files were reviewed (Staff #2, #4, #5, #6, #7, #8 and #9).

  Staff #6 was hired on 5-14-13 and was a CNA. A criminal history background check and child and dependent adult abuse record checks were completed on 10-2-13. The criminal history background check indicated further research was required.

  Staff #7 was hired on 7-23-13 and was a CMA. A criminal history background check and child and dependent adult abuse record checks were completed on 10-2-13. The criminal history background check indicated further research was required.

  Staff #8 was hired on 6-6-13 and was a CNA. A criminal history background check and child and dependent adult abuse record checks were completed on 10-2-13. There was no further research indicated.

  Staff #9 was hired on 6-5-13 and was a CNA. A criminal history background check and child and dependent adult abuse record checks were completed on 10-2-13. There was no further research indicated.

  The Divisional Director of Operations indicated that during the recertification visit it was realized that some employee background checks had not been completed by the former Director. Upon realizing the background checks had not been completed they were immediately completed. The employee files completed earlier in the recertification period prior to the former Director were audited and were completed. All background checks had been run on time for all employees hired since the former Director's termination.

  Review of staff files indicated Staff #6, #7, #8 and #9 did not have criminal history background checks and child and dependent adult abuse checks completed prior to employment. The criminal history background checks for Staff #6 and Staff #7 indicated further research was required.

- Regulatory Insufficiency: Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and department adult abuse record checks of the person in this state. (IAC r. 481-67.19(3))

I. Other

- Monitoring Observation: Seven staff files were reviewed (Staff #2, #4, #5, #6, #7, #8 and #9).

  Staff #4, #5, #7, #8 and #9 did not have mandatory abuse training; however, were within six months of hire. Staff #6 was hired on 5-14-13 and had a Certificate of Completion dated 4-21-11. The activity was Mandatory Reporter: Child and Dependent Adult Abuse and credits were two contact hours. Staff #6 had a combined two hour child and dependent adult abuse course; however, was within six months of hire to complete the required training.

Staff #2 was hired on 3-18-09 and had a Certificate of Completion dated 10-18-11. The activity was Mandatory Reporter: Child and Dependent Adult Abuse and credits were two contact hours. Staff #2 had a combined two hour child and dependent adult abuse course. Staff #2 did not have a mandatory abuse course with two hours dedicated to dependent adult abuse.

Review of staff files indicated Staff #2 did not have the required hours of mandatory dependent adult abuse training.

- Regulatory Insufficiency: A person required to report cases of dependent adult abuse pursuant to section 235B.3, other than a physician whose professional practice does not regularly involve providing primary health care to adults, shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment or self-employment which involved the examination, attending, counseling, or treatment of adults on a regular basis. Within one month of initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person's employer, or if self-employed, from the department. The person shall complete at least two hours of additional dependent adult abuse identification and reporting every five years. (235B.16.5.b))